

The meeting of the Board of Directors held in public will take place on
Wednesday 26 September 2018
Boardroom, Harrogate District Hospital, HG2 7SX

AGENDA			
Item No.	Item	Lead	Paper No.
9.00am – 9.20am			
Patient Story			
9.20am – 10.30am			
1.0	Welcome and Apologies for Absence <i>To receive any apologies for absence:</i>	Mrs A Schofield, 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 A Schofield, Chairman	2.0
3.0	Minutes of the Board of Directors meeting held on 25 July 2018 <i>To review and approve the minutes</i>	Mrs A Schofield, Chairman	3.0
4.0	Review Action Log and Matters Arising <i>To provide updates on progress of actions</i>	Mrs A Schofield, Chairman	4.0
Overview by the Chairman		Mrs A Schofield, Chairman	-
5.0	Report by the Chief Executive incl IBR	Dr R Tolcher, Chief Executive	5.0
To deliver high quality health care			
6.0	6.0 Patient and Public Participation Framework for development – <i>for approval</i>	Mrs J Foster, Chief Nurse	6.0
	6.1 Workforce Race Equality Standard (WRES) report – <i>for approval</i>	Mrs J Harrison, Interim Director of Workforce and Organisational Development	6.1
	6.2 HEE Education and Training Self-Assessment – <i>for approval</i>	Mrs J Harrison, Interim Director of Workforce and Organisational Development	6.2
	6.3 Flu Vaccination Action Plan – <i>for scrutiny/comment</i>	Mrs J Harrison, Interim Director of Workforce and Organisational Development	6.3
	6.4 Freedom to Speak Up Guardian Report – <i>for scrutiny/comment</i>	Mrs J Foster, Chief Nurse Dr S Wood, Freedom to Speak Up Guardian	6.4

	6.5 Summary from Quality Committee (written and oral) 6.6 Consideration of IBR metrics relating to quality	Mrs L Webster Chairman of the Quality Committee	6.5
To work with partners to deliver integrated care			
7.0	7.0 WY&H HHCP MOU – <i>for approval</i> 7.1 Updates on partnership working: WY&H ICS, WYAAT 7.2 Consideration of IBR metrics relating to integrated care	Dr R Tolcher, Chief Executive	7.0
10.30am – 10.40am			
Break			
10.40am – 12.30pm			
To ensure clinical and financial sustainability			
8.0	8.0 Summary from Finance Committee (written and oral) 8.1 Terms of Reference of Resources Committee – <i>for approval</i> 8.2 Transformation and Improvement Strategy bi-annual report – <i>for scrutiny/comment</i> 8.3 Operational Plan – <i>for scrutiny/comment</i> 8.4 Summary of relevant workforce metrics (cost, WTE plan vs actual etc) 8.5 Consideration of IBR metrics related to financial performance and contracts	Mrs M Taylor, Chairman of Finance Committee Mrs M Taylor, Chairman of Finance Committee Mrs J Harrison, Interim Director of Workforce and Organisational Development Mr J Coulter, Director of Finance/Deputy Chief Executive	8.0 8.1 8.2 8.3
Governance			
9.0	9.0 Medical Revalidation Annual Statement of Compliance – <i>for approval</i> 9.1 Non-Executive Director responsibilities – <i>for approval</i> 9.2 Council of Governors' Meeting Minutes – 2 May 2018 9.3 Summary from Audit Committee	Dr D Scullion, Medical Director Mrs A Schofield, Chairman Mrs A Schofield, Chairman Mr C Thompson, Chairman of Audit Committee	9.0 9.1 9.2 9.3
10.0	Any other relevant business <i>By permission of the Chairman</i>	Mrs A Schofield, Chairman	-
	Board Evaluation	Mrs A Schofield, 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>			



Harrogate and District
NHS Foundation Trust

BOARD OF DIRECTORS – REGISTERED DECLARED INTERESTS

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

The register is maintained by the Company Secretary and was last updated in September 2018.

Name	Position	Interests Declared
Mr Andrew Alldred	Clinical Director LTUC	None
Mr Jonathan Coulter	Deputy Chief Executive/ Finance Director	Director of Harrogate Healthcare Facilities Management Limited (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Mrs Jill Foster	Chief Nurse	None
Mr Robert Harrison	Chief Operating Officer	1. Appointed Voluntary Member of the Strategy and Resources Committee of the Methodist Church 2. Charity Trustee of Acomb Methodist Church, York
Dr Kat Johnson	Clinical Director PSC	None
Dr Natalie Lyth	Clinical Director CCCC	None
Mrs Joanne Harrison	Interim Director of Workforce and Organisational Development	None
Ms Laura Robson	Non-Executive Director	None
Mrs Angela Schofield	Chairman	1. Volunteer with Supporting Older People (charity).
Dr David Scullion	Medical Director	1. Member of the Yorkshire Radiology Group
Mr Richard Stiff	Non-Executive Director	1. Director of (and 50% owner) Richard Stiff Consulting Limited 2. Director of NCER CIC 3. Director and Trustee of TCV (The Conservation Volunteers) 4. Governor of Selby College

You matter most

Mrs Maureen Taylor	Non-Executive Director	None
Mr Christopher Thompson	Non-Executive Director	<ol style="list-style-type: none"> 1. Director of Harrogate Healthcare Facilities Management Limited (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust) 2. Director – Neville Holt Opera 3. Member – Council of the University of York 4. Chair – Audit Yorkshire Consortium
Dr Ros Tolcher	Chief Executive	<ol style="list-style-type: none"> 1. Specialist Adviser to the Care Quality Commission 2. Member of NHS Employers Policy Board (Vice Chair). 3. Harrogate Ambassador on behalf of Harrogate Convention Centre
Mr Ian Ward	Non-Executive Director	<ol style="list-style-type: none"> 1. Non-Executive Director of : <ul style="list-style-type: none"> • Charter Court Financial Services Limited, • Charter Court Financial Services Group Limited, • Exact Mortgage Experts Limited, • Broadlands Finance Limited • Charter Mortgages Limited. <p>In respect of the five companies above, Mr Ward is Chairman of the Remuneration Committee and Chairman of the Nominations Committee. Also, for each of them, he is a member of the Board Risk and Audit Committees.</p> 2. Non-Executive Director of Newcastle Building Society and a member of the Group Risk Committee. Also, he is Chairman of its subsidiary companies, Newcastle Systems Management Limited and Newcastle Financial Advisers Limited. 3. Member, Leeds Kirkgate Market Management Board
Mrs Lesley Webster	Non-Executive Director	None
Deputy Directors		
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
Mr Jordan McKie	Deputy Director of Finance	1. Familial relationship with NMU Ltd, a company providing services to the NHS
Mrs Alison Mayfield	Deputy Chief Nurse	None
Mr Paul Nicholas	Deputy Director of Performance and Informatics	None



Report Status: Open

BOARD OF DIRECTORS MEETING

Minutes of the Board of Directors' meeting held in public on
Wednesday 25 July 2018 at 9.00am in the Boardroom at Harrogate General Hospital

Present: Mr Jonathan Coulter, Deputy Chief Executive/Finance Director
Mr Robert Harrison, Chief Operating Officer
Mr Phillip Marshall, Director of Workforce and Organisational
Development
Ms Laura Robson, Non-Executive Director
Mrs Angela Schofield, Chairman
Dr David Scullion, Medical Director
Mrs Maureen Taylor, Non-Executive Director
Mr Chris Thompson, Non-Executive Director/Vice Chairman
Dr Ros Tolcher, Chief Executive
Mrs Lesley Webster, Non-Executive Director

In attendance: Mr Andrew Alldred, Clinical Director, Long Term and Unscheduled Care
Mr Andrew Forsyth, Interim Company Secretary
Dr Jenny Child, Director of Infection Prevention and Control
Dr Claire Hall, Deputy Medical Director
Dr Kat Johnson, Clinical Director, Planned and Surgical Care
Dr Natalie Lyth, Clinical Director, Children's and County Wide Community
Services
Mrs Alison Mayfield, Deputy Chief Nurse
Dr Matt Shepherd, ED Consultant (patient story only)
Mrs Katherine Roberts, Company Secretary (minutes)
Mr H (patient story only)

Patient Story

Mrs Schofield welcomed Mr H and Dr Shepherd to the meeting.

Mr H described his experience of accessing services at Harrogate District Hospital when he experienced back pain in May 2017. Mr H's GP had been concerned and referred Mr H to the hospital's Accident and Emergency Department. Over a number of weeks Mr H attended the hospital on multiple occasions and described symptoms which should have indicated a condition called Cauda Equina Syndrome (CES). There was a delay in Mr H seeing a Consultant and in providing an MRI scan. Once a scan was provided CES was diagnosed and Mr H was transferred to Leeds Teaching Hospitals Trust for urgent treatment.

Mr H said he had almost fully recovered following treatment for CES. He confirmed that the complaint he raised with the Trust following his treatment had been dealt with well; a swift and thorough response had been provided.

Dr Shepherd provided details of the changes made as a result of Mr H's complaint. These included a new single pathway for which the Emergency Department assumed responsibility, refreshed guidelines for the time in which MRI scans should be completed and updated patient information leaflets.

Dr Tolcher thanked Mr H for sharing his experience and Dr Shepherd for outlining the positive learning which had been implemented as a result. She said she took confidence from Mr H's reassurance about the level of response he had received.

Dr Scullion apologised to Mr H for his experience of treatment at Harrogate District Hospital. He noted that Mr H's experience highlighted the importance of senior clinicians having the right conversation at the right time and the importance of an early scan as soon as potential Cauda Equina Syndrome symptoms are identified.

Mr H and Dr Shepherd left the meeting.

Mr Harrison expressed concern about the apparent issue with Consultants not taking ownership for Mr H's care; this was a professional and cultural issue. It was noted that the Trust did not provide spinal surgery.

ACTION: Dr Johnson to discuss pathways for referral of back pain patients to specialist centres with Dr Shepherd.

ACTION: Mr Alldred to confirm that a written protocol is in place to ensure that any patient who re-attends the Emergency Department with repeated symptoms should be seen by a senior clinician.

1.0 Welcome and Apologies for Absence

1.1 Mrs Schofield noted there were three apologies for absence from Mrs Jill Foster, Chief Nurse, Mr Richard Stiff, Non-Executive Director and Mr Ian Ward, Non-Executive Director.

1.2 It was confirmed a quorum was present at the meeting.

1.3 Mrs Schofield welcomed observers to the meeting; Mr Robert Cowans (Public Governor), Mrs Sheila Fisher (Public Governor) and Mr Paul Widdowfield (Communications & Marketing Manager).

2.0 Declarations of Interest and Board Register of Interests

2.1 No declarations of interest were received. All Directors confirmed that they had no direct or indirect interest in any item on the agenda which they were required to disclose to the meeting.

2.2 It was noted Mr Coulter and Mr Thompson were Directors of Harrogate Healthcare Facilities Management (HHFM). No agenda items were planned which would present a conflict of interest. It was however agreed that Mr Coulter and Mr Thompson could participate fully in any items which included reference to HHFM.

3.0 Minutes of the meetings of the Board of Directors on 27 June 2018

The draft minutes of the meeting held on 27 June 2018 were approved with the following amendments:

- Minute 10.12 should read; *“Following a question from Ms Robson, Mr Harrison confirmed that the SDS plus model would contribute ten beds to the NHS Improvement challenge.”*
- Minute 10.13 should read; *“Dr Scullion noted that clinicians may express concern about introducing differential waiting lists for patients.”*
- Minute 10.19 should read; *“All members of the Board confirmed their support and approval for the Supported Discharge Service Business Case and associated costs of (£707k).”*
- Minute 13.2 should read; *“Dr Scullion highlighted re-certification of JAG accreditation for the Trust.”*
- The action at minute 14.6 should be removed from the minutes.

APPROVED:

The Board of Directors approved the minutes of the meeting held on 27 June 2018 as an accurate record of proceedings subject to five amendments.

4.0 Review of Action Log and Matters Arising

4.1 Completed actions were noted.

4.2 Action 99; Mr Harrison confirmed his team had prepared a separate GDPR privacy statement for children and young people, this had been shared with the Youth Forum for comment and would be published in mid-August 2018. It was agreed this action was closed.

4.3 Action 103; Mr Marshall confirmed that in accordance with the Health and Social Care Act all Non-Executive Directors, Executive Directors and Clinical Directors completed Fit and Proper Person Tests. It was not recommended that this was extended to Operational Directors because they did not regularly attend meetings of the Board. This position was agreed by the Board. It was agreed this action was closed.

4.4 Action 105; Dr Johnson confirmed work was ongoing to mitigate the impact of Consultant holidays during August 2018. Mr Harrison noted 136 fewer patient slots had been planned during August 2018, this was reflected in current run rates, and was aligned to capacity plans. The Operational Director for Planned and Surgical Care was completing work to ensure theatre capacity was maximised. Dr Tolcher sought further assurance that activity planned during August 2018 would be delivered. Furthermore she sought assurance that paired consultant specialists would not be absent at the same time leaving specialist gaps. It was agreed this action was closed.

ACTION: Dr Johnson and Dr Tolcher to discuss the matter further following the Board meeting.

4.5 There were no other matters arising.

APPROVED:

The Board of Directors noted completed actions and received an update on actions

and agreed to close actions 99, 103 and 105.

Overview by the Chairman

Mrs Schofield noted a number of items:

- The NHS 70 celebrations had been very successful. She expressed the Board's thanks to Mr Widdowfield and highlighted the positive media coverage the Trust had received.
- The staff long service awards had celebrated staff employed within the NHS for 25, 35 and 45 years.
- Long service awards had been issued to the Trust's volunteers.
- The Annual Members Meeting would take place on 3 September 2018 from 6pm at The Pavilions in Harrogate.
- There would be a dinner for members of the Board on 4 September 2018 to say farewell to Mr Ian Ward and Mr Phillip Marshall.
- Mrs Schofield would be Chairman of the West Yorkshire Association of Acute Trusts (WYAAT) Committee in Common for the coming six months.
- Mrs Schofield had also been asked to chair the North Region Talent Board.

The Board expressed their best wishes to Mrs Roberts who would soon commence maternity leave. They welcomed Mr Forsyth and expressed their thanks to him for covering the Company Secretary role.

It was noted the meeting would be Mr Marshall's final meeting before leaving the Trust to assume a role at another NHS Trust. Mrs Schofield said that Mr Marshall had been an outstanding Director of Workforce. All members of the Board expressed their thanks to Mr Marshall.

Mrs Schofield confirmed the theme for the meeting would be governance.

Dr Tolcher confirmed she had no additional urgent matters to report to the Board.

5.0 Board Terms of Reference

5.1 Mrs Roberts confirmed the three changes requested by the Board in June 2018 had been incorporated into an updated version of the Board Terms of Reference.

APPROVED:

The Board of Directors considered and approved the updated Board of Directors Terms of Reference.

6.0 Third Party Schedule Annual Update

6.1 Dr Tolcher explained the Third Party Schedule was a requirement of the Code of Governance for NHS Foundation Trusts. The document was updated on an annual basis.

6.2 Mr Alldred noted that the Royal College of Pharmacy should be retitled The Royal Pharmaceutical Society.

ACTION: Mrs Roberts to update the Third Party Schedule and retitled the Royal

Pharmaceutical Society.

APPROVED:

The Board of Directors received and approved the updated Third Party Schedule.

7.0 Review of the Trust's Constitution and Standing Orders

7.1 Mrs Roberts noted that a working group which included four Governors and members of the Board had supported a review of the Constitution. She highlighted the most significant changes proposed; these including the merger of the Nominations and Remuneration Committee, clarity regarding the procedure to appoint the Senior Independent Director and the Vice Chairman, a change to the stakeholder Governors appointed to the Council and a change to the quorum for the Council of Governors.

7.2 The Board approved the proposed amendments to the Constitution and agreed to recommend them to the Council of Governors for approval on 1 August 2018.

7.3 Mrs Roberts explained the Trust's Standing Orders required regular review. A number of proposed changes had been identified in order to reflect current practice within the organisation and to adopt best governance practice.

7.4 Referring to the Scheme of Reservation and Delegation Mrs Webster queried whether delegation to the Remuneration and Nominations Committee should include "other senior employees". Mrs Roberts explained that this description was intended to apply to any other Trust employees engaged on a 'Very Senior Manager' contract but who was not a member of the Board of Directors. At the present time no employees fell into this category.

ACTION: Mrs Roberts and Mr Marshall to update the Scheme of Reservation and Delegation to clarify the description of "other senior employees" in relation to the Remuneration and Nominations Committee.

7.5 Mrs Webster queried whether the responsibilities delegated to the Quality Committee reflected the most recent Terms of Reference. It was agreed this section would be updated following a review of the Quality Committee's Terms of Reference in October 2018.

ACTION: Mr Forsyth to update Scheme of Reservation and Delegation following a review of the Quality Committee's Terms of Reference in October 2018.

APPROVED:

The Board of Directors:

- Agreed the proposed amendments to the Constitution and recommends them to the Council of Governors for approval on 1 August 2018;
- Approved the revised Standing Orders; and
- Approved the revised and Scheme of Reservation and Delegation.

8.0 Dispute Resolution Procedure for disputes between the Board of Directors and Council of Governors

8.1 Mrs Schofield reported it was recommended governance practice for the Trust to have an agreed procedure which would be used in the event of a dispute between the

Board of Directors and Council of Governors.

APPROVED:

The Board of Directors:

- **Approved the ‘Dispute Resolution Procedure for disputes between the Board of Directors and Council of Governors’ and recommended the procedure to the Council of Governors for approval in August 2018.**

9.0 Harrogate Healthcare Facilities Management – Accounting Reference Date

9.1 Mr Coulter explained that it was proposed the accounting reference date for Harrogate Healthcare Facilities Management (HHFM) should be moved to 31 March in order to align with the Trust’s accounting timetable. The Board of HHFM was supportive of the proposal. It was noted that this was a power which was reserved to the Trust Board.

APPROVED:

The Board of Directors:

- **Approved the recommendation from the Board of Harrogate Healthcare Facilities Management Limited, that the accounting reference date of the company be altered from 30 November to 31 March.**

10.0 Report by the Chief Executive (excluding finance matters)

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

10.2 Dr Tolcher echoed Mrs Schofield’s comments regarding Mr Marshall. He was a very valued Executive Director and colleague who would be greatly missed.

10.3 Dr Tolcher welcomed staff who had transferred to the Trust on 1 July 2018 in Gateshead and Sunderland. Community Children’s Services continued to perform well against the contractual targets.

10.4 Operational performance in June 2018 had not been as good as in May 2018. The Trust had failed to meet the four hour Emergency Department target, noting there had been a 9.5% increase in attendance. As a result it had been decided to put additional resource into the Emergency Department at the current time, rather than wait until winter.

10.5 Performance against the Referral to Treatment (RTT) target continued to improve but remained below the 92% standard. It was confirmed the Trust had met all cancer pathway standards, including the 14 day symptomatic breast patient target, in June 2018. Dr Tolcher said she forecast that sustaining and improving performance against the national standards would remain very difficult. Dialogue was ongoing with the Clinical Commissioning Group (CCG) about how to mitigate the cost of non elective care within a finite finance resource. It was expected there may be an impact on the time patients would wait for elective treatment.

10.6 It had been agreed that an element of the West Yorkshire and Harrogate Integrated Care System national discretionary funding would be allocated to Urgent and Emergency care and arrangements to distribute this were being finalised by the Systems Leadership Executive.

10.7 Dr Tolcher provided an update on capital bids through the West Yorkshire and Harrogate Integrated Care System. No schemes related to Harrogate had scored highly and informal feedback suggested it was unlikely many bids across the region would be successful in securing funding via this route. Successful schemes would be those that supported system level working, rather than individual organisations. It was noted the Board would consider capital funding at the Board's workshop in August 2018.

10.8 Dr Tolcher confirmed the Trust had received a Prior Information Return (PIR) from the Care Quality Commission (CQC). It was therefore anticipated service inspections would commence from September / October onwards, with a 'well led' inspection in December 2018 or early in the New Year. All necessary actions were in hand.

10.9 The Trust had received a draft report from NHS Improvement (NHS I) following their recent diagnostic review of financial governance. The report was largely positive and the Trust was currently considering NHS I's recommendations. Mr Coulter explained the recommendations could be grouped into four broad areas; forecasting and information included within Board reports; how the Board and Finance Committee operated; performance management and financial improvement structures. He confirmed that he felt the draft report was accurate.

10.10 It was agreed the Board would establish a working group to consider the report in further detail and provide recommendations to the Board at the workshop in August 2018.

10.11 The Board agreed to adopt the Trust's updated vision, mission, values and strategic objectives.

10.12 Mr Coulter confirmed the Trust had received the funding allocation for the 2018/19 Agenda for Change pay award, which was largely in line with the Trust's forecasts. It was noted there remained a risk of £250k in relation to staff on Agenda for Change Terms and Conditions which had been transferred to the Trust's wholly owned subsidiary company, HHFM. It was also noted that the funding award did not include pay awards for medical, dental or VSM staff.

10.13 Mrs Taylor sought further information about how the Yorkshire and Humber Local Health and Care Record Exemplar would fit with the Trust's Web-V system. Mr Harrison explained that there was no duplication between the programmes. The Local Health and Care Record Exemplar would consider how to link individual Trust IT systems and build on the shared imaging collaborative and shared pathology systems.

APPROVED:

The Board of Directors:

- **Noted progress on risks recorded in the BAF and Corporate Risk Register and confirmed that progress reflected the current risk appetite;**
- **Endorsed use of the Trust's seal and agreement of a licence as detailed in the report: and**
- **Approved and adopted the updated suite of vision, mission and values, objectives and goals statement.**

11.0 Annual Infection Prevention and Control Report 2017-18

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

11.2 Dr Child highlighted the achievements in Infection Prevention and Control during 2017/18. She also noted aims for 2018/19 including the introduction of same-day laboratory screening for respiratory viruses, and support for the T&O team to implement the QIST project.

11.3 Dr Child provided an update on Infection Prevention and Control activity during 2018/19. Seven Clostridium Difficile cases had been identified year to date; this equalled the total number of Clostridium Difficile cases during 2017/18. Dr Child confirmed she continued investigations to understand why there had been an increase in the number of cases. A number of factors were being considered, including the use of antibiotics and the use of fans during the current spell of hot weather.

11.4 Dr Child reported there had been a recent case of pseudomonas on the Intensive Care Unit. The Infection Prevention and Control team were reviewing cleaning and the potential need to reintroduce filters.

11.5 Following a question from Mr Thompson, Dr Child responded that the increase in infections could theoretically be the result of an amendment to the programme of deep cleans, but this was unknown. Mr Harrison clarified that planned cleaning maintenance had not been amended; the Board had agreed to reduce a programme of additional cleaning as part of the 2017/18 financial recovery plan. This decision was taken in the context of a falling rate of CDI which was sustained.

11.6 Mr Thompson noted that UPV machines had not been fully utilised. Dr Child expressed her frustration and confirmed the machines had been returned to the manufacturer.

ACTION: Mr Harrison to look into the reasons why the UPV machines had not been fully utilised by the Domestic team.

11.7 Mrs Webster noted the meeting attendance levels listed in the annual report were low. Mr Harrison clarified that the meeting attendance included within the report did not relate to the Infection Prevention Committee, and he confirmed that the Infection Prevention Committee had an appropriate level of attendance.

11.8 Mr Schofield thanked Dr Child for her report and for her leadership of Infection Prevention and Control.

APPROVED:

The Board of Directors received and noted the contents of the Annual Infection Prevention and Control Report

12.0 Finance Report including Financial Recovery Plan and CIP update

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

12.2 Mr Coulter said financial performance during quarter one of 2018/19 had been poor. Although the NHSI target had been achieved, targets set within the Trust's internal plan had not been realised. There had been a year to date deficit of £3.2m, and this position included full receipt of quarter one Provider Sustainability Funding.

12.3 Mr Coulter confirmed the level of activity was largely on plan. There were

concerns about expenditure, particularly in relation to delivery of Cost Improvement Plans (CIPs) and spending of staffing wards and theatres.

12.4 In response to concerns about spend on staffing a number of new measures had been introduced during May 2018, with further controls implemented in June 2018. Although there had been some improvement it was recognised that there was more work to do. Mr Coulter confirmed that there were no establishment gaps for Care Support Workers, but there had been a 20% overspend. Following the new measures, bank and agency requests had reduced but remained too high.

12.5 The governance arrangements to provide oversight and assurance of CIPs had been altered. A significant level of CIPs had been actioned during the month, but increased scrutiny had highlighted a number of additional risks. This included the level of CIP achieved by the Corporate Directorate.

12.6 The Trust would meet with NHSI on Friday 27 July; Mr Coulter said the Board should not be under any illusions that the Trust's position was not as hoped. The best, medium and worst case forecasts had been updated; Mr Coulter felt the Trust was currently on course to meet the medium risk scenario. Achieving the best scenario was required in order to deliver the plan and secure Provider Sustainability Funds.

12.7 There had been a marginal improvement in month relating to the Trust's cash position.

12.8 Ms Robson queried what the theatre utilisation data was telling the Board. Mr Harrison explained this data focused on utilisation of planned theatre activity, this was different from 'lost lists'.

12.9 Ms Robson sought further information about which wards were overspending on staffing. Mr Coulter explained that this data was analysed by the Workforce Efficiency Group. Mr Alldred provided reassurance that this data was also scrutinised at a Directorate level.

12.10 Dr Tolcher reaffirmed that an absolute direction had been issued to wards that no above establishment requests should be made. Any requests would be considered by Mr Harrison or Mrs Foster on a case by case basis, based on clinical risk. However recent data suggested that some additional staffing had been put in place despite Mr Harrison or Mrs Foster not providing approval; this was being investigated. The level of supernumerary posts was also being analysed.

12.11 Mr Thompson highlighted the need to achieve a step change, and noted NHSI had highlighted enhanced care staffing within their report. He welcomed the peer review of staffing and the value of benchmarking staffing against other Trusts. Dr Tolcher reported that it was a disappointment that the staffing review had been postponed by NHSI.

12.12 Mr Coulter emphasised the need to focus beyond enhanced care because this was only one element of the staffing overspend. Mrs Mayfield confirmed bank and agency staffing was being cancelled wherever it was not required. Mr Alldred provided reassurance that the Directorate were looking at all aspects of staffing overspend. Mr Marshall noted work to strengthen the governance around staff rosters. Dr Tolcher said she was losing patience that the additional management measures introduced had not secured the necessary reduction in spending. An alternative approach may be required.

The Director Team would discuss this matter further at their meeting on 26 July.

12.13 Mrs Webster reflected on the challenge of ensuring staff could provide the level of care they aspired to, while operating within agreed establishment levels. She noted that this required a change in the mind-set of front line staff. Mr Alldred agreed a cultural change was required and highlighted the critical role of Ward Managers in operating within their ward budget and agreed establishment levels which were based on safe staffing levels. He noted that the Directorate continued to monitor incidents and complaints to ensure safe care was being provided.

12.14 It was noted that activity levels had reduced as a result of a reduction in bed occupancy.

12.15 Dr Tolcher said that on recent regular visits to wards within the hospital, ward staff had accepted the measures put in place to control ward staffing. Staff had also confirmed to her that services being provided felt safe. Benchmarking of care hours per patient per day (CHPPD) suggested that staffing levels were towards the top of the range nationally.

12.16 Mrs Taylor emphasised the need to remove the ability of wards to engage additional staff; this should only be possible via escalation.

12.17 Mr Harrison emphasised that quality metrics were being regularly monitored to ensure safe services, and no adverse impact had been identified to date.

12.18 Based on the forecast, Mrs Schofield asked what a realistic year end position for CIPs would be. Mr Coulter said the full year position was recoverable. He explained that the Savings and Delivery Oversight Group had tasked all Directorates to identify additional CIP schemes to cover gaps and Trust-wide slippage. It was noted a vacancy factor may be introduced within the Corporate Directorate to support achievement of the CIP target.

12.19 Mrs Taylor asked for further information about the specific schemes which had not been achieved during quarter one, and had resulted in underperformance against the CIP target. Mr Coulter highlighted the failure to reduce agency spend, achieving savings in relation to pathology joint working and achieving forecast pathology savings.

12.20 Mr Coulter reported his forecast for the Trust's overall financial position was not positive. He highlighted an expectation there would be no any additional national funding in year, year to date the CCG had breached affordability level of the contract with the Trust, Provider Sustainability Funding may not be achieved during future quarters and cash would remain a challenge. He therefore expected there would be increased intervention by NHSI.

12.21 Mrs Webster expressed her concern about activity against the level forecast within the 2018/19 plan. Mr Harrison explained activity was reviewed on a weekly basis by the Operational Delivery Group; there was a granular level of focus on each service area.

12.22 The Board approved the Trust's Reference Costs submission. Mr Thompson confirmed the Audit Committee had received a review by Internal Audit of reference costs.

12.23 Following a query by Mrs Taylor, Dr Tolcher confirmed that the Executive Directors were preparing a Financial Recovery Plan for consideration by the Finance Committee and Board in September 2018.

APPROVED:**The Board of Directors:**

- **Noted the contents of the report and the actions that were being progressed to achieve the financial plan and**
- **Considered and approved the relevant points in relation to the Reference Costs submission included in the finance report.**

13.0 Integrated Board Report

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

13.2 Mr Thompson expressed concern about the data included within the Integrated Board Report regarding incident reporting. From a governance perspective he did not feel that he could determine whether the Trust's position was positive or negative. Mr Harrison explained that although incident reporting had increased it was below the benchmark level, this was a concern and work continued to improve the level of incident reporting within the Trust. Mrs Webster confirmed that the Quality Committee regularly received information about incidents within the Trust and this topic was a quality priority during 2018/19. In explaining the Trust's below average benchmark position, two causes had been identified, culture within the organisation and difficulties with the incident reporting software.

ACTION: Following a suggestion from Dr Johnson, Mr Harrison to update the Integrated Board Report to include the national average benchmark on the chart showing incident reporting data.

APPROVED:

The Board of Directors received and noted the Integrated Board Report.

14.0 Report from the Chief Operating Officer

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

14.2 Mr Harrison highlighted ongoing issues regarding access to historical records in Sunderland; the issue had been escalated to the Chief Executive. The Directorate continued to work with staff to mitigate the issue as far possible.

14.3 Mr Harrison confirmed he had written to NHSI regarding recognition of performance data in determining achievement of the Accident and Emergency target. No response had been received to date.

APPROVED:

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

15.0 Report by the Director of Workforce and Organisational Development

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

15.2 Mr Marshall noted this would be his final meeting as Director of Workforce and Organisational Development. He highlighted an increase of 5% in the number of staff who would recommend the Trust as a place to work through the latest Friends and Family

Test.

15.3 Mrs Taylor asked whether progress made on job planning had started to reverse. Mr Marshall acknowledged performance was not as he had hoped, and confirmed he was discussing progress with the Directorates. He also noted he was working with Dr Tolcher and Dr Scullion to develop a new job planning policy.

APPROVED:

The Board of Directors noted items included within the report.

16.0 Report from the Chief Nurse

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

16.2 Mrs Mayfield confirmed she had no items to highlight.

APPROVED:

The Board of Directors:

- **Confirmed they were assured by the work being undertaken to improve nurse recruitment and retention and the governance process for assuring safe staffing levels;**
- **Noted actions being undertaken to maintain safe staffing levels, quality of care and reduce cost;**
- **Approved the new formats for Director Inspections and Safety Visits;**
- **Noted community and hospital acquired pressure ulcers in month were about the same;**
- **Noted the work around falls reduction;**
- **Confirmed they were assured about the monitoring of care provided by the Community Care Teams;**
- **Confirmed they were informed about the outcomes and next steps for the work with the NHSI Collaborative to improve Enhanced Care; and**
- **Noted the achievement of County Durham 0 -19 Children's Service.**

17.0 Report from the Medical Director

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

17.2 Dr Scullion provided reassurance about initial findings from the review of Trauma and Orthopaedic deaths by Dr Rebecca Leigh and Dr Angela Bell; the review had identified no major lapses in care.

APPROVED:

The Board of Directors received and noted the report.

18.0 Guardian of Safe Working Hours Quarterly Report

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

APPROVED:

The Board of Directors received and noted the report and considered the points at the end of the report.

19.0 Learning from Deaths Quarterly Update

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

19.2 Dr Scullion noted the Board had discussed a recent patient death at the June 2018 meeting; this case was referenced within the report.

19.3 There were no questions or comments.

APPROVED:

The Board of Directors received and noted the report.

20.0 Oral Reports from Directorates

20.1 Planned and Surgical Care Directorate

20.1.1 Dr Johnson confirmed she had no urgent issues regarding the Planned and Surgical Care Directorate about which to update the Board.

20.2 Children's and County Wide Community Services Directorate

20.2.1 Dr Lyth confirmed she had no urgent issues regarding the Children's and County Wide Community Services Directorate about which to update the Board.

20.3 Long Term and Unscheduled Care Directorate

20.3.1 Mr Alldred confirmed he had no urgent issues regarding the Long Term and Unscheduled Care Directorate about which to update the Board.

21.0 Committee Chair Reports

Mrs Schofield welcomed reports from the Board's committees.

21.1 Report from the Quality Committee meeting held on 4 July 2018

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

APPROVED:

The Board of Directors:

- **Noted implementation of the new Quality Dashboard; and**
- **Noted Quality Committee meeting date changes.**

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

22.1 It was confirmed there were no items to be reported.

23.0 Any other relevant business not included on the agenda

There was one other item of business. Mrs Roberts confirmed the Trust would move to a new software product called Diligent which would support more efficient use of electronic

Board paper packs.

24.0 Board Evaluation

Mr Thompson said he felt the meeting had stuck to the theme of governance. He noted that, as highlighted by NHSI in their draft report, the meeting had been a little rushed towards the end of the agenda.

Mrs Schofield noted that in future months the Board's agenda may look different and would likely be shorter.

Mrs Taylor said she felt it had been a good patient story.

25.0 Confidential Motion

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

The Board agreed the motion unanimously. The meeting closed at 12.30pm.

DRAFT

HDFT Board of Directors Actions Schedule
Action Log
September 2018

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.

4

Ref	Meeting Date	Item Description	Director/Manager Responsible	Completion date	Detail of progress
81	January 2018	Further consideration to include additional measures within the integrated board report regarding patient experience in adult and children community services.	Mr Harrison, Chief Operating Officer / Mr Alldred, Clinical Director LTUC / Dr Lyth, Clinical Director CCWC	September 2018	
102	June 2018 (minute 5.5)	Mrs Roberts and Mrs Webster to agree an appropriate resolution, and amend the Quality Committee terms of reference accordingly.	Mrs Webster, Non Executive Director & Mr Forsyth, Interim Company Secretary	October 2018	
106	June 2018 (minute 8.4)	Mr Harrison to consider whether previous year trends could be added to a number of measures within the Integrated Board Report.	Mr Harrison, Chief Operating Officer	October 2018	
107	June 2018 (minute 14.6)	Quality Committee to consider further whether the Trust could adopted a different approach to the management of action plans following external reports and clinical audits.	Mrs Webster, Non-Executive Director	October 2018	
108	June 2018 (minute 16.2.3)	At future meetings, the Finance Committee report to be taken alongside the Finance Report.	Mr Forsyth, Interim Company Secretary	October 2018	Complete. New Board agenda in place.
109	July 2018 (minute 6.3)	Update the Third Party Schedule to retitle the Royal College of Pharmacy to the Royal Pharmaceutical Society	Mr Forsyth, Interim Company Secretary	September 2018	Complete. Schedule amended
110	July 2018 (minute 7.5)	Update the Scheme of Reservation and Delegation to clarify the description of 'other senior employees' in relation to the Remuneration and Nominations Committee	Mr Forsyth, Interim Company Secretary	September 2018	Complete. Scheme updated.
111	July 2018 (minute 7.7)	Update the Scheme of Reservation and Delegation following review of Quality Committee Terms of Reference	Mr Forsyth, Interim Company Secretary	October 2018	

1



112	July 2018 (minute 11.7)	Understand the reasons why the UPV machines were not fully utilised by the domestic team	Mr Harrison, Chief Operating Officer	September 2018	Verbal update at meeting
113	July 2018 (minute 13.3)	Update the Integrated Board Report to include the national average benchmark on the chart showing incident reporting data	Mr Harrison, Chief Operating Officer	September 2018	Verbal update at meeting





Date of Meeting:	26 September 2018	Agenda item:	5.0								
Report to:	Board of Directors										
Title:	Report from the Chief Executive										
Sponsoring Director:	Dr Ros Tolcher, Chief Executive										
Author(s):	Dr Ros Tolcher, Chief Executive, Jonathan Coulter, Deputy CEO and Finance Director and Andrew Forsyth, Interim Company Secretary										
Report Purpose:	<table border="1"> <tr> <td>Decision</td> <td></td> <td>Discussion/ Consultation</td> <td>✓</td> <td>Assurance</td> <td>✓</td> <td>Information</td> <td>✓</td> </tr> </table>			Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓
Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓				
Executive Summary:	<ul style="list-style-type: none"> Financial performance remains extremely challenging with an in-month deficit of £0.9m in August. ED, RTT and cancer performance standards remain challenging The West Yorkshire and Harrogate Integrated Care System partnership has reached a significant milestone with the Memorandum of Understanding ready for sign-off by all partners The Trust will receive £605k national capital funds to support increased capacity and improved urgent and emergency care performance this winter A programme on promoting a fair and just culture has commenced with positive staff engagement. Fairness Champions will complement the work of the Freedom to Speak Up Guardian. Arrangements are in place to deliver the flu campaign for this winter 										
Related Trust Objectives											
<table border="1"> <tr> <td>To deliver high quality care</td> <td>✓</td> <td>To work with partners to deliver integrated care:</td> <td>✓</td> <td>To ensure clinical and financial sustainability:</td> <td>✓</td> </tr> </table>				To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓		
To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓						
Key implications											
Risk Assessment:	Strategic and operational risks are noted in section 7. Risks associated with this report are reflected in the Board Assurance Framework: BAF 14: risk to deliver of integrated models of care; BAF 15: misalignment of partner strategic plans; and BAF 9; failure to deliver the operational plan.										
Legal / regulatory:	There are no legal/regulatory implications highlighted within the report.										
Resource:	There are no resource implications highlighted within the report.										
Impact Assessment	Not applicable.										
Conflicts of Interest:	None identified.										
Reference documents:											
Assurance:	Not applicable.										
Action Required by the Board of Directors:											
<ul style="list-style-type: none"> 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 requested to endorse use of the Trust's seal and agreement of a Lease as detailed in the report. <p><i>This report should be read alongside the Trust's Integrated Board Report which contains further information on key quality, operational and finance metrics.</i></p>											

1.0 QUALITY AND PERFORMANCE

1.1 Operational Performance

Operational performance has continued to be challenging over the two months to which this report relates. Financially, during month 4 (July) the Trust reported a surplus although in-month performance remained slightly adverse of plan. In month 5 (August) adverse variance in expenditure resulted in an in-month loss of £925k and a year to date deficit position of £3.9m against a planned breakeven.

Elective activity remains above planned levels for the year to date with non-elective activity marginally lower than planned. The high rates of Emergency Department (ED) attendances reported in previous months have continued and remain 8.5% above plan.

Performance on RTT and the A&E 4 hour standard remain below the required standard at 91.0% and 94.0% respectively. The Directorate has put in place reviewed workforce rosters to mirror changes in the pattern of ED attendances and has also improved access to senior clinical decision makers as part of an ED recovery plan designed to ensure attainment of the Q2 standard.

The delivery of the cancer access standard for two week breast symptomatic referrals and 62 day treatment standard remains challenging, with August performance for both standards below the required level; for the breast symptomatic standard it is unlikely that quarter 2 will now be achieved. The under achievement of the 62 day standard across the ICS has meant that a 25% reduction in funding for the Cancer Transformation Fund has been applied to Q1 and Q2 funding and, based on current performance projections, it is likely that Q3 and Q4 funding will be reduced by 50%. Therefore our contribution to the achievement of this standard both locally and regionally is essential to support the funding flow to support the transformation schemes.

1.2 Quality Charter

I am pleased to confirm that all members of the Executive Team have now achieved the bronze Quality of Care accreditation. This includes on-line training in Quality Improvement and the selection of a designated quality improvement project.

Members of the Board will be aware that the Quality Charter includes Quality of Care Champion training (bronze, silver, gold and platinum levels), Quality of Care Team awards (bronze, silver and gold), the Trust's annual Quality Conference and the very popular Team of the Month and Making a Difference Awards. We now have almost 300 Quality of Care Champions across the Trust.

1.3 Promoting a Fair and Just Culture

A fair and just culture is a fundamental building block to sustaining safe, compassionate and resilient care.

The NHS Staff Survey and Workforce Race Equality (WRES) data give some insight in to the experiences of colleagues across the Trust, and how this compares with the NHS as a whole. Staff survey results for HDFT from 2017 show that, overall, bullying, harassment and abuse occur less frequently in the Trust than the national average; there is, however,

considerable scope for improvement. This is particularly so for colleagues from black, Asian and minority ethnic groups whose experience is worse than the national average.

A programme of work designed to promote a fair and just culture has commenced, building also on the work of our Freedom to Speak up (FTSU) Guardian. I have held three focus groups/listening events which have been well attended and highly productive. The first of a number of community listening events takes place next month. We have received a very positive response from staff regarding expressions of interest in becoming Fairness Champions in support of the FTSU initiative. I will keep the board informed on progress.

1.4 Key quality indicators

It is pleasing to report that the number of falls reduced during August to its lowest number for over two years. There were also no falls causing fracture.

There has also been a reduction in hospital acquired pressure ulcers, with the year to date number being lower than the equivalent period last year.

These are key quality indicators and it is very encouraging that the work we are doing in these areas is having an impact at a time of continued staffing pressure within our inpatient wards.

2.0 FINANCIAL POSITION

2.1 Financial performance

The Trust delivered a deficit of £0.9m in the month of August, and whilst the year to date position is in line with the NHSI plan, we are £3.8m behind our internal financial plan. Key drivers remain related to staffing and CIP delivery, but there are also pressures in relation to drug expenditure that need rapid analysis and action. The cash impact of the I&E position will necessarily mean that capital spend this year and next will need to be very carefully managed.

The Trust reported a rating of 3 in August, in line with the annual plan submitted to NHS Improvement.

Further information is contained within the IBR and the detailed financial position will be discussed at the Finance Committee and key issues brought to the Board's attention.

Elective activity undertaken on behalf of Harrogate Commissioners for the year to date exceeds demand assumptions within the Aligned Incentive Contract by approximately 1.7% and work continues to explore the cost and implications of this. Despite this overtrade, waiting list numbers have increased by 8.2%, creating both financial and performance risks for the system. It is imperative that early agreement on the management of these risks is reached and a continued focus on care quality is sustained.

2.2 National Capital Support for Urgent and Emergency Care

The Trust will receive £605k national capital funds to support increased capacity and improved urgent and emergency care performance this winter. This welcome investment will be used to take expedite plans for zoning of first contact services in which we will create a Medical Ambulatory Care Unit on the ground floor immediately adjacent to the Emergency

Department, diagnostics and GP Out of Hours facilities. The scheme will contribute to the Trust achieving the ED 4-hour standard and reducing acute bed use, and will also create a better environment in which to provide care. The scheme needs to be operational by 24 December and will be progressed immediately.

2.3 NHSI Diagnostic

The report of the NHSI Diagnostic was considered in detail by three task and finish groups which each examined a different element. Proposals were taken for discussion to the Board development day on 29 August and the responses to the NHSI comments were agreed. These include changes to the role and frequency of the Finance Committee (to become the Resources Committee); a revised process for the detailed examination of Cost Improvement; changes to the format of the Board Agenda and substantial changes to the Integrated Board Report (IBR). The new style IBR will be structured around six key domains (safe, effective, caring, workforce, finance and efficiency and activity) and will encompass key updates and forecasts as well as some structured benchmarking data. Implementation of all actions is now underway.

3.0 STRATEGIC UPDATE

3.1 West Yorkshire and Harrogate Health and Care Partnership (HCP)

Positive progress on the Memorandum of Understanding (MOU) between the HCP and member organisations has been made and the final version is ready for approval by the Board later in the meeting. At a meeting of the West Yorkshire Association of Acute Trusts (WYAAT) on 12 September it was agreed, after discussion, that member Trusts would be invited to approve the MOU, whilst recording a small number of observations by which it would hope to improve the governance of the Integrated Care System (ICS). These were:

- By further developing our understanding of mutual accountability and decision making as an ICS, we must achieve greater clarity in the relationship between the Partnership Board, System Leadership Executive Group and System Assurance & Oversight Group, and especially the flow of information between them.
- We strongly support the invitation for a provider chair to take on the role of Vice Chair of the Partnership Board. This would help shape the future development of partnership working to ensure all voices are heard.
- Becoming an ICS is a journey so WYAAT recommends that the MOU should be reviewed within the first year to ensure that it is fit for purpose in the context of the NHS 10- year plan and as our thinking on mutual accountability and ICS decision making develops. It should be reviewed at least biannually thereafter.

4.0 WORKING IN PARTNERSHIP

4.1 Harrogate System Leadership Executive Group

The HSLEG met on 26 July 2018. The Terms of Reference for the group were approved. The group received and endorsed the Harrogate Winter Plan.

5.0 SENIOR MANAGEMENT TEAM (SMT) MEETING

The SMT met on 22 August and 19 September 2018. The following key areas are for noting:

- The Flu campaign for 2018/19 will reflect the ambition to achieve 100% vaccination rates for key staff, with a stronger focus on an approach of comply or explain, and targets for areas to achieve. Same-day flu testing equipment will also be purchased;
- Detailed discussion about the financial position and key drivers, with emphasis on ensuring that individual budget holders exercise the necessary financial controls across all Directorates;
- Work is ongoing to improve ophthalmology productivity;
- The risk to delivery of the Emergency Department standard and actions required to improve current performance;
- The risk in relation to achievement of the key cancer standards and the work being done across WYAAT to ensure delivery;
- Positive position in relation to key quality indicators on our inpatient wards;
- Timeliness of complaint responses and the possible increase in complainants responding adversely to our initial report will be analysed for future meetings;
- Recruitment to the Supported Discharge Service is going well;
- The outcome of the Workforce Race Equality Scheme assessment and associated action plan was noted;
- Work continues in relation to our policy for Supporting Professional Activities time for medical staff, with the intention of drawing the discussions to a close shortly; and
- A framework for Patient and Public Participation was discussed.

6.0 COMMUNICATIONS RECEIVED AND ACTED UPON

6.1 NHSI winter letters on supporting delivery of elective and emergency care

Ian Dalton, NHSI CEO, wrote to all Trust CEOs and Chairs on 23 August regarding elective care, RTT and waiting list numbers. Pauline Phillip, National Director of Urgent and Emergency Care, also wrote to all NHS Trusts and Foundation Trusts on 7 September reminding them of the requirement to reduce long stay patient numbers by 25%, achieving the ED 95% standard and setting an expectation of 100% 'flu vaccination rates for front line staff.

Trusts are asked to review performance and delivery forecasts and take action where these are below plan.

- Our year to date performance on long-stay patients (>21 days) is a reduction from 82 to 50 since April 2018 and allocated target is the achievement of 53 on average between January and March 2019.
- The Trust has zero 52-week waits; our waiting list in July was 14,818 compared to 14,006 in March.
- Elective activity and spend year to date exceed demand and cost assumptions within the aligned incentive contract. Any slowdown in activity would lead to further waiting list and waiting time growth.

We are currently in dialogue with commissioners within the ICS regarding current performance trajectories and the opportunity for the Trust to offer support to other Trusts where some patients are experiencing extremely long waits.

Our annual 'flu campaign commences on 1 October with the goal of vaccinating 75% of front line staff with direct patient/service user contact by the end of the month and 100% by the end of November. Following learning from prior years, our campaign this year will also focus on early diagnosis of 'flu in patients and pro-active vaccination of vulnerable inpatients to reduce the risk of hospital acquired infections.

6.2 Preparations for Brexit

The Department for Health and Social Care (DHSC) has provided a letter which informs all Trusts, CCGs and other organisations in the NHS about the Government's preparations in response to EU Exit, including in the event that the UK leaves the EU without a deal in March 2019. The letter covers the Government's plans in relation to the continuity of supply of medicines and other preparatory work that is taking place. DHSC has also published a letter to the pharmaceutical industry and a letter to the suppliers of medical devices and clinical consumables, which provides details on how the Government will support pharmaceutical companies in ensuring continuity in the supply of medicines after EU Exit.

NHS Providers has also published briefing documents reflecting on these letters and subsequent briefings from the Department and on the Government's wider preparations for a 'no deal' Brexit.

The strategic risk to the Trust of this scenario has now been assessed and, where appropriate, the Board Assurance Framework reflects the current position.

6.3 Development of the NHS 10-Year Plan

The Government has set out its priorities for the plan, as presented by the Prime Minister, including five financial tests to show how the service will be put on a more sustainable footing. A delivery plan to underpin the first few years of the 10-year strategic plan is being developed.

A number of national working groups have been established, under three broad headings: Life Course Programmes, Clinical Priorities and Enablers. Engagement has been taking place during September and the Boards of NHS England and NHSI will meet jointly at the end of September to discuss the plan. The plan will be published in November and an NHS Assembly will be established to oversee delivery of it.

6.4 Diversity – the new prescription for the NHS

This is a joint report produced by the Good Governance Institute and Simon Fanshawe, Co-Founder, Diversity By Design.

This report is aimed at Board members and Chief Executives/executive teams of acute NHS Trusts in England as the leaders who have the responsibility and the power to make the changes needed. This report is designed to open up a new approach to diversity that makes it central to an NHS trust because it delivers a dividend to patients and staff – in terms of health, and clinical and personal success – in line with the NHS Constitution: the NHS "is there to improve our health and well-being, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can to the end of our lives".

While the diversity deficits must be tackled, the motivation to enhance diversity should be widened beyond compliance and tackling injustice. As talent is unblocked by dealing with

the deficits, diversity should be pursued for the considerable added value which it can bring to the core purposes of the NHS.

The report will be placed in the Reading Room.

7.0 BOARD ASSURANCE AND CORPORATE RISK

7.1.1 Board Assurance Framework (BAF)

No new risks have been added to the BAF this month. Six risks (no change from July 2018) are currently assessed as having achieved their target risk score. The BAF has been reviewed and revised to reflect the risks associated with the Aligned Incentive Contract and Brexit. This has resulted in the risk score for BAF 1 being reduced, as all Trust actions are fully on plan, whilst BAF 9 has increased to 16, reflecting the challenging financial position reported elsewhere. The risk score for BAF 17 now reflects the increased pressure on Operational Directors from the Allied Incentive Contract. The strategic risks are as summarized as follows:

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

7.2 Corporate Risk Register (CRR)

The CRR was reviewed at the monthly meeting of the Corporate Risk Review Group on 14 September 2018. The Corporate Risk Register contains one new risk, taking the total to 12 risks. The new risk relates to delays in the delivery of inactive client records in the 0 – 19 Children's Services and this has a risk score of 12. The descriptor for CR2 has been updated to better reflect the current risk but the risk score remains unchanged. The date for achieving the target risk for CR5 has been extended as a realism measure. CR14, the risk of a financial deficit, has been updated to a risk score of 16, reflecting an increased likelihood, as has CR27 around cash available to support the capital programme.

Corporate Risk Register Summary

Corporate risk register summary of changes: Updated September 2018

Ref	Description	Current risk score	Risk movement	Current progress score	Target date for risk reduction	Notes
CR2	Risk to the quality of service delivery in Medicine due to gaps in rotas; reduction in trainee numbers; agency cap rate; quality control of locums.	12	↔	2	Mar-19	Risk description and controls updated to focus on LTUC risk.
CR5	Risk to service delivery due gaps in registered nurses establishment	12	↔	2	Oct-20	
CR13	Capacity to support timely discharge for community ready patients	12	↔	2	Mar-19	
CR14	Risk of financial deficit and impact on service delivery due to failure to deliver the Trust annual plan by having excess expenditure or a shortfall in income.	16	↑	2	Mar-19	
CR17a	Risk of patient harm as a result of being lost to follow-up as a result of current processes	12	↔	3	Sep-18	Progress and reporting to be followed up
CR17b	Risk of patient harm as a result of being lost to follow up as a result of historic processes	12	↔	3	Dec-18	Progress and reporting to be followed up
CR18	Risk to provision of service and not achieving national standards in cardiology due to potential for lab equipment breaking down	12	↔	4	Mar-19	Risk description to be updated following breakdown of Cath Lab equipment
CR24	Risk to patient safety, quality, experience, reputation, staff wellbeing due to reduced capacity in the Community Care teams (CCTs).	12	↔	3	Mar-19	
CR26	Risk of inadequate antenatal care and patients being lost to follow up - due to inconsistent process for monitoring attendance at routine antenatal appointments in community	12	↔	3	Nov-18	
CR27	Risk to service delivery due to failure to have sufficient cash to support the capital programme including replacement of equipment due to delay in payment from commissioners or shortfall in delivering the financial plan	16	↑	4	Apr-19	Progress score decreased to 4
CR29	Risk to patient safety, quality of care, patient experience and privacy and dignity due to environmental factors on CATT Ward and Clinic. Environment also impacting on recruitment and retention	12	↔	2	Sep-19	
CR30	Risk to Gateshead and Sunderland 0-19 Service Delivery, Reputation and Patient Safety due to delayed access to Inactive Client Records which are legally owned by STFT.	12	New	2	Jul-18	Target date to be reviewed

Progress key

- 1 = fully on plan across all actions
- 2 = actions defined - most progressing, where there are delays, interventions are being taken
- 3 = actions defined - work started but behind plan
- 4 = actions defined but largely behind plan
- 5 = actions not yet fully defined

8.0 DOCUMENTS SIGNED AND SEALED

The following document has been signed and sealed during the month:

- The lease for the Wetherby Outreach Clinic

In addition the following documents have been signed during the month:

- The Trust has completed and signed a Tenancy at Will for accommodation for the newly awarded Leeds Childhood Flu Immunisations contract at Beeston Health Centre
- The Trust has signed seven Licences with York Trust as landlord, for its community services accommodation in the following sites:
 - Clementhorpe Health Centre
 - Tadcaster Health Centre
 - Tang Hall
 - Whitecross Court
 - Selby Hospital
 - Malton Hospital
 - Springhill House

Dr Ros Tolcher
Chief Executive
20 September 2018

Date of Meeting:	26 September 2018	Agenda item:	5.0 Re: 6.6, 7.2, 8.5
Report to:	Board of Directors		
Title:	Integrated Board Report		
Sponsoring Director:	Dr Ros Tolcher, Chief Executive		
Author(s):	Ms Rachel McDonald, Head of Performance & Analysis		
Report Purpose:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Decision	Discussion/ Consultation	Assurance
		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
			Information
			<input checked="" type="checkbox"/>
Executive Summary:	<p>The Trust is required to report its operational performance to NHS Improvement and to routinely submit performance data to NHS England and Harrogate and Rural District CCG. The Board of Directors are asked to note that:</p> <ul style="list-style-type: none"> The Trust reported a deficit of £925k in August, behind both the internal plan and the control total for the month. This results in a significant deficit to date of £3.9m, £3.8m behind plan. This variance will require further action in relation to recovery plans to rectify the position. The rate of inpatient falls reduced this month and there were no falls resulting in a fracture. There were 2 further hospital acquired cases of C.difficile reported in August, bringing the year to date total to 9 cases. Staff sickness decreased in August to 3.6%. HDFT's performance remains below the required level for both the A&E 4-hour standard and the 18 weeks waiting times standard in August. 2 cancer waiting times standards were not achieved in August. There is now a significant risk that the 2 week wait standard for breast symptomatic patients will not be achieved for the second successive quarter. Delayed transfer of care decreased in August and now stand at 2.0%, the lowest level reported for a number of months. 		
Related Trust Objectives			
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
To deliver high quality care		To work with partners to deliver integrated care:	To ensure clinical and financial sustainability:
Key implications			
Risk Assessment:	Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF 4: risk of a lack of interoperable systems across New Care Models partners; BAF 9: risk of a failure to deliver the operational plan; BAF 10: risk of a breach of the terms of the NHS Provider licence; BAF 16: risk to delivery of integrated care models.		
Legal / regulatory:	None identified.		
Resource:	Not applicable.		
Impact Assessment:	Not applicable.		
Conflicts of Interest:	None identified.		
Reference documents:	None.		
Assurance:	Report reviewed monthly at Senior Management Team in Operational Delivery Group.		
Action Required by the Board of Directors:			
The Board of Directors are asked to receive and note the content of the report.			

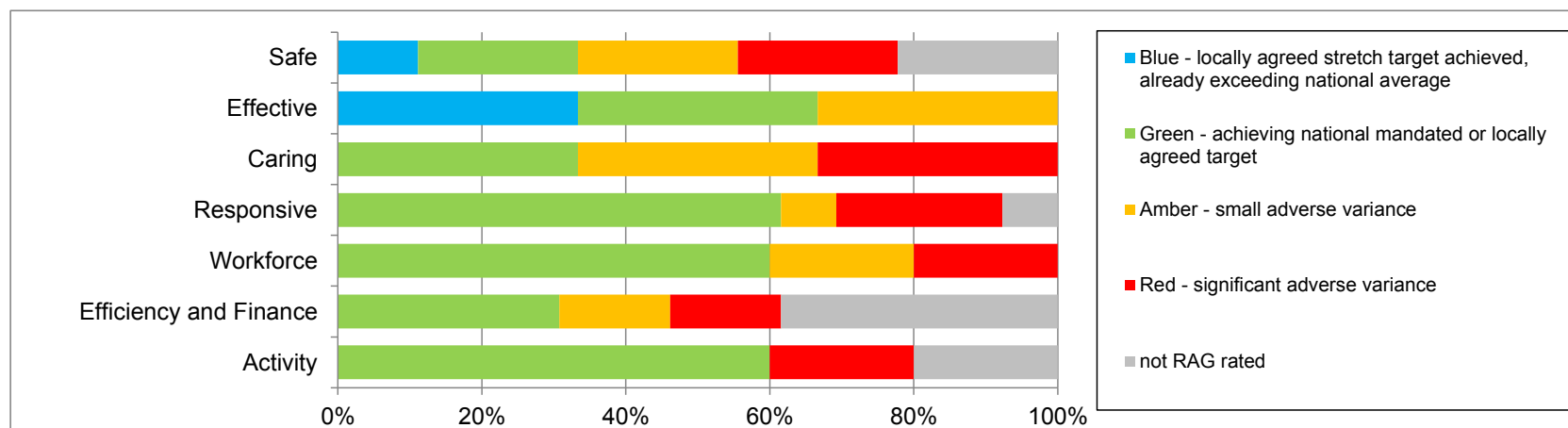


Integrated board report - August 2018

Key points this month

1. The Trust reported a deficit of £925k in August, behind both the internal plan and the control total for the month. This results in a significant deficit to date of £3.9m, £3.8m behind plan. This variance will require further action in relation to recovery plans to rectify the position.
2. The rate of inpatient falls reduced this month and there were no falls resulting in a fracture.
3. There were 2 further hospital acquired cases of C.difficile reported in August, bringing the year to date total to 9 cases.
4. Staff sickness decreased in August to 3.6%.
5. HDFT's performance against the A&E 4-hour standard remained below 95% in August.
6. The Trust's 18 weeks performance remained below the 92% standard in August.
7. 2 cancer waiting times standards were not achieved in August. There is now a significant risk that the 2 week wait standard for breast symptomatic patients will not be achieved for the second successive quarter.
8. Delayed transfer of care decreased in August and now stand at 2.0%, the lowest level reported for a number of months.

Summary of indicators - current month



Safe - August 2018


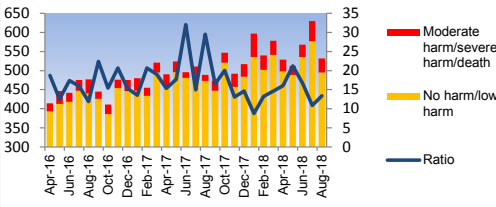

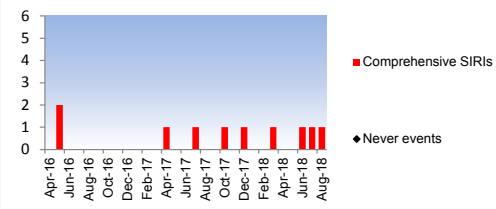

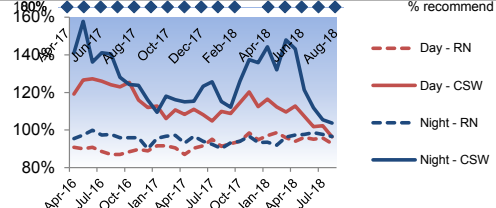
Indicator name / data quality assessment	Description	Trend chart	Interpretation
<p></p> <p>Pressure ulcers hospital acquired</p>	<p>The chart shows the cumulative number of category 3, category 4 or unstageable hospital acquired pressure ulcers in 2018/19. The Trust has set a local trajectory for 2018/19 to reduce the number of avoidable category 3, category 4 or unstageable pressure ulcers. The data includes hospital teams only.</p>		<p>There were 4 hospital acquired unstageable or category 3 pressure ulcers reported in August, bringing the year to date total to 19. This compares to an average of 5 per month reported in 2017/18.</p> <p>For the 19 cases reported in 2018/19 to date, 4 have been assessed as avoidable, 8 as unavoidable and 7 are still under root cause analysis (RCA). No category 4 hospital acquired pressure ulcers have been reported in 2018/19 to date.</p>
<p></p> <p>Pressure ulcers hospital acquired</p>	<p>The chart includes category 2, 3 and 4 and unstageable hospital acquired pressure ulcers. The data includes hospital teams only.</p>		<p>The number of hospital acquired category 2-4 (or unstageable) pressure ulcers reported in August was 16, a decrease on last month and below the average per month reported in 2017/18.</p>
<p></p> <p>Pressure ulcers community acquired</p>	<p>The chart shows the cumulative number of category 3, category 4 or unstageable community acquired pressure ulcers in 2018/19. This metric includes all pressure ulcers identified by community teams including pressure ulcers already present at the first point of contact. The Trust has set a local trajectory for 2018/19 to reduce the number of avoidable category 3, category 4 or unstageable pressure ulcers. The data includes community teams only.</p>		<p>There were 15 community acquired unstageable or category 3 pressure ulcers reported in August, compared to 19 last month. The average per month reported in 2017/18 was 12.</p> <p>For the 55 cases reported in 2018/19 to date, 1 has been assessed as avoidable, 38 as unavoidable and 16 are still under root cause analysis (RCA).</p>
<p></p> <p>Pressure ulcers community acquired</p>	<p>The chart includes category 2, 3 and 4 and unstageable community acquired pressure ulcers. The data includes community teams only.</p>		<p>The number of community acquired category 2-4 (or unstageable) pressure ulcers reported in August was 29, a decrease on last month but remaining above the average per month reported in 2017/18.</p>

Safe - August 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<p>Safety Thermometer - harm free care</p>	<p>Measures the percentage of patients receiving harm free care (defined as the absence of pressure ulcers, harm from a fall, urine infection in patients with a catheter and new VTE) in the Safety Thermometer audits conducted once a month. The data includes hospital and community teams. A high score is good. Whilst there is no nationally defined target for this measure, a score of 95% or above is considered best practice.</p>		<p>The harm free percentage for August was 95.7%, above 95% and an improvement on last month.</p>
<p>Safety thermometer - harm free care - Community Care Teams</p>	<p>Measures the percentage of patients receiving harm free care (defined as the absence of pressure ulcers, harm from a fall, urine infection in patients with a catheter and new VTE) in the Safety Thermometer audits conducted once a month. A high score is good. Whilst there is no nationally defined target for this measure, a score of 95% or above is considered best practice.</p>		<p>The harm free percentage for August was 97.6%, remaining well above 95%.</p>
<p>Falls</p>	<p>The number of inpatient falls expressed as a rate per 1,000 bed days. The data includes falls causing harm and those not causing harm. A low rate is good.</p>		<p>The rate of inpatient falls was 5.29 per 1,000 bed days in August, a decrease on last month and below the average HDFT rate for 2017/18. There were no falls resulting in a fracture in August (3 last month).</p>
<p>Infection control</p>	<p>The chart shows the cumulative number of hospital apportioned C. difficile cases during 2018/19. HDFT's C. difficile trajectory for 2018/19 is 11 cases, a reduction of 1 on last year's trajectory. Cases where a lapse in care has been deemed to have occurred would count towards this. Hospital apportioned MRSA cases will be reported on an exception basis. HDFT has a trajectory of 0 MRSA cases for 2018/19. The last reported case of hospital acquired MRSA at HDFT was in Oct-12.</p>		<p>There were 2 cases of hospital apportioned C. difficile reported in August, bringing the year to date total to 9 cases. 7 of the 9 cases have had root cause analysis completed and agreed with HARD CCG. The outcome for 6 out of 7 was that no lapse of care had occurred. 1 case has been deemed to be due to a lapse in care in relation to antibiotics. 2 cases are still under root cause analysis.</p> <p>No hospital apportioned MRSA cases have been reported in 2018/19 to date.</p>



Safe - August 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<p>Incidents - all</p> 	<p>The chart shows the number of incidents reported within the Trust each month. It includes all categories of incidents, including those that were categorised as "no harm". The data includes hospital and community services. A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture</p>		<p>The latest published national data (for the period Apr - Sep 17) shows that Acute Trusts reported an average ratio of 44 no harm/low harm incidents for each incident classified as moderate harm, severe harm or death (a high ratio is better). HDFT's published ratio was 26, a minor improvement on the last publication but remaining in the bottom 25% of Trusts nationally. HDFT's latest local data gives a ratio of 13, a deterioration on this position. The focus going forward is to improve our incident reporting rate particularly encouraging staff to report no harm/ near miss incidents. Options to improve the Datix system to simplify the incident reporting process are being explored.</p>
<p>Incidents - SIRIs and never events</p> 	<p>The chart shows the number of Serious Incidents Requiring Investigation (SIRIs) and Never Events reported within the Trust each month. The data includes hospital and community services. Only comprehensive SIRIs are included in this indicator, as concise SIRIs are reported within the pressure ulcer / falls indicators above.</p>		<p>There was 1 comprehensive SIRI reported in August. No Never Events were reported in 2017/18 or in 2018/19 to date.</p>
<p>Safer staffing levels</p> 	<p>Trusts are required to publish information about staffing levels for registered nurses/midwives (RN) and care support workers (CSW) for each inpatient ward. The chart shows the overall fill rate at HDFT for RN and CSW for day and night shifts. The fill rate is calculated by comparing planned staffing with actual levels achieved. A ward level breakdown of this data is published on the Trust website.</p>		<p>Overall staffing compared to planned was at 96% in August. Care Support Worker staffing levels have reduced which may reflect a decrease in the need for 1-1 care. Whilst safer staffing levels for registered nurses remains below 100%, the staffing level achieved still enables the delivery of safe care. Achieving safe staffing levels remains challenging and requires the increasing use of temporary staff through the nurse bank and agencies.</p>

Narrative

This is the fourth consecutive month that the total number of inpatient falls has decreased. We are continuing to work with the new Natural Health School regarding their course accreditation and governance structure and therefore will provide appropriate assurance to Board in November 2018. The care support worker staffing levels has decreased which reflects robust work regarding the risk assessment and escalation processes and the response to the 'living within our means' challenge.

Actual Versus Planned Nurse Staffing - Inpatient Areas

The table below summarises the average fill rate on each ward during August 2018. The fill rate is calculated by comparing planned staffing hours and actual staffing achieved.

In addition we are required to submit information on the total number of patients that were on each ward throughout the month – this is then used to calculate the "Care Hours per Patient Day" (CHPPD) metric. Our overall CHPPD for August was 8.23 care hours per patient per day.



Safe - August 2018

Indicator name / data quality assessment	Description				Trend chart			Interpretation
	Aug-2018							
	Day		Night		Care hours per patient day (CHPPD)			
Ward name	Average fill rate - registered nurses/ midwives	Average fill rate - care staff	Average fill rate - registered nurses/ midwives	Average fill rate - care staff	Registered nurses/ midwives	Care Support Workers	Overall	
AMU	98.1%	96.8%	97.6%	128.0%	4.43	2.89	7.32	
Byland	98.2%	106.0%	100.0%	104.3%	2.91	3.90	6.81	
CATT	87.5%	96.8%	96.0%	103.2%	5.24	3.19	8.42	
Farndale	96.2%	81.7%	100.0%	104.8%	3.51	3.90	7.41	
Granby	97.2%	106.5%	100.0%	98.4%	3.88	3.49	7.36	
Harlow	105.6%	95.2%	100.0%	-	6.58	1.75	8.33	
ITU/HDU	96.8%	-	93.5%	-	25.77	1.00	26.77	
Jervaulx	91.5%	94.9%	92.2%	105.9%	2.82	3.53	6.36	
Lascelles	98.9%	95.5%	100.0%	100.0%	4.89	4.34	9.24	
Littondale	90.4%	112.9%	95.7%	129.0%	4.24	2.70	6.95	
Maternity Wards	88.9%	86.3%	94.5%	77.9%	11.72	3.12	14.84	
Nidderdale	103.9%	80.2%	103.2%	96.8%	3.53	3.08	6.61	
Oakdale	95.4%	102.7%	94.4%	116.1%	4.58	2.88	7.46	
Special Care Baby Unit	91.2%	33.3%	100.0%	-	15.88	1.47	17.35	
Trinity	98.9%	92.9%	100.0%	100.0%	4.00	4.31	8.30	
Wensleydale	85.8%	122.6%	100.0%	103.2%	3.25	2.54	5.79	
Woodlands	73.0%	96.8%	89.2%	90.3%	9.81	3.30	13.10	
Trust total	92.8%	96.4%	96.5%	103.7%	5.05	3.18	8.23	
ED	94%	88%	96%	90%				

Safe - August 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
	<p>Further information to support the August safer staffing data</p> <p>On the wards Byland, CATT, Oakdale, Jervaulx and Farndale, where the Registered Nurse (RN) fill rate was less than 100% against planned, this reflects current band 5 Registered Nurse vacancies and is reflective of the local and national position in particular regarding the difficulties in recruiting Registered Nurses. The Trust is engaged in an extensive recruitment plan in response to this.</p> <p>In addition, planned staffing levels on Byland and Nidderdale were adjusted in August to reflect the closure of beds in these areas in response to activity levels.</p> <p>The ITU /HDU day and night staffing levels which appear as less than planned are flexed when not all beds are occupied and staff assist in other areas. National standards for RN's to patient ratios are maintained.</p> <p>The planned staffing levels on the Delivery Suite and Pannal ward (maternity wards) have been combined to reflect the close working relationship of these two areas and the movement of staff between the wards in response to fluctuating occupancy and activity levels. Some of the Registered Midwife and care staff gaps were due to sickness in August; however a professional assessment was made on a shift by shift basis to ensure that nurse staffing numbers matched the activity.</p> <p>In some wards the actual care staff hours show additional hours used for enhanced care for those patients who require intensive support. In August this is reflected on the wards AMU, CATT, Farndale, Granby, Jervaulx and Littondale.</p> <p>For the Special Care Baby Unit (SCBU), although the day time RN and care staff hours appear as less than planned, it is important to note that the bed occupancy levels fluctuate in this area and a professional assessment was undertaken on a shift by shift basis to ensure that the planned staffing matched the needs of both babies and families.</p> <p>The staffing complement for the children's ward, Woodlands, is designed to reflect varying levels of occupancy. Due to vacancies and sickness, the day and night time RN hours are less than planned in August, however the ward occupancy levels vary considerably which means that particularly in this area, the number of planned and actual nurses is kept under constant review.</p>		

Caring - August 2018


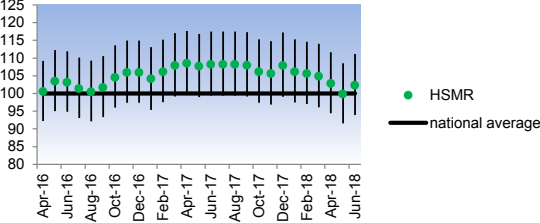

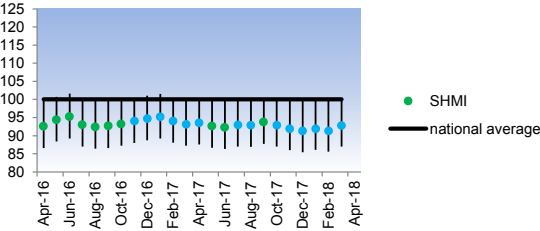

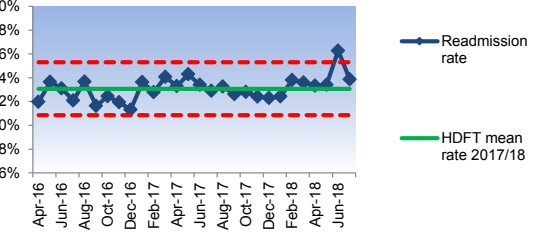
Indicator name / data quality assessment	Description	Trend chart	Interpretation
<p>Friends & Family Test (FFT) - Patients</p>	<p>The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of hospital and community services including inpatients, day cases, outpatients, maternity services, the emergency department, some therapy services, district nursing, community podiatry and GP OOH. A high percentage is good.</p>		<p>94.6% of patients surveyed in August would recommend our services, a decrease on last month but remaining above the latest published national average (93.5%).</p> <p>Around 4,600 patients responded to the survey this month.</p>
<p>Friends & Family Test (FFT) - Adult community services</p>	<p>The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of adult community services including specialist nursing teams, community care teams, community podiatry and GP OOH. A high percentage is good.</p>		<p>91.2% of patients surveyed in August would recommend our services, a reduction on recent months and below the national average performance for community services (95.5%). 390 patients from adult community services responded to the survey this month. The data for March 2018 is not available as there were very few surveys conducted for community services due to a temporary issue with the automated phone call surveys.</p>
<p>Complaints</p>	<p>The number of complaints received by the Trust, shown by month of receipt of complaint. The criteria define the severity/grading of the complaint with green and yellow signifying less serious issues, amber signifying potentially significant issues and red for complaints related to serious adverse incidents. The data includes complaints relating to both hospital and community services.</p>		<p>29 complaints were received in August, an increase on last month and above the average for 2017/18. However, no complaints were classified as amber or red this month. The complaints received this month are in relation to a number of different HDFT services. Of note this month, there are again a number of complaints about a failure to diagnose (including a missed fracture) and attitude of staff.</p>

Narrative

The formal complaints received in August 2018 are comparatively high but not the highest number we have received in month. Only four complaints are related to the inpatient areas.



Effective - August 2018


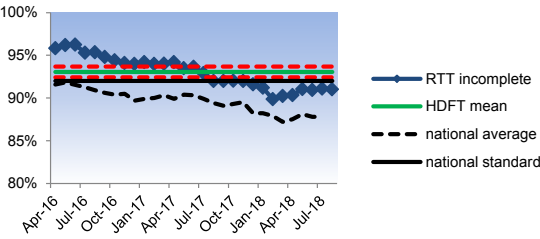

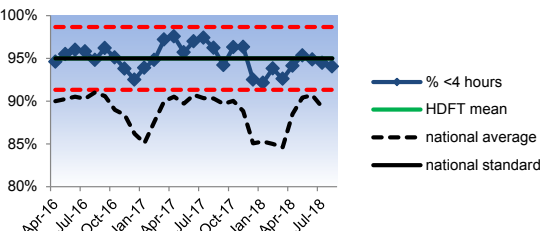

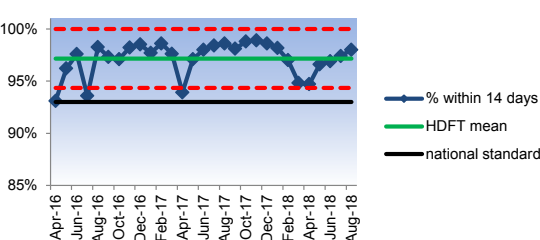

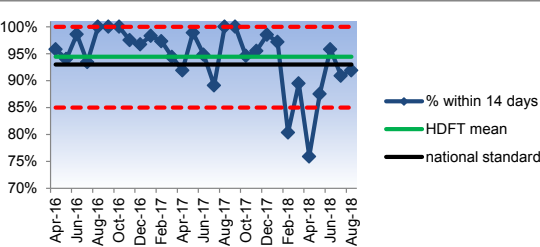
Indicator name / data quality assessment	Description	Trend chart	Interpretation
<p>Mortality - HSMR</p> 	<p>The Hospital Standardised Mortality Ratio (HSMR) looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care. A low figure is good.</p>	 <p>● HSMR — national average</p>	<p>HDFT's HSMR for the rolling 12 months ending June 2018 was 102.3, an increase on last month but remaining within expected levels.</p> <p>At specialty level, three specialties have a higher than expected standardised mortality rate (General Medicine, Geriatric Medicine and Trauma & Orthopaedics).</p>
<p>Mortality - SHMI</p> 	<p>The Summary Hospital Mortality Index (SHMI) looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care. A low figure is good.</p>	 <p>● SHMI — national average</p>	<p>HDFT's SHMI for the rolling 12 months ending March 2018 was 92.8. This remains below expected levels.</p> <p>At specialty level, three specialties (Geriatric Medicine, Respiratory Medicine and one small volume surgical specialty) have a standardised mortality rate above expected levels.</p>
<p>Readmissions</p> 	<p>% of patients readmitted to hospital as an emergency within 30 days of discharge (PbR exclusions applied). To ensure that we are not discharging patients inappropriately early and to assess our overall surgical success rates, we monitor the numbers of patients readmitted. A low number is good performance. This data is reported a month behind so that any recent readmissions are captured in the data.</p>	 <p>◆ Readmission rate — HDFT mean rate 2017/18</p>	<p>The number of emergency readmissions in July (after PbR exclusions are applied) was 254. This equates to 13.9% when expressed as a percentage of all emergency admissions. This is a reduction on last month but remains above the HDFT average for 2017/18. Following the spike in emergency redmissions in some surgical specialties last month, the data is being reviewed including ensuring that patients who present at the Surgical Assessment Unit (SAU) are being recorded correctly.</p>



Effective - August 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<p><u>Narrative</u></p> <p>NHS Blood Transfusion has identified HDFT as 1 of 3 centres to be classified as a prime tissue centre. As part of this work, 5 sets of corneas have been supplied from Harrogate since April 2018.</p> <p>The latest SSNAP (Sentinel Stroke National Audit Programme) results were published recently. HDFT was rated D overall, no change on the last publication. Our score has been impacted by the two data quality indicators - our overall score prior to the data quality adjustment was 58, this reduced to 47 after the data quality adjustment.</p> <p>Of the 10 domains in the SSNAP data set, 7 have remained at the same score. 1 has seen an improvement since the last report - Speech and language therapy (C to B). 2 domains have seen a deterioration - Scanning (D to E) – 22% patients scanned within 1 hour (no change on last publication) but only 78% scanned within 12 hours (90% last publication) and MDT working (C to D).</p> <p>90% of eligible patients were thrombolysed in the latest data set (75% in the last publication), but only 11% within 1 hour (17% in the last publication).</p>			

Responsive - August 2018


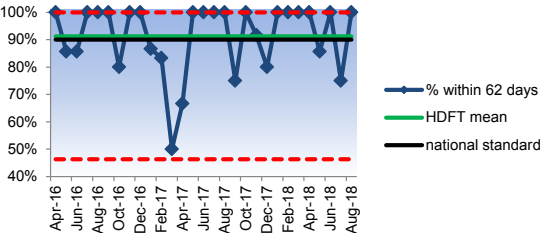

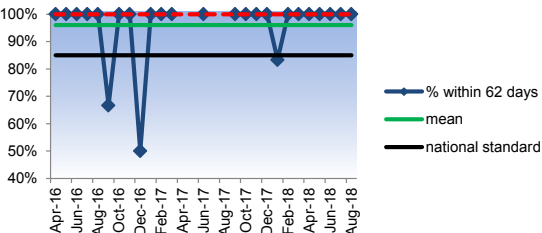

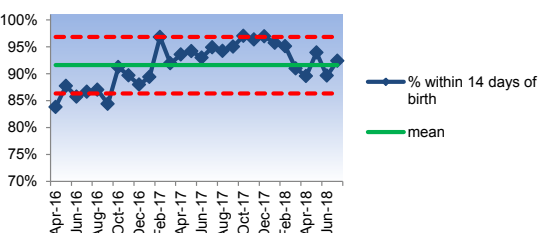

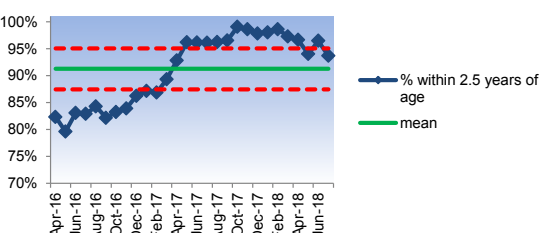
Indicator name / data quality assessment	Description	Trend chart	Interpretation
<p>RTT Incomplete pathways performance</p> 	<p>Percentage of incomplete pathways waiting less than 18 weeks. The national standard is that 92% of incomplete pathways should be waiting less than 18 weeks.</p> <p>A high percentage is good.</p>		<p>Performance was at 91.0% in August, remaining below the minimum standard of 92%. The same two specialties (Trauma & Orthopaedics and Ophthalmology) remain below the 92% standard.</p>
<p>A&E 4 hour standard</p> 	<p>Percentage of patients spending less than 4 hours in Accident & Emergency (A&E). The operational standard is 95%.</p> <p>The data includes all A&E Departments, including Minor Injury Units (MIUs). A high percentage is good.</p>		<p>HDFT's Trust level performance for August was 94.0%, a reduction on last month and below the required 95% standard. This includes data for the Emergency Department at Harrogate and Ripon MIU.</p>
<p>Cancer - 14 days maximum wait from urgent GP referral for suspected cancer referrals</p> 	<p>Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%. A high percentage is good.</p>		<p>Provisional performance for August was at 98.0%, remaining above the 93% standard.</p>
<p>Cancer - 14 days maximum wait from GP referral for symptomatic breast patients</p> 	<p>Percentage of GP referrals for breast symptomatic patients seen within 14 days. The operational standard is 93%. A high percentage is good.</p>		<p>Provisional performance for August was at 91.9%, remaining below the 93% standard. There is now a significant risk that this standard will not be achieved for the second successive quarter. The Clinical Directorates continue to work together to manage the volume of referrals received and match this with appropriate clinic capacity.</p>

Responsive - August 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Cancer - 31 days maximum wait from diagnosis to treatment for all cancers 	Percentage of cancer patients starting first treatment within 31 days of diagnosis. The operational standard is 96%. A high percentage is good.		Delivery at expected levels.
Cancer - 31 day wait for second or subsequent treatment: Surgery 	Percentage of cancer patients starting subsequent surgical treatment within 31 days. The operational standard is 94%. A high percentage is good.		Delivery at expected levels.
Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug 	Percentage of cancer patients starting subsequent drug treatment within 31 days. The operational standard is 98%. A high percentage is good.		Provisional performance for August is below the 98% standard at 97.4%. However it is anticipated that the standard will be delivered for Quarter 2 overall.
Cancer - 62 day wait for first treatment from urgent GP referral to treatment 	Percentage of cancer patients starting first treatment within 62 days of urgent GP referral. The operational standard is 85%. A high percentage is good.		Provisional performance for August was above the required 85% standard at 85.6% with 9 accountable breaches. Of the 11 tumour sites, 4 had performance below 85% in August - colorectal (1.0 breach), haematological (1.5), lung (1.5) and upper gastrointestinal (0.5). 1 patient waited over 104 days in August. The main reason for the delay was a complex diagnostic pathway.


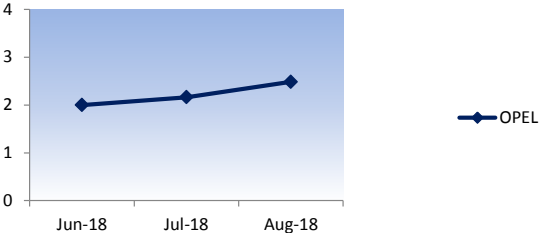


Responsive - August 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<p>Cancer - 62 day wait for first treatment from consultant screening service referral</p> 	<p>Percentage of cancer patients starting first treatment within 62 days of referral from a consultant screening service. The operational standard is 90%. A high percentage is good.</p>		<p>Delivery at expected levels.</p>
<p>Cancer - 62 day wait for first treatment from consultant upgrade</p> 	<p>Percentage of cancer patients starting first treatment within 62 days of consultant upgrade. The operational standard is 85%. A high percentage is good.</p>		<p>Delivery at expected levels.</p>
<p>Children's Services - 10-14 day new birth visit</p> 	<p>The percentage of babies who had a new birth visit by the Health Visiting team within 14 days of birth. A high percentage is good. Data shown is for the 0-5 Health Visiting Service in North Yorkshire and the Healthy Child Programme in Darlington, Co. Durham, Middlesbrough and Stockton. A high percentage is good. The contract does not specify a required level.</p>		<p>In July, the validated performance position is that 92% of babies were recorded on Systmone as having had a new birth visit within 14 days of birth. The data is reported a month in arrears so that the validated position can be shared. The chart presents a combined performance position for all Children's Services contracts and includes data for Stockton from April 2018 onwards. Data for Gateshead and Sunderland will be included from October onwards.</p>
<p>Children's Services - 2.5 year review</p> 	<p>The percentage of children who had a 2.5 year review. A high percentage is good. Data shown is for the 0-5 Health Visiting Service in North Yorkshire and the Healthy Child Programme in Darlington, Co. Durham, Middlesbrough and Stockton. A high percentage is good. The contract does not specify a required level.</p>		<p>In July, the validated performance position is that 94% of children were recorded on Systmone as having had a 2.5 year review. The data is reported a month in arrears so that the validated position can be shared. The chart presents a combined performance position for all Children's Services contracts and includes data for Stockton from April 2018 onwards. Data for Gateshead and Sunderland will be included from October onwards.</p>



Responsive - August 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation								
<p>OPEL level - Community Care Teams</p> 	<p>The OPEL (Operational Pressures Escalation Level) is a measure of operational pressure being experienced by the community care teams. A value of 1 to 4 is agreed each day, with 1 denoted the lowest level of operational pressure and 4 denoting the highest. The chart will show the average level reported by adult community services during the month.</p>	 <table border="1"> <caption>OPEL Trend Data</caption> <thead> <tr> <th>Month</th> <th>OPEL Level</th> </tr> </thead> <tbody> <tr> <td>Jun-18</td> <td>2.0</td> </tr> <tr> <td>Jul-18</td> <td>2.2</td> </tr> <tr> <td>Aug-18</td> <td>2.5</td> </tr> </tbody> </table>	Month	OPEL Level	Jun-18	2.0	Jul-18	2.2	Aug-18	2.5	<p>The Trust has been using the OPEL measure for community services since November 2017. This has been shared within the Trust on operational reports each day. From the beginning of June, the information is being recorded and retained in a database so that we can start to track the trend over time. During August, the average OPEL level reported was 2.5, an increase on last month. The reported level was at 2 for 14 days and was at 3 for 16 out of 31 days during the month.</p>
Month	OPEL Level										
Jun-18	2.0										
Jul-18	2.2										
Aug-18	2.5										

Narrative

Emergency Care 4-hour standard

In light of the continued challenges with activity and consequent performance, a 4 hour standard recovery plan has now been drawn up. This has involved some additional resources being committed to support minor injury capacity between 4pm and 10pm each evening.

Performance against the 4-hour standard is at 94.5% for Quarter 2 to date (up to 18 September). This means that if we have no more than 2 breaches of the 4 hour standard each day for the rest of September that we can still deliver 95% for the Quarter overall.

The Trust has secured £372k funding from the West Yorkshire and Harrogate Health and Care Partnership to support this year's cost of the Supportive Discharge Service and the additional minor injury capacity within our Emergency Department. The cost of Winter has been calculated at £1.5m which means there is still a potential pressure of £1.1m if there is no national funding made available.

The Trust has recently been successful in securing winter funding to support the development of a new unit for same day emergency care. Phase 1 will provide a solution for a medical assessment unit to support delivery of the Winter plan for 2018/19. The aim is to manage ambulatory attenders and provide assessment and streaming for ED attenders and GP referrals through a single unit which will assess and treat or transfer to the appropriate speciality at the most appropriate point in the patient pathway. The new unit will be located in the old Endoscopy Unit, which will enable improved communication and efficiency between teams in the Emergency Department and the Clinical Assessment and Treatment unit. The scheme is due to start on site at the end of September 2018, with completion in early November 2018. The existing CAT team will transfer to the new facility over the winter period.

Responsive - August 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<p data-bbox="197 320 779 347"><u>Elective care expectations and the 18 weeks standard</u></p> <p data-bbox="197 347 1995 405">The Trust has responded to the letter from Ian Dalton, NHS Improvement dated 22nd August, which asked Trusts to provide assurance on delivering elective care performance and activity levels and has agreed to take the following actions:</p> <ul data-bbox="197 432 1973 651" style="list-style-type: none"> - Capacity will be made available to neighbouring Trusts for long wait patients, this will assist in system wide performance but impact on the reduction in HDFT's waiting list. - Continue to work with commissioners to support the demand reduction programme. - Continue to focus on the transformation work to deliver cost reductions in the elective pathways. - Continue to focus on theatre productivity, utilising our new performance dashboard and the benchmarking work within the West Yorkshire and Harrogate ICS. - In line with national guidelines, the Trust will continue to book patients in clinically appropriate chronological order and in line with good practice continue to validate elective pathways of patients waiting. - Continue discussions with HaRD CCG, in conjunction with NHSI and NHSE, about the resources available to support winter and deliver elective work, which at present places a significant financial risk on the local system. <p data-bbox="197 683 909 710"><u>HHFM (Harrogate Healthcare Facilities Management) Performance</u></p> <p data-bbox="197 710 1989 767">The contract management process is now in place with HHFM and the first meeting has taken place. There was one major KPI breach which was discussed and actions are now in place to resolve. Staff shortages in SSD and domestics has affected service delivery during August, actions are now in place to mitigate this.</p>			


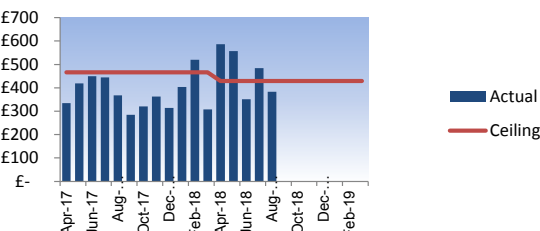


Workforce - August 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation																		
Staff appraisal rates 	<p>The chart shows the staff appraisal rate over the most recent rolling 12 months. The Trust aims to have 90% of staff appraised. A high percentage is good.</p>		<p>Appraisal compliance is remaining fairly static during the appraisal period and has been reported at 75.7% in August. At the closing of the Appraisal Window for the same period last year we had over 85% completion, at the end of August we were at 54% and we have until the end of September to achieve 90% completion. Directorates are taking forward their plans to ensure the completion of outstanding appraisals.</p>																		
Mandatory training rates 	<p>The table shows the most recent training rates for all mandatory elements for substantive staff.</p>	<table border="1"> <thead> <tr> <th>Competence Name</th> <th>% Completed</th> </tr> </thead> <tbody> <tr> <td>Equality, Diversity and Human Rights - Level 1</td> <td>90</td> </tr> <tr> <td>Fire Safety - Level 1</td> <td>80</td> </tr> <tr> <td>Infection Control - No Renewal</td> <td>98</td> </tr> <tr> <td>Data Security Awareness</td> <td>93</td> </tr> <tr> <td>Safeguarding Children & Young People Level 1 - Introduction eLearning</td> <td>94</td> </tr> <tr> <td>Risk Awareness - No Renewal (Replaced Basic Risk Management May 2018)</td> <td>97</td> </tr> <tr> <td>Manual Handling eLearning (Nov 2016)</td> <td>92</td> </tr> <tr> <td>Health & Safety Elearning (June 2016)</td> <td>95</td> </tr> </tbody> </table>	Competence Name	% Completed	Equality, Diversity and Human Rights - Level 1	90	Fire Safety - Level 1	80	Infection Control - No Renewal	98	Data Security Awareness	93	Safeguarding Children & Young People Level 1 - Introduction eLearning	94	Risk Awareness - No Renewal (Replaced Basic Risk Management May 2018)	97	Manual Handling eLearning (Nov 2016)	92	Health & Safety Elearning (June 2016)	95	<p>The data shown is for the end of August and excludes the Harrogate Healthcare Facilities Management (HHFM) staff who transferred into the new organisation on the 1st March 2018 and excludes Stockton, Gateshead and Sunderland staff who Tupe transferred in to the Trust during 2018/19. The overall training rate for mandatory elements for substantive staff is 92% and has increased 1% since the last reporting cycle.</p>
Competence Name	% Completed																				
Equality, Diversity and Human Rights - Level 1	90																				
Fire Safety - Level 1	80																				
Infection Control - No Renewal	98																				
Data Security Awareness	93																				
Safeguarding Children & Young People Level 1 - Introduction eLearning	94																				
Risk Awareness - No Renewal (Replaced Basic Risk Management May 2018)	97																				
Manual Handling eLearning (Nov 2016)	92																				
Health & Safety Elearning (June 2016)	95																				
Sickness rates 	<p>Staff sickness rate - includes short and long term sickness. The Trust has set a threshold of 3.9%. A low percentage is good.</p>		<p>Staff sickness absence continues to fall with the preliminary absence data for August indicating 3.6%. The Attendance Management lead continues to have an oversight on those areas with higher level of sickness absence with specific focus on long term absences. One of the main causes of absence for the long term sickness continues to be anxiety/stress. A Mental Health Steering Group has been established. This group will lead some planned activity across the Trust with a focus on the 'time to change' pledge.</p>																		
Staff turnover rate 	<p>The chart shows the staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. The turnover figures include both voluntary and involuntary turnover. Voluntary turnover is when an employee chooses to leave the Trust and involuntary turnover is when the employee unwillingly leaves the Trust. Data from the Times Top 100 Employers indicated a turnover rate norm of 15%, i.e. the level at which organisations should be concerned.</p>		<p>The labour turnover rate remains fairly static at 11.5%. The Recruitment and Retention Group are exploring retention strategies for Band 5 Registered Nurses, where we tend to have higher levels of turnover. Action are being explored with a more detailed plan going to the group next month.</p>																		



Workforce - August 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation																																							
<p>Agency spend in relation to pay spend</p> 	<p>Expenditure in relation to Agency staff on a monthly basis as a percentage of total pay bill. The Trust aims to have less than 3% of the total pay bill on agency staff.</p>	 <table border="1"> <caption>Approximate data from Trend Chart</caption> <thead> <tr> <th>Month</th> <th>Actual (£k)</th> <th>Ceiling (£k)</th> </tr> </thead> <tbody> <tr><td>Apr-17</td><td>350</td><td>495</td></tr> <tr><td>Jun-17</td><td>450</td><td>495</td></tr> <tr><td>Aug-17</td><td>350</td><td>495</td></tr> <tr><td>Oct-17</td><td>300</td><td>495</td></tr> <tr><td>Dec-17</td><td>350</td><td>495</td></tr> <tr><td>Feb-18</td><td>450</td><td>495</td></tr> <tr><td>Apr-18</td><td>550</td><td>495</td></tr> <tr><td>Jun-18</td><td>450</td><td>495</td></tr> <tr><td>Aug-18</td><td>380</td><td>495</td></tr> <tr><td>Oct-18</td><td>350</td><td>495</td></tr> <tr><td>Dec-18</td><td>350</td><td>495</td></tr> <tr><td>Feb-19</td><td>380</td><td>495</td></tr> </tbody> </table>	Month	Actual (£k)	Ceiling (£k)	Apr-17	350	495	Jun-17	450	495	Aug-17	350	495	Oct-17	300	495	Dec-17	350	495	Feb-18	450	495	Apr-18	550	495	Jun-18	450	495	Aug-18	380	495	Oct-18	350	495	Dec-18	350	495	Feb-19	380	495	<p>Agency expenditure in August reduced to £383k in month, compared to the average monthly figure of £495k in the year to date. The Trust remains above the agency ceiling to date by £216k which remains a significant issue.</p>
Month	Actual (£k)	Ceiling (£k)																																								
Apr-17	350	495																																								
Jun-17	450	495																																								
Aug-17	350	495																																								
Oct-17	300	495																																								
Dec-17	350	495																																								
Feb-18	450	495																																								
Apr-18	550	495																																								
Jun-18	450	495																																								
Aug-18	380	495																																								
Oct-18	350	495																																								
Dec-18	350	495																																								
Feb-19	380	495																																								

Narrative


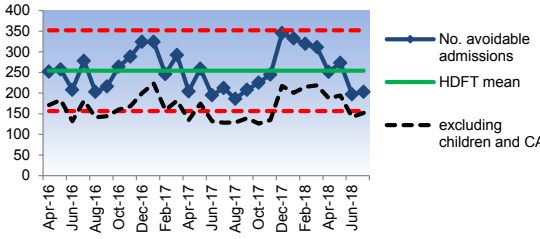

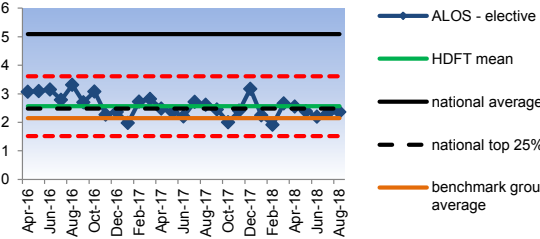

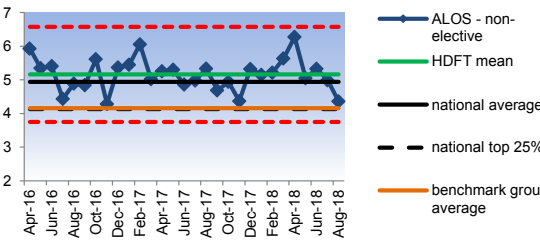

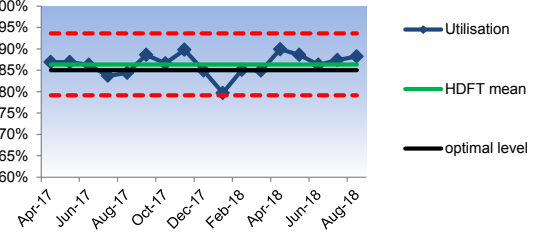
The workforce metrics for sickness absence, labour turnover and mandatory training are all in line with our internal targets and work continues in these areas to maintain and where possible improve performance.

The appraisal period is behind plan in terms of delivery against the Trust target of 90% of appraisals completed within the Appraisal period (1st April- 30th September). Directorates are asked to focus on this important review to ensure that all staff have had an appraisal within the last 12 months.

Although the agency ceiling fell below the target in August, it remains above the ceiling year to date. Work continues in this area from both a medical and nursing perspective. The Trust has undertaken a procurement exercise to implement an internal bank for medical staff. It is anticipated that this will go live in October 2018. In addition to this, the Trust is embarking on an auto-enrolment process for registered nurses during September with the aim of increasing the registered nurses who are active on the bank. The Trust will also ensure that new starters are automatically enrolled onto the bank at point of recruitment going forwards. For those that do not wish to join the bank, there is the ability to opt out. Both of these initiatives aim to reduce reliance on agency staff moving forwards and have savings anticipated.


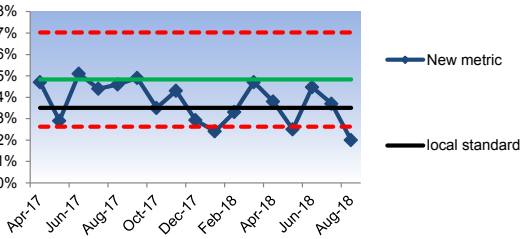

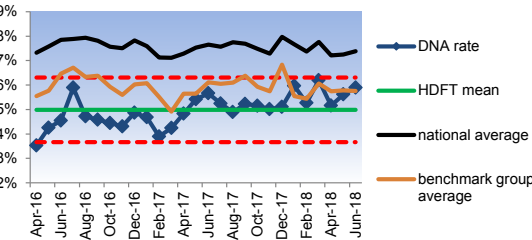

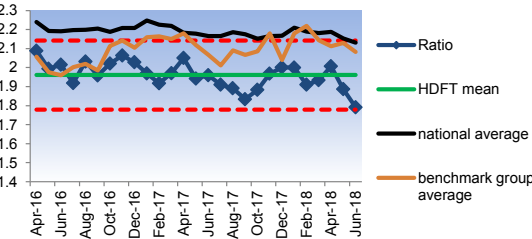

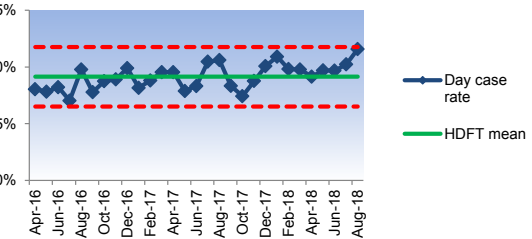


Efficiency and Finance - August 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<p>Avoidable admissions</p> 	<p>The chart shows the number of avoidable emergency admissions to HDFT as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require a hospital admission. Conditions include pneumonia and urinary tract infections in adults and respiratory conditions in children.</p>		<p>Provisional data indicates that there were 203 avoidable admissions in July, an increase on last month but remaining in line with the usual seasonal trend of less avoidable admissions during the summer months.</p> <p>Adult avoidable admissions (excluding CAT attendances) showed a similar trend this month.</p>
<p>Length of stay - elective</p> 	<p>Average length of stay in days for elective (waiting list) patients. The data excludes day case patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.</p>		<p>HDFT's average elective length of stay for August was 2.4 days, no significant change on last month. HDFT remains in the top 25% of Trusts nationally in the most recently available benchmarking data.</p>
<p>Length of stay - non-elective</p> 	<p>Average length of stay in days for non-elective (emergency) patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.</p>		<p>HDFT's average non-elective length of stay for August was 4.4 days, a decrease on last month. The Trust remains in the middle 50% of Trusts nationally when compared to the most recently available benchmarking data.</p>
<p>Theatre utilisation</p> 	<p>The percentage of time utilised during elective theatre sessions (i.e. those planned in advance for waiting list patients). The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc.</p> <p>A higher utilisation rate is good as it demonstrates effective use of resources. A utilisation rate of around 85% is often viewed as optimal.</p>		<p>Elective theatre utilisation was at 88.2% in August, remaining above the 85% optimal level. This utilisation only reflects the elective lists that took place as planned and does not factor in planned elective lists that were cancelled. A list cancellation metric is being incorporated into the new theatres dashboard and will be considered for inclusion in this report.</p>


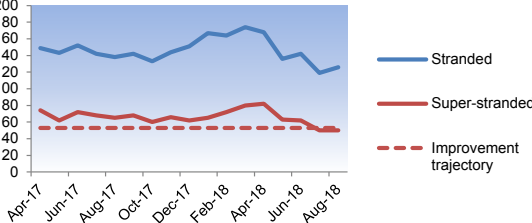

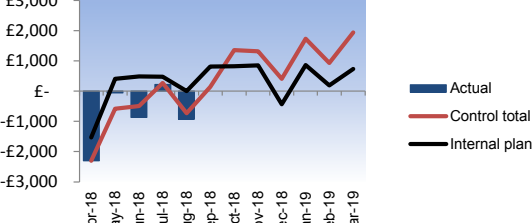


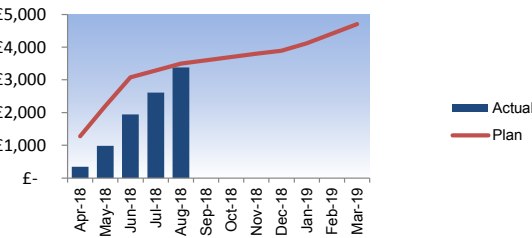


Efficiency and Finance - August 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<p>Delayed transfers of care</p> 	<p>The proportion of bed days lost due to being occupied by patients who are medically fit for discharge but are still in hospital. A low rate is preferable.</p> <p>The maximum threshold shown on the chart (3.5%) has been agreed with HARD CCG.</p>		<p>In August, 2.0% of bed days were lost due to delayed transfers of care, an improvement on last month and below the local standard of 3.5%.</p>
<p>Outpatient DNA rate</p> 	<p>Percentage of new outpatient attendances where the patient does not attend their appointment, without notifying the trust in advance.</p> <p>A low percentage is good. Patient DNAs will usually result in an unused clinic slot.</p>		<p>HDFT's DNA rate increased to 5.9% in June. This is above the level reported by the benchmarked group of trusts but below the national average. Due to ongoing concerns regarding the rise in DNA rates, it has been agreed that the PMO and Quality Improvement Team will develop a toolkit to support teams in actions they can take to reduce this waste.</p>
<p>Outpatient new to follow up ratio</p> 	<p>The number of follow-up appointments per new appointment. A lower ratio is preferable. A high ratio could indicate that unnecessary follow ups are taking place.</p>		<p>Reducing the number of follow ups is a major part of HARD CCG's financial recovery plan. HDFT's new to follow up ratio was 1.79 in June, a decrease on recent months and remaining well below both the national and benchmark group average. There remains a focus on ensuring patients continue to be seen within expected timeframes for follow up where appropriate and for capacity released to either enable reduction in cost or realignment to support alternative activity.</p>
<p>Day case rate</p> 	<p>The proportion of elective (waiting list) procedures carried out as a day case procedure, i.e. the patient did not stay overnight.</p> <p>A higher day case rate is preferable.</p>		<p>The day case rate was 91.6% in July, an increase on last month and remaining above the average day case rate for 2017/18 (89.3%).</p>



Efficiency and Finance - August 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation																					
<p>Stranded patients</p> 	<p>This indicator shows the average number of patients that were in the hospital with a length of stay of over 7 days (defined as stranded patients by NHS Improvement) or over 21 days (super-stranded patients). A low number is good.</p>		<p>The number of super-stranded patients at HDFT has reduced in recent months. NHS Improvement has set improvement trajectories for Trusts to reduce the number of super-stranded patients by around 25% by December 2018. HDFT's trajectory has been set at 53, which equates to a 27% improvement on the 2017/18 baseline position. A methodology document has also been published recently - the Information Team are reviewing this to ensure that we are reporting on the correct cohort of patients and can replicate the data published by NHS Improvement for our Trust. Any amendments will be reflected in the metric presented here once this work concludes.</p>																					
<p>Surplus / deficit and variance to plan</p> 	<p>Monthly Surplus/Deficit (£'000s). In some months, a deficit is planned for. This indicator reports positive or adverse variance against the planned position for the month.</p>		<p>The Trust reported a deficit of £925k in August, a significantly adverse position against the break even internal plan. This results in a year to date deficit of £3.9m, again significantly behind the year to date internal plan. This continued deficit run rate is a significant concern, with August performance placing more pressure on the limited cash resources available to the Trust. By the end of Quarter 2 the plan required a surplus position, therefore as previously discussed recovery plans need to make up this lost ground in the first part of the financial year, as well as address the adverse run rate. Key issues remain the adverse positions relating to ward expenditure, theatre staffing and progress against the cost improvement programme. Added to this are emerging issues in relation to drug expenditure, private patients and additional lists which need to be addressed.</p>																					
<p>NHS Improvement Single Oversight Framework - Use of Resource Metric</p> 	<p>From 1st October 2016, NHS Improvement introduced the Single Oversight Framework. As part of this this, Use of Resource Metric was introduced to replace the previous Financial Sustainability Risk Rating. This is the product of five elements which are rated between 1 (best) to 4.</p>	<table border="1" data-bbox="846 861 1375 1029"> <thead> <tr> <th>Element</th> <th>Plan</th> <th>Actual</th> </tr> </thead> <tbody> <tr> <td>Capital Service Cover</td> <td>4</td> <td>4</td> </tr> <tr> <td>Liquidity</td> <td>1</td> <td>1</td> </tr> <tr> <td>I&E Margin</td> <td>4</td> <td>4</td> </tr> <tr> <td>I&E Variance From Plan</td> <td>1</td> <td>1</td> </tr> <tr> <td>Agency</td> <td>2</td> <td>2</td> </tr> <tr> <td>Financial Sustainability Risk Rating</td> <td>3</td> <td>3</td> </tr> </tbody> </table>	Element	Plan	Actual	Capital Service Cover	4	4	Liquidity	1	1	I&E Margin	4	4	I&E Variance From Plan	1	1	Agency	2	2	Financial Sustainability Risk Rating	3	3	<p>The Trust reported a 3 in August, in line with the planned risk rating. The current rate of agency spend means that it is a weaker 3 than planned.</p>
Element	Plan	Actual																						
Capital Service Cover	4	4																						
Liquidity	1	1																						
I&E Margin	4	4																						
I&E Variance From Plan	1	1																						
Agency	2	2																						
Financial Sustainability Risk Rating	3	3																						
<p>Capital spend</p> 	<p>Cumulative Capital Expenditure by month (£'000s)</p>		<p>Capital expenditure continues to be behind plan, however, this is the result of phasing of larger schemes which are anticipated to be finalised soon. Issues which have emerged through the year are resulting in forecast pressure on the capital programme. The resource for any capital schemes, small or large, is limited to those items which have already been approved due to the current financial performance of the Trust. This is a significant risk.</p>																					



Efficiency and Finance - August 2018

Indicator name / data quality assessment	Description	Trend chart						Interpretation
		Standard	Q1	Q2 to date	Q3	Q4	YTD	
NHS Improvement Single Oversight Framework 	NHS Improvement use a variety of information to assess a Trust's governance risk rating, including CQC information, access and outcomes metrics, third party reports and quality governance metrics. The table to the right shows how the Trust is performing against the national performance standards in the "operational performance metrics" section. From 1st April 2018, dementia screening performance forms part of this assessment.	RTT incomplete pathways	90.8%	91.1%			90.9%	In Quarter 2 to date, HDFT's performance remains below the required level for 3 of the operational performance metrics - 18 weeks, the A&E 4-hour standard and the 6-week diagnostic waiting times standard.
		A&E 4-hour standard	94.8%	94.3%			94.6%	
		Cancer - 62 days	87.3%	86.1%			86.8%	
		Diagnostic waits	98.4%	98.7%			98.5%	
		Dementia screening - Step 1	95.6%	94.5%			95.2%	
		Dementia screening - Step 2	95.7%	100.0%			97.2%	
		Dementia screening - Step 3	97.4%	100.0%			98.1%	

Narrative

Financial Headlines

As highlighted above and in the supporting financial information, the current financial position is adverse to plan. The deficit of £925k in month was significantly behind the internal plan which required a breakeven position. The year to date deficit now stands at £3.9m. This is slightly favourable against the control total requirement, however, it is £3.8m behind the Trusts annual plan.

Issues are discussed in more detail in the supporting information. They include -

- Ward Nursing
- Theatre Staffing
- CIP
- Drug Expenditure
- Private Patients
- Additional waiting lists

There are also a number of smaller overspends, which plans are being developed to address.


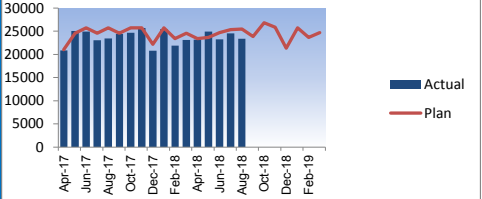

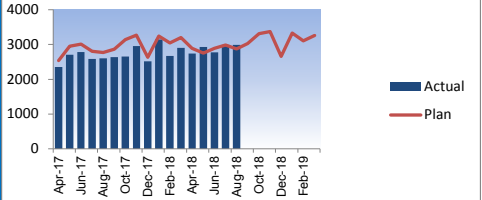

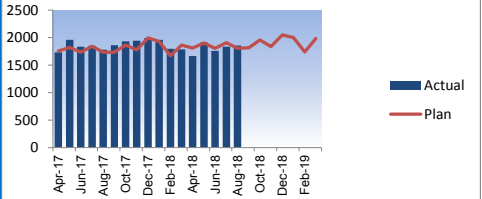

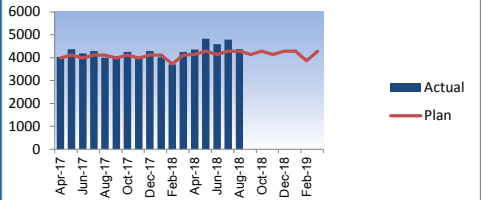

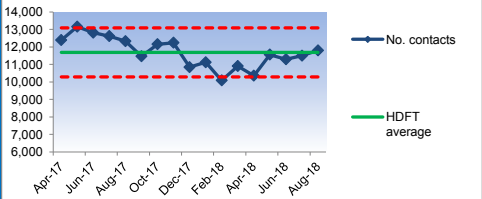
Despite some pressures in relation to activity, income is broadly at planned levels. Performance at point of delivery is detailed in the activity section. Forecast information is being developed for discussion at finance committee, incorporating pressures such as expenditure as a result of demand during winter.

As a result of performance against Revenue plans, cash and capital are particularly pressured. Cash is being managed carefully on a ongoing basis. Capital resource is continually requiring prioritisation following a number of issues arising.

Supportive Discharge Service

We have now recruited to the majority of the roles in the new team and will be looking to launch the service on the 5th November with the full service being available from the end of November 2018 to support our winter resilience. We have developed a range of KPIs to allow us to monitor the impact of the team.

Activity - August 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<p>Outpatient activity against plan</p> 	<p>The chart shows the position against plan for outpatient activity. The data includes all outpatient attendances - new and follow-up, consultant and non-consultant led.</p>		<p>Outpatient activity was 8.2% below plan in August and 2.7% below plan year to date.</p>
<p>Elective activity against plan</p> 	<p>The chart shows the position against plan for elective activity. The data includes inpatient and day case elective admissions.</p>		<p>Elective activity was 4.1% above plan in August and 0.2% above plan year to date.</p>
<p>Non-elective activity against plan</p> 	<p>The chart shows the position against plan for non-elective activity (emergency admissions).</p>		<p>Non-elective activity was 2.8% above plan in August but is 2.3% below plan year to date.</p>
<p>A&E activity against plan</p> 	<p>The chart shows the position against plan for A&E attendances at Harrogate Emergency Department. The data excludes planned follow-up attendances at A&E.</p>		<p>A&E attendances were 2.2% above plan in August. This is a reduction on the period May to July where attendances were significantly above plan. The year to date position remains 8.6% above plan.</p>
<p>Community Care Teams - patient contacts</p> 	<p>The chart shows the number of face to face patient contacts for the community care teams.</p>		<p>There were 11,800 face to face patient contacts in August, an increase on last month. During 2017/18, there were a number of restructures of the teams within these services and a reduction to baseline contracted establishment as the Vanguard work came to an end. This will have impacted upon the activity levels recorded over this period. Therefore caution should be exercised when reviewing the trend over time.</p>

Activity - August 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
--	-------------	-------------	----------------

Narrative

As highlighted in the Efficiency and Finance section, income continues to report a balanced position. Although this is positive there are some issues at point of delivery level. The table below highlights performance against the plan at point of delivery.

New outpatient attendances were below plan in month, but 310 higher than in August 2017. Follow up outpatient attendances remained below plan and reflects the ongoing focus on appropriately reducing these. It should be noted however, that Ophthalmology continues to over perform on the follow up plan (18.8% up for August), this is positive as it reflects an improvement in available workforce to support the ongoing clinical demand in this speciality.






Day cases for the month of August were 200 over plan and 700 cases above August 2017. This represents an improvement in capacity management in August and was achieved through an increase in the run rate in Endoscopy and by backfilling a number of theatre lists vacated due to annual leave with surgeons undertaking day case procedures, particularly in Orthopaedics with middle grade surgeons undertaking a back log of hand and wrist work. Elective inpatient work was in line with August 2017 and 18 cases below plan.

Non-elective activity was above plan in month mainly due to surgical emergency cases which were 15.5% above plan (703 against a plan of 608).

During September, the Cardiac Catheter Lab will be unavailable for a period of time due to failure of the power unit. Contingency plans have been put in place with patients transferred to neighbouring units as necessary. Clearly this will also impact on the daycase activity carried out in month.

Activity type	Aug-17 YTD			Jul-18			Aug-18			Aug-18 YTD		
	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
New outpatients	39764	40445	-1.7%	8798	8468	3.9%	8401	8523	-1.4%	41730	41010	1.8%
Follow-up outpatients	77512	81116	-4.4%	15700	16896	-7.1%	14958	16918	-11.6%	77297	81531	-5.2%
Elective inpatients	1391	1573	-11.6%	292	282	3.6%	252	271	-7.0%	1429	1469	-2.7%
Elective day cases	11645	12508	-6.9%	2700	2704	-0.1%	2740	2602	5.3%	12993	12931	0.5%
Non-electives	9167	8893	3.1%	1832	1910	-4.1%	1856	1806	2.8%	9019	9237	-2.4%
A&E attendances	21872	20333	7.6%	4787	4279	11.9%	4373	4279	2.2%	22929	21117	8.6%

Data Quality - Exception Report

Domain	Indicator	Data quality rating	Further information
Safe	Pressure ulcers - community acquired - grades 2, 3 or 4	Amber 	The observed increase in reported cases over the last two years may be partly due to improvements in incident reporting during the period.
Caring	Friends & Family Test (FFT) - Adult Community Services	Amber 	The number of patients surveyed represents a small proportion of the community based contacts that we deliver in a year.
Efficiency and Finance	Theatre utilisation	Amber 	<p>This metric has been aligned with the new theatre utilisation dashboard from December 2017. Further metrics from the new dashboard are being considered for inclusion in this report from April 2018.</p> <p>The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc.</p> <p>There are some known data quality issues with the utilisation data but it is anticipated that increased visibility of the data via the new dashboard will help to resolve these in the coming months.</p>
Responsive	OPEL level - Community Care Teams	Amber 	This indicator is in development.
Activity	Community Care Teams - patient contacts	Amber 	During 2017/18, there were a number of restructures of the teams within these services and a reduction to baseline contracted establishment as the Vanguard work came to an end. This will have impacted upon the activity levels recorded over this period. Therefore caution should be exercised when reviewing the trend over time.




Indicator traffic light criteria

Domain	Indicator	Further detail	Traffic light criteria	Rationale/source of traffic light criteria
Safe	Pressure ulcers - hospital acquired	No. category 3 and category 4 avoidable hospital acquired pressure ulcers	tbc	tbc
Safe	Pressure ulcers - community acquired	No. category 3 and category 4 community acquired pressure ulcers	tbc	tbc
Safe	Safety thermometer - harm free care	% harm free	Blue if latest month >=97%, Green if >=95% but <97%, red if latest month <95%	National best practice guidance suggests that 95% is the standard that Trusts should achieve. In addition, HDFT have set a local stretch target of 97%.
Safe	Safety thermometer - harm free care - community care teams	% harm free		
Safe	Falls	IP falls per 1,000 bed days	Blue if YTD position is a reduction of >=50% of HDFT average for 2017/18, Green if YTD position is a reduction of between 20% and 50% of HDFT average for 2017/18, Amber if YTD position is a reduction of up to 20% of HDFT average for 2017/18, Red if YTD position is on or above HDFT average for 2017/18.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Safe	Infection control	No. hospital acquired C.diff cases	Green if below trajectory YTD, Amber if above trajectory YTD, Red if above trajectory at end year or more than 10% above trajectory in year.	NHS England, NHS Improvement and contractual requirement
Safe	Incidents - all	Incidents split by grade (hosp and community)	Blue if latest month ratio places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%	Comparison of HDFT performance against most recently published national average ratio of low to high incidents.
Safe	Incidents - comprehensive SIRIs and never events	The number of comprehensive SIRIs and the number of never events reported in the year to date. The indicator includes hospital and community data.	Green if none reported in current month; Red if 1 or more never event or comprehensive reported in the current month.	
Safe	Safer staffing levels	RN and CSW - day and night overall fill rates at trust level	Green if latest month overall staffing >=100%, amber if between 95% and 100%, red if below 95%.	The Trusts aims for 100% staffing overall.
Effective	Mortality - HSMR	Hospital Standardised Mortality Ratio (HSMR)	Blue = better than expected (95% confidence interval), Green = as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval).	Comparison with national average performance.
Effective	Mortality - SHMI	Summary Hospital Mortality Index (SHMI)		
Effective	Readmissions	No. emergency readmissions (following elective or non-elective admission) within 30 days.	Blue if latest month rate < LCL, Green if latest month rate < HDFT average for 2017/18, Amber if latest month rate > HDFT average for 2017/18 but below UCL, Red if latest month rate > UCL.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Caring	Friends & Family Test (FFT) - Patients	% recommend, % not recommend - combined score for all services currently doing patient FFT	Green if latest month >= latest published national average, Red if < latest published national average.	Comparison with national average performance.
Caring	Friends & Family Test (FFT) - Adult Community Services	% recommend, % not recommend - combined score for all services currently doing patient FFT		
Caring	Complaints	No. complaints, split by criteria	Blue if no. complaints in latest month is below LCL, Green if below HDFT average for 2017/18, Amber if on or above HDFT average for 2017/18, Red if above UCL. In addition, Red if a new red rated complaint received in latest month.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Responsive	RTT Incomplete pathways performance	% incomplete pathways within 18 weeks	Green if latest month >=92%, Red if latest month <92%.	NHS England
Responsive	A&E 4 hour standard	% patients spending 4 hours or less in A&E.	Blue if latest month >=97%, Green if >=95% but <97%, amber if >= 90% but <95%, red if <90%.	NHS England, NHS Improvement and contractual requirement of 95% and a locally agreed stretch target of 97%.
Responsive	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	% urgent GP referrals for suspected cancer seen within 14 days.	Green if latest month >=93%, Red if latest month <93%.	NHS England, NHS Improvement and contractual requirement
Responsive	Cancer - 14 days maximum wait from GP referral for symptomatic breast patients	% GP referrals for breast symptomatic patients seen within 14 days.	Green if latest month >=93%, Red if latest month <93%.	NHS England, NHS Improvement and contractual requirement
Responsive	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	% cancer patients starting first treatment within 31 days of diagnosis	Green if latest month >=96%, Red if latest month <96%.	NHS England, NHS Improvement and contractual requirement
Responsive	Cancer - 31 day wait for second or subsequent treatment: Surgery	% cancer patients starting subsequent surgical treatment within 31 days	Green if latest month >=94%, Red if latest month <94%.	NHS England, NHS Improvement and contractual requirement
Responsive	Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug	% cancer patients starting subsequent anti-cancer drug treatment within 31 days	Green if latest month >=96%, Red if latest month <96%.	NHS England, NHS Improvement and contractual requirement
Responsive	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	% cancer patients starting first treatment within 62 days of urgent GP referral	Green if latest month >=85%, Red if latest month <85%.	NHS England, NHS Improvement and contractual requirement
Responsive	Cancer - 62 day wait for first treatment from consultant screening service referral	% cancer patients starting first treatment within 62 days of referral from a consultant screening service	Green if latest month >=90%, Red if latest month <90%.	NHS England, NHS Improvement and contractual requirement
Responsive	Cancer - 62 day wait for first treatment from consultant upgrade	% cancer patients starting first treatment within 62 days of consultant upgrade	Green if latest month >=85%, Red if latest month <85%.	NHS England, NHS Improvement and contractual requirement
Responsive	Children's Services - 10-14 day new birth visit	% new born visit within 14 days of birth	Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%.	Contractual requirement

NHS
Harrogate and District
 NHS Foundation Trust

Domain	Indicator	Further detail	Traffic light criteria	Rationale/source of traffic light criteria
Responsive	Children's Services - 2.5 year review	% children who had a 2 and a half year review	Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%.	Contractual requirement
Responsive	OPEL level - Community Care Teams	OPEL (Operational Pressures Escalation Level) experienced by the community care teams	tbc	Locally agreed metric
Workforce	Staff appraisal rate	Latest position on no. staff who had an appraisal within the last 12 months	Annual rolling total - 90% green. Amber between 70% and 90%. red<70%.	Locally agreed target level based on historic local and NHS performance
Workforce	Mandatory training rate	Latest position on the % staff trained for each mandatory training requirement	Blue if latest month >=95%; Green if latest month 75%-95% overall, amber if between 50% and 75%, red if below 50%.	Locally agreed target level - no national comparative information available until February 2016
Workforce	Staff sickness rate	Staff sickness rate	Green if <3.9% , amber if between 3.9% and regional average, Red if > regional average.	HDFT Employment Policy requirement. Rates compared at a regional level also
Workforce	Staff turnover	Staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts.	Green if remaining static or decreasing, amber if increasing but below 15%, red if above 15%.	Based on evidence from Times Top 100 Employers
Workforce	Agency spend in relation to pay spend	Expenditure in relation to Agency staff on a monthly basis (£'s).	Green if <1% of pay bill, amber if between 1% and 3% of pay bill, red if >3% of pay bill.	Locally agreed targets.
Efficiency and Finance	Avoidable admissions	The number of avoidable emergency admissions to HDFT as per the national definition.	tbc	tbc
Efficiency and Finance	Length of stay - elective	Average LOS for elective patients	Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
Efficiency and Finance	Length of stay - non-elective	Average LOS for non-elective patients	Green = >=85%, Amber = between 75% and 85%, Red = <75%	A utilisation rate of around 85% is often viewed as optimal.
Efficiency and Finance	Theatre utilisation	% acute beds occupied by patients whose transfer is delayed - snapshot on last Thursday of the month.	Red if latest month >3.5%, Green <=3.5%	Contractual requirement
Efficiency and Finance	Outpatient DNA rate	% first OP appointments DNA'd		
Efficiency and Finance	Outpatient new to follow up ratio	No. follow up appointments per new appointment.	Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
Efficiency and Finance	Day case rate	% elective admissions that are day case		
Efficiency and Finance	Stranded patients	Average number of stranded patients (LOS >7 days) and super-stranded patients (LOS >21 days).	tbc	as defined by NHS Improvement
Efficiency and Finance	Surplus / deficit and variance to plan	Monthly Surplus/Deficit (£'000s)	Green if on plan, amber <1% behind plan, red >1% behind plan	Locally agreed targets.
Efficiency and Finance	NHS Improvement Financial Performance Assessment	An overall rating is calculated ranging from 4 (no concerns) to 1 (significant concerns). This indicator monitors our position against plan.	Green if rating =4 or 3 and in line with our planned rating, amber if rating = 3, 2 or 1 and not in line with our planned rating.	as defined by NHS Improvement
Efficiency and Finance	Capital spend	Cumulative capital expenditure	Green if on plan or <10% below, amber if between 10% and 25% below plan, red if >25% below plan	Locally agreed targets.
Efficiency and Finance	NHS Improvement governance rating	Trust performance on Monitor's risk assessment framework.	As per defined governance rating	as defined by NHS Improvement
Activity	Outpatient activity against plan (new and follow up)	Includes all outpatient attendances - new and follow-up, consultant and non-consultant led.		Locally agreed targets.
Activity	Elective activity against plan	Includes inpatient and day case activity		Locally agreed targets.
Activity	Non-elective activity against plan			Locally agreed targets.
Activity	Emergency Department attendances against plan	Excludes planned followup attendances.	Green if on or above plan in month, amber if below plan by < 3%, red if below plan by > 3%.	Locally agreed targets.
Activity	Community Care Teams - patient contacts	Face to face patient contacts	tbc	Locally agreed metric

Data quality assessment

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

IBR Appendix 1

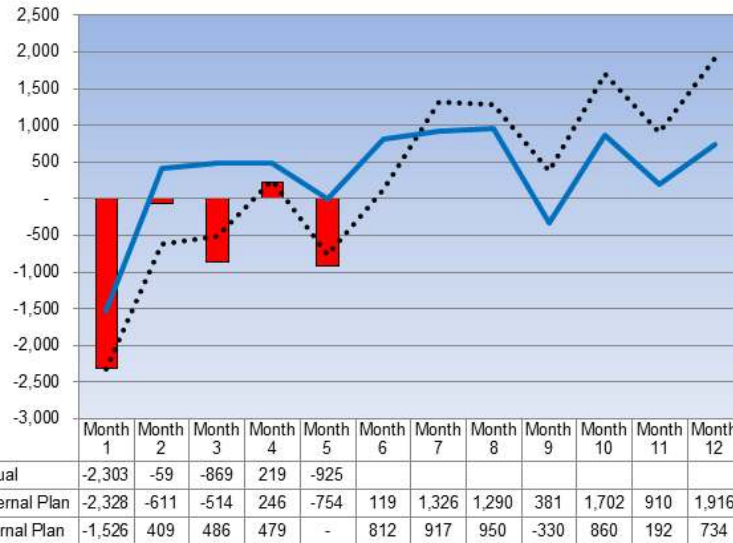
Supporting Financial Information

August 2018 Financial Position

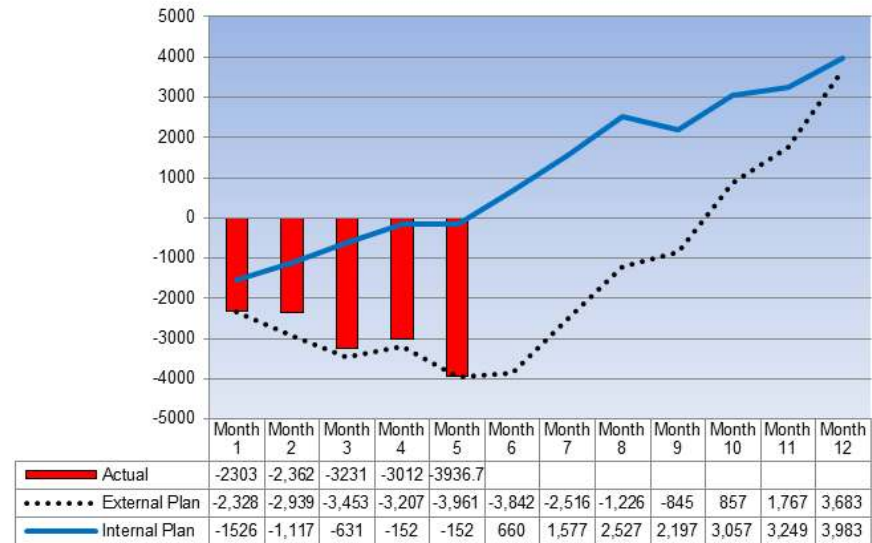
Financial Performance

- The Trust reported a deficit of £925k in August, a significantly adverse position against the break even internal plan. This results in a year to date deficit of £3.9m, again significantly behind the year to date internal plan. Monthly and cumulative performance is highlighted below.

HDFT Monthly Financial Performance (£'000s)



HDFT Cumulative Financial Performance (£'000s)

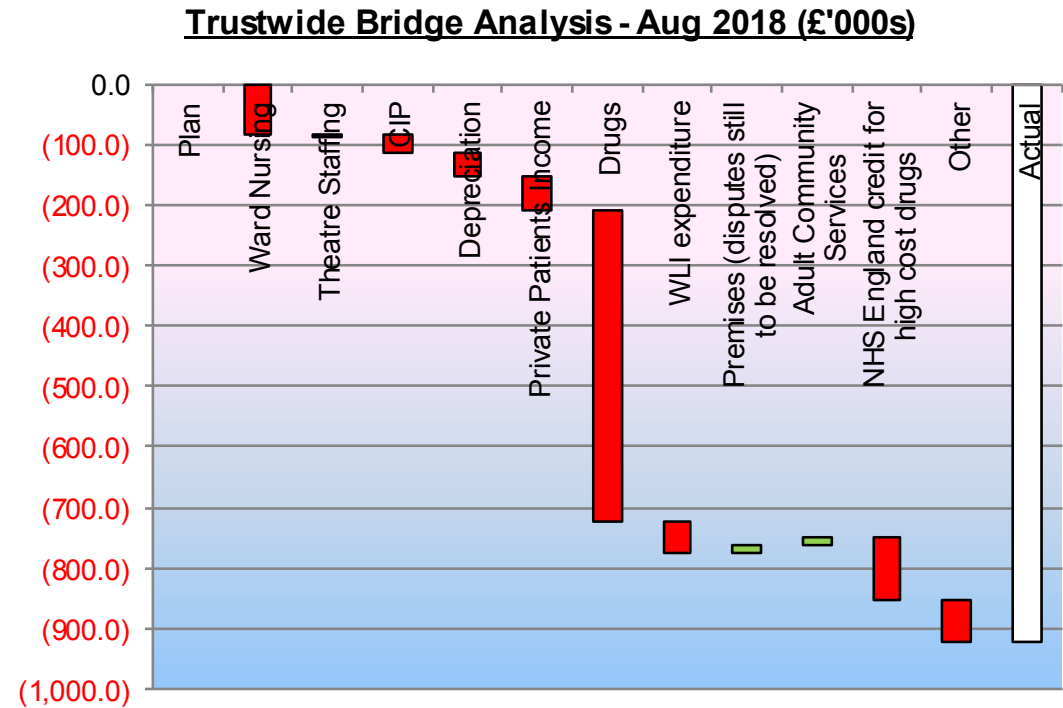


- This continued deficit run rate is a significant concern, with August performance placing more pressure on the limited cash resources available to the Trust. By the end of quarter 2 the plan required a surplus position, therefore as previously discussed recovery plans need to make up this lost ground in the first part of the financial year, as well as address the adverse run rate.
- As a result of being ahead of the external plan set with NHS Improvement, the Trust is currently reporting full achievement of the Provider Sustainability Funding (PSF, formally Sustainability and Transformation Funding). As previously discussed there is some risk in relation to the performance element linked to A&E.

August 2018 Financial Position

Financial Performance Cont. – In Month Key Drivers

Variance to Budget	£'000s
Plan	-
Ward Nursing	(81)
Theatre Staffing	-
CIP	(32)
Depreciation	(39)
Private Patients Income	(57)
Drugs	(515)
WLI expenditure	(51)
Premises (disputes still to be resolved)	14
Adult Community Services	13
NHS England credit for high cost drugs	(106)
Other	(71)
Actual	(925)



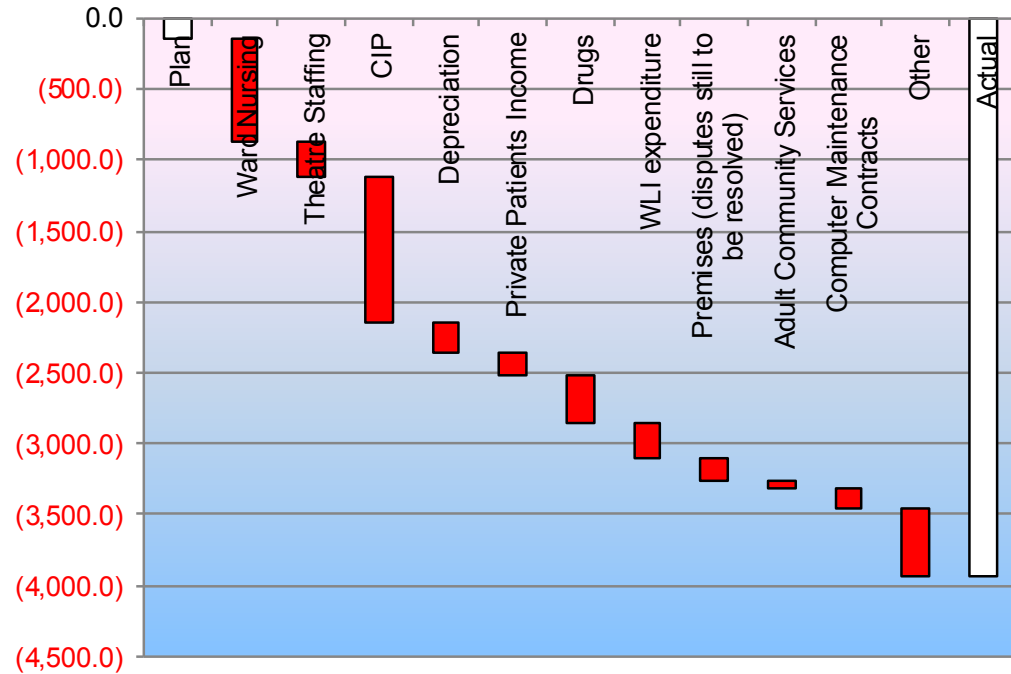
- The key drivers for the in month deficit position are outlined above.
- The predominant emerging issue is in relation to drug expenditure, where it is anticipated that the high cost drug reserve will be significantly overdrawn by year end. Work is underway to establish the issues driving this. In total, the Trust has spent £1m more on drugs this year compared to the same period last year.
- Waiting List Initiative expenditure is another emerging issue, with the WLI reserve forecast to overspend by £500k. Spend has remained in line with 2017/18.

August 2018 Financial Position

Financial Performance Cont. – Year to Date Key Drivers

Variance to Budget	£'000s
Plan	(152)
Ward Nursing	(725)
Theatre Staffing	(241)
CIP	(1,025)
Depreciation	(222)
Private Patients Income	(162)
Drugs	(322)
WLI expenditure	(259)
Premises (disputes still to be resolved)	(162)
Adult Community Services	(42)
Computer Maintenance Contracts	(151)
Other	(474)
Actual	(3,937)

Trustwide Bridge Analysis - YTD 2018/19 (£'000s)



- As outlined above, Ward Nursing, Theatre Staffing and CIP remain key issues of overspend. Added to this are emerging issues in relation to Private Patients, Drugs and WLI expenditure, some of which was highlighted on the previous page.
- Adult community services related to an overspend at the start of the financial year which is reducing as we progress through the financial year. Issues with premises and depreciation are continuing, and computer maintenance contracts predominantly relates to prior year issue.

August 2018 Financial Position

Financial Performance Cont.

- The following forecast outturn scenarios outline the financial impact of the risks currently faced by the Trust.

Forecast Outturn Scenarios as at Month 5 2018/19 (£'000s)



	Best Case £m	Medium Case £m	Worse case £m
Plan	4.00	4.00	4.00
Ward staffing pressures	-0.50	-1.20	-2.40
theatre staffing	-0.30	-0.50	-1.00
CIP delivery		-1.40	-3.00
Income risk		-1.00	-2.00
historic issues	-1.00	-1.00	-3.80
depreciation	-0.40	-0.40	-0.40
living w age	0.30	0.20	0.10
CIP contingency	1.90	1.90	1.90
S&T funding impact		-2.59	-3.39
sub-total	4.00	-1.99	-9.99
w inter costs		-0.70	-1.50
pay award funding - calculation		-0.32	-0.32
pay award funding - HHFM			-0.41
TOTAL	4.00	-3.01	-12.22

August 2018 Financial Position - CIP

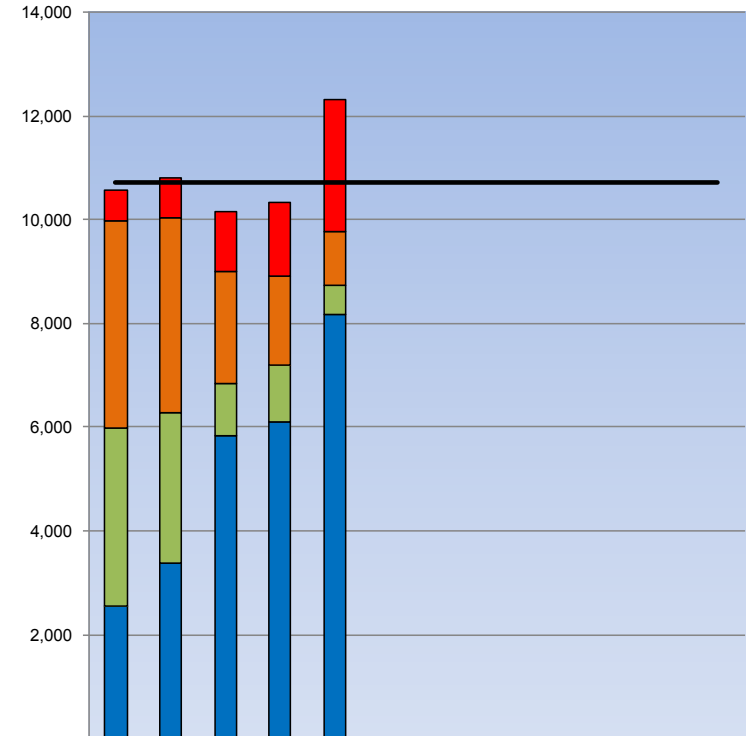
- The Trustwide CIP programme continues its development and implementation, with 102% of plans in place against the £10.7m target. This reduces to 91% following risk adjustment. Information by directorate is highlighted below, as well as progress against key schemes and areas with a high risk to delivery.

Trustwide Efficiency Programme Summary

Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Trustwide Summary	10,700	8,162	581	980	1,180	10,903	102%	9,734	91%
% age of target			5%	9%	11%				

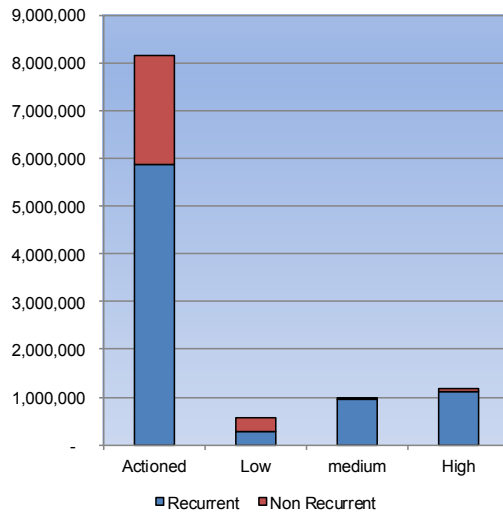
Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Children's and Countywide	1,433	1,191	170	0	64	1,425	99%	1,365	95%
Corporate	1,450	1,313	32	20	110	1,475	102%	1,382	95%
Other and/or Central Schemes	3,867	2,613	0	646	594	3,852	100%	3,248	84%
Long Term and Unscheduled	1,945	1,455	252	110	100	1,917	99%	1,803	93%
Planned and Surgical Care	2,005	1,591	127	204	312	2,233	111%	1,937	97%

Monthly Progress Against Full Year Target (£'000s)

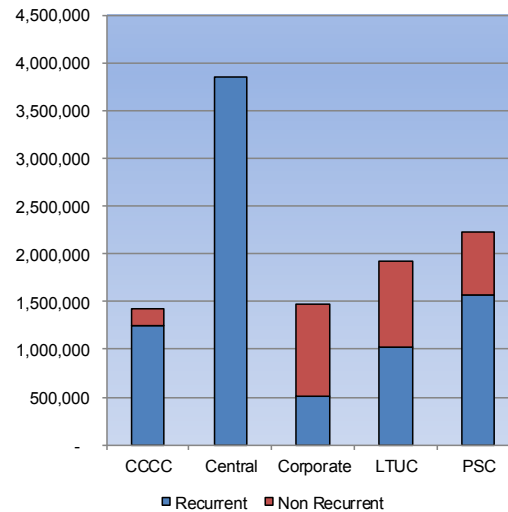


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
High	591	771	1,170	1,412	2,540							
Medium	4,004	3,774	2,154	1,732	1,024							
Low	3,430	2,894	998	1,090	581							
Actioned	2,542	3,376	5,845	6,100	8,162							
Target	10,70	10,70	10,70	10,70	10,70	10,70	10,70	10,70	10,70	10,70	10,70	10,70

Recurrent/Non Recurrent Split by Risk Rating (£s)



Recurrent/Non Recurrent Split by Directorate (£s)



August 2018 Financial Position

Cash and Capital resource

Statement of Cash Flows Summary

Statement of cash flows summary	Current month				Year to date			
	Plan £000s	Actual £000s	Variance £000s	%	Plan £000s	Actual £000s	Variance £000s	%
Cash and cash equivalents at start of period	750	3,905	3,155	420.6%	5,411	5,411	0	0.0%
Net cash generated from / (used in) operations	1,773	1,629	(144)	(8.1%)	2,411	4,041	1,630	67.6%
Net cash generated from / (used in) investing activities	(195)	(1,633)	(1,438)	(737.5%)	(6,056)	(6,112)	(56)	(0.9%)
Net cash generated from / (used in) financing activities	(668)	(644)	24	3.6%	(106)	(83)	23	21.8%
Cash and cash equivalents transferred by absorption or FT transfer and unrealised gains/(losses) on F/ex	0	0	0		0	0	0	
Cash and cash equivalents at end of period	1,660	3,257	1,597	96.2%	1,660	3,257	1,597	96.2%

• The table above outlines the cash position of the Trust. It should be noted that while the actual contains HHFM balances, the plan does not.

• Cash remains a significant risk for the Trust, with a need to establish some recovery and resilience while providing resource for a limited capital programme. The cash position at the end of August was £3,257k. Although this is ahead of plan, any favourable variance needs to be seen in the context of the overall improvement required during 2018/19. The position therefore remains significantly pressured.

• Performance in relation to the Better Payment Practice Code is on the following page.

• Reporting of a 13 week cash flow forecast will be added to the pack in future months.



August 2018 Financial Position

Cash and Capital resource cont.

- The table below outlines BPPC performance. The reporting in this area will be expanded in future months.

Other indicators	Year to date			
	Current month %	Previous month %	Movement %	Trend
BPPC % of bills paid in target				
- By number	6.7%	6.8%	(0.0%)	↔
- By value	42.9%	42.4%	0.6%	↗
Creditor days	107	108	(1)	↘
Debtor days	31	34	(3)	↘

	Year to date		
	Current month	Previous month	Movement
BPPC % of bills paid in target			
Non NHS			
- By number	6.6%	6.6%	(0.1%)
- By value	46.0%	45.2%	0.8%
NHS			
- By number	9.7%	9.2%	0.6%
- By value	3.9%	4.8%	(1.0%)

- It should be noted that the Trust is continuing to reach the target within 60 days, with considerable pressure to do so.
- As a result of financial performance, Capital resource continues to be stretched. A summary of this years programme was outlined at a previous finance committee, with a total resource requirement for 2018/19 of £10.9m. This was dependant on achieving the full PSF funding which clearly is a risk at present.
- As well as the risk to resource availability, further requirements have been identified in relation to the Cardiac Cath Lab, the replacement of computer servers, Orthopaedic equipment and other smaller items.
- This position has been escalated on the Corporate Risk Register and plans are being developed to ensure resource is available for those areas of greatest need. These plans will be brought to the next finance committee.

Date of Meeting:	26 September 2018	Agenda item:	6.0								
Report to:	Board of Directors										
Title:	HDFT Patient and Public Participation Strategy 2018 – 2021										
Sponsoring Director:	Jill Foster – Chief Nurse										
Author(s):	Katherine Roberts – Company Secretary Andrew Forsyth – Interim Company Secretary										
Report Purpose:	<table border="1"> <tr> <td>Decision</td> <td>✓</td> <td>Discussion/ Consultation</td> <td>✓</td> <td>Assurance</td> <td>✓</td> <td>Information</td> <td>✓</td> </tr> </table>			Decision	✓	Discussion/ Consultation	✓	Assurance	✓	Information	✓
Decision	✓	Discussion/ Consultation	✓	Assurance	✓	Information	✓				
Executive Summary:	<p>The HDFT Strategic Narrative sets out our plans to sustain high quality care over the next five years and describes the local and national context within which we work. The Patient and Public Participation Strategy 2018 – 2021 is being developed to provide a framework for how we work with people to achieve continual improvement and sustainable services and support the strategic narrative. This paper provides an overview of the direction of travel after consultation with multiple stakeholders. The next steps is to decide if the Patient and Public Participation Strategy is clear about the opportunity to promote patient- focussed care at an individual level and to turn the framework into a strategy document with a defined implementation plan.</p>										
Related Trust Objectives											
<table border="1"> <tr> <td>To deliver high quality care</td> <td>✓</td> <td>To work with partners to deliver integrated care:</td> <td>✓</td> <td>To ensure clinical and financial sustainability:</td> <td>✓</td> </tr> </table>				To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓		
To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓						
Key implications											
Risk Assessment:	None identified.										
Legal / regulatory:	None identified.										
Resource:	None identified.										
Impact Assessment:	Not applicable.										
Conflicts of Interest:	None identified.										
Action Required by the Board of Directors:											
<p>It is recommended that the Board</p> <ul style="list-style-type: none"> • Notes the framework for the development of the Patient and Public Participation Strategy included within the report • Approves the development of the framework for the Patient and Public Participation Strategy • Discusses whether the Patient and Public Participation Strategy should also include the opportunity to promote patient-focussed care at an individual level • Subject to comments received from the Board, endorses the work to date and agrees with the next steps 											

HDFT Patient and Public Participation Strategy 2018 – 2021

*Working with our patients and local
people of all ages to achieve
continuous improvement*

Introduction

The HDFT Strategic Narrative sets out our plans to sustain high quality care over the next five years and beyond. It describes the local and national context in which we work and our strategic priorities over the next 1-2 year and 3-5 years.

This Patient and Public Participation Strategy is one of a suite of strategies underpinning our Strategic Narrative which together will enable the Trust to fulfil its Vision and Mission statements.

The Trust's 'You Matter Most' philosophy is just one demonstration of the importance we place on delivering care which is safe, effective, caring, responsive and personal. We recognise that without involving and engaging the people whom we serve in our quest for continuous improvement, we will forever fall short of our Vision, to truly deliver Excellence Ever Time.

What do we mean by 'participation'?

Why 'participation'?

Our ambition is to deliver Excellence Every Time for our patients and for people who use our services. The best outcomes are secured by designing care around the needs of people. The only way in which we can do this well is to move away from doing things *'for'* patients, towards doing things *'with and alongside'* patients so that ultimately our services are fine-tuned to the things which matter most for those who rely upon them.

'Participation' is dynamic and adaptive. 'Participation' covers the full spectrum of activities which might more usually be called 'engagement' or 'involvement' - it is intended to capture the continuous and 'live' elements of feedback as well as structured engagement activities, to shift our emphasis towards active inclusion of those who use services in the shaping of those services, and describe the many small steps which collectively create the conditions for innovation, learning and improvement. Participation demands inclusivity and adaptability so that the needs of all people are truly represented.

The quality of care we provide is defined in terms of safety, effectiveness (outcomes) and patient experience. We believe that active participation of patients can significantly contribute to achieving not just a great experience of care, but safer care and better outcomes. Indeed we believe that *without* patient participation, we will forever fall short of truly outstanding care quality.

What is Public and Patient Participation?

Public and patient participation is all about continuous improvement. Defined as "the active participation of citizens, patients, service users and carers and their representatives and Foundation Trust members in the development of health services" it shows our commitment to embedding in our decisions and actions the feedback from the people whom we serve.

Why do we need a Public and Patient Participation Strategy?



We can only achieve our Vision and Mission through working in partnership with the people who use our services.

In order to live up to our pledge of 'You Matter Most' we need to truly appreciate the things which matter to our patients by making it possible for them to participate in our continuous improvement.

In order to achieve continuous improvement we need information (data) about what is working well, and perhaps as importantly what needs to be changed, and that data needs to be truly representative of the population we serve. We need an appreciation of what people value as much as we need to know about complaints, concerns and claims.

How will we achieve participation?

This document describes the steps we will take towards a truly inclusive and participatory approach to gaining feedback from people and patients.

Feedback comes from many sources - formal and informal, proactive and spontaneous. We recognise that the systems and processes we use to capture feedback need to be designed to work for those from whom we seek participation. They need to be truly inclusive, intelligent and adaptive.

We recognise that the first step to developing our strategy needs to be involving our patients and local people in the design of the strategy itself. We also recognise that participation can take many forms and our approach will evolve over time.

We will strive to ensure that the public/patient voice is in the room and that there is a continuous presence through, for example, representation at boards, engagement with existing reference/advisory groups, people stories, events, focus groups and public questions at meetings.

Our Pledges



We will increase the involvement of the communities we are part of, including those who unable to represent themselves, the vulnerable, marginalised or seldom heard.



We will actively seek patient and public feedback on our services in a variety of ways, listen to and review what people are saying and take action.



We will improve the patient experience by listening to and acting on what patients tell us; sharing what patients have told us to drive change. We will use information from many sources.



We will share what we have done in response to feedback.



When we redesign our services we will do this working in partnership with patients and the public.



We will involve patients and carers in decisions about their care at all stages of their patient journey, and support them to manage as much of their care and treatment as they wish and are able to

A guiding principle for Harrogate and District NHS Foundation Trust is to put patients first: *'You Matter Most'*.

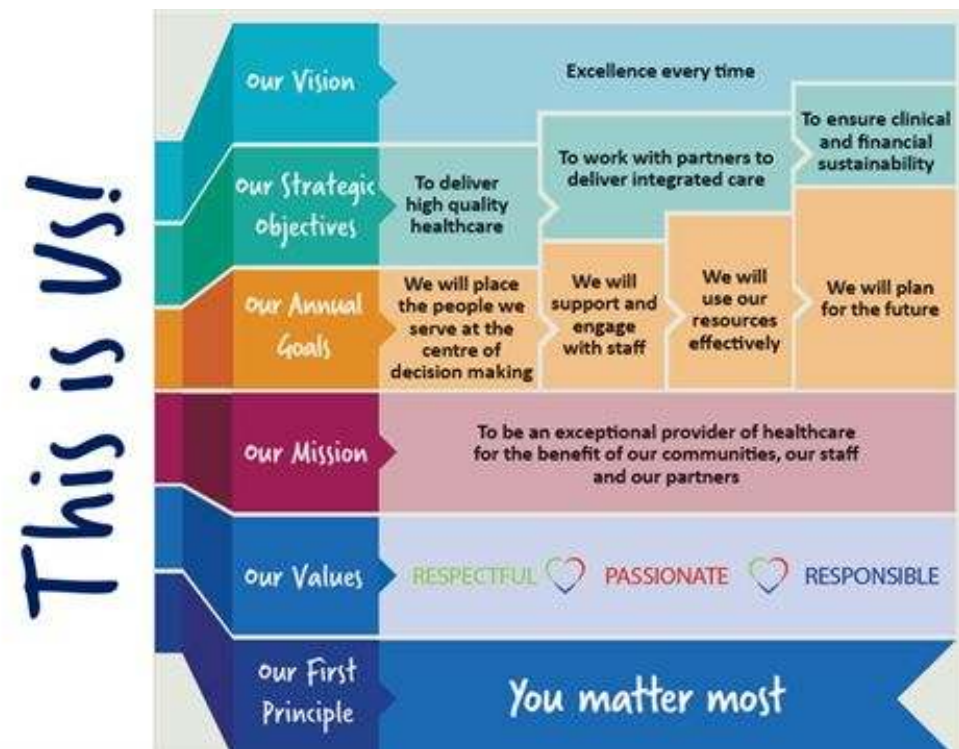


The Trust's values describe and define our culture – it's the way we do things round here.

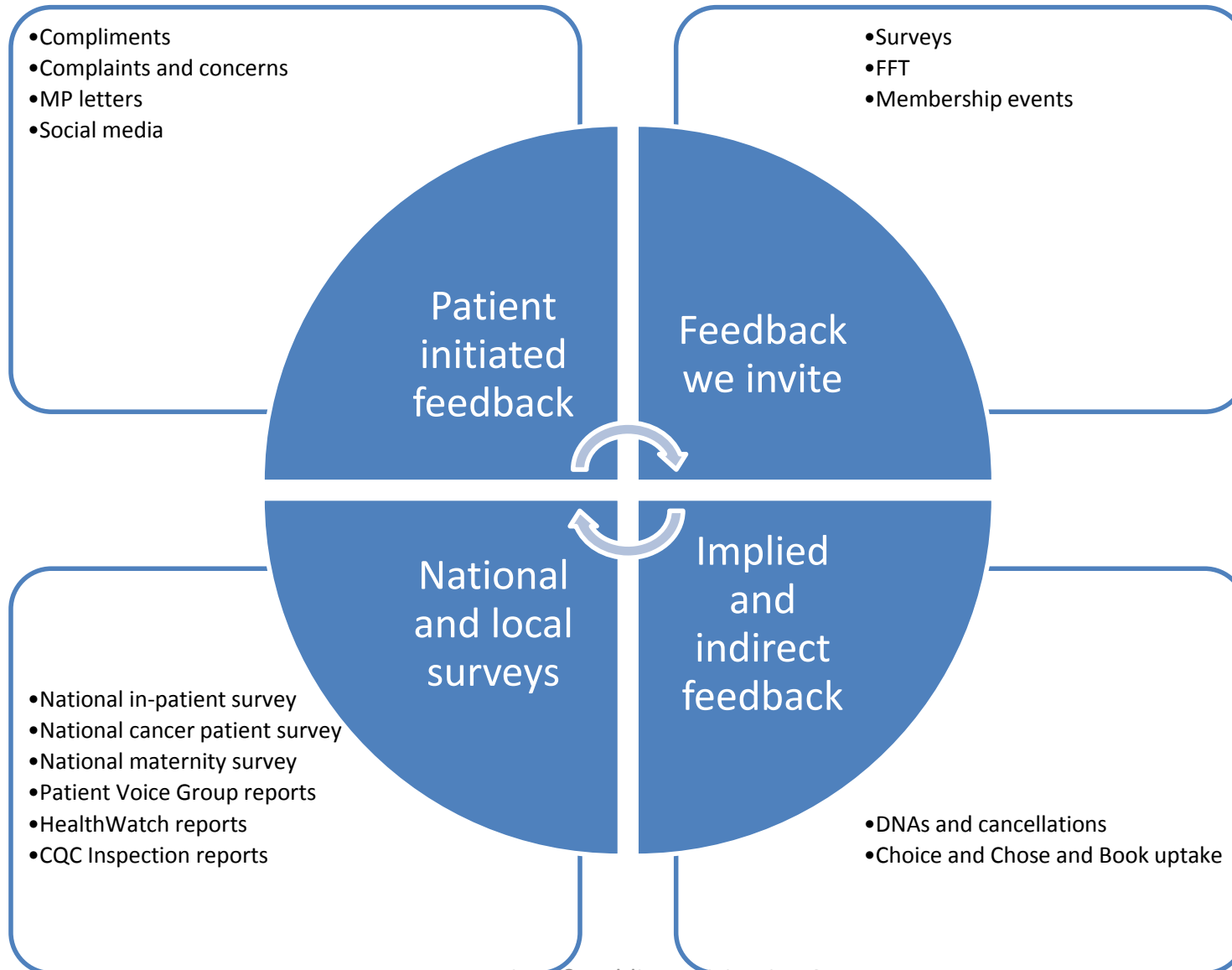
Respectful: We will treat people with respect. People using our services will be treated with dignity and compassion. We will listen to people and treat everyone fairly.

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.



Sources of feedback



Aims of the Patient and Public Participation Strategy

- 1. Service delivery, development and transformation:** we will ensure that the organisation delivers excellent, efficient health care which is responsive to individual needs, including from those who are seldom heard.
- 2. Strategy:** patients, governors, members, the local community and our stakeholders will have a greater opportunity to inform the development of Trust planning and strategic development.
- 3. Assurance:** we will have evidence that a culture of genuine patient and public participation is embedded in the organisation.
- 4. Legal:** we will meet our statutory and regulatory obligations

How will we achieve the Strategy?

- Provide our staff with the tools and resources they need to engage with citizens, patients, service users and carers and their representatives.
- Encourage a culture of genuine patient and public participation in all aspects of the organisation.

How do we get the patient/public voice in to every room?

- Patient stories at every level
- Patient involvement in priority projects

Year One

- Develop a suite of resources to support staff, including:
 - tips how to engage with the public
 - model questionnaires
 - signposts to patient and carer groups
 - technology??
- Continue support for the development of the Youth Forum.
- Continue to draw on the work of the Patient Voice Group.
- Explore the development of digital tools to facilitate participation.
- Continue opportunities for the public to inform the development of Trust planning and strategic development through the Annual Members' Meeting and Council of Governors' meetings.
- Build links with GP Patient Representative Groups within the Harrogate area.
- Ensure patient and public participation is embedded within the Quality Charter, Business Case template and Impact Assessment process.
- Continue work following the Hopes for Health consultation
- Continue to act on feedback from all sources to improve services.
- Gather assurance about what is happening through Directorate meetings, quality of care teams, the Learning from Patient Experience Group, Youth Forum, Board, Committee, Patient Stories and Council of Governors' meetings.

Designing a better system

- Professor Don Berwick stressed that: ‘a new care system is one that is co-designed with the patients’ communities and carers who are getting the help. They have better ideas than the people providing care of what care should look like. It’s listening to and incorporating the voice of the people served everywhere in all phases of design and having the patients’ families, carers, community in the room as partners in the design and redesign of the system of care’.

Stakeholder consultation

- Patient Voice Group
- HealthWatch
- Members
- Governors
- The Youth Forum
- Directorates
- CVS, Carers support etc

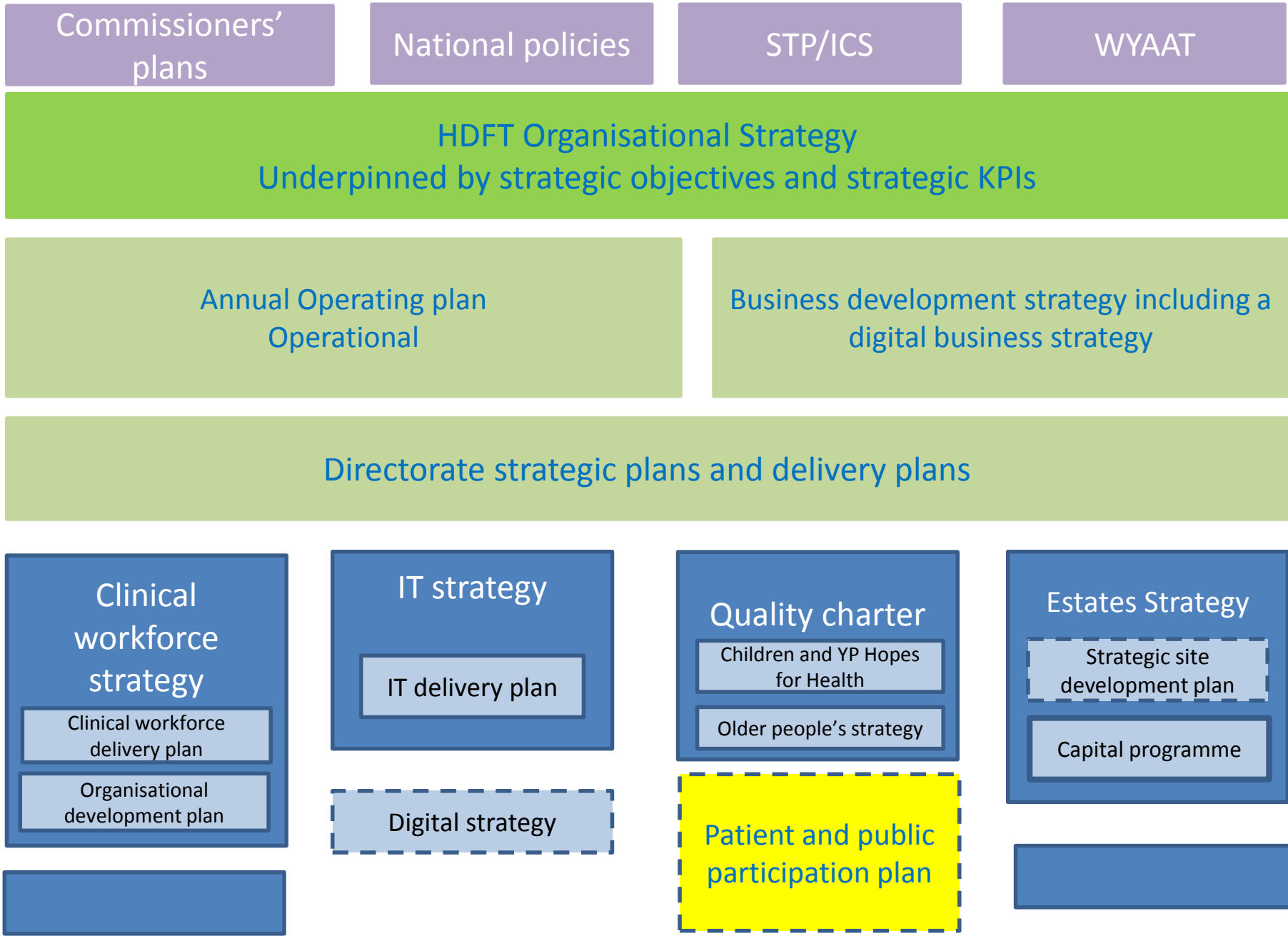
Other considerations

- Use of accessible information
- Targeting under represented groups
- How to evaluate effectiveness
- Interface with ICS structures
- Digitisation

Next steps

1. Discussion with stakeholders
2. Implementation plan

HDFT Organisation strategy and underpinning plans





Date of Meeting:	26 September 2018	Agenda item:	6.1
Report to:	Board of Directors		
Title:	Workforce Race Equality Standard (WRES) Metrics and Action Plan 2018		
Sponsoring Director:	Joanne Harrison, Interim Director of Workforce and Organisational Development		
Author(s):	Katherine Duke, HR Business Partner		
Report Purpose:	Decision	Discussion/ Consultation	✓
		Assurance	✓
		Information	✓
Executive Summary:	<ul style="list-style-type: none"> The Workforce Race Equality Standard (WRES) consists of nine metrics to indicate the workplace experiences of Black, Asian and Minority Ethnic (BAME) staff, including a specific indicator to address the low numbers of BAME Board members across organisations. It is important to demonstrate progress in improving the culture across the Trust to ensure all staff are treated fairly and diversity is valued. The analysis of the data collected for the 2018 submission highlighted deterioration across key metrics. An action plan owned by the Workforce Equality Group will support the Trust work towards improvements over the next 12 months. 		
Related Trust Objectives			
To deliver high quality care	✓	To work with partners to deliver integrated care:	✓
		To ensure clinical and financial sustainability:	✓
Key implications			
Risk Assessment:	Any identified risks are included in the Directorate and Corporate Risk Registers and the Board Assurance Framework.		
Legal / regulatory:	The Trust is required to publicise the metrics and action plan by 28th September 2018 on the Trusts website		
Resource:	Not applicable		
Impact Assessment:	Not applicable		
Conflicts of Interest:	None identified		
Reference documents:	Workforce Race Equality Standard 2018		
Assurance:	The metrics and action plan has been shared at the Workforce and Organisational Development Steering Group and Senior Management Team.		
Action Required by the Board of Directors:			
It is recommended that the Board notes the metrics, as well as the contents of the action plan and approves for publication on the Trust website on 28 September 2018.			

6.1



WORKFORCE RACE EQUALITY STANDARD (WRES) 2018

There is robust evidence that a diverse workforce in which all staff members' contributions are valued is linked to high quality patient care. With over one million employees, it is important that the NHS can demonstrate actions in relation to valuing workforce diversity. The Workforce Race Equality Standard (WRES) consists of nine metrics to indicate the workplace experiences of Black, Asian and Minority Ethnic (BAME) staff, including a specific indicator to address the low numbers of BAME Board members across organisations. The metrics are monitored on an annual basis with a requirement for the Trust to demonstrate progress year on year through an action plan.

The WRES is a mandated requirement of the NHS standard contract, it should be noted that as with previous WRES submissions Trusts will not be managed on their performance against these metrics, though it remains important for the Trust to demonstrate progress to improve the culture, to ensure that all staff are treated fairly and diversity is valued.

The WRES should be used in conjunction with the Equality Delivery System to support the Trust deliver its Public Sector Equality Duty. Benchmarking is undertaken at a national level to understand progress across the NHS as a whole. According to NHS England, the 2017 WRES submissions show improvement nationally in relation to the key metrics.

When analysing the data collected for the 2018 submission, the Trust has seen deterioration across key metrics. The full submission is included as Annex A, however key points to highlight include:

- BAME candidates are 2.14 times less likely to be appointed following shortlisting than white candidates.
- BAME members of staff are 2.36 times more likely to be disciplined than white members of staff.
- 27.78% of BAME staff reported harassment from patients, relatives and the public in the last 12 months (21.97% for white staff).
- 34% of BAME staff reported harassment, bullying or abuse from staff in last 12 months (19% for white staff).
- 96% of BAME staff believe the Trust provides equal opportunities for career progression or promotion (91% for white staff).

These results represent a concerning picture for the Trust, included in the submission is an action plan which will be owned by the Workforce Equality Group to support the Trust work towards improvements over the next 12 months. The Trust is required to publish the metrics and action plan by 28th September 2018 on the Trusts website. In addition, further analysis is being undertaken to understand the metrics in more detail. This will include, where possible, analysis of the different geographies in which the Trust operates, allowing for a more detailed understanding of key drivers behind the metrics to ensure actions taken are meaningful and appropriate for all areas of the Trust.

The metrics and action plan has been shared at the Workforce and Organisational Development Steering Group and Senior Management Team. Board members are asked to note the contents of the metrics and action plan and approve for publication on the Trust website on 28th September 2018.

Annex A - Workforce Race Equality Scheme (WRES) action plan 2018

Number	Indicator	Data for reporting year Clinical Workforce (CW) and Non Clinical Workforce (NCW)	Narrative - the implications of the data and any additional background explanatory narrative	Actions required	Owner	Timescale	
1	Percentage of staff in each of the Agenda for Change (AFC) Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	<p>CW Under Band 1- 0%</p> <p>CW Band 1-0%</p> <p>CW Band 2- 9.94%</p> <p>CW Band 3- 2.59%</p> <p>CW Band 4- 0.57%</p> <p>CW Band 5- 10.64%</p> <p>CW Band 6- 3.46%</p> <p>CW Band 7- 2.83%</p> <p>CW Band 8a- 0%</p> <p>CW Band 8b-0%</p> <p>CW Band 8c-0%</p> <p>Cw Band 8d- 100%</p> <p>CW Band 9-0%</p> <p>CW VSM-0%</p> <p>CW Consultants 18.18%</p>	<p>CW Career Grade 44.59%</p> <p>CW TraineeGrade23.97%</p> <p>CW Other- 17.28%</p> <p>NCW Under Band 1 12.5%</p> <p>NCW Band 1-0%</p> <p>NCW Band 2- 1.79%</p> <p>NCW Band 3- 1.63%</p> <p>NCW Band 4- 3.10%</p> <p>NCW Band 5- 4.41%</p> <p>NCW Band 6- 2.04%</p> <p>NCW Band 7- 2.78%</p> <p>NCW Band 8a- 0%</p> <p>NCW Band 8b-0%</p> <p>NCW Band 8c-0%</p> <p>NCW Band 8d- 0%</p> <p>NCW Band 9-0%</p> <p>NCW VSM-0%</p>	<p>This data indicates that a greater understanding of progression routes and career pathways may be required in relation to BAME staff.</p>	<ul style="list-style-type: none"> A new starter questionnaire to be rolled out to understand the experiences of new starters and their views on the recruitment process. Consideration will be given to how we can include individuals who were not appointed following shortlisting. The Trust's Pathway to Management training programme (for managers) is currently being reviewed with a view to including unconscious bias training, and more detail on the benefits of diversity. The Trust is initiating listening events to explore staff experiences across the Trust and determine whether more can be done to encourage progression within the organisation. 	Workforce Equality Lead/ Call to Action Lead/ Chief Executive	Apr-19
2	Relative likelihood of BAME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts.	2.14	This shows that a BAME applicant is less likely to be appointed following shortlisting than a white candidate.	<ul style="list-style-type: none"> Continue to run nurse recruitment open days alongside considering what different advertising methods can be used to access underrepresented groups. Unconscious bias training and training on the benefits of diversity to be included in Pathway to Management Training. Review and consider alternative shortlisting and appointment techniques, to include consideration of internal and external processes. 	Workforce Equality Lead/ Workforce Equality Group	Jan-19	
3	Relative likelihood of BAME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation* *Note: this indicator will be based on data from a two year rolling average of the current year and the previous year.	2.36	This shows the a BAME member of staff is more likely to enter a formal disciplinary process than a white member of staff.	The Trust's Pathway to Management training programme for managers is currently being reviewed with a focus on unconscious bias training.	Workforce Equality Lead	Feb-19	
4	Relative likelihood of BAME staff accessing non-mandatory training and Continued Professional Development (CPD) as compared to White staff	0.03	This shows that BAME members of staff are less likely to access non-mandatory training and CPD compared to white staff.	The Trust is initiating listening events to explore staff experiences across the Trust and determine whether more can be done to encourage progression and development within the organisation.	Workforce Equality lead/ Chief Executive	Apr-19	
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White - 21.97% BAME - 27.78%	BAME staff report higher levels of bullying and harassment from patients, relatives and the public in the last 12 months than white staff.	<ul style="list-style-type: none"> Workforce Equality Group to engage with BAME staff to drive participation in the National Staff Survey. Continue efforts to increase the core membership of the Security Forum and have directorate representation to act as security co-ordinators. The Trust is participating in a national call to action in relation to Bullying and Harassment which will pay particular attention to the experiences of BAME staff. The Trusts Pathway to Management training is being developed to give line managers more confidence in dealing with concerns early and aligning this to the values and behaviours framework across the Trust 	Workforce Equality Group/ Site Security Manager	Jan-19	
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White - 19% BAME - 34%	BAME staff report higher levels of bullying and harassment from staff in the last 12 months than white staff. There is a 15% point difference in the reported experiences of BAME staff and white staff which is a deteriorating position from 2017.	<ul style="list-style-type: none"> Workforce Equality Group to engage with BAME staff to drive participation in the National Staff Survey. The Trust is participating in a national call to action in relation to Bullying and Harassment which will pay particular attention to the experiences of BAME staff. The Trusts Freedom to Speak up Guardian is seeking to introduce Fairness Champions who will be able to support individuals who may be experiencing harassment or bullying and embed the Speaking Up principles across the Trust 	Workforce Equality Group / Freedom to Speak up Guardian	Jun-19	

7	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promotion	White - 91% BAME - 96%	A greater percentage of white staff than BAME staff believe that the Trust does not offer them equal opportunities for career progression.	<ul style="list-style-type: none"> The Workforce Equality Group to engage with BAME staff to drive participation in the National Staff Survey. The Trust's Pathway to Management training programme for managers is currently being reviewed with a focus on unconscious bias training. Specific work is being undertaken across the Trust to educate managers in how to support progression. The Trust is considering implementing a programme of reverse mentoring with Board members and BAME staff to support learning across the organisation and also support progression routes. The Nurse Recruitment and Retention group is exploring options in relation to career coaching as a route to improve progression across the Trust. 	Workforce Equality Lead/ Workforce Equality Group / Nurse Recruitment and Retention Group	Jun-19
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? a) Manager/team leader or other colleagues	White - 4% BAME - 0%	A greater percentage of white staff than BAME staff believe that they have experienced discrimination from their manager or other colleagues.	<ul style="list-style-type: none"> Continue training for new line managers with the Trust's Pathway to Management program with regards to equality and employment law. The Trust's Pathway to Management training programme for managers is currently being reviewed with a focus on unconscious bias training and having difficult conversation in order to address matters at an early stage. Workforce Equality Group to engage with BAME staff to drive participation in the National Staff Survey. <p>The Trusts Freedom to Speak up Guardian is seeking to introduce Fairness Champions who will be able to support individuals who may be experiencing discriminatory behaviour and embed the Speaking Up principles across the Trust.</p>	Recruitment Manager/ Workforce Equality Lead/ Workforce Equality Group	Jun-19
9	Percentage difference between the organisations' Board voting membership and its overall workforce.	White - 22.3% BAME - 7.1%	This shows that white board members are overrepresented compared to the demography of the workforce, and BAME board members are underrepresented compared to the demography of the workforce.	<ul style="list-style-type: none"> Ensure Board level positions are broadly advertised when they arise. Review and consider alternative shortlisting and appointment techniques to improve diversity. 	Company Secretary/ Workforce Equality Lead	Ongoing



Date of Meeting:	26 September 2018	Agenda item:	6.2
Report to:	Board of Directors		
Title:	Health Education England Education and Training Self-Assessment		
Sponsoring Director:	Joanne Harrison, Interim Director of Workforce and Organisational Development		
Author(s):	Shirley Silvester, Head of Learning & Organisational Development (Various Contributors)		
Report Purpose:	Decision	Discussion/ Consultation	Information
		✓	✓
Executive Summary:	<ul style="list-style-type: none"> The Trust is able to demonstrate appropriate and positive activity across all 6 domains of the HEE Quality Framework as demonstrated in the self-assessment. The self-assessment demonstrates the good practice and priority that we place on learning across the multi-professional workforce and how that relates to the Quality domains. Like many NHS organisations, the Trust is experiencing workforce challenges, particularly relating to some medical specialties and in-patient ward nursing, which can impact on the experience of our learners, actions are being progress to mitigate these. 		
Related Trust Objectives			
To deliver high quality care	✓	To work with partners to deliver integrated care:	✓
		To ensure clinical and financial sustainability:	✓
Key implications			
Risk Assessment:	Any identified risks are included in the Directorate and Corporate Risk Registers and the Board Assurance Framework.		
Legal / regulatory:	Health Education England has requested this submission by 28 September 2018.		
Resource:	Not applicable		
Impact Assessment:	Not applicable		
Conflicts of Interest:	None identified		
Reference documents:	2018 Education and Training Self-Assessment Report (SAR)		
Assurance:	Report compiled by the various training and educational leads across the Trust.		
Action Required by the Board of Directors:			
It is recommended that the Board: Approves the submission of the Self-Assessment to Health Education England.			



2018 Education & Training Self-Assessment Report (SAR)

Reporting Period: 1 August 2017 to 31 July 2018

Deadline for submission to HEE: 31 October 2018

Trust's name:	Harrogate and District NHS Foundation Trust
Value of contract / funding with HEE:	<ol style="list-style-type: none"> 1. Total initial 18/19 LDA value (<i>including undergraduate</i>): £ 4,296,513.83 2. Total for salaries for doctors in training in 18/19: £ 1,542,923.00 3. Total estimated Medical placement tariff in 18/19: £ 814,821.00 4. Total estimated Non-medical placement tariff in 18/19: £ 309,096.36
Trust Chief Executive's name:	Dr Ros Tolcher
Director(s) of Education's name: (or equivalent, please state job title):	<p>Joanne Harrison Interim Director of Workforce & Organisational Development</p> <p>Dr Simon Holbrook Director of Medical Education</p>
Name of Board Level Exec/Non-exec Director responsible for Education and Training strategy within your organisation:	Joanne Harrison Interim Director of Workforce & Organisational Development
Report compiled by (responsible for completion of):	Shirley Silvester, Head of Learning & OD Diane Fisher, Medical Education Manager/ Pamela Dunn, Medical Education Manager
Report signed off by:	Joanne Harrison Interim Director of Workforce & Organisational Development
Date signed off:	18 September 2018
Board Approval:	
<ol style="list-style-type: none"> 1. Approved by / on behalf of the Trust Board: (date / details) 2. Date seen at or scheduled for Board meeting 	26 September 2018

Contents

[Section 1: Organisation overview linked to the HEE Quality Framework.....4](#)

[1.1. Statement of how the HEE Quality Domains are being met organisationally 4](#)

[1.2. Top three successes 4](#)

[1.3. Top three challenges or prominent issues that HEE should be aware of 6](#)

[1.4. Strategic workforce plan 6](#)

[Section 2: Exception Reporting against HEE Quality Domains7](#)

[2.1. Multi-professional 7](#)

[2.1.1. Organisation overview linked to the HEE Quality Domains 7](#)

[2.1.2. Good Practice Items 10](#)

[2.1.3. Challenges or important issues that HEE should be aware of 11](#)

[2.2. Postgraduate Medical 12](#)

[2.2.1. Organisation overview linked to the HEE and GMC Standards 12](#)

[2.2.2. Good Practice Items 17](#)

[2.2.3. Challenges or important issues that HEE should be aware of 20](#)

[2.2.4. Medical faculty roles, organisation and accountability 21](#)

[2.2.5. Staff and Specialty Grade Doctors \(SASG\) and Locally Employed Doctors \(LEDs\) Faculty development 22](#)

[2.3. Undergraduate Medical 24](#)

[2.3.1. Organisation overview linked to the HEE and GMC Standards 24](#)

[2.3.2. Good Practice Items 27](#)

[2.3.3. Challenges or important issues that HEE should be aware of 29](#)

[2.4. Academic Training 32](#)

[Section 3: Reference List of Supporting Information33](#)

[Section 4: 17/18 and 18/19 LDA Funding34](#)

[Section 5: Simulation, Patient Safety and Human Factors36](#)

[Section 6: Equality and Diversity37](#)

[Section 7: Libraries and Knowledge Services \(LQAF\)40](#)

[Section 8: Additional Information40](#)

[8.1 Supporting Learners at Coroners’ Court and following Serious Incidents42](#)

[8.2. Educational Opportunities during winter pressures45](#)

6.2

Section 1: Organisation overview linked to the HEE Quality Framework

1.1. Statement of how the HEE Quality Domains are being met organisationally

This SAR is aligned to the HEE Quality Framework: <https://hee.nhs.uk/our-work/quality>

For medical education the SAR is also aligned to the GMC Standards:

<http://www.gmc-uk.org/education/index.asp>

Trust's response (max of 500 words)

HDFT is committed to supporting the development of the future NHS workforce. We take this responsibility very seriously and many of our clinicians are passionate about the education agenda and as a Trust we aim to harness this to provide clinical supervision and mentorship to undergraduate and post graduates as well as non-medical students.

Our Learning Environment Monitoring meeting held in May 2018 was a positive and helpful meeting. The integration of the review of learning environments across medical and non-medical professions is a very welcomed move and reflects the culture and approach we aspire to within the way our clinical teams work in practice.

We are able to demonstrate appropriate and positive activity across all six domains of the HEE Quality Framework and have a robust educational governance infrastructure in place to manage, support and improve this on an ongoing basis.

Alongside the majority of NHS Trusts, we are experiencing challenges around both medical and non-medical staffing, experiencing gaps in Band 5 registered nursing and in medical staffing. We believe that we are doing our utmost to manage these gaps with innovative workforce solutions, and in working in collaboration across our STP to maximise efficiencies and gains. The Trust participates actively in the Integrated Care System (ICS) and Local Workforce Action Board (LWAB) and is proud of the contribution we are able to make in these forums. For example, our Chief Executive is the Chair of the LWAB and our Chairman is the Chair of the newly established North Regional Talent Board.

We value highly our positive working relationships with HEE and are confident that this Self-Assessment Report is an accurate reflection of the high quality educational placements that we provide to the NHS workforce of the future.

1.2. Top three successes

This section should be used to document a high-level summary of the successes your organisation is most proud of achieving during the reporting period.

Description of success	Domain(s)	Standard(s)
Global Health Exchange – leading Trust on the establishment of the Earn, Learn and Return programme for International Recruitment. We have relocated 11 nurses to date to work in our Trust for a 3 year period, securing a talent pipeline and providing development and growth	6 – Developing a sustainable workforce	6.3 and 6.4

<p>opportunities which are translated back into the originating country on their return. Through providing practice placement infrastructure, supported by HEE, we have delivered a 100% success rate with gaining NMC registration for nurses on this programme to-date.</p>		
<p>Continued success and positive evaluation of our clinical skills training across the Trust. This incorporates ward-based clinical skills teachers, simulation lead and human factors training; supporting the embedding of learning and education across the multi-professional workforce.</p>	<p>1, Learning environment and culture 3, Supporting and empowering learners 4, Supporting and empowering educators 5, Delivering curricula and assessments</p>	<p>1.1, 1.3, 1.6 3.1, 3.5 4.2 5.1, 5.3</p>
<p>HDFT has a Quality Charter to recognise and reward excellent quality of care. The scheme provides QI training across the Trust and supports all staff and trainees to deliver improvement projects within their area of practice. The scheme also recognises and rewards teams who identify, work towards, achieve and then sustain a vision for providing high quality services in their area. All Foundation Year 1 doctors undertake Bronze Quality Improvement Training.</p>	<p>1, Learning environment and culture 3, Supporting and empowering learners</p>	<p>1.3, 1.6 3.3</p>

1.3. Top three challenges or prominent issues that HEE should be aware of

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section.

Description of challenges	Domain(s)	Standard(s)
Geographical spread of Community Services across the North East and North Yorkshire. As our geographical footprint grows this creates specific challenges in relation to multiple education providers working to a variety of assessment tools.	5. Delivering of curricula and assessment	5.1
Vacancy rates within Doctor in Training rotas and career grades for medical and dental staff as a result of national labour market shortages.	1, Learning environment and culture; 5. Delivering of curricula and assessment	1.1 5.1
Vacancy rates within Registered Nurses establishment as a result of national labour market shortages.	1, Learning environment and culture; 5. Delivering of curricula and assessment	1.1 5.1

6.2

1.4. Strategic Workforce Plan

Does your organisation have a strategic workforce plan (delete as appropriate)?

Yes	
------------	--

Who within your organisation is responsible?

Name and job title	Joanne Harrison Director of Workforce & Organisational Development (Interim)
--------------------	---

Section 2: Exception Reporting against HEE Quality Domains

2.1. Multi-professional

2.1.1. Organisation overview linked to the HEE Quality Domains

Please report, by exception, where your organisation does not meet the HEE Quality Framework within the reporting period for the groups listed in the guidance notes. In addition, please provide an overall narrative along with some organisational / departmental / unit examples which support the domain having been met overall. If you wish to highlight organisational policies, please detail these in section 3.

<p>HEE Domain 1 Learning Environment and Culture For additional guidance refer to HEE Quality Framework, page 10</p>
<p>HEE priority for 2018 reporting in this domain is:</p> <ul style="list-style-type: none"> • A focus on workplace behaviours and strategies for resolution of issues of concern
<p>External metrics:</p> <ul style="list-style-type: none"> • Practice Placement Quality Assurance (PPQA) • Mentor Register compliance of 100% • Investors in People Bronze level award • NHS National Staff Survey • Staff Friends & Family Test • Our rating for the last CQC inspection in 2016 was “Good” overall with a rating of “Outstanding” for “Caring”; “Good” for “Effective”; but “Needs Improvement” for “Safe”. • Professional Body Programme revalidations for all professional groups require practice input. <p>A Practice Placement Quality Assurance Report is produced every alternate year, which includes a review of placement quality and identifies the Service Specification for the services provided by the Practice Education Team.</p> <p>The Trust has a clearly defined set of Values and Behaviours. These are included in student induction and are role-modelled by the staff they are working with on placement. Specific actions taken include:</p> <ul style="list-style-type: none"> • The Trust has implemented a process of student forums, open to all students, four times a year. • Issues arising at student forums are discussed and any concerns raised are discussed with appropriate practice areas for action. • At least one senior manager is available at all sessions for discussion. • The Trust promotes a culture of openness and has a number of forums for people to share their views and escalate concerns. • There are clear processes with Higher Educational Institutions partners upon escalating concerns. <p>At the beginning of 2017 the Trust wrote a learning and development plan for maternity.</p> <p>We planned to deliver a robust programme of multidisciplinary training, delivered in house by our own faculty, using externally validated programmes where required. Each element of the programme aimed to incorporate acquisition of knowledge and its application through team work.</p> <p>We had learnt that human factors affect all aspects of clinical care, not just decision making in acute emergency situations. Patient safety in maternity is dependent upon strong inter-disciplinary relationships, effective teamwork and evidence-based clinical care. We therefore committed to building on our multi-disciplinary training in a way that fostered trust between individuals and staff groups, ensuring that our workforce maintains the knowledge underlying the provision of safe care and promotes excellent team</p>

6.2

working.

We used funds from the Maternity safety-training fund we were awarded in 2017 to train eight human factors trainers who have an impact on Maternity training. Human Factors training is now embedded in all training we deliver to medical staff, midwives, support staff and student midwives.

HEE Domain 2 Educational Governance and Leadership

For additional guidance see HEE Quality Framework, page 11 -12

HEE is keen to understand new models of learning in practice and the impact this is having on your organisation. Please include within your response:

- *Have you increased capacity for learners in your organisation?*
- *Have you increased your numbers of supervisors/mentors?*

HEE priority for 2018 reporting in this domain is:

- *Monitoring of LEP use of financial resources provided by HEE to support training. The new Learning Development Agreement (LDA) will be used to link financial resource to quality of training. (See SAR section 4, page 18)*
- *Governance of programmes with complex structures (e.g. Pharmacy & Healthcare Science) where nationally coordinated processes can impact on local delivery within HEE.*
- *Clear identification through STEIS (Live Flow) reporting of trainees/learners involved in Never Events and SUIs for both pastoral support and revalidation reasons. (See SAR section 8.1, page 26)*

The Trust has increased capacity by introducing a pathway for Leeds Beckett University and University of Bradford. Overall capacity will increase by 60 placements by 2020 by 20 per year.

Due to the NMC changes we are actively working across our HEI providers to ensure a consistent approach to the development of the roles Practice Supervisor and Practice Assessor as an inconsistent approach would be challenging for the Trust to manage.

The Trust uses DATIX to record and investigate Serious Untoward Incidents and Never Events. If a student becomes involved in such an event, the Clinical Lead for Practice Education would liaise directly with the student and the university.

The Trust has increased its capacity for providing Operating Department Practitioners to 14 per year.

At HDFT we have increased capacity for student midwives and now offer placements to students from York (17) and Bradford Universities (4) This has proved challenging as we have had a number of experienced mentors retire. We are proactively supporting more midwives to train as mentors. Our learning and development midwife has taken on the role of student learning environment manager to improve communication between students, mentors and University link lecturers.

HEE Domain 3 Supporting and Empowering Learners

For additional guidance refer to HEE Quality Framework, page 13-14

HEE priority for 2018 reporting in this domain is:

- *Improving support given to learners/trainees involved in Never Events/other adverse outcomes and subsequent clinical governance processes including Route Cause Analysis, Coronial Inquiries etc.*

<p><i>(See SAR section 8.1, page 26)</i></p>
<p>To support our learners in clinical areas we have employed practice educators across our medical and surgical areas to provide additional ward based clinical support and teaching, and also to offer additional pastoral support. Each student is assigned a sign off mentor to support and assess their learning and progress in the workplace.</p> <p>We support and empower learners via our student forums, which are held 4 times per year and include senior managers who are able to receive feedback directly from students. We also monitor students' evaluations and feedback and act upon these via clinical areas.</p> <p>Student midwives are all allocated to a sign off mentor who has responsibility to complete assessments and take part in intermediate and final interviews. The feedback we receive via the universities and from students reports a consistently high level of satisfaction with HDFT as a learning environment. Any learners who are involved in or witness incidents are identified and escalated to their relevant training institution. They are offered the opportunity to discuss and reflect with a Professional Midwifery advocate via a process of restorative clinical supervision.</p> <p>The Learning Environment Manager and Matron for maternity hold bi-monthly student learning forums, which also provide a safe space for students to discuss concerns, or issues that are impacting their learning.</p>
<p>HEE Domain 4 Supporting and Empowering Educators <i>For additional guidance refer to HEE Quality Framework, page 15</i></p>
<p><i>HEE priority for 2018 reporting in this domain is:</i></p> <ul style="list-style-type: none"> • <i>Use of the LDA to link the control/distribution of the financial resources provided by HEE to those managing training placements and the individual support to those providing educational supervision.</i> <p><i>(See SAR section 4)</i></p>
<p>Tariff funding is centrally managed by the Workforce and Organisational Development Team.</p> <p>Funds are used to provide substantive posts for the Clinical Lead for Practice Education, Practice Educators and the Practice Education Administrator.</p> <p>The Trust has an excellent library facility with IT equipment and clinical skills training labs contain manikins and equipment for teaching by educators as required.</p> <p>Numbers of mentors overall have increased slightly due to specific Harrogate programmes being taught by Leeds Beckett University, but concerns in the long term continue due to the number of retiring mentors. An additional mentor programme was provided by Leeds Beckett University on site at HDFT which allowed us to train a further 20 mentors. The number of mentors is kept under review, and negotiations are currently being undertaken with Leeds Beckett for the provision of further mentor training on site.</p> <p>All midwifery mentors attend an annual mentor update and are expected to keep their own learning up to date. This update includes information from a Link lecturer on ensuring a consistent approach to student assessment and gives mentors the opportunity to liaise with each other. A database of the mentorship status of all midwives is kept and sent to the Learning Environment Manager.</p>
<p>HEE Domain 5 Delivering Curricula and Assessments <i>For additional guidance refer to HEE Quality Framework, page 16</i></p>
<p><i>HEE priority for 2018 reporting in this domain is:</i></p> <ul style="list-style-type: none"> • <i>Assessment of the effects of 'Winter Pressures' on the ability to deliver training curricula across LEPs and the strategies being developed to mitigate impact across individual training placements</i>

<i>and programmes. (See SAR Section 8.2, page 27)</i>
<p>Winter pressures continue to stretch educational resources in terms of individual clinical workloads. This has been mitigated following the recent introduction of a number of Practice Educator posts. Student evaluations identify some concerns with regard to mentor's workload but on the whole remain positive in terms of meeting learning outcomes.</p> <p>All student midwives are allocated to the learning environment relevant to their stage of curriculum. They are taught in the clinical environment and encouraged to attend multidisciplinary training opportunities alongside their mentor.</p> <p>Qualified senior midwives share their knowledge and skills of specialist areas (emergency skills management, and Human Factors) in practical and classroom based teaching at York University. They also take part in student interviews, presentations and viva examinations.</p>
HEE Domain 6 Developing a Sustainable Workforce
<i>For additional guidance refer to HEE Quality Framework, page 17</i>
<p><i>HEE priority for 2018 reporting in this domain is:</i></p> <ul style="list-style-type: none"> • <i>Monitoring placement capacity where the LEP's own service workforce may be insufficient to deliver training, especially for 'at risk' placements.</i> • <i>Triangulation of training data with exception reporting data regarding implementation of the Junior Doctor contract.</i> • <i>LEP engagement with HEE across the STP/Integrated Care System for all training & workforce planning to avoid loss of training approval in changing clinical services.</i>
<p>The Trust has developed a Harrogate specific nursing pathway and is now working with three Universities to deliver the programme – this will make better use of the available capacity, and provide a talent pipeline for the Trust.</p>

2.1.2. Good Practice Items

Please list any good practice items that you would like to highlight to HEE. These items should be as an exception and over and above the expectation of the HEE Quality Standards. These may include trust wide initiatives as well as departmental / unit examples. You do not need to duplicate items from the successes section of the SAR (section 1.2).

Description of good practice and profession(s) it relates to (and a named contact for further information)	Description of why this is considered to be good practice	HEE Domain(s)	HEE Standard(s)
We have increased our resources in Practice Education to 8 across the Trust to provide supplementary placement based clinical education support to learners in practice.	Practice educators are able to focus solely on the educational needs of the individual, as they are not working within ward/departmental establishment numbers.	3. Supporting and empowering learners	3.2
Students participating as patients in Advanced Life Support Training.	Students are exposed to the development of other staff and are immersed in the clinical practice of resuscitation – feedback from students is that this is a really valuable learning experience.	3. Supporting and empowering learners	3.3 3.5
Formation of a Forum of Midwifery clinical educators from across	Share best practice and learn from each other. Improve	4. Supporting and	4.1

Yorkshire and the Humber and the LMS (York, Bradford, Airedale, Calderdale, Mid-Yorks, Doncaster, Harrogate) who meet 4 times / year.	consistency of training programmes. Improve support for learners and newly qualified staff. Creating a shared vision.	empowering educators.	
Multi-agency study day related to perinatal mental health drawing on the experience from General Practice, Health visitors, Midwives, service users and charity.	Promotes inter-professional learning. Promotes peer support. Uses the patient story to aid learning.	1. Learning environment and culture	1.6
Multi-agency training in pre-hospital management of maternity emergencies (midwives, medical staff, nurses, student midwives, paramedics, student paramedics).	Promotes inter-professional learning. Promotes peer support.	1. Learning environment and culture	1.6

2.1.3. Challenges or important issues that HEE should be aware of.

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section. Challenges identified already but that have been resolved within the reporting period or any ongoing challenges. You do not need to duplicate items from the top three challenges section of the SAR (section 1.3).

Description of challenges (please include the profession / professions)	HEE Domain(s)	HEE Standard(s)
The re-organisation of community nursing teams combined with the retirement of a considerable number of experienced mentors has led to challenges within the teams to adequately support the required number of nursing students. To address this we are actively seeking to train further mentors and fully utilise existing mentors who may not have previously regularly supported students.	1, Learning environment and culture. 5, Delivering curricula and assessment.	1.5 5.1
Band 5 registered nurse vacancies in ward based placement areas create pressure for both mentors and students as demand and capacity are stretched. This causes conflict for mentors in terms of their dual role both as a care provider and educator. To overcome this, the Trust has a Recruitment & Retention Group and is actively seeking to appoint to all vacant posts; extra support is provided to newly qualified band 5s through preceptorship; the global health exchange programme is enabling experienced nurses from overseas to work with the Trust for a period of 3 years; the Harrogate Pathway will also result in students signing up to this programme and being retained in the organisation for a minimum of 2 years; the introduction of Associate Nurse roles will support improvements in the ward environments and staffing levels.	4, Supporting and empowering educators. 5, Delivering curricula and assessment. 6, Developing a sustainable workforce.	4.3 5.1 6.3

2.2. Postgraduate Medical

2.2.1. Organisation overview linked to the HEE and GMC Standards

Please report, by exception, where your organisation does not meet the HEE Quality Framework/GMC Standards within the reporting period for postgraduate medical training. In addition, please provide an overall narrative along with some organisational / departmental / unit examples may support the domain having been met overall. If you wish to highlight organisational policies, please detail these in section 3.

GMC theme 1 Learning Environment and Culture

For additional guidance refer to <http://www.gmc-uk.org/education/index.asp>

HEE priority for 2018 reporting in this domain is:

A focus on workplace behaviours and strategies for resolution of issues of concern

Our external quality metrics are:

- GMC National Training Survey (NTS)
- National Education & Training Survey (NETS)
- Friends and Family Test
- Staff Survey
- Library Quality Assurance Framework
- University of Leeds Student Clinical Placement Evaluation Data
- Our rating for the last CQC inspection in 2016 was “Good” overall with a rating of “Outstanding” for “Caring”; “Good” for “Effective”; but “Needs Improvement” for “Safe”.

Internal quality metrics:

- Trainee Forum - bi-monthly – attended by Guardian of Safe Working, Director of Medical Education (Chair), BMA representative and the Medical Staffing Manager. Minutes are circulated to all trainees.
- Medical Education Strategy Group – chaired by DME; attended by college tutors and trainee representatives and other employees in medical educational roles.
- Foundation Year doctors engagement event – annually in June – this is used specifically to identify challenges that doctors have encountered throughout the year and to resource solutions.
- Equality and Diversity Mandatory Training

Quality Standard 1.1 and 1.2

There are various different ways that staff can raise a concern. Doctors in training can raise it formally or informally with their lead clinician or named supervisor. There is also a Speaking Up Policy which includes information for doctors on reporting an incident using Datix. HDFT has a Freedom to Speak Up Guardian who is also currently the Deputy Director of Governance.

All the above metrics are used to identify challenges with respect to all quality standards. We specifically target workforce behaviours in the Trainee Forum and engagement events, to ensure trainees are not subject to negative attitudes or behaviours, and that they are treated fairly. Identification of any negative behaviour is escalated directly to the DME and addressed personally with the relevant individuals. The DME takes advice from Human Resources and Health Education England (through Monitoring of the Learning Environment Meetings).

Quality Standard 1.3

HDFT has a Quality Charter to recognise and reward excellent quality of care. The scheme provides Quality Improvement training across the Trust and supports all staff to deliver improvement projects within their area of practice. The scheme also recognises and rewards teams who identify, work towards, achieve and then sustain a vision for providing high quality services in their area. Both individuals and teams can become accredited Quality of Care Champions achieving bronze, silver or gold status. All Foundation Year 1 doctors undertake Bronze Quality Improvement Training. There is an annual multi-professional Quality Care conference which showcases individual and team endeavours that promote care of the highest

quality.

The Trust has been running an exceptionally successful Project Leadership Programme for SAS Doctors. Nine doctors signed up to the programme and together they led on eight separate projects. The projects were ones that they identified as being important to improving quality in the areas in which they work.

Quality Standard 1.5 and 1.6

The Trust continues to invest in postgraduate medical education programmes, including clinical skills and simulation, IT facilities and access to a quality assured library which is accessible 24 hours a day, 7 days a week.

The Trust has recently invested in NHS Wi-Fi which is accessible by staff in all ward areas.

The Trust has invested one Additional Programmed Activity per week in a Simulation Lead, who has been pioneering inter-professional Human Factors training throughout the organisation. See Sections 5 and 7. During the academic year the Department of Medical Education organise a Continuing Professional Development lecture programme which is inter-professional. All members of staff are invited to attend, and educational leads in all specialties (including nursing and allied healthcare professionals) are encouraged to present.

GMC theme 2 Educational Governance and Leadership

For additional guidance refer to <http://www.gmc-uk.org/education/index.asp>

HEE priority for 2018 reporting in this domain is:

- *Monitoring of LEP use of financial resources provided by HEE to support training. The new Learning Development Agreement (LDA) will be used to link financial resource to quality of training. (See SAR section 4, page 18)*
- *Governance of programmes with complex structures (e.g. Pharmacy & Healthcare Science) where nationally coordinated processes can impact on local delivery within HEE. Clear identification through STEIS (Live Flow) reporting of trainees/learners involved in Never Events and SUIs for both pastoral support and revalidation reasons. (See SAR section 8.1, page 26)*

There is a clear Educational Governance Structure. This commences with the Medical Education Strategy Group (MESG - see above) whose members include college tutors, Foundation and GP Training Programme Directors. The MESG monitors learners' progression and outcomes, ensuring the Trust are meeting standards for the quality of education and training. It also allows the medical education department to respond to concerns or quality issues. The GMC NTS and the NETS are circulated to all members of the MESG: college tutors are asked to share results with clinical colleagues (including named supervisors) and asked to feed back to the DME with any required actions. The MESG feeds into the Senior Management Team/Director Team plus the GMC NTS is presented to the SMT on an annual basis. The Director of Workforce and Organisational Development has responsibility at Board Level for all education and training.

Doctors in training are informed about local processes for educational and clinical governance and local protocols for clinical activities through: the induction process; the trainee forum; and through trainee representatives on the MESG. The trainee forum and the MESG also provide trainees with the opportunity to raise concerns about education and training. Educational exception reports are raised through an electronic reporting system which can also be discussed with the Guardian of Safe Working at the trainee forum. The DME is responsible for feeding back any issues to the individuals concerned and also for sharing specific issues with the Medical Director and the Director of Workforce and Organisational Development. Broader issues will be raised by the DME at SMT.

The Department of Postgraduate Medical Education has a clear process for supporting doctors in training who have been identified within a Complaint, Serious Incident or Significant Event. The Complaints and

Risk Management Group contact the Compliance and Revalidation Manager when a trainee has been identified. This Manager generates a draft Exception Report and forwards the details to the DME. The DME contacts the trainee to ensure they are adequately supported throughout the process by their named supervisors and their clinical team. The DME also meets with the trainee and directs them to educational and pastoral resources locally, regionally and nationally, such as Take Time, HEE guidance on statement writing. The DME shares the Exception Report with the trainee both at the draft stage and again when the investigations have been completed, prior to submission to the revalidation team at HEE.

The DME, Foundation School TPDs and College Tutors are informed of trainees with Protected Characteristics, through channels such as Transfer of Information forms. All staff undertake Equality and Diversity Mandatory Training. Any adjustments required are defined between the College Tutors and the specialty schools; any relevant issues are discussed confidentially between the DME and college tutors, usually through the MESG.

Please see GMC themes 3 and 4 regarding processes to ensure trainees have appropriate support and supervision.

GMC theme 3 Supporting Learners

For additional guidance refer to <http://www.gmc-uk.org/education/index.asp>

HEE priority for 2018 reporting in this domain is:

- *Improving support given to learners/trainees involved in Never Events/other adverse outcomes and subsequent clinical governance processes including Route Cause Analysis, Coronial Inquiries etc. (See SAR section 8.1, page 26)*

All trainees have pre-allocated trained Clinical and Educational Supervisors throughout their posts in Harrogate: see GMC theme 4 regarding the training of named supervisors.

All trainees receive organisational and departmental induction during the first of two days of starting their posts. HDFT utilise the HEE electronic induction “passport” to streamline and quality assure the induction process. The Department of Medical Education has produced a document that details Standards for Specialty Induction for the organisation.

With regard to study leave, HDFT supports and implements the HEE Curriculum Delivery guidance document and associated processes.

Learners receive informal and formal feedback from all healthcare professionals, most notably through Multi Source Feedback / Team Assessment Behavioural tools. They also receive formal feedback through Supervised Learning Events (etc.) documented in their training portfolios and through regular mandated meetings with trained supervisors. The quality of feedback and both the frequency and adequacy of trainer meetings/interviews are assured through Annual Review of Competence Progression (ARCP) panels. The quality of feedback is also measured through the GMC National Training Survey, the NETS, the Trainee Forum and through Foundation Year engagement events.

The Department of Postgraduate Medical Education has a clear process for supporting doctors in training who have been identified within a Complaint, Serious Incident or Significant Event. The Complaints and Risk Management Group contact the Compliance and Revalidation Manager when a trainee has been identified. This Manager generates a draft Exception Report and forwards the details to the DME. The DME contacts the trainee to ensure they are adequately supported throughout the process by their named supervisors and their clinical team. The DME also meets with the trainee and directs them to educational and pastoral resources locally, regionally and nationally, such as:

- HDFT – Statement Writing Guidance
- HEE - Take Time; Supporting trainees involved in Serious Incidents and attendance at the Coroner’s court; Support on statement writing;
- MDDUS – advice on Coroner’s Inquests

- The DME shares the Exception Report with the trainee both at the draft stage and again when the investigations have been completed, prior to submission to the revalidation team at HEE.

There are numerous resources to support learners with health and wellbeing issues including: an Occupational Health and Staff Counselling Service, Mental Health Champions, Schwartz Rounds and Personal Resilience Training.

GMC theme 4 Supporting Educators

For additional guidance refer to <http://www.gmc-uk.org/education/index.asp>

HEE priority for 2018 reporting in this domain is:

- *Use of the LDA to link the control/distribution of the financial resources provided by HEE to those managing training placements and the individual support to those providing educational supervision. (See SAR section 4)*

The Department of Postgraduate Medical Education maintains an educator database of named Clinical (CS) and Educational Supervisors (ES) working within HDFT: this data is shared with HEE for submission to the GMC.

We currently rely on the GMC NTS and NETS with regard to educators' familiarity with learners' programme/curriculum and with regard to educators' access to resources.

All educators are currently advised to contact college tutors or the DME directly with any concerns or difficulties they have encountered as part of their educational responsibilities.

The DME and other Senior Educators within HDFT rely on feedback from college tutors, through the MESH, to ensure a consistent approach to education and training within specialties. Feedback from trainees through the external metrics listed in GMC Theme 1 allows monitoring of this.

For the first time this year we have asked Foundation Year doctors to complete a feedback questionnaire on the quality of supervision provided by named Educational Supervisors. This includes trainers' familiarity with the curriculum and will be rolled out to **all** trainees prior to completing their posts. The response will be fed back to Educational Supervisors. The Supervisor Feedback Form gathers data on performance against many of the quality standards for educators.

Educational Supervisors are currently supported in job plans (within their SPA time) for 0.125 APA per trainee (although this is set to increase to 0.25 following the ratification of the Job Planning policy). This not only allows time to deliver formal supervision duties, but also to maintain their continuing professional development. The current job plan template requires educators to document the names of the trainees they are supervising.

All educators are required to have their educational performance assessed as part of the appraisal and revalidation process. We currently rely on this process to identify, manage and support educators whose conduct or performance falls below the expected standard.

The DME is currently writing guidance for supervisors which suggest evidence for trainers to collect in relation to the role for revalidation and appraisal. This will be mapped to the Academy of Medical Educators (AoME) 7-key areas of supervisory practice and endorsed by the GMC in the Recognition and Approval of Trainers. This will ultimately be tabulated and used by educators to populate as evidence for appraisal and revalidation.

All named Clinical Supervisors and Educational Supervisors are invited to attend Foundation Year ARCPs to maintain CPD and to aid quality assurance of supervision they provide for trainees.

The DME is currently negotiating some time in job plans for named Clinical Supervisors.

The DME has written job descriptions for named Clinical Supervisors and Educational Supervisors utilising the documents produced by the National Association of Clinical Teachers. These are awaiting approval by the Trust through the LNC.

GMC theme 5 Developing and implementing curricula and assessments

For additional guidance refer to <http://www.gmc-uk.org/education/index.asp>

HEE priority for 2018 reporting in this domain is:

- *Assessment of the effects of 'Winter Pressures' on the ability to deliver training curricula across LEPs and the strategies being developed to mitigate impact across individual training placements and programmes. (See SAR Section 8.2, page 27)*

The metrics listed in GMC Theme 1 are used to inform whether the balance between service delivery and training is being achieved by HDFT. The bi-monthly Trainee Forum allows us the opportunity to monitor the balance more closely. The number of Educational Exception Reports to the Guardian of Safe Working over the last year has been minimal, and the same issues were identified within NETS.

HDFT implement the HEE policy on cross-cover by doctors in training.

No training activity was cancelled at HDFT during the winter pressure period 2017/2018 therefore their training placements were not affected.

HEE Theme 6 Developing a sustainable workforce

For additional guidance refer to HEE Quality Framework, page 17

HEE priority for 2018 reporting in this domain is:

- *Monitoring placement capacity where the LEP's own service workforce may be insufficient to deliver training, especially for 'at risk' placements.*
- *Triangulation of training data with exception reporting data regarding implementation of the Junior Doctor contract.*
- *LEP engagement with HEE across the STP/Integrated Care System for all training & workforce planning to avoid loss of training approval in changing clinical services.*

The Trust is fully engaged with developing the alternative workforce of Advanced Clinical Practitioners (ACP) and Physician Associates (PA). Anecdotal feedback from trainees is that these roles are eating in to their supervision/training time, however evidence suggests that all trainees are still able to meet their outcomes, therefore supervisors are taking on additional supervision responsibilities but are still meeting their supervision duties.

Summary of exception reporting and triangulation with gaps in Junior Doctor rota's to determine driving factors and roles that we are exploring to support with this. i.e. FY3, ACP's, PA's substantive recruitment (1 General Surgery and 1 Gastroenterology).

Advanced Clinical Practitioners

The Trust has recruited to two cohorts of ACP trainees. The first Cohort of eight trainees in January 2015 qualified in January 2017. The training was two years during which time they were supernumerary, working alongside consultants and senior doctors within a speciality. We have six remaining from cohort 1; two in Elderly Medicine, one in Acute Medicine and three in the Emergency Department.

There are currently two trainees in cohort 2 who are due to complete in January 2020; one in CAAT and one in the Emergency Department.

The Trust's Clinical Workforce Strategy is focused on delivering excellent services through a sustainable workforce. In relation to Medical and Dental staff the sustainability challenge is, in the main, driven by senior gaps in key specialities and on Doctors in Training rotas. Prior to the August 2018 rotation 13.9 (11.7%) of the Trust's Doctors in Training posts were vacant. The Trust was successful in recruiting to five of these posts which brought the overall Health Education England fill rate to 92.5%. Unfortunately a large portion of

the gaps remaining were at ST3+ level which significantly impacts on Tier 3 rotas, especially in Medicine.

In addition, the Trust has a number of gaps at consultant and SAS level in key specialities across the Trust, including Paediatrics, Gastroenterology, Acute Medicine, General Surgery and Oncology. Currently the Trust attempts to fill gaps across all grades with temporary medical staff, this is currently managed by the internal bank arrangements and the Trust’s master vendor, Medacs. Current fill rate for Medacs is 66%, this is an increase from previous fill rates in 2017 which were 39%. This demonstrates a significant improvement in relation to temporary medical staff and supports the overall sustainability of the medical workforce.

The Trust is also exploring several other workstreams as part of the Clinical Workforce Strategy in pursuit of developing a sustainable workforce. This includes the ongoing support of an ACP programme with a focus now being given to the ongoing development of the roles, including the exploration of SCPs within surgical specialities. The Trust is also exploring the use of alternative roles such as Physicians Associates and ‘F3’ roles. The Trust has an established CESR programme within the Emergency Department with recruitment ongoing to a similar programme within Paediatrics and further work to potentially establish a programme within General Surgery. These key advancements form fundamental elements of specific directorate plans linked to the Clinical Workforce Strategy to support the sustainability of the medical workforce and also will enhance the learner experience through a more sustainable workforce model.

2.2.2. Good Practice Items

Please list any good practice items that you would like to highlight to HEE. These items should be as an exception and over and above the expectation of the HEE Quality Standards. These may include trust wide initiatives as well as departmental / unit examples. You do not need to duplicate items from the successes section of the SAR (section 1.2). When considering items to list here, please consider the GMC definition of good practice.

Description of good practice (and a named contact for further information)	Description of why this is considered to be good practice	HEE/GMC Domain(s)	HEE/GMC Standard(s)
<p>The Trust has developed a training programme in ‘Building Personal Resilience’ This is an evidence-based psychological skills training programme open to all staff and medical students. It is facilitated by a number of trainers who have undertaken training by City, University of London, and demonstrates a range of techniques designed to enhance psychological health, personal resilience, and general life effectiveness.</p>	<p>The aim is to enable staff and medical students to learn and practise techniques that have a strong evidence base in behavioural science and have the potential to transform an individual’s experience in the workplace and other areas of their lives, and runs over a 4-week period. This provides support for both learners and educators to develop the personal skills necessary for learning and delivering services in the complex healthcare environment.</p>	<p>1, Learning environment and culture 3, Supporting and empowering learners/ Supporting learners 4, Supporting and empowering educators/ Supporting educators</p>	<p>1.2 / S1.2 3.1 / S3.1 4.4 / S4.2</p>
<p>The Directors of Postgraduate and Undergraduate Medical Education have named Deputy Directors with specific roles in order to support the programme and provide an opportunity for succession planning.</p>	<p>The deputies provide support with specified areas of responsibility and during periods of leave and clinical commitments. This provides for the future continuity of direction of the programmes to ensure alignment of strategy.</p>	<p>1, Learning environment and culture; 2, Educational governance and leadership 6, Developing a sustainable</p>	<p>1.1, 1.5 / S1.1,S1.2 2.1, 2.2, 2.5 / S2.1, S2.2</p>

		workforce	6.3
<p>Foundation doctor year 1 handover sessions and 'jobs booklet' (Dawn Martin, Foundation Programme Manager; Shakeel Rahman FY1 Training Programme Director)</p> <p>The FY1 jobs booklets are produced annually, written by FY1 doctors for the following cohort of their FY1 colleagues providing a brief description of key tasks, contacts and tips for assessment. The FY1 handover sessions provide the opportunity for FY1 doctors at the end of their 4 month rotation to handover to the doctors moving in to these roles.</p>	<p>These sessions and the FY1 jobs booklet provide current information from those with direct experience in each post, ensuring FY1 doctors feel better prepared to meet the challenges of their new roles.</p>	<p>3, Supporting and empowering learners/ Supporting learners 6, Developing a sustainable workforce</p>	<p>3.1, 3.4, 3.5 / S3.1</p> <p>6.2,6.4</p>
<p>From July 2018 onwards, foundation year doctors are asked to complete a feedback questionnaire on the quality of supervision provided by named Educational Supervisors. This includes trainers' familiarity with the curriculum and will be rolled out to all trainees prior to completing their posts. The response will be fed back to ESs.</p>	<p>This form gathers data on performance against many of the quality standards for educators and will support the development of the Educational Supervisors in their roles.</p>	<p>1, Learning environment and culture; 2, Educational governance and leadership; 3, Supporting and empowering learners/ Supporting learners 4, Supporting and empowering educators/ Supporting educators 5, Delivering curricula and assessments/ Developing and implementing curricula and assessments 6, Developing a sustainable workforce</p>	<p>1.2 / S1.2</p> <p>2.1, 2.2 / S2.1,S2.2</p> <p>3.3 / S3.1</p> <p>4.3 / S4.1</p> <p>5.1, 5.2, 5.3 / S5.2</p> <p>6.3</p>
<p>Foundation Year End of Year Engagement Session (focus groups)</p>	<p>This annual session was initiated in 2016 by the DME to gain feedback from F1 and F2 doctors to address conditions against the Trust</p>	<p>1, Learning environment and culture; 2, Educational</p>	<p>1.1, 1.2 / S1.1, S1.2</p> <p>2.1, 2.2, 2.4 /</p>

6.2

	<p>and to find solutions to the challenges. The feedback was circulated to all Consultants in the Trust and to HEE. The session was so successful that it has been repeated for the last two years. This confidential forum has allowed us to develop and enhance junior doctor training and, importantly, has allowed us to provide positive and specific feedback to substantive doctors.</p>	<p>governance and leadership; 3, Supporting and empowering learners/ Supporting learners 4, Supporting and empowering educators 5, Delivering curricula and assessments/ Developing and implementing curricula and assessments 6, Developing a sustainable workforce</p>	<p>S2.1, S2.3 3.2, 3.3 / S3.1 4.3 5.1, 5.2, 5.3/ S5.2 6.3</p>
<p>Emergency Department: GREATix – Learning from Excellence (led by Dr Helen Law)</p>	<p>This allows staff in the Emergency Department to nominate another staff member when they observe excellence in patient care in the workplace. The system provides feedback to nominated individuals to recognise greatness and allows these examples to be shared and learned. We would like to roll this out across the Trust.</p>	<p>1, Learning environment and culture; 3, Supporting and empowering learners/ Supporting learners 5, Delivering curricula and assessments 6, Developing a sustainable workforce</p>	<p>1.1,1.4,1.6 / S1.1 3.3, 3.5 / S3.1 5.3 6.3</p>
<p>Department of Anaesthesia – Weekly Interesting Case Meetings; Educational WhatsApp Group (led by Dr Martin Huntley)</p>	<p>Dr Huntley has pioneered two successful educational forums in Anaesthesia. The first is a weekly 'Interesting Case Meeting' which is open to all medical staff in the department to share any cases that they have encountered over the previous week which they have learned from and feel that a wider audience would benefit from through</p>	<p>1, Learning environment and culture; 2, Educational governance and leadership; 3, Supporting and empowering learners/ Supporting</p>	<p>1.1, 1.3, 1.4, 1.6 / S1.1, S1.2 2.4 / S2.3 3.1, 3.5 / S3.1</p>

6.2

	<p>discussion.</p> <p>The second is an Anaesthesia & Critical Care WhatsApp Group that allows all medical staff to share educational opportunities. These may be practical (e.g. CVC insertion, regional block insertion) or academic (e.g. interesting articles, formal teaching). This can be updated in real-time using the Trust's Wi-Fi.</p>	<p>learners</p> <p>5, Delivering curricula and assessments / Developing and implementing curricula and assessments</p> <p>6, Developing a sustainable workforce</p>	<p>5.1, 5.2, 5.3 / S5.2</p> <p>6.2, 6.3, 6.4</p>
--	---	---	--

6.2

2.2.3.Challenges or important issues that HEE should be aware

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section. Challenges identified already but that have been resolved within the reporting period or any ongoing challenges. You do not need to duplicate items from the top three challenges section of the SAR (section 1.3).

Description of challenges (please include the programme this relates to)	HEE/GMC Domain(s)	HEE/GMC Standard(s)
<p>Handover in Medical and Surgical Specialties. A condition regarding safe patient handover in medicine and surgery has been in place since 2015. A task force has been established and an action plan initiated to develop an electronic handover system. The clinical portal WebV has been set up which will receive patient information from the other clinical IT systems and present them as a single patient record which will be viewable from anywhere within the Trust's secure network from an electronic computer device. This will allow the creation of patient handover lists but this is unlikely go live until early 2019.</p>	<p>1, Learning environment and culture;</p> <p>3, Supporting and empowering learners;</p>	<p>1.1, 1.6 / S1.1</p> <p>3.3</p>
<p>Workload and Senior Support for Trainees in Gastroenterology Historically senior support for trainees in Gastroenterology has been reported to be inadequate. A Medical Training Initiative to employ middle grade doctors has been unsuccessful. The specialty has instituted a Consultant of the Week Model to increase senior supervision and has employed two SASG doctors. The Directorate is exploring the employment of Physician' Associates. Recruitment to a vacant Consultant Post has been unsuccessful and a further substantive Consultant is planning to retire in 2019. The team also cover the care of general medical patients on outlying surgical wards, which is substantially more onerous during winter months. The Directorate is exploring different working models to cover medical outliers e.g. an Elderly Medicine Consultant for General Surgical patients. Reducing the burden for Gastroenterology will hopefully improve training conditions for trainees and make Consultant posts more attractive.</p>	<p>1, Learning environment and culture;</p> <p>3, Supporting and empowering learners / Supporting learners</p> <p>5, Delivering curricula and assessments/ Developing and implementing curricula and assessments</p> <p>6,</p>	<p>1.1, / S1.1</p> <p>3.1, 3.3 / S3.1</p> <p>5.1 / S5.2</p> <p>6.3</p>

	Developing a sustainable workforce	
Undermining in Obstetrics and Gynaecology. There have been conditions against the Trust with respect to this intermittently over the past five years. An action plan was instituted successfully in 2016/2017 but unfortunately challenges became apparent again through a serious incident earlier this year. Subsequent MLEs and a triggered visit from the HEE Yorkshire and Humber Quality Assurance team and the Head of School for Obstetrics & Gynaecology have resulted in a further action plan in September 2018.	1, Learning environment and culture; 3, Supporting and empowering learners/ Supporting learners	1.1, 1.2 / S1.1 3.1, 3.3 / S3.1
Clinic attendance for Core and Higher Specialty Trainees in Medicine Clinic attendance for Core and Higher Trainees has been a challenge over the last few years. The Trust was under Enhanced Monitoring in 2016 for Core Trainee attendance – this was addressed and the condition closed. This remains a challenge because of a physical lack of outpatient clinic space to accommodate independent practice for trainees. The College Tutor is aware of the problem and has been exploring a variety of ways to address attendance to fulfil CMT requirements. Clinic attendance becomes a greater challenge during periods of high activity, especially for Higher Trainees in Elderly Medicine. To the best of our knowledge Higher Trainees in medicine continue to fulfil their training requirements for ARCP, however it continues to remain an area of concern.	1, Learning environment and culture; 3, Supporting and empowering learners/ Supporting learners 5, Delivering curricula and assessments/ Developing and implementing curricula and assessments 6, Developing a sustainable workforce	1.2, 1.5 / S1.1 3.1,3.5 /S3.1 5.1 / S5.2 6.3

2.2.4. Medical faculty roles, organisation and accountability

If there have been any changes to your organisation's educational governance structures within the reporting period please detail this here, otherwise please state 'no changes'.

If there are any vacant roles, or risks to medical education please describe these here, including any plans to mitigate that risk.

No Changes. There has been a vacancy at Deputy Director of Postgraduate Medical Education for maternity leave since January 2018. We hope that the Consultant will return to the post in January 2019.

The post of Medical Education Manager was vacant between August 3rd and September 5th 2018. The new post holder has been recruited and is currently in a period of induction. A handover with the previous post holder has been undertaken to ensure continuity of work and actions.

2.2.5. Staff and Specialty Grade Doctors (SASG) and Locally Employed Doctors (LEDs) Faculty development

Please provide answers to the following questions. You may wish to include funding details, as required. For further information in relation to LEDs please review the following NACT document LEDs across the UK <http://www.nact.org.uk/documents/national-documents/>

Questions	Trust Answers	
Number of SASG doctors within the trust	65	
Total SASG funding received	16931.31	
Is the SASG funding ring-fenced to support SASG doctors only? (Y/N)	The system has changed. We do not get an allocation of SAS funding. We have to claim back what we have spent after we have spent it. We only claim back funding for things that directly relate to supporting our SAS doctors.	
Please describe the process by which the development needs of SASG doctors within your organisation were individually and collectively identified. Using funding allocated for SASG development; How were priorities decided?	All SAS doctors have appraisals to establish their development needs. We carried out an initial needs analysis of the SAS doctors by questionnaire. We used this as the basis for our first generic programme. At each event we ask what further training they would like. This is discussed at SAS forum and a programme for the year is agreed.	
SASG nominated lead within the trust	Dr Natalie Lyth	
Please provide a description of how the Trust makes decisions about the allocation of funding (1-5 below)		
	Spending	Detail
1. Individual doctor's development (i.e. details of spending used to support the development of individual doctors including an anonymised list of amounts and what it was used for)	750.00	24/05/2017 39th Annual International Congress of the European Hernia Society
2. Courses/meetings arranged which are open to all SAS doctors (number of sessions, attendance and topics covered)	8,181.31 (We also had £10000 from 16-17 towards the funding of the project leadership course)	18/07/2017 Project Leadership Day one 29/09/2017 Project Leadership Day two 10/01/2018 Project Leadership Day three 18/07/2017 29/09/2017 Project Leadership Day one, two and three - Travel and Subsistence 10/01/2018 29/09/2017 SAS Forum 20/10/2017 Medico-Legal Skills 20/10/2017 Medico-Legal Skills 15/12/2017 Preparing for CESR

		15/12/2017	Preparing for CESR
		15/12/2017	SAS Forum
		16/03/2018	Being an Effective Clinician
		16/03/2018	Being an Effective Clinician
3. Payment for SAS tutors/leads sessions	5000.00		
4. Administrative costs to support SAS tutors	3000.00		
5. Miscellaneous (i.e. any other use of the funding which falls outside the above with details of amounts and what it has been used for)	0	0	

6.2

2.3. Undergraduate Medical

2.3.1. Organisation overview linked to the HEE and GMC Standards

Please report, by exception, where your organisation does not meet the HEE Quality Framework/GMC Standards within the reporting period for undergraduate medical training. In addition, please provide an overall narrative along with some organisational / departmental / unit examples may support the domain having been met overall. If you wish to highlight organisational policies, please detail these in section 3.

GMC standard theme 1 – Learning Environment and Culture
<ul style="list-style-type: none"> ▪ Students were provided with sufficient opportunities to meet learning outcomes ▪ Students received sufficient feedback to track and direct their learning ▪ Students were satisfied with the overall organisation of the placement ▪ Students were satisfied with the overall quality of the Stage ▪ Clinical teachers were punctual and reliable in their attendance. (Due regard will be given to mitigating circumstances of urgent clinical need) ▪ The overall quality of the teaching was of a consistently high standard
<p>We receive detailed feedback on 50% of placements from year 3, 4 and 5 medical students and all Physicians' Associate student placements. The summary bar charts evidences that we are meeting GMC standards.</p> <p>The annual MPET review has highlighted sub-section problems within the overall scores (e.g. inaccurate timetables and some end of placement sign off issues with year 5) which are being addressed in an action plan.</p> <p>The introduction of ward based clinical teachers has enhanced individual students' supervision by identifying learning needs at an early stage. They have provided enhanced support (often signposting clinical experiences), they meet students regularly to monitor progress, provide feedback and to ensure students' placement are organised. This has helped identify problems early and provide prompt solutions to enhance the quality of the placements we provide.</p> <p>All student groups have organised teaching sessions in addition to ward-based teaching opportunities. Feedback has been of a consistently high standard. An example of good practice was highlighted at the Clinical Teacher's day where Matt Milsom received an award for his 4th year teaching sessions on prescribing.</p>

GMC standard theme 2 – Educational Governance and Leadership
<ul style="list-style-type: none"> ▪ Trust systems are in place to detect and investigate patient harm involving or as a result of student activity ▪ Trust systems are in place to ensure informed consent is taken in areas where patients may encounter students ▪ Clinicians / teachers are appraised against their teaching
<p>We have assisted in Leeds Medical School's development of coloured badges to identify year groups, and an 'entrustability' chart, showing when, for any given year, for a range of clinical tasks, each year group can be considered independent, need some supervision, etc., to help avoid staff asking students to do tasks outside their competence: prevention being better than cure.</p> <p>All student activity is supervised, and the Trust's Datix reporting system would be used to report any patient harm from student activity.</p> <p>In endoscopy and outpatient areas it is routine practice for patients to be informed of student presence,</p>

6.2

and to be offer the opportunity to ask students to leave before procedures/consultations begin.

Clinicians involved in teaching list this in their appraisals with evidence of teaching feedback, we can provide evidence of this, although have never done a systematic audit of all undergraduate teachers.

GMC standard theme 3 – Supporting Learners

- Appropriate guidance and support was available outside of formal teaching
- Students were satisfied with the overall quality of the facilities for students.
- Teaching took place in appropriate settings and surroundings
- Good quality learning resources were available to support learning
- Access to IT facilities was adequate
- The programme of study outlined for the course was delivered

Again, these standards are covered by the Medical School’s MPET feedback to us.

The students are aware of placement leads, year leads and overall undergraduate leads to contact if there are problems. They meet the clinical skills and ward-based teachers at induction and maintain regular contact throughout their placement. In addition, they have daily contact with the admin staff who are able to identify and address any problems raised early.

We try to maximise ward-based teaching and in addition have a well-equipped clinical skills lab to deliver skills teaching. Students have access to simulation manikins to practice examination routines / practice clinical skills e.g. phlebotomy / practice simulation scenarios. They have a wide choice of additional clinical skills sessions to sign up for depending on their learning needs. We have access to laptops which are used for classroom based prescribing teaching (4th years and PAs) and we use our facilities to provide teaching OSCEs to support the 3rd years.

Students have access to a purpose designed education centre, undergraduate room with IT, and EDUROAM Wi-Fi is available throughout the Trust. These facilities have ensured we are able to deliver the various elements of the course as outlined by the University of Leeds.

6.2

GMC standard theme 4 – Supporting Educators

- Clinicians / teachers have time in job plans for teaching including educational supervision.

Main undergraduate leads have job planned time for teaching (three individual year group leads each with 1PA allocated). In addition individual placement leads all have a 0.25 PA SPA allowance in recognition of teaching duties. We have two full-time, Education Centre based, Clinical Skills Educators who devote around half their time each week to undergraduate teaching. Our two ward-based clinical skills educators (1.5 WTE) are fully job planned to deliver student teaching.

From September we have job planned consultant sessions (1.5 PA) to provide enhanced teaching and supervision of acute medical placements (year 4, 5, Physician Associates). Due to the demanding acute medical need of this area we recognise the need to provide enhanced support in this area to ensure quality training.

GMC standard theme 5 – Developing and implementing curricula and assessments

- The Trust has processes to ensure those undertaking summative assessments are appropriately trained
- The Trust has a system in place to provide educational supervision
- The Trust has an executive or non-executive director at board level responsible for supporting training

programmes
<p>The two senior undergraduate educators at Harrogate (Dr G Davies and Dr Peter Hammond) have both been involved with the evolution of the undergraduate curriculum for 20 years (Dr Davies at one stage seconded to the university one session a week for three years). They have set the standards with colleagues as the course has evolved, and new placement leads who do assessments sit in with an experienced assessor before making independent judgements. Dr Davies will review any summative assessment challenged by the students.</p> <p>Educational supervision of students is central to all activities: education supervision of teachers happens proactively for juniors, e.g. FY1 weekly teaching sessions of year 5 students are peer reviewed by a consultant (around 80% of sessions) and the FY1 receives formal feedback on their teaching in their e-portfolio.</p>

<p>HEE Theme 6 Developing a sustainable workforce For additional guidance refer to HEE Quality Framework, page 17</p>
<p>Last year we took part in training of Physicians Associates from University of Leeds for the first time, and the Trust sees this, in addition to our extensive work in Associate Nurse training, as helping to develop a sustainable workforce.</p>

2.3.2. Good Practice Items

Please list any good practice items that you would like to highlight to HEE. These items should be as an exception and over and above the expectation of the HEE Quality Standards. These may include trust wide initiatives as well as departmental / unit examples. You do not need to duplicate items from the successes section of the SAR (section 1.2). When considering items to list here, please consider the GMC definition of good practice.

Description of good practice (and a named contact for further information)	Description of why this is considered to be good practice	HEE/GMC Domain(s)	HEE/GMC Standard(s)
<p>Ward-based clinical teacher The trainers teach, support and participate in the assessment of 3rd, 4th and 5th year medical students on ward-based placement at the Trust studying for their MBChB degree, to help transition from campus to clinical area. The Trust has approximately 40 medical students on placement at any one time. (named contact, Stuart Cook)</p>	<p>Undergraduates tend to struggle in early years to feel confident and part of the team in clinical areas - our ward-based teachers 'lead them by the hand' in the clinical environment and help them build clinical confidence and practice skills. The role ensures that all clinical skills training and support enables the development of skills, knowledge, competence and attitude required to ensure the delivery of competent high quality and compassionate patient care in line with best practice guidance. They also support clinical skills teaching and simulation for other staff groups as part of the Trust clinical skills and simulation curriculum and Strategy, encouraging multi-professional learning and working.</p>	<p>1, Learning environment and culture; 2, Educational governance and leadership; 3, Supporting and empowering learners/ Supporting learners 4, Supporting and empowering educators/ Supporting educators 5, Delivering curricula and assessments/ Developing and implementing curricula and assessments 6, Developing a sustainable workforce</p>	<p>1.1,1.2, 1.4,1.5 / S1.1, S1.2 2.4 / S2.1 3.1, 3.2, 3.5 / S3.1 4.1, 4.2, 4.4 / S4.1/ S4.2 5.1, 5.2 / S5.1 6.4</p>
<p>Summary MPET assessment for University of Leeds Medical School shows overall highest level of satisfaction with undergraduate courses in recent years. (Dr Gareth Davis)</p>	<p>Wide ranging external assessment of all aspects of undergraduate medical student teaching delivery.</p>	<p>1, Learning environment and culture; 2, Educational governance and leadership; 3, Supporting and empowering</p>	<p>Demonstrates good practice across framework</p>

6.2

		learners; 4, Supporting and empowering educators; 5, Delivering curricula and assessments 6, Developing a sustainable workforce	
The University of Leeds has a 'green card ' system, whereby students can make a citation for exceptional teaching. Last academic year Harrogate received 18 cards - higher than neighbouring and much larger Trusts. (Dr Gareth Davies)	The citations are only given when the student feels there has been exceptional teaching. The citations evidence-base this across a broad spectrum of teaching activity at Harrogate.	1, Learning environment and culture; 3, Supporting and empowering learners/ Supporting learners 4, Supporting and empowering educators/ Supporting educators 5, Delivering curricula and assessments / Developing and implementing curricula and assessments	1.1, 1.2 / S1.1, S1.2 3.1 / S3.1 4.1, 4.2, 4.3, 4.4 / S4.2 5.1 / S5.1
Dr Hugh Larkin has been awarded a longstanding teaching award, in recognition of decades of high quality teaching to undergraduates at Harrogate in cardiology, evidenced by colleague and student citations. (Dr Gareth Davies)	Individuals going the extra mile.	1, Learning environment and culture; 3, Supporting and empowering learners/ Supporting learners 4, Supporting and empowering educators/ Supporting educators 5, Delivering curricula and assessments/	1.1, 1.2 / S1.1, S1.2 3.1 / S3.1 4.1, 4.2, 4.3, 4.4 / S4.2 5.1 / S5.1

6.2

		Developing and implementing curricula and assessments	
University of Leeds clinical teachers award to Matt Milsom (4 th year student lead) for developing prescribing teaching sessions at HDFT. (Matt Milsom)	Developing a novel teaching session on prescribing which is often challenging to teach in a clinical environment. The sessions received excellent feedback and his work was presented at the clinical teachers' conference in Leeds.	1, Learning environment and culture; 3, Supporting and empowering learners/ Supporting learners 4, Supporting and empowering educators/ Supporting educators 5, Delivering curricula and assessments/ Developing and implementing curricula and assessments	1.1, 1.2 / S1.1, S1.2 3.1 / S3.1 4.1, 4.2, 4.3, 4.4 / S4.2 5.1 / S5.1

2.3.3. Challenges or important issues that HEE should be aware of

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section. Challenges identified already but that have been resolved within the reporting period or any ongoing challenges. You do not need to duplicate items from the top three challenges section of the SAR (section 1.3).

Description of challenges (please include the programme this relates to)	HEE/GMC Domain(s)	HEE/GMC Standard(s)
The Director of the undergraduate training programme, Dr Gareth Davies is due to retire in June 2019. This will inevitably pose a challenge during the transitional period.	1, Learning environment and culture; 2, Educational governance and leadership; 6, Developing a sustainable workforce	1.1, 1.5 / S1.1 2.1, 2.2 6.3
Reconfiguration of the gastroenterology timetable for year 5 undergraduates (as described previously) to a self-directed format has	1, Learning environment	1.1, 1.5 / S1.1, S1.2

<p>created new difficulties for some undergraduates, as raised at the annual MPET meeting in May 2018. An action plan to address these issues has been produced and is being pursued.</p>	<p>and culture; 2, Educational governance and leadership; 3, Supporting and empowering learners/ Supporting learners 5, Delivering curricula and assessments / Developing and implementing curricula and assessments 6, Developing a sustainable workforce</p>	<p>2.3 / S2.1 3.1, 3.2, 3.5 / S3.1 5.1 / S5.1 6.4</p>
<p>Programming and hosting placements for students on the MSc programme in Physician Associate Studies during 2017 has had an impact on the organisation and delivery of the undergraduate training programme due to a delay in the recruitment of a consultant lead and the ward-based teachers, who were not in post until several months after the placements began.</p>	<p>1, Learning environment and culture; 2, Educational governance and leadership; 3, Supporting and empowering learners/ Supporting learners 4, Supporting and empowering educators / Supporting educators 5, Delivering curricula and assessments / Developing and implementing curricula and assessments</p>	<p>1.1, 1.5 / S1.1, S1.2 2.3 3.1, 3.2, 3.5 / S3.1 4.4 / S4.2 5.1 / S5.1</p>

6.2

	6, Developing a sustainable workforce	6.3
--	--	-----

2.4. Academic Training

Please describe how your organisation supports academic learners, including Integrated Academic Training Programmes e.g. NIHR, clearly highlighting any challenges or good practice items.

N/a

6.2

Section 3: Reference List of Supporting Information

Organisational policies and processes in support of delivery of the HEE Quality Framework.

This section will need completing once, in subsequent annual returns only changes and updates will need to be highlighted.

Please list key policies and processes and provide a brief narrative how the policy helps the organisation to meet the domains and standards. Add as many rows as required.

Please advise which domains and standards are being supported the policy.

Please note, we do not require copies of documents. Please do not embed documents or insert links. If required the quality team will request a copy by exception.

Please advise if you have made a reference to a policy/process in other section(s) of the SAR.

6.2

Description of supporting information	HEE/GMC Domain(s)	HEE/GMC Standard(s)	Please advise if document referenced in the SAR e.g. <i>SAR, section 1.4 and 2.1.1</i>
HDFT Library Strategy	1	1.3 1.5 2.4	SAR section 7.1
Quality Assured Practice Placement Report	1 to 6	All	SAR section 2.1
Values & Behaviours Framework	1	1.1 1.2	SAR section 2.1
Workforce & OD Strategy 2015	1 to 6	All	
Clinical Workforce Strategy	1 to 6	All	SAR section 1.4
Bullying & Harassment Policy	1	1.1 1.2	
Guardian of Safe Working quarterly report	2	2.1 2.2 2.3 2.4 2.5	
Notes of Monitoring Learning Environment	1 to 6	All	
Equality & Diversity Group Terms of Reference	2	2.4	SAR Section 6
Supervisor Feedback form	2	2.2	2.2.1
Appraisal Policy	3 4	3.1 3.2 3.3 4.3	
Disciplinary, Capability, Ill Health & Appeals Policy & Procedure for Drs and	3 4	3.2 4.3	

Dentists			
Induction Policy	3	3.4 3.5	
Managing Attendance and Promoting Health & Well-being Policy	3 4	3.2 4.3	
Manging Work Pressures Policy	3	3.1	
Flexible Working Policy	3	3.3	
Capability Policy	2	2.1	
Professional Clinical Registration Policy	2	2.1	
Medical Appraisal Policy	3 4	3.1 3.2 3.3 4.3	
Human Factors & Ergonomics Group Terms of Reference	1 3	1.1 1.2 1.3 1.4 1.5 1.6 3.3	SAR Section 5.3
Simulation Strategy	1	1.6	SAR Section 5.2
Board Assurance Framework	2	2.1 2.5	
Grievance Policy and Procedure	3 4	3.2 4.3	
Child Protection allegations against staff policy	2	2.1	
Quality Charter	1	1.3	SAR Section 2 2.2.1
Medical Education Strategy Group Terms of Reference	2	2.1 2.2 2.3 2.4 2.5	SAR Section 2 2.2.1
Quality of Care Teams – Terms of Reference Template	1	1.3	
Speaking Up Policy	1 2 3	1.1 2.5 3.3	SAR Section 2.2.1
FYI Job Booklet	3	3.4 3.5	SAR Section 2
Incidents Reporting Policy	2	2.5	SAR Section 8

6.2

Section 4: 17/18 and 18/19 LDA Funding

	Total paid in	Estimated 18/19 funding
--	---------------	-------------------------

		17/18	
Total paid to the trust in 17/18:		£ 5,607,211.13	n/a
Total initial 18/19 LDA value (including undergraduate):		n/a	£ 4,296,513.83
Total for salaries for doctors in training:		£ 1,622,711.00	£ 1,542,923.00
Tariff for placement activity			
Postgraduate Medical	Tariff (as per DoH guidance* £12,152 + MFF)	£ 788,446.00	£ 814,821.00
	Contribution to basic salary costs (as per DoH Annex A*)	£ 1,622,711.00	£ 1,542,923.00
	Total	£ 2,411,157.00	£ 2,357,744.00
Total Non-medical placement tariff: (as per DoH guidance* £3,112 + MFF)		£ 309,095.00	£ 309,096.36

[*2017-18 Education & training placement tariffs: Tariff guidance and prices from 1st April 2017](#)

A placement in England that attracts a tariff payment must meet each of the criteria in line with the DoH guidance*. Please provide details of how you utilised your 17/18 placement tariff within the financial year April 17 to March 18 to support learners and educators.

Please note figures entered below should reconcile to the 17/18 tariff figures shown in the table above. Please provide details of expenditure and associated costs.

	Trust's Response
Postgraduate Medical Placement Tariff <i>The E&T placement tariffs cover funding for all direct costs involved in delivering E&T by the provider, for example (please see DoH guidance page 6): Direct staff teaching time within a clinical placement Teaching and student facilities, including access to library services Administration costs Infrastructure costs</i>	Direct Staff teaching time £159,009.32 Education Supervisors £53,115.13 Administration Costs £162,019.04 Infrastructure Costs £157,689.20 Trainee Study leave £169,277.93 Course fees and expenses £15,642.79 Student trainee Accommodation Costs £51,762.50 Teaching and Student Facilities £19,930.09 Total Tariff costs £788,446.00 Contribution to Salary Costs £1,622,711.00 Total £2,411,157.00
Non-Medical Placement Tariff <i>As above</i>	Direct Staff teaching time £51,900.00 Education Supervisors £38,200.00 Administration Costs £69,340.47 Infrastructure Costs £72,257.00 Trainee Study leave £75,000.00 Course fees and expenses £2,397.53 Total £309,095.00
Additional Funding <i>Please confirm how any additional money has been spent.</i>	

Section 5: Simulation, Patient Safety and Human Factors

5.1. Patient safety

Please consider the following questions below.

Questions	Trust's response
1. Who is the Lead for Patient Safety in your organisation? What support do they receive in delivering this role? E.g. job-planned time, resources etc.	Dr David Scullion, Medical Director, is chair of the Improving Patient Safety Group. Dr David Earl, Deputy Medical Director also sits on the group and acts as chair when the Medical Director is absent.
2. Please advise up to three areas relating to patient safety agenda that you have worked on in the last two years and you are most proud of? Could these be applied regionally and be shared with HEE?	3 areas would be: i) Sepsis care - now hitting 90% target for prompt antibiotics ii) Operating theatre checks/WHO checklist - now 99% compliant iii) Electronic observations/NEWS2 implementation i) and ii) have been discussed locally via the Improvement Academy. iii) is very system dependent.
3. In which areas would you like support from HEE? E.g. educational events, funding, specific areas of training for example quality improvement?	Supporting regional events aimed at standardisation of pathways would be helpful - too many variations in approached to common issues does not help trainees.

6.2

5.2. Simulation

Prompt: We advise you to consult with your Simulation Manager or Lead when compiling your response.

Questions	Trust's response
1. Who is the Simulation lead in your organisation? Please advise on name, job title and email address. What support do they receive in delivering this role? E.g. job-planned time, resources etc. Are they linked in with the HEE Simulation Network in their locality?	Dr Will Peat – Simulation Lead. 1 PA – for Simulation and Human Factors Support from Clinical Skills Trainer - Band 7 and Band 6. Plus 2 x ward based practitioners Linked to the HEE Simulation network
2. Who is responsible for keeping an inventory of the simulation equipment within the Trust including all task trainers and low fidelity mannequins?	Band 7 Clinical Skills Trainer keeps inventory. Commitment from the Trust to meet cost of ongoing sim equipment. Shared between directorates.
3. How many simulation specific trained faculty does the trust have?	Clinical Skills Trainers Simulation Lead Multi-disciplinary staff- Emergency Department, Paediatrics', Surgery, Anaesthetics, Midwifery and Obstetrics and Gynaecology
4. Which directorates or inter-professional groups are actively engaged with simulation based education within your organisation? How do you encourage equitable access to	Health care workers, Midwives, Nurses, Physiotherapists and Doctors. I encourage access by engagement events across the Trust.

simulation for all staff?	
5. Is there strategic engagement and representation in simulation activity in the organisation i.e. board level, clinical governance, patient safety, incident reviews?	Simulation Strategy delivered to the Board of Directors 2017. Commitment from the Board to fund ongoing simulation costs. Patient safety initiatives and incident review in relation to Human Factors is ongoing using the Yorkshire Human Factors toolkit.

5.3. Human Factors

Questions	Trust's response
1. Who is the Lead for Human Factors in your organisation? What support do they receive in delivering this role? E.g. job-planned time, resources etc.	Dr Will Peat Simulation and Human Factors together constitute 1 PA – job planned. Human Factors Group put together in the last year under the patient safety governance framework.
2. Please describe the extent to which your HF training covers the following domains: <ul style="list-style-type: none"> • People – the individual & teamwork • Environment – the physical aspects of a workspace • Equipment and technology • Tasks and processes • Organisation • Ergonomics and research methods 	Human Factors Group has been started following funding for training from sign up to safety. This has enabled a faculty of trainers in the Trust. We have instituted the first Human Factors study day. Have been involved in clinical areas walk round. The equipment library band 7 nurse is a member of the Human Factors Group. As such human factors decisions are involved in equipment procurement.
3. For the training delivered in the reporting period please also consider and describe the following: <ul style="list-style-type: none"> • The audience to which HF training is being delivered, including details of multi-professional staff. • Frequency of training, or whether ad hoc events. • Who are the faculty that deliver the training? Please describe their “HF expertise”, professional background, specialty, whether they have job-planned time to deliver HF training. • What is the wider Trust context within which HF training is delivered. Is there a link between patient safety incidents, SI investigations, root cause analysis? • To what extent is HF training seen as part of a wider patient quality and safety agenda or integrated into clinical governance structure/process? 	The Human Factors Group is completing a training needs analysis for the Trust and has started a Human Factors study day for nursing staff. Human Factors is now embedded into simulation training, including resus training. It is also embedded into multi-disciplinary courses. We have completed a human factors walk round to look at aspects in the pathology department. The aim is to suggest bronze level Human Factors training (through the improvement academy for all staff members). A half day of Human Factors training was delivered by Kathy McClune and Helen Woollatt to midwifery students at York University. Human Factors training is incorporated into both the multi-disciplinary PROMPT training day and the half day on Fetal monitoring.

6.2

Section 6: Equality and Diversity

The HEE Quality Framework states clearly that education and training opportunities should be based on principles of diversity and inclusion.

The HEE equality, diversity and inclusion strategy reflects HEE's commitment to this important area of work and features strategy for HEE employees, as well as the opportunity to influence wider. An example of this is the HEE workforce strategy, used to inform our work in developing a comprehensive system-wide understanding of workforce needs for the future. Diversity and inclusion will be integral in how we look to influence the healthcare system to achieve greater representation and social mobility.

As well as applying these principles across all professional groups, there is also a specific work stream and duty to consider and capture information for doctors in training. The GMC continue their work in equality and diversity, reflecting their standards; promoting excellence.

For medical education, the GMC and local offices continue to consider differential attainment; different rates of attainment between different groups of doctors. This work includes ethnicity and country of primary medical qualification.

Prompt: In the responses below, please consider:

- *Organisation wide themes*
- *Examples of good practice from across professional groups*
- *As well as specific consideration and comment on differential attainment for doctors in training*

Question	Trust Response
Name of Trust Equality, Diversity and Inclusion Lead:	Dr Sylvia Wood – Deputy Director of Governance (Trust lead) Katherine Duke – HR Business Partner (Workforce lead)
1. How do you ensure that learners with different protected characteristics are welcomed and supported into the trust, demonstrating that you value diversity as an organisation?	<p>During the induction process all learners are encouraged to familiarise themselves with the Trust's values and behaviours which fully demonstrate a commitment to valuing diversity. Values and behaviours are also explored further during some exercises included as part of induction.</p> <p>All staff are required to undertake Equality and Diversity training which highlights key legislative requirements but also elements around promoting fairness and the principles of diversity.</p> <p>Adjustments to induction processes are made where required e.g. documents compliant with the Accessible Information Standard.</p>
2. How do you liaise with your trust Equality, Diversity and Inclusion Lead to: <ul style="list-style-type: none"> • Ensure trust reporting mechanisms and data collection take learners into account? • Implement reasonable adjustments for disabled learners? • Ensure your policies and procedures do not negatively impact learners who may share protected characteristics? • Analyse outcome data (such as exam results, assessments, ARCP outcomes) by protected characteristic? 	<p>The Workforce Equality Group has oversight of all reporting mechanisms related to protected characteristics. The Trust is fully compliant with all statutory data collection and reporting requirements e.g. Workforce Race Equality Scheme (WRES), Gender Pay Gap (GPG), data includes learners where appropriate.</p> <p>Any reasonable adjustments required would be managed jointly by the Operational HR team, medical staffing and medical education. Full consideration would be given to adjustments and how these can be accommodated. Examples include adjustments to shifts and working environments.</p>

	<p>All policies and procedures are agreed collectively with trade union colleagues and go through an equality impact screening with full assessment as required. Where a potential impact is identified a full impact assessment would be required, this will ensure that the impact is removed or appropriate monitoring is put in place.</p> <p>No specific analysis is routinely done on the data on ARCP outcomes, because all foundation doctors have passed this over a number of years. Should the pass rate ever fall below 100% then this analysis would be undertaken.</p>
<p>3. How do you support learners with protected characteristics to ensure that known barriers to progression can be managed effectively?</p>	<p>The Trust has recently undertaken a series of listening events, led by Dr Ros Tolcher, Chief Executive. The focus of these events was to give all staff, including learners, the opportunity to give feedback and to help identify any potential barriers to progression.</p> <p>The Trust is also looking to establish a staff network which would be open to learners, part of the remit of this network would be to understand barriers and contribute to the effective management of this.</p>
<p>4. How do you educate learners on equality and diversity issues that may relate to themselves, their colleagues, or the local population of the trust?</p>	<p>All staff are required to undertake Equality and Diversity training which highlights key legislative requirements but also elements around promoting fairness and the principles of diversity.</p> <p>In addition, action plans and data submission e.g. WRES are shared within clinical directorates to ensure that all staff are aware of equality and diversity issues which may relate to themselves or others.</p> <p>The Trust operates Schwartz rounds which give participants the opportunity to explore current workplace issues, these have relevance to learners and a number of learners have attended events in the past.</p>
<p>5. How do you support your educators to develop their understanding of, and support for, learners with protected characteristics?</p>	<p>All staff are required to undertake Equality and Diversity training which highlights key legislative requirements but also elements around promoting fairness and the principles of diversity.</p> <p>In addition to the above the Trust is considering the roll out of unconscious bias training to complement the existing Equality and Diversity training. Elements of this already exist in the Trust's Pathway to Management training session which is mandatory for all managers.</p>

Section 7: Libraries and Knowledge Services (LQAF)

We recommend that you consult with your Library and Knowledge Services Manager or Lead to complete this section. Please provide narrative and evidence (for 1, 3 and 4) on the following 4 areas for your Library and Knowledge Service. Please also highlight any issues or concerns, including any areas which are not being met. If your Library and Knowledge Service is provided via a service level agreement, please consult with the providing Library and Knowledge Services Manager. Additional prompts have been added under each heading.

1. Describe how your Trust is implementing the **HEE Library and Knowledge Services Policy** (<https://hee.nhs.uk/sites/default/files/documents/NHS%20Library%20and%20Knowledge%20Services%20in%20England%20Policy.pdf>) namely:

“To ensure the use in the health service of evidence obtained from research, Health Education England is committed to:

- Enabling all NHS workforce members to freely access library and knowledge services so that they can use the right knowledge and evidence to achieve excellent healthcare and health improvement.
- Developing NHS librarians and knowledge specialists to use their expertise to mobilise evidence obtained from research and organisational knowledge to underpin decision-making in the National Health Service in England.”

Prompt: We advise you to consult with your Library and Knowledge Services Manager or Lead when compiling your response. You could provide evidence from your Library and Knowledge Services’ strategy or annual action/implementation/business/service improvement plan.

The Library provides a multi-disciplinary service to support the information needs of all staff of the Trust in both clinical and non-clinical roles, of students on placement or studying with the Trust as a training provider, and staff and students of partner organisations under Service Level Agreements. It facilitates staff to carry out their various roles to a high standard by ensuring provision of the necessary information resources to help staff provide a safe, effective and high quality service. This supports patient care through staff learning, training and continuing professional development, and helps to promote a learning culture throughout the organisation in order to best inform core decision making and to disseminate evidence of best practice.

Library strategy, section 1.2.3 “Library context and aims”

Library staff development needs are identified and supported to meet both service and personal objectives through annual appraisal, during which developmental needs are identified and recorded, and through additional learning and development opportunities throughout the year. All library team members participate in staff development and CPD activities offered by local and regional networks.

(LQAF section 3.2: LKS staff development: Fully compliant)

1. HEE's **Library and Knowledge Services Policy** is delivered primarily through local NHS Library and Knowledge Services.
 - Please identify the budget allocated to your Library and Knowledge Service in the current financial year.
 - If possible please identify the sources of this funding, differentiating for example between educational tariff funding and any contribution from your organisation.

Prompt: Your Finance department and/or your Library and Knowledge Service Manager should be able to supply this information.

The total library budget for April 2018 – March 2019 is £98,700.
 Of this amount, £61,000 is allocated as Pay budget, and £37,700 Non Pay.

 £33,700 of the library budget is funded through educational tariff funding from HEE.
 The remainder is funded by the Trust.

2. Please tell us about any areas of Library and Knowledge Services good practice that you would like to highlight.

Prompt: We advise you to consult with your Library and Knowledge Services Manager or Lead when compiling your response. You could provide evidence of impact on clinical practice, impact on management decision-making (including cost savings) and any innovation submissions originating from your Library and Knowledge Service.

The library's partnership working around the provision of health information to the public was commended in the 2017 LQAF validation report. This collaboration is being further developed, and supports clinical practice by assisting patients and the public to access good quality health care information and develop their health information literacy skills.

3. The **Learning and Development Agreement** that Health Education England has with your organisation states that the LKS should achieve a minimum of 90% compliance with the national standards laid out in the current Library Quality Assurance Framework (LQAF).

If your LKS has a score below 90% please describe the improvements you are planning to attain this minimum requirement in 2018-19.

Prompt: We advise you to consult with your Library and Knowledge Services Manager or Lead when compiling your response. The details should be available from the LQAF Action Plan developed following the 2017-18 LQAF.

Harrogate and District NHS Foundation Trust's Library and Information Service has a verified LQAF compliance score of 96% following the 2017 assessment.

It is anticipated that this score will be maintained for 2017-18, following August submission of the self-assessment report. Verified LQAF results are expected in December 2018.

There are no areas of non-compliance with LQAF criteria.

An action plan is in place to address areas of partial compliance, and will be further developed when feedback from the external verification process is received.

For example, the measurement of impact is being improved, using additional methods to gather responses. The systematic process for gathering impact is being strengthened. Library reports such as the annual review will demonstrate how feedback / impact information is used to meet the changing needs of the organisation.
(Actions re: LQAF criterion 1.3c, demonstration of positive impact.)

Section 8: Additional Information

8.1 Supporting Learners at Coroners’ Court and following Serious Incidents

To help HEE better understand how your organisation supports learners please complete the questions below.

Serious Incidents and Never Events

Questions	Trust’s Response
Please provide an account of how your organisation identifies learner involvement in Serious Incidents. How is that degree of involvement defined?	Immediate fact finding through the Real Time Manager 72 hour report identifies key witnesses/those involved. Directorate Quality Assurance Leads gather information and may seek statements from learners if required.
What support systems exist to support learners? How are these systems monitored?	Support and guidance is detailed in the Investigating Learning & Supporting Guide and in the statement writing guidelines. Support systems are signposted in the guide and include educational supervisor, Risk Management, Occupational Health etc. The DME meets with all trainees who are identified as being involved in a Serious Incident to ensure they are adequately supported and to discuss the Exception Reporting system. This also provides an opportunity to direct trainees to HEE Y & H resources on Coroner’s Inquests and Statement Writing, and to the Take Time counselling service.
What feedback do you receive from learners about their experience of being involved in Serious Incidents?	Depending on the incident a staff debrief may be organised if appropriate. The DME discusses with trainees the support they receive during the course of the investigation of a Serious Incident before submitting the final draft of an exception report. The DME will meet with the trainee if they request.
What formal organisational links exist between the Governance team coordinating investigations and the Postgraduate team supervising the trainees? the HEIs supporting learners?	At the time of the 72 hour report, the Quality Assurance Leads share the details of any trainees involved with the Compliance & Revalidation Manager who completes the exception report. This is forwarded to the DME who proof reads the report and shares it with the trainee. The DME arranges to meet the trainee to offer support and to ensure the trainee has been supported throughout the process by his/her educational supervisor. The Exception Report draft is sent to the revalidation team at HEE. When the investigation is complete, the DME updates the report with any actions that have been identified for the trainee. The report is shared again with the trainee and the final report is submitted to the revalidation team at HEE. For non-medical students clear processes for adverse incident reporting are in place across the Trust and set out in the Incidents Policy. These are communicated to all staff and are available to all students via student handbooks. The Practice Education Team is available to support on an individual basis as events occur. Students are advised to obtain individual support from personal tutors. The Trust carries out Root Cause Analysis (RCA) with all adverse events and provides additional support to all involved.

6.2

How many patient safety incidents have you reported to NHSI.	HDFT reported 2,416 incidents during the period April 2017 – September 2017 (latest published NRLS data).
How many serious incidents impacting on trainees' revalidation have you made to your HEE local office within the reporting period? What proportions of these have been resolved/ closed after completion of investigations?	6 Exception reports resulting from trainee involvement in Serious Incidents have been reported to the local office over the last year. To the best of our knowledge, none of these have impacted on trainees' revalidation.
How does your organisation disseminate learning from Root Cause Analysis reports? How does your organisation promote a patient safety culture?	We have a variety of mechanisms to disseminate learning from RCAs, such as learning events, newsletters, targeted emails and sharing of reports across staff groups. We actively encourage an open patient safety culture and are currently undertaking a Quality Improvement Project with the aim of embedding this further including work to promote just culture and freedom to speak up. If additional training is identified for staff as a result of a RCA then an educational programme is rolled out. In 2017 the Critical Care Outreach Team delivered a series of inter-professional tracheostomy training sessions as a result of a SUI.

Coroners Hearings

Questions	Trust's Response
What support is available for learners who are required to provide statements and/or attend Coroners hearings?	As regards Coroner's inquests: When a notified inquest involves learners, there is support provided through the local educational and risk management process. Learners are given guidance on statement writing, and the workings of the Coronial process generally. Where appropriate, learners will be given access to the Trust's legal advisors in order to support them through what is a very stressful time. On the day there will be a presence from a senior member of the risk management team, and in some cases the Medical Director or designated representative. Learners are encouraged, when appropriate, to access their own legal support. This happens relatively infrequently, though when it does I have always been impressed with the regard for, and care of learners when they find themselves in this situation. The credit for this goes to the Risk Management team. We also get excellent back up from our own legal advisors and the in-house post-grad education team. Feedback from learners has been good.
How is your organisation involving learners in responding to Duty of Candour responsibilities?	The general principles of DoC should be well known to all doctors. We do not have a specific policy for the involvement of learners in this process, simply because in the vast majority of cases the written response will originate from a more senior member of the organisation such as the Consultant of care, Medical Director or CEO. All learners should of course be aware of the principles of being open and honest. This is distinct from, but related to the statutory duty of candour.

Guardians of Safe Working

Questions	Trust's Response
<p>10. Please describe the interrelationship between the GOSW and the Director of Education?</p>	<p>The interrelationship between the Director of Medical Education (DME) and the Guardian of Safe Working Hours (GOSW) is professional and close. Both meet the trainees together in their Forum at least bi-monthly. Individual case work leads to personal meetings and discussions.</p> <p>Both will share strategic issues emerging in their respective fields and with regard to information emerging from regional networks and authorities and national conferences. Both face the intractable problem of workforce recruitment and consequent rota gaps; both interact with directorate middle management in cases where trainee doctors are facing difficulties.</p> <p>Doctors in Difficulty will come to the attention of both but ultimately the Director of Education has the managerial authority to deal with any issues of attendance, performance, health and safety. The GOSW has no managerial authority and can give no orders. He does prepare a quarterly report to the Board of Directors.</p>
<p>11. Please provide a summary of the exception reports you have received within the reporting period, number, type and time to resolve.</p>	<p>Exception reports:</p> <p>Closed hours/rest: 103 Closed education: 7 Total closed: 110</p> <p>Top 5 specialties:</p> <p>Gen Med: 66 Gen Surg: 33 Ophthalmology: 7 Paediatrics: 2 EM: 2</p> <p>Top 5 grades:</p> <p>F1: 58 F2: 24 Specialty Trainees: 28</p> <p>Exception reports are dealt with and concluded within 4 week of receipt. The outcome is either time off in lieu; payment for extra hours worked or no action at all.</p> <p>In addition, the Trust's Guardian of Safe Working regularly monitors exception reports received from Doctors in Training providing a quarterly report to the Trust board. Recent trends in exception reporting indicate that 'hot spot' areas include General Medicine and General Surgery, this is consistent with areas where gaps go unfilled on Doctors in Training rotas</p>

6.2

8.2. Educational Opportunities during winter pressures

Please describe how your organisation Maintains curriculum delivery opportunities during winter pressures

Questions	Trust's response
<p>1a) Please describe how winter pressures in 2017/18 affected your ability to deliver training to all learners within your organisation?</p> <p>1b) Please detail the specific areas, placements and programmes which were adversely affected by last winter's pressures.</p>	<p>The fact that we do not cancel elective work during winter ensures the continuity of our training. Cancellations will only be made in exceptional circumstances and therefore will have a minimal impact on the learning experience. In theatres 55 patients were cancelled due to winter pressures.</p> <p>Non-Medical Placements - Movement of staff proved to be particularly challenging in affecting our ability to ensure sufficient sign off mentors for adult nursing students within acute medical areas within the Trust.</p> <p>Contributing factor - Vacancies that we have had in Elderly medical wards.</p> <p>Core Trainee vacancies in Trauma and Orthopaedics last winter resulted in trainees missing out on theatre sessions to cover ward activity. The Directorate have been advised to direct locum doctors to ward cover and Core Trainee to theatre work in the future.</p>
<p>2. Please describe what strategies you used to protect training for all learners across their whole placement with your organisation in 2017/18 e.g. moving educational sessions to times of less pressure, ring-fencing specific clinics, lists etc. for training</p>	<p>Non-Medical Placements – to overcome the challenge described in 1 above additional sign off mentor workshops were held which enabled (in the longer-term) additional sign off mentors within the identified areas. The Clinical Lead for Practice Education was able to also step in and sign off students where required. Lists are ring fenced for training in some specialities to ensure that they go-ahead.</p>
<p>3. Please describe what plans you are putting in place to mitigate the effects of winter service pressures on training in 2018/19.</p>	<p>System wide Winter Plan developed to support service pressures over winter. This includes:</p> <ul style="list-style-type: none"> • Additional agency junior support during the period when the number medical outliers are at their highest. • Additional medical and HCA support into ED during the winter period. • A new Supportive Discharge Service which will increase community capacity to manage patients in their own home. This will ensure escalation beds are kept to a minimum. <p>The intention is this will support the increased work load and the associated impact on training.</p> <p>Elective activity is planned to continue as normal with the exception of the fortnight after the Christmas and New Year periods where there will be an organisational focus on acute work. This will mean the impact on training opportunities will be minimised.</p>

6.2

	<p>Movement of staff across wards to level out staffing and ensure all ward areas have sufficient RNs. Therefore plugging the gaps in key specialities such as Elderly Medical wards.</p> <p>We are working to identify areas where there is a short-fall of sign off mentors and then targeting the specific areas to provide sign off mentor workshops.</p>
--	---

Date of Meeting:	26 September 2018	Agenda item:	6.3
Report to:	Board of Directors		
Title:	Flu Action Plan		
Sponsoring Director:	Joanne Harrison, Interim Director of Workforce and Organisational Development		
Author(s):	Anna Mitchell, HR Business Partner & Heather Singleton, Occupational Health Services Manager		
Report Purpose:	Decision	Discussion/ Consultation	Information
		✓	✓
Executive Summary:	<ul style="list-style-type: none"> NHS England and NHS Improvement have recently written to all Trust's expressing the ambition for 100% of healthcare workers with direct patient contact to be vaccinated. The Trust target is to vaccinate 75% of healthcare workers by the end of October 2018 and 100% by the end of November. The Trust is review the approach locally to deliver this ambition. The Chief Nurse has been confirmed as the Board champion for the flu campaign. 		
Related Trust Objectives			
To deliver high quality care	✓	To work with partners to deliver integrated care:	To ensure clinical and financial sustainability: ✓
Key implications			
Risk Assessment:	Any identified risks are included in the Directorate and Corporate Risk Registers and the Board Assurance Framework.		
Legal / regulatory:	NHS England and NHS Improvement included a healthcare worker flu vaccination best practice management checklist and have requested each Trust publishes a self-assessment against these measures in their Trust board papers by December 2018. This is included in this paper.		
Resource:	Not applicable		
Impact Assessment:	Not applicable		
Conflicts of Interest:	None identified		
Reference documents:	None identified		
Assurance:	The 2017/18 report for the flu season was presented to the W&OD Steering Group in June 2018. Learnings have been incorporated for this years' flu campaign.		
Action Required by the Board of Directors:			
The Board is invited to approve the plan for the flu campaign.			

FLU CAMPAIGN 2018

NHS England (NHSE) and NHS Improvement (NHSI) have recently written to all Trusts expressing the ambition for 100% of healthcare workers with direct patient contact to be vaccinated. Flu vaccination uptake amongst frontline/clinical healthcare workers at HDFT for the 2017/18 season was 60.4% at the end of the reporting period (the National average was 68.7%). Although this was a significant improvement on the 2016/17 season which was 42.1%, it is still significantly adrift from the ambition of 100%.

We have detailed below the key elements of this year's Flu Campaign:

- Regular Flu Steering Group meetings have been taking place with sub-groups working on specific aspects of the campaign e.g. communications, peer vaccinator training.
- Maximum effort will be focused during October with the target of 75% of front line healthcare workers to be vaccinated within the month. The first vaccination sessions start on 1 October 2018.
- Six face-to-face peer vaccinator training sessions have been delivered as well as an alternate option to complete the e-learning package.
- Invitation to the flu drop in session will be sent to new starters and personal reminder letters to staff not recorded as vaccinated by the end of November. This will include a reply form on which vaccination elsewhere and active decline can be notified.
- Community staff will have the option of visiting local partner Occupational Health departments' vaccination sessions or reimbursement of the costs of purchase via their local pharmacy to obtain their flu vaccination.
- KitKats have been purchased to give to staff once they've been vaccinated and promotional posters, leaflets and stickers have been delivered from NHS Flu Fighter. Communications about the campaign started week commencing 10 September 2018.
- National reporting of uptake will occur monthly, however as a Trust we will report weekly the numbers of staff vaccinated to aid uptake and show progress against our overall target. The aim is that this will create competition between departments to ensure that their teams are protected.
- Communication will focus on the safety messages. It is important that our workforce take positive action to protect themselves, our patients/service users and their families.
- We will continue to review our local approach to delivering 100% vaccination as we move through the campaign.

NHSE and NHSI included a healthcare worker flu vaccination best practice management checklist and have requested each Trust publish a self-assessment against these measures in their Trust Board papers by December 2018. Below is the completed assessment for HDFT's 2018/19 staff flu vaccination campaign for approval.

2

You matter most

**Healthcare worker flu vaccination best practice management checklist
for public assurance via Trust boards**

A	Committed leadership	Trust self-assessment
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	Target to vaccinate 75% of healthcare workers by the end of October 2018 and 100% by the end of November. All healthcare workers who have not had a flu vaccination at the end of November will be asked for their reason why and/or to record if they have obtained one elsewhere. This information will be collated by Occupational Health anonymously.
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers	3300 QIV flu vaccinations have been purchased and 100 aTIV vaccinations (for healthcare workers aged 65 or over) were ordered in line with the National recommendations published in early 2018.
A3	Board receive an evaluation of the flu programme 2017-18, including data, successes, challenges and lessons learnt	2017/18 report was presented to the Workforce and Organisational Development Steering Group in June 2018. A subsequent paper was sent to Director Team in June 2018 incorporating lessons learnt and outlining the approach for the 2018/19 campaign.
A4	Agree on a Board champion for flu campaign	Chief Nurse confirmed as Board champion.
A5	Agree how data on uptake and opt-out will be collected and reported	Uptake and opt-out to be recorded in Occupational Health using a spreadsheet of staff extracted from ESR. Information will be collected via: completed vaccination consent forms (from Occupational Health sessions and peer vaccinators) recording vaccination or opt-out; intranet link to notify vaccination received elsewhere; form on reverse of reminder letter (to be issued at the end of November) and new starter letter (to be issued at Induction) to notify vaccination received elsewhere or opt-out. Vaccination sessions will be available for new starters at the end of the day two induction. Reporting from the spreadsheet will be undertaken weekly in addition to the mandatory monthly ImmForm reporting to show uptake by staff group and location.
A6	All Board members receive flu vaccination and publicise this	<i>Comment: most Board members are not included in the mandatory uptake data.</i> A vaccination session has been arranged for Board members to receive their flu vaccination on 1 October and this will be widely publicised at the start of the campaign.

A7	Flu team formed with representatives from all directorates, staff groups and trade union representatives	Flu Steering Group was re-established and includes representation from all directorates and some trade unions. Staff groups represented are mainly nursing and medical.
A8	Flu team to meet regularly from August 2018	Monthly meetings have been held since May 2018.
B	Communication Plan	
B1	Rationale for the flu vaccination programme and myth busting to be published – sponsored by senior clinical leaders and trade unions	Communication plan includes myth busting and the rationale for having the flu vaccination programme. The flu steering group is working with the Clinical Lead for Infection Prevention and Control for a combined patient and staff safety focused communication campaign.
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Harrogate District Hospital drop-in clinics are scheduled to run over 4 weeks in October, drop-in clinics at other Trusts covering the HDFT geographical footprint and peer vaccinator details will be published via intranet (with printable poster versions available) and promoted via staff bulletins, Team Brief and social media.
B3	Board and senior managers having their vaccinations to be publicised	All staff will be invited to take a selfie to post. This will include photos in regular communications about the flu vaccination sessions
B4	Flu vaccination programme and access to vaccination on induction programmes	Planning to provide information via letter handed out at induction, vaccination access to be provided on day 2 of induction.
B5	Programme to be publicised on screensavers, posters and social media	Flu Fighter posters have been ordered, use of screensavers, social media etc. is part of communications planning.
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	Will be provided from the Occupational Health spreadsheet uptake data.
C	Flexible accessibility	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	Directorates have been requested to identify an adequate number of vaccinators for each of their wards/departments. A number of matrons will act as peer vaccinators and will be able to visit multiple areas. Training by alternative options of e-learning or face-to-face sessions has been delivered since early August. The list of per vaccinators across the Trust has been discussed at Director Team in September and actions have been taken to follow in areas that have a low number of peer vaccinators.
C2	Schedule for easy access drop in clinics agreed	Occupational Health to deliver daily drop-in clinics through first 4 weeks of October, 3 weeks of 11.00 - 14.00 in Herriot's and 1 week of 7.30 - 8.30 in Radiology. Regional clinics delivered by associated Occupational Health



		units will be advertised.
C3	Schedule for 24 hour mobile vaccinations to be agreed	Shift working peer vaccinators will be able to offer vaccinations for night staff during or at the beginning or end of shift.
D	Incentives	
D1	Board to agree on incentives and how to publicise this	Board agreed to purchase Kit Kats to give to each individual vaccinated
D2	Success to be celebrated weekly	Weekly 'totaliser' updates of numbers vaccinated to be included in all user communications



Harrogate and District
NHS Foundation Trust

Date of Meeting:	26 September 2018	Agenda item:	6.4
Report to:	Board of Directors		
Title:	Freedom to Speak Up Guardian Report		
Sponsoring Director:	Dr Ros Tolcher, Chief Executive		
Author(s):	Dr Sylvia Wood, Deputy Director of Governance and Freedom to Speak Up Guardian		
Report Purpose:	Decision	Discussion/ Consultation	Information
		✓	✓
Executive Summary:	Freedom to Speak Up Guardians are to provide regular, comprehensive reports to their Board so that barriers to speaking up are identified and addressed. This report outlines current work at national and local level, progress with the development of a positive speaking up culture, and further actions planned.		
Related Trust Objectives			
To deliver high quality care	✓	To work with partners to deliver integrated care:	✓
		To ensure clinical and financial sustainability:	✓
Key implications			
Risk Assessment:	There is a risk that poor standards of care can proliferate unless patients and staff are listened to and their concerns welcomed and acted upon.		
Legal / regulatory:	All NHS trusts were required to appoint a Freedom to Speak Up Guardian and an assessment of speaking up is at the heart of the well led domain of CQC inspections of NHS trusts.		
Resource:	There is a time resource required to progress the actions and recommendations from national and local findings.		
Impact Assessment:	This work aims to impact positively on all staff but particularly on staff who might be more vulnerable to speaking up.		
Conflicts of Interest:	None identified.		
Reference documents:	HDFT Speaking Up Policy		
Assurance:	This report provides assurance that the Board is informed about national and local work in relation to developing a culture of speaking up about concerns.		
Action Required by the Board of Directors:			
It is recommended that the Board:			
<ul style="list-style-type: none"> • Notes the content, progress and further actions planned; • Reviews the NHSI and NGO Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts and self-review tool at the next Board strategy day. 			

6.4

1 Introduction

Freedom to Speak Up Guardians are to challenge and change culture within their organisations so that barriers to speaking up, whatever they are, wherever they are, are identified and addressed. An important part of the process is for each FTSU Guardian to provide in person regular, detailed and comprehensive Board reports, to support the development of a positive speaking up culture.

2 National Picture

2.1 NHS Improvement and National Guardians Office

NHSI and the NGO published [Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts](#) (May 2018), and a self-review tool. Boards are asked to treat this guide as a benchmark; review where they are against it and reflect on what they need to do to improve. The Board, and in particular the executive and non-executive leads for FTSU, are expected to complete the review with proportionate support from the trust's FTSU Guardian. Expectations are that:

- Leaders are knowledgeable about FTSU
- Leaders have a structured approach to FTSU
- Leaders actively shape the speaking up culture
- Leaders are clear about their roles and responsibilities
- Leaders are confident that wider concerns are identified and managed
- Leaders receive assurance in a variety of forms
- Leaders engage with all relevant stakeholders
- Leaders are focused on learning and continual improvement

The HDFT self-review has been drafted by some members of the Board, with input from the FTSU Guardian. Some further work is required and then the guidance and self-review needs to be considered by the Board, and any actions to be agreed. The Board is asked to consider this at the next strategy day.

2.2 National Guardian's Office

The next report by the National Guardian's Office (NGO) of data submitted to the office by Freedom to Speak Up Guardians in all NHS trusts and foundation trusts will be published on 20 September 2018 and will cover all four quarters of 2017/18.

The NGO continues to undertake case reviews - see [Case reviews | Care Quality Commission](#). Individuals or organisations are able to refer cases where they think there is evidence that the handling of a speaking up case did not meet with good practice. The purpose of a case review is to identify areas that can be improved, make recommendations on how improvements can be made and commend examples of good practice. Case reviews are to promote learning, so trusts have been encouraged to reflect on the recommendations and to look at how they might improve and apply the learning to their own cultures and processes.

Key recommendations from the published reports on case reviews undertaken at Southport and Ormskirk Hospital NHS Trust, and North Lincolnshire and Goole NHS Foundation Trust were included in the last board report in March 2018.

A [case review of speaking up processes, policies and culture at Derbyshire Community Health Services NHS FT](#) was published in June 2018. 14 recommendations were published, the majority specific to the trust. There was one recommendation for the Department for Health and Social Care to commission NHS Employers to develop and communicate guidance to NHS trusts and foundation trusts that will help ensure HR policies and processes do not present real or perceived barriers to speaking up. This should focus on how trusts can ensure that investigations into speaking up matters are undertaken by suitably independent persons and are completed within reasonable timescales, to enable workers who speak up to have trust and confidence in the process. Guidance should also be provided on how to support individuals who are speaking up about a grievance to prevent undue burdens being placed on those individuals and to ensure that they receive the support they need at what is likely to be a difficult and stressful time.

Further case reviews are underway at:

- Royal Cornwall Hospitals NHS Trust
- Nottinghamshire Healthcare NHS Foundation Trust

2.3 Current related national initiatives

2.3.1 Tackling Bullying – A Call to Action

The Social Partnership Forum launched the [Tackling Bullying Call to Action](#) in December 2016. A range of suggested actions supported by resources, advice, guidance and good practice are available to help organisations develop their own plans in partnership to tackle bullying. The agreed goal is for NHS organisations to provide excellent, compassionate leadership in a supportive culture where staff can flourish and problem behaviours such as bullying disappear. The Call to Action invites all NHS organisations to:

- achieve the overarching leadership and cultural change to tackle bullying;
- support staff to respectfully challenge problem behaviours;
- publish their plans and progress so staff, patients and the public can hold them to account.

Workforce and Organisational Development are leading the work within HDFT regarding the Call to Action.

[Caring to change: how compassionate leadership can stimulate innovation in health care](#)

The King's Fund published this paper in May 2017 about compassion, which involves attending, understanding, empathising and helping as a core cultural value of the NHS and how compassionate leadership results in a working environment that encourages people to find new and improved ways of doing things. Key findings are:

- Compassionate leadership activities have many positive outcomes, at all levels of the health sector, from individuals and teams, to organisations and the system as a whole.
- Staff are more likely to find new and improved ways of doing things if they feel they are listened to, valued and supported as this provides a sense of psychological safety.
- Giving staff autonomy in their work is also important, along with developing a shared responsibility – a shared leadership is much more effective than a hierarchical one.
- Positive attitudes to diversity, to inclusion and to creativity and innovation must be nurtured at every level of the organisation.
- Innovation is often spurred by a challenge or a problem and compassionate leadership is a powerful facilitator at each stage of the problem-solving process.

2.3.4 [Sign up to Safety](#)

This national patient safety campaign was launched in 2014; HDFT had a successful bid for some funding to promote human factors training in Maternity. The focus of the campaign nationally has become one of helping the right safety culture grow and flourish, in essence helping people talk to each other.

Whilst the campaign will be finishing in 2019, the team have developed resources to facilitate conversations where people have a chance to speak, to be listened to, to feel heard and understood. Rather than focusing on “safety” as a problem that can be fixed by a set of tasks or interventions, they are promoting behaviours that help us work safely. Things that help:

- Removal of physical barriers (tables) and classifications or stereotypes (job titles and biographies);
- Create an environment where individuals feel accepted and respected – (psychological safety);
- Kindness, respect, humility, curiosity;
- Sit on your hands! (resist the urge to interrupt);
- Cherish the fact that we each see something different because of who we are and where we sit in the system;
- Call out rudeness and lack of respect – in a kind way - help people who are being bullied and those that are bullying;
- Major on kindness and say thank you as often as you can (#Kind2018).

2.3.5 [RCS \(Ed\) Anti-bullying and Undermining Campaign](#)

This campaign by the Royal College of Surgeons of Edinburgh RCS (Ed) states that the link between bullying and undermining behaviour and patient safety is now clear. Evidence that this kind of behaviour has a negative impact on the workings of a team is getting bigger year on year. The extent of bullying and undermining throughout healthcare is well documented, and surgery in particular is often reported as being a specialty where it is particularly prevalent. In the College’s own membership survey, nearly 40% of respondents (aimed at healthcare professionals

who work with adult patients) reported they had been victims of such behaviour, with the same amount reporting that they had witnessed it.

It has been estimated that this issue costs organisations in the UK £13.75 billion annually, and healthcare professionals have attributed disruptive behaviour in the perioperative area alone to 67% of adverse events, 71% of medical errors, and 27% of perioperative deaths.

The RCS (Ed) has a zero tolerance approach to bullying, undermining and harassment and categorically condemns this in all circumstances. This website has really useful case studies, resources, information and advice.

#LetsRemoveIt



Bullying harms your profession and your patients.

2.3.6 Civility saves lives

This campaign has been started by a small number of healthcare professionals – largely doctors - aiming to raise awareness of the power of civility in medicine. It describes rudeness as: shouting; belittling; talking over someone; stubbornness and non-co-operation; undermining; aggression, and clarifies that rudeness is defined by the interpretation of the recipient, regardless of intent.

It highlights that incivility affects more than just the recipient – it affects everyone. Civil work environments matter because they reduce errors, reduce stress and foster excellence. @civilitysaves.

2.3.7 CQC well-led

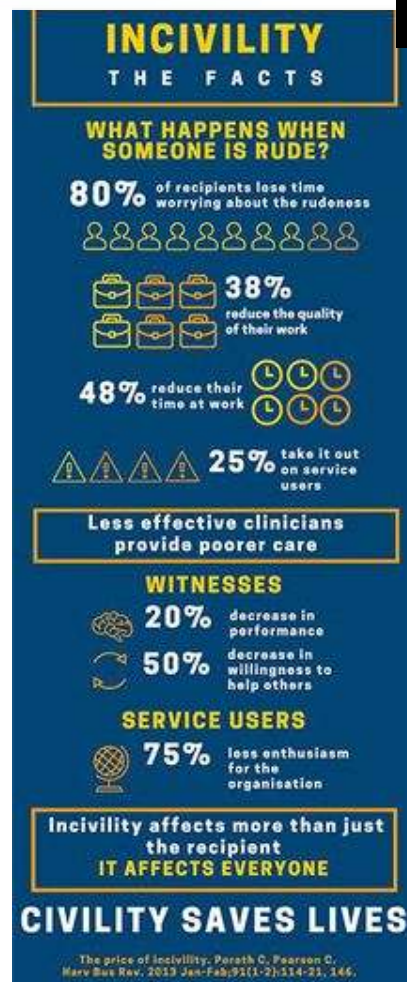
The National Guardian’s Office has worked with the CQC to ensure that an assessment of speaking up is at the heart of inspecting the well led domain. The CQC also support the Call to Action and have suggested that CQC inspectors can:

- ✓ Ask whether Trusts are signed up to the Call to Action
- ✓ Look at what measurable action Trusts are taking
- ✓ Look at how they are monitoring progress

There are several key lines of enquiry and prompts relevant to speaking up and bullying including:

- How trusts support the guardian role;
- How trusts respond to the concerns raised by their workers;
- Evidence of a positive speaking up culture in the trust;
- Steps to support minority and vulnerable staff groups to have a voice.

6.4



3 Local Picture

The Deputy Director of Governance was appointed as HDFT Freedom to Speak Up (FTSU) Guardian in October 2016. The detail of the initial work undertaken was reported to the Board in March 2018.

3.1 Contacts

The Guardian works alongside many existing systems and processes for staff to raise concerns. The cases logged and reported below are those which are specifically raised to the FTSU Guardian, and do not include cases raised directly with other departments e.g. HR, Risk Management.

The numbers of cases are small but increasing. Informal feedback suggests that many staff have been unaware of the support available to speak up, but considerable progress has been made in recent weeks with communication and awareness raising.

	2017/18				2018/19		Total cases
	Q1	Q2	Q3	Q4	Q1	Q2	
Cases referred	4	2	2	0	4	8	20
Raised anonymously	0	0	0	0	0	0	0
Element of patient safety / quality	1	0	0	0	0	0	1
Element of bullying / harassment	4	2	2	0	3	4	15
Cases closed and feedback requested	4	2	2	0	3	0	11
Feedback received	1	1	0	0	1	0	3
Suffering detriment as a result of speaking up	0	1	0	0	0	0	1

3.2 Analysis

The number of cases raised has increased in 2018/19. As numbers are small there is a risk of identifying staff by publishing detail of contacts by location and staff groups, but it is possible to say:

- Staff speaking up represent nursing, support services and administration staff, Band 2 to Band 6;
- Staff have been based in acute and community services; HDFT and HHFM;
- Concerns have been raised by more than one member of staff from some teams;
- Staff are raising concerns confidentially because they fear any impact on their job. On a number of occasions staff have not wanted me to share their name with any others for fear of recrimination from either peers or managers, which sometimes limits the actions that can be taken;
- There has been an element of perceived bullying and harassment in the majority of cases – either impacting on the member of staff raising the concern or on their colleagues. Issues relate to personalities and perceived power;

- When a case is closed, the staff member is asked for feedback, and although this request is followed up, the number of staff giving feedback about their experience of speaking up is disappointingly few;
- In their feedback, one member of staff described experiencing detriment as a result of speaking up. When confidential feedback was given to the person the concern was about, they interrogated the team to find out who had raised the concern outside the department, and they and other staff accused suspects. Whilst a culture of speaking up is easy to advocate, it can be challenging for those who feel their jobs and personal well-being may be in jeopardy;
- There is a need to ensure managers are trained and supported to manage staff effectively, and to encourage speaking up as a way of improving;
- Insight into disciplinary processes suggests a need to review these to ensure consistency and fairness, and the provision of appropriate advice and support for staff;
- One member of staff reported being criticised by their manager for reporting patient safety concerns on Datix.
- There have been no other particular concerns that have been raised in relation to patient safety, although it is important to note that research suggests that there is an impact on patient safety when staff experience poor behaviours and bullying.

3.4 Feedback about the speaking up process

“Speaking up puts you in a very lonely place and to be able to share with a buddy would be very beneficial”.

“I found it very helpful and reassuring that someone was willing to listen to my concerns and then act on my behalf. Especially when I felt that I was in a position where no one else was listening to my concerns and dealing with them effectively or professionally”.

“Although senior management dealt with the problems - more junior management have not done”.

“I was treated with the upmost respect and dignity. I felt believed which is the biggest risk when committing to the decision to speak up, especially when you are speaking up about a person held in high regard”.

3.5 Actions taken since last report

Actions have been taken to continue to embed the FTSU Guardian role, to address some of the recommendations from Internal Audit Report: Raising Concerns (Whistleblowing) H2017/17 and to act on some of the learning identified in the last report.

- The Speaking Up Policy has been reviewed, updated, presented to Policy Advisory Group, Partnership Forum and Audit Committee and approved in August 2018. This updated version makes the support available to staff and the process for raising a concern more visible;
- The log of concerns raised, which is maintained by the Guardian, has been further developed to capture more detail and to try to focus on identifying any

learning and actions. A more systematic method of logging emails and notes has also been established, but the log and notes are not shared with anyone else to preserve confidentiality;

- The FTSU Guardian job description has been updated and is awaiting approval. Protected time of ½ day a week for the FTSU Guardian role has been agreed;
- Resources have been highlighted and can be accessed from the intranet home page;
- Further communications and awareness raising to increase the visibility of the FTSU Guardian and promote the speaking up processes have been undertaken and include:
 - Highlighting at Team Brief, and attending meetings to highlight work e.g. Bullying and Harassment Advisors meetings; Council of Governors; LTUC Quality Governance Group;
 - Inclusion of reference to the FTSU Guardian and the Trust's encouragement for individuals to 'Speak Up' in various induction and training packages and events;
 - Development of a poster for all staff facing areas, and walking round to distribute, talk to staff and promote speaking up;
 - Inclusion of an item in Chatter Matters staff bulletin;
- Development of the work involved to improve the culture of speaking up and fairness as a silver level QI project;
- Contributing to the Board self-assessment using the NHSI and NGO Freedom to Speak Up self-review tool for NHS trusts and foundation trusts;
- Contributing to a question on the Q2 staff FFT to enable staff to say whether they feel valued and supported within a fair and just workplace;
- Continuing quarterly reporting to National Guardians Office and attendance at regional FTSU guardian meetings.

3.6 Improvements as a result of speaking up

- Regular meetings have started with HR business partners to share learning and agree actions, and to triangulate intelligence from FTSU reporting with other data relating to teams to identify hot-spots of concerns and enable focused work;
- Working with CEO and HR colleagues to develop anti-bullying focus groups. These have encouraged staff who may be unaware of the process and who find it difficult to speak up to have their voices heard in a safe environment;
- Development of Fairness Champions with defined roles and responsibilities. Over 30 staff have expressed a formal interest and a small number of applications have been received. We hope to appoint our first Fairness Champions soon and use this as a further opportunity to highlight the role. We plan to provide the champions with specific lanyards / badges to increase visibility, and will provide training and ongoing support.

3.7 Further actions planned

Actions identified from work to date, and informed by NGO case reviews and the NHSI self-assessment include:

1. Development of a vision and strategy for speaking up, with input from staff, and linking into:
 - The Trust's overall vision "Excellence every time" and values and behaviours framework;
 - Existing strategies e.g. Leadership Development Strategy, Clinical Workforce Strategy, Staff Engagement Strategy;
 - Just culture framework.
2. Considering how to triangulate relevant data to identify hot spots / areas of concern for focused work, including:
 - Incidents and complaints;
 - NHS staff survey (questions related to staff engagement and speaking up), and WRES data;
 - Learning from bullying and harassment reports, grievance cases, staff sickness, stress and retention data, exit interviews, staff suspensions and rulings from employment tribunals involving staff.
3. Continuing to promote communication and awareness raising by:
 - Feeding back to staff actions taken in response to speaking up;
 - Tackling barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers;
 - Recruiting Fairness Champions across all staff groups, teams, and services to promote increased visibility of speaking up, values and behaviours and support for staff;
 - Actively promoting what a "just culture" means so staff feel confident that reporting concerns leads to improving systems, processes, behaviours and working practices;
4. Ensure staff are skilled to deal positively with issues raised by:
 - Promoting to staff the benefits of speaking up and tackling perceived bullying behaviours;
 - Continuing to promote awareness about policy and resources and culture at induction;
 - Ensuring additional training and resources for those with responsibility for handling concerns, empowering managers to address concerns positively;
 - Continuing to promote compassionate and inclusive leadership.
5. Clear policies, processes and information including:
 - Developing a Speaking Up Policy on a page;
 - Supporting a review of HR policies especially B&H Policy and Disciplinary Policy, to ensure fair and compassionate management of staff.
6. Ensure a focus on identifying underlying lessons to be learnt and improvement by:
 - Regular meetings with executive and non-executive leads to maintain a focus on learning and positive change, and reporting through the governance framework.

4 Summary

There have been an increasing number of contacts to the Freedom to Speak up Guardian recently, which may reflect the focus on behaviours and inclusion led by Ros Tolcher. Those individuals who have spoken up have cast some light on behaviours within teams which do not fit with the Trust's values and expectations. The information available from other trusts in the NGO case reviews also provides useful insight and learning.

Linking to the wider initiatives such as Call to Action, compassionate leadership, Sign up to Safety, RCS (Ed) Anti-bullying and Undermining Campaign and Civility Saves Lives, and actively promoting a "just culture", has the potential to support our work to positively shape the behaviour of everyone who works in the organisation, the quality of care it provides and its overall performance.

Some of these resources will be used to support the Fairness Champions who are volunteering to play an important part in driving the cultural change toward an expectation of fairness, listening to colleagues who have concerns and signposting them to those who can help them to speak up.

Considerable progress has been made since the last report with communication across the Trust about equality and inclusion, intolerance of bullying and undermining behaviours, and awareness of speaking up. However there are a number of actions that have been identified to further progress this aspiration for speaking up to become a normal and positive behaviour that is seen to contribute to a better working environment for staff and a safer environment for patients. The feedback from staff and the information gathered from focus groups will be used to refine and develop these actions further.

Board Committee report to the Board of Directors

Committee Name:	Quality Committee (QC)
Committee Chair:	Mrs LA Webster
Date of last meeting:	5 September 2018
Date of Board meeting for which this report is prepared	26 September 2018

6.5

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

Hot Spots: Following a report of a potential breach of professional standards in relation to Information Governance, an update and assurance was received, of 'no evidence that a culture of inappropriate accessing of records was in play'. The Committee was further assured in relation to Freedom to Speak Up, in that a member of staff had felt comfortable raising this concern in the first instance.

Board Request for QC to seek assurance: No active requests in month.

Reports Received:

QC received assurance from the following reports:

- Quality Dashboard: The new format still requires some work, but is a very positive step in providing a good overview in respect of the provision of safe, high quality patient care.
- Quality Priorities Qtr 2 Updates received for
 - Ensuring effective learning from incidents complaints and good practice
 - Increasing patients and the public participation in the development of services
- Patient Safety Report Qtr 2
- Antenatal & Newborn Screening Annual Report – The committee noted the very good results and the significant amount of work conducted in year.
- National Maternity and Perinatal Audit
- Nursing Clinical Skills Framework – Assured that a good process for recording skills is now in place. Annual audit to be introduced to provide ongoing assurance.
- Clinical Audit plan – Qtr 2
- NICE Compliance report

Other Items

On behalf of the Board, the Committee received the Tees Esk and Wear Valleys NHS Foundation Trust annual report, which confirmed the status of the contract TEWV are delivering, and can confirm this is within the statutory guidelines for mental health services and support delivered to HDFT.

A review of the Report of Gosport Independent Panel by Dr Wood, Freedom to Speak Up Guardian was received. In summary the Committee was assured to hear that such events are unlikely in the present day with the processes in place at HDFT, e.g. multi-disciplinary team working, incident reporting, speaking up processes, learning from deaths, performance and benchmarked reporting, regular audit of medicines and pain management, oversight by Pharmacists, all provided assurance that any concerns would be identified, including identifying any competency issues.

Are there any significant risks for noting by Board? (list if appropriate)
<ol style="list-style-type: none"> 1. Quality Impact Assessment (QIA) - Lack of Process. Whilst there is work underway to address this, the Committee is not assured that there is a suitable QIA process in place in relation to Trust wide transformational CIP schemes. The committee is assured that there are suitable processes in place at Directorate level in relation to local CIP schemes. 2. The Committee is concerned about the large number of out of date policies and procedure documents located on the Intranet.
Matters for decision
<ul style="list-style-type: none"> • Propose that the QC no longer receives the annual Infection Prevention and Control report as this is duplicated activity at Board.

<p>Action Required by Board of Directors:</p> <ul style="list-style-type: none"> • Note risks identified by this Committee; • Note receipt of TEWV Annual Report; and • Note Assurance re Gosport Independent Panel Report.

6.5





Date of Meeting:	26 September 2018	Agenda item:	7.0
Report to:	Board of Directors		
Title:	West Yorkshire and Harrogate Integrated Care System - Memorandum of Understanding		
Sponsoring Director:	Dr Ros Tolcher, Chief Executive		
Author(s):	Anthony Kealy, NHS England		
Report Purpose:	Decision <input checked="" type="checkbox"/>	Discussion/ Consultation <input checked="" type="checkbox"/>	Assurance <input checked="" type="checkbox"/> Information <input type="checkbox"/>
Executive Summary:	<ul style="list-style-type: none"> • The MOU has been developed over a number of months between the partners in the Health Care Partnership • The Board has previously discussed the broad thrust and direction over a number of months • The final draft was discussed at the WYAAT meeting on 12 September and it was supported, subject to a number of observations 		
Related Trust Objectives			
To deliver high quality care	<input checked="" type="checkbox"/>	To work with partners to deliver integrated care:	<input checked="" type="checkbox"/> To ensure clinical and financial sustainability: <input checked="" type="checkbox"/>
Key implications			
Risk Assessment:	None identified		
Legal / regulatory:	None identified.		
Resource:	None identified		
Impact Assessment:	Not applicable		
Conflicts of Interest:	None identified		
Reference documents:	Not applicable.		
Assurance:	Senior Management Team		
Action Required by the Board of Directors:			
It is recommended that the Board of Directors: <ul style="list-style-type: none"> • Approves the Memorandum of Understanding • Endorses the three observations outlining proposed strengthening of the ICS governance 			

7

A Memorandum of Understanding (MOU) for the West Yorkshire and Harrogate Health and Care Partnership

Introduction

1. The purpose of this paper is to seek the Board's approval for:
 - the Memorandum of Understanding (MoU) for the West Yorkshire and Harrogate Health and Care Partnership; and
 - Harrogate and District NHS Foundation Trust commit to working in partnership by authorising the Chief Executive to sign the MoU.

Background

2. West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs), in response to the NHS Five Year Forward View. It brings together all health and care organisations in our six places: Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield, including Harrogate and District NHS Foundation Trust.
3. In November 2016 the STP published high level proposals to improve health, reduce care variation and manage our finances. Since then the partnership has made significant progress to build capacity and infrastructure and establish the governance arrangements and ways of working that will enable us to achieve our collective aims.
4. The partnership has already begun to make an impact in other important areas. Our Cancer Alliance Board is a national exemplar, and has attracted £12.6m in funding to transform cancer diagnostics. We have developed a strategic case for change for stroke from prevention to after care. We have streamlined management of CCGs and established a Joint Committee of CCGs and Committee in Common for acute trusts; these will strengthen collaborative working and facilitate joint decision making. We have secured £31m in transformation funding for A&E, cancer, mental health, learning disabilities and diabetes, and £38m capital from the Autumn budget for CAMHS, pathology, telemedicine, and digital imaging.
5. In October 2017 the System Leadership Executive Group agreed that a new MoU should be developed to formalise working arrangements and support the next stage of development of the WY&H HCP. The MoU builds on the existing partnership arrangements to establish more robust mutual accountability.
6. The final draft of the MoU is attached at Annex to this paper, for approval.

Purpose of the MoU

7. The MoU is an agreement between the WY&H health and care partners. It sets out the details of our commitment to work together in partnership to realise our

shared ambitions to improve the health of the 2.6 million people who live in our area, and to improve the quality of their health and care services.

8. The MoU does not seek to introduce a hierarchical model; rather it provides a mutual accountability framework to underpin collective ownership of delivery. It also provides the basis for a refreshed relationship between local NHS organisations and national oversight bodies.
9. The MoU is not a legal contract, but is a formal agreement between all of the partners. It is based on an ethos that the partnership is a servant of the people in West Yorkshire and Harrogate and of its member organisations. It does not replace or override the legal and regulatory frameworks that apply to our statutory NHS organisations and Councils. Instead it sits alongside and complements these frameworks, creating the foundations for closer and more formal collaboration.
10. The draft MoU should be read in conjunction with the STP Plan, published in November 2016, the Next Steps (February 2018) and the local plan for Harrogate.
11. The MoU provides a platform for:
 - a) a refresh of the governance arrangements for the partnership, including across WY&H, and the relationship with individual Places and statutory bodies;
 - b) the delivery of a mutual accountability framework that ensures we have collective ownership of delivery, rather than a hierarchical approach
 - c) a new approach to commissioning, and maturing provider networks that collaborate to deliver services in place and at WY&H level;
 - d) clinical and managerial leadership of change in major transformation programmes;
 - e) a transparent and inclusive approach to citizen engagement in development, delivery and assurance;
 - f) better political ownership of, and engagement in the agenda, underpinned by regular opportunities for challenge and scrutiny; and
 - g) a new assurance and accountability relationship with the NHS regulatory and oversight bodies that provides new flexibilities for WY&H to assert greater control over system performance and delivery and the use of transformation and capital funds; and
 - h) the agreement of an effective system of risk management and reward for NHS bodies.
12. The text of the MoU sets out details of:
 - The context for our partnership;
 - The partner organisations;
 - How we work together in WY&H, including our principles, values and behaviours;
 - The objectives of the partnership, and how our joint priority programmes and
 - enabling workstreams will improve service delivery and outcomes across WY&H;
 - Our mutual accountability and governance arrangements, including how

- we will move towards a new approach to assurance, regulation and accountability with the NHS national bodies;
- Our joint financial framework;
- The support that will be provided to the Partnership by the national and regional teams of NHSE and NHSI;
- Which aspects of the agreement apply to particular types of organisation.

Becoming an Integrated Care System

13. In May 2018 NHS England and NHS Improvement announced that WY&H HCP would be one of four health and care systems to join the Integrated Care System (ICS) Development Programme. This demonstrated national recognition for the way our WY&H partnership works and for the progress we have made. It means we can join the leading edge of health and care systems, gaining more influence and more control over the way we deliver services and support for the 2.6 million people living in our area.
14. The importance of joining up services for people at a local level in Bradford District and Craven; Calderdale; Harrogate and Rural District; Kirklees; Leeds; and Wakefield is at the heart of our local plans and our WY&H programmes. All decisions on services are made as locally and as close to people as possible. Our move to becoming an ICS is predicated on this continuing to be the case.
15. This integrated approach to health and care will continue to support much closer working between our organisations. The MoU will provide a firm foundation for this. It reflects and builds on the current ways of working and agreed principles for the partnership and maintains an ethos of the primacy of local Place.

Progress to Date

16. Over recent months drafts of the MoU have been discussed in development sessions by members of the Boards and Governing Bodies of partner organisations and by members of Health and Wellbeing Boards and the WY&H Joint Overview and Scrutiny Committee.
17. Feedback from these discussions has directly influenced the development of the final draft, which has now been agreed by the WY&H HCP System Leadership Executive Group.
18. The Board has previously had sight and discussed a previous draft of the MOU in May 2018.
19. The HCP core team has sought a legal opinion on the text of the MoU, on behalf of all Partner organisations. The lawyers were able to provide helpful suggestions to improve clarity and remove elements of ambiguity. They also confirmed that the MoU was sound, and was not inconsistent with statutory or regulatory frameworks, or with the powers and duties of individual partners.

What it means for Harrogate and District NHS Foundation Trust

20. By signing the MoU we will commit to play our full role as a member of WY&H HCP and to work within the frameworks described. Accepting our share of collective responsibility will give us and our partners the opportunity to achieve greater autonomy and control over how we develop and transform our health and care services.
21. The partnership will be an overall collaborative framework for local Accountable Care Partnerships.

Next steps

22. Each Partner organisation is being asked to approve and sign the MoU. It is expected that this process will be completed over the early autumn.

Recommendations

23. Members of the Board are asked to:
 - Approve the MoU, whilst recording the following observations by which it is hoped to improve the governance of the HCP (ICS):
 - By further developing our understanding of mutual accountability and decision-making as an ICS, we must achieve greater clarity in the relationship between the Partnership Board, System Leadership Executive Group and System Assurance & Oversight Group, and especially the flow of information between them.
 - We strongly support the invitation for a provider chair to take on the role of Vice Chair of the Partnership Board. This would help shape the future development of partnership working to ensure all voices are heard.
 - Becoming an ICS is a journey so WYAAT recommends that the MOU should be reviewed within the first year to ensure that it is fit for purpose in the context of the NHS 10-year plan and as our thinking on mutual accountability and ICS decision-making develops. It should be reviewed at least biannually thereafter.
 - Authorise the Chief Executive to sign the MoU.

Annex: Memorandum of Understanding between HDFT and WY&H HCP

DRAFT

West Yorkshire and Harrogate
Health and Care Partnership



7

Memorandum of Understanding

DRAFT

August 2018

180817 WYHDraft MoU vFinal.docx

DRAFT

DRAFT

Contents

Foreword.....2

1. Parties to the Memorandum4

2. Introduction and context7

3. How we work together in West Yorkshire and Harrogate10

4. Partnership Governance.....13

5. Mutual accountability framework17

6. Decision-Making and Resolving Disagreements.....21

7. Financial Framework23

8. National and regional support.....25

9. Variations25

10. Charges and liabilities25

11. Information Sharing.....25

12. Confidential Information25

13. Additional Partners.....26

14. Signatures26

Schedule 1 - Definitions and Interpretation28

Annex 1 – Applicability of Memorandum Elements.....32

Annex 2 – Schematic of Governance and Accountability Arrangements33

Annex 3 - Terms of Reference.....34



DRAFT

Foreword

Since the creation of West Yorkshire and Harrogate Health and Care Partnership in March 2016, the way we work has been further strengthened by a shared commitment to deliver the best care and outcomes possible for the 2.6 million people living in our area.

Our commitment remains the same and our goal is simple: we want everyone in West Yorkshire and Harrogate to have a great start in life, and the support they need to stay healthy and live longer. We are committed to tackling health inequalities and to improving the lives of the poorest fastest. Our commitment to an NHS free at the point of delivery remains steadfast, and our response to the challenges we face is to strengthen our partnerships.

The proposals set out in our plan are firming up into specific actions, backed by investments. This is being done with the help of our staff and communities, alongside their representatives, including voluntary, community organisations and local councillors. Our bottom-up approach means that this is happening at both a local and WY&H level which puts people, not organisations, at the heart of everything we do.

We have agreed to develop this Memorandum of Understanding to strengthen our joint working arrangements and to support the next stage of development of our Partnership. It builds on our existing collaborative work to establish more robust mutual accountability and break down barriers between our separate organisations.

Our partnership is already making a difference. We have attracted additional funding for people with a learning disability, and for cancer diagnostics, diabetes and a new child and adolescent mental health unit.

However, we know there is a lot more to do. The health and care system is under significant pressure, and we also need to address some significant health challenges. For example we have higher than average obesity levels, and over 200,000 people are at risk of diabetes. There are 3,600 stroke incidents across our area and we have developed a strategic case for change for stroke from prevention to after care and are identifying and treating people at high risk of having a stroke.

We all agree that working more closely together is the only way we can tackle these challenges and achieve our ambitions. This Memorandum demonstrates our clear commitment to do this.

Rob Webster
West Yorkshire and Harrogate Health and Care Partnership Lead
CEO South West Yorkshire Partnership NHS FT

DRAFT

1. Parties to the Memorandum

1.1. The members of the West Yorkshire and Harrogate Health and Care Partnership (the **Partnership**), and parties to this Memorandum, are:

Local Authorities

- City of Bradford Metropolitan District Council
- Calderdale Council
- Craven District Council
- Harrogate Borough Council
- Kirklees Council
- Leeds City Council
- North Yorkshire County Council¹
- Wakefield Council

NHS Commissioners

- NHS Airedale, Wharfedale and Craven CCG
- NHS Bradford City CCG
- NHS Bradford Districts CCG
- NHS Calderdale CCG
- NHS Greater Huddersfield CCG
- NHS Harrogate and Rural District CCG
- NHS Leeds CCG
- NHS North Kirklees CCG
- NHS Wakefield CCG
- NHS England

NHS Service Providers

- Airedale NHS Foundation Trust
- Bradford District Care NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Calderdale and Huddersfield NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Leeds Community Healthcare NHS Trust
- The Leeds Teaching Hospitals NHS Trust
- The Mid Yorkshire Hospitals NHS Trust

DRAFT

- South West Yorkshire Partnership NHS Foundation Trust¹
- Tees, Esk, and Wear Valleys NHS Foundation Trust¹
- Yorkshire Ambulance Service NHS Trust¹

Health Regulator and Oversight Bodies

- NHS England
- NHS Improvement

Other National Bodies

- Health Education England
- Public Health England
- Care Quality Commission [TBC]

Other Partners

- Locala Community Partnerships CIC
- Healthwatch Bradford and District
- Healthwatch Calderdale
- Healthwatch Kirklees
- Healthwatch Leeds
- Healthwatch North Yorkshire
- Healthwatch Wakefield
- Yorkshire and Humber Academic Health Science Network¹.

1.2. As members of the Partnership all of these organisations subscribe to the vision, principles, values and behaviours stated below, and agree to participate in the governance and accountability arrangements set out in this Memorandum.

1.3. Certain aspects of the Memorandum are not relevant to particular types of organisation within the partnership. These are indicated in the table at **Annex 1**.

Definitions and Interpretation

1.4. This Memorandum is to be interpreted in accordance with the Definitions and Interpretation set out in Schedule 1, unless the context requires otherwise.

Term

1.5. This Memorandum shall commence on the date of signature of the Partners, and shall continue for an initial period of three (3) years and thereafter subject to an annual review of the arrangements by the [Partnership Board].

¹ These organisations are also part of neighbouring STPs.

DRAFT**Local Government role within the partnership**

1.6. The West Yorkshire and Harrogate Health and Care Partnership includes eight local government partners. The five Metropolitan Councils in West Yorkshire and North Yorkshire County Council lead on public health, adult social care and children's services, as well as statutory Health Overview and Scrutiny and the local Health and Wellbeing Boards. The Metropolitan Councils, Harrogate Borough Council and Craven District Council lead on housing. Together, they work with the NHS as commissioning and service delivery partners, as well as exercising formal powers to scrutinise NHS policy decisions.

1.7. Within the WY&H partnership the NHS organisations and Councils will work as equal partners, each bringing different contributions, powers and responsibilities to the table.

1.8. Local government's regulatory and statutory arrangements are separate from those of the NHS. Councils are subject to the mutual accountability arrangements for the partnership. However, because of the separate regulatory regime certain aspects of these arrangements will not apply. Most significantly, Councils would not be subject a single NHS financial control total and its associated arrangements for managing financial risk. However, through this Memorandum, Councils agree to align planning, investment and performance improvement with NHS partners where it makes sense to do so. In addition, democratically elected councillors will continue to hold the partner organisations accountable through their formal Scrutiny powers.

Partners in Local Places

1.9. The NHS and the Councils within the partnership have broadly similar definitions of place. (The rural Craven district is aligned with Bradford for NHS purposes, but is seen as a distinct local government entity in its own right within North Yorkshire.)

1.10. All of the Councils, CCGs, Healthcare Providers and Healthwatch organisations are part of their respective local place-based partnership arrangements. The extent and scope of these arrangements is a matter for local determination, but they typically include elements of shared commissioning, integrated service delivery, aligned or pooled investment and joint decision-making. Other key members of these partnerships include:

- GP Federations
- Specialist community service providers
- Voluntary and community sector organisations and groups
- Housing associations.
- other primary care providers such as community pharmacy, dentists, optometrist
- independent health and care providers including care homes

2. Introduction and context

2.1. This Memorandum of Understanding (Memorandum) is an understanding between the West Yorkshire and Harrogate health and care partners. It sets out the details of our commitment to work together in partnership to realise our shared ambitions to improve the health of the 2.6 million people who live in our area, and to improve the quality of their health and care services.

2.2. West Yorkshire and Harrogate Health and Care Partnership began as one of 44 Sustainability and Transformation Partnerships (STPs) formed in 2016, in response to the *NHS Five Year Forward View*. It brings together all health and care organisations in our six places: Bradford District and Craven², Calderdale, Harrogate, Kirklees, Leeds and Wakefield.

2.3. Our partnership is not a new organisation, but a new way of working to meet the diverse needs of our citizens and communities. NHS services have come together with local authorities, charities and community groups to agree how we can improve people's health and improve the quality of their health and care services.

2.4. We published our high level proposals to close the health, care and finance gaps that we face in November 2016. Since then we have made significant progress to build our capacity and infrastructure and establish the governance arrangements and ways of working that will enable us to achieve our aims.

Purpose

2.5. The purpose of this Memorandum is to formalise and build on these partnership arrangements. It does not seek to introduce a hierarchical model; rather it provides a mutual accountability framework, based on principles of subsidiarity, to ensure we have collective ownership of delivery. It also provides the basis for a refreshed relationship with national oversight bodies.

2.6. The Memorandum is not a legal contract and is not intended to be legally binding and no legal obligations or legal rights shall arise between the Partners from this Memorandum. It is a formal understanding between all of the Partners who have each entered into this Memorandum intending to honour all their obligations under it. It is based on an ethos that the partnership is a servant of the people in West Yorkshire and Harrogate and of its member organisations. It does not replace or override the legal and regulatory frameworks that apply to our statutory NHS organisations and Councils. Instead it sits alongside and complements these frameworks, creating the foundations for closer and more formal collaboration.

2.7. Nothing in this Memorandum is intended to, or shall be deemed to, establish any partnership or joint venture between the Partners to the

² Whilst Craven is organisationally aligned with the NHS in Bradford, it is a distinctive place in its own right, forming part of North Yorkshire.

DRAFT

Memorandum, constitute a Partner as the agent of another, nor authorise any of the Partners to make or enter into any commitments for or on behalf of another Partner.

2.8. The Memorandum should be read in conjunction with the Partnership Plan, published in November 2016, the Next Steps (February 2018) and the six local Place plans across West Yorkshire and Harrogate.

Developing new collaborative relationships

2.9. Our approach to collaboration begins in each of the 50-60 neighbourhoods which make up West Yorkshire and Harrogate, in which GP practices work together, with community and social care services, to offer integrated health and care services for populations of 30-50,000 people. These integrated neighbourhood services focus on preventing ill health, supporting people to stay well, and providing them with high quality care and treatment when they need it.

2.10. Neighbourhood services sit within each of our six local places (Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield). These places are the primary units for partnerships between NHS services, local authorities, charities and community groups, which work together to agree how to improve people's health and improve the quality of their health and care services.

2.11. The focus for these partnerships is moving increasing away from simply treating ill health to preventing it, and to tackling the wider determinants of health, such as housing, employment, social inclusion and the physical environment.

2.12. These place-based partnerships, overseen by Health and Wellbeing Boards, are key to achieving the ambitious improvements we want to see. However, we have recognised that there also clear benefits in working together across a wider footprint and that local plans need to be complemented with a common vision and shared plan for West Yorkshire and Harrogate as a whole. We apply three tests to determine when to work at this level:

- to achieve a critical mass beyond local population level to achieve the best outcomes;
- to share best practice and reduce variation; and
- to achieve better outcomes for people overall by tackling 'wicked issues' (ie, complex, intractable problems).

2.13. The arrangements described in this Memorandum describe how we will organise ourselves, at West Yorkshire & Harrogate level, to provide the best health and care, ensuring that decisions are always taken in the interest of the patients and populations we serve.

DRAFT

Promoting Integration and Collaboration

2.14. The Partners acknowledge the statutory and regulatory requirements which apply in relation to competition, patient choice and collaboration. Within the constraints of these requirements we will aim to collaborate, and to seek greater integration of services, whenever it can be demonstrated that it is in the interests of patients and service users to do so.

2.15. The Partners are aware of their competition compliance obligations, both under competition law and, in particular (where applicable) under the NHS Improvement Provider Licence for NHS Partners and shall take all necessary steps to ensure that they do not breach any of their obligations in this regard. Further, the Partners understand that in certain circumstances collaboration or joint working could trigger the merger rules and as such be notifiable to the Competition and Markets Authority and Monitor/NHS Improvement and will keep this position under review accordingly.

2.16. The Partners understand that no decision shall be made to make changes to services in West Yorkshire and Harrogate or the way in which they are delivered without prior consultation where appropriate in accordance with the partners statutory and other obligations.

3. How we work together in West Yorkshire and Harrogate

Our vision

3.1. We have worked together to develop a shared vision for health and care services across West Yorkshire and Harrogate. All proposals, both as Partner organisations and at a Partnership level should be supportive of the delivery of this vision:

- Places will be healthy - you will have the best start in life, so you can live and age well.
- If you have long term health conditions you will be supported to self-care through GPs and social care services working together. This will include peer support and via technology, such as telemedicine.
- If you have multiple health conditions, there will be a team supporting your physical, social and mental health needs. This will involve you, your family and carers, the NHS, social care and voluntary and community organisations.
- If you need hospital care, it will usually mean going to your local hospital, which works closely with others to give you the best care possible
- Local hospitals will be supported by centres of excellence for services such as cancer and stroke
- All of this will be planned and paid for together, with councils and the NHS working together to remove the barriers created by planning and paying for services separately. For example community and hospital care working together.
- Communities and staff will be involved in the development and design of plans so that everyone truly owns their health care services.

Overarching leadership principles for our partnership

3.2. We have agreed a set of guiding principles that shape everything we do through our partnership:

- We will be ambitious for the people we serve and the staff we employ
- The West Yorkshire and Harrogate partnership belongs to its citizens and to commissioners and providers, councils and NHS so we will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on people's health and wellbeing.
- 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

DRAFT

place at the appropriate level and as near to local as possible

Our shared values and behaviours

3.3. We commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our place and of West Yorkshire and Harrogate;
- We support each other and work collaboratively;
- We act with honesty and integrity, and trust each other to do the same;
- We challenge constructively when we need to;
- We assume good intentions; and
- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery.

Partnership objectives

3.4. Our ambitions for improving health outcomes, joining up care locally, and living within our financial means were set out in our STP plan (November 2016, available at: <https://wyhpartnership.co.uk/meetings-and-publications/publications>). This Memorandum reaffirms our shared commitment to achieving these ambitions and to the further commitments made in *Next Steps for the West Yorkshire and Harrogate Health and Care Partnership*, published in February 2018.

3.5. In order to achieve these ambitions we have agreed the following broad objectives for our Partnership:

- i. To make fast and tangible progress in:
 - enhancing urgent and emergency care,
 - strengthening general practice and community services,
 - improving mental health services,
 - improving cancer care,
 - prevention at scale of ill-health,
 - collaboration between acute service providers,
 - improving stroke services, and
 - improving elective care, including standardisation of commissioning policies.
- ii. To enable these transformations by working together to:
 - Secure the right workforce, in the right place, with the right skills, to deliver services at the right time, ensuring the wellbeing of our staff ,

DRAFT

- Engage our communities meaningfully in co-producing services,
 - Use digital technology to drive change, ensure systems are interoperable, and create a 21st Century NHS,
 - Place innovation and best practice at the heart of our collaboration, ensuring that our learning benefits the whole population,
 - Develop and shape the strategic capital and estates plans across West Yorkshire and Harrogate, maximising all possible funding sources and ensuring our plans support the delivery of our clinical strategy, and
 - Ensure that we have the best information, data, and intelligence to inform the decisions that we take.
- iii. To manage our financial resources within a shared financial framework for health across the constituent CCGs and NHS provider organisations; and to maximise the system-wide efficiencies necessary to manage within this share of the NHS budget;
- iv. To operate as an integrated health and care system, and progressively to build the capabilities to manage the health of our population, keeping people healthier for longer and reducing avoidable demand for health and care services;
- v. To act as a leadership cohort, demonstrating what can be achieved with strong system leadership and increased freedoms and flexibilities.

Delivery improvement

3.6. Delivery and transformation programmes have been established to enable us to achieve the key objectives set out above. Programme Mandates have been developed for each programme and enabling workstream. These confirm:

- The vision for a transformed service
- The specific ambitions for improvement and transformation
- The component projects and workstreams
- The leadership arrangements.

3.7. Each programme has undergone a peer review 'check and confirm' process to confirm that it has appropriate rigour and delivery focus.

3.8. As programme arrangements and deliverables evolve over time the mandates will be revised and updated as necessary.

4. Partnership Governance

4.1. The Partnership does not replace or override the authority of the Partners' Boards and governing bodies. Each of them remains sovereign and Councils remain directly accountable to their electorates.

4.2. The Partnership provides a mechanism for collaborative action and common decision-making for those issues which are best tackled on a wider scale.

4.3. A schematic of our governance and accountability relationships is provided at **Annex 2** and terms of reference of the Partnership Board, System Leadership Executive and System Oversight and Assurance Group are provided at **Annex 3**.

Partnership Board

4.4. A Partnership Board will be established to provide the formal leadership for the Partnership. The Partnership Board will be responsible for setting strategic direction. It will provide oversight for all Partnership business, and a forum to make decisions together as Partners on the range of matters highlighted in section 7 of this Memorandum, which neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum.

4.5. The Partnership Board is to be made up of the chairs and chief executives from all NHS organisations, elected member Chairs of Health and Wellbeing Boards, one other elected member, and chief executives from Councils and senior representatives of other relevant Partner organisations. The Partnership Board will have an independent chair and will meet at least four times each year in public.

4.6. The Partnership Board has no formal delegated powers from the organisations in the Partnership. However, over time our expectation is that regulatory functions of the national bodies will increasingly be enacted through collaboration with our leadership. It will work by building agreement with leaders across Partner organisations to drive action around a shared direction of travel.

System Leadership Executive

4.7. The System Leadership Executive (SLE) Group includes each statutory organisation and representation from other Partner organisations. The group is responsible for overseeing delivery of the strategy of the Partnership, building leadership and collective responsibility for our shared objectives.

4.8. Each organisation will be represented by its chief executive or accountable officer. Members of the SLE will be responsible for nominating an empowered deputy to attend meetings of the group if they are unable to do so personally. Members of the SLE will be expected to recommend that their organisations support agreements and decisions made by SLE (always subject to each Partner's compliance with internal governance and approval procedures).

System Oversight and Assurance Group

4.9. A new system oversight and assurance group (SOAG) will be established in 2018/19 to provide a mechanism for Partner organisations to take ownership of system performance and delivery and hold one another to account. It will:

- be chaired by the Partnership Lead;
- include representation covering each sector / type of organisation;
- regularly review a dashboard of key performance and transformation metrics; and
- receive updates from WY&H programme boards.

4.10. The SOAG will be supported by the partnership core team.

West Yorkshire and Harrogate programme governance

4.11. Strong governance and programme management arrangements are built into each of our West Yorkshire and Harrogate priority and enabling programmes (the **Programmes**). Each programme has a Senior Responsible Owner, typically a Chief Executive, accountable officer or other senior leader, and has a structure that builds in clinical and other stakeholder input, representation from each of our six places and each relevant service sector.

4.12. Programmes will provide regular updates to the System Leadership Executive and System Oversight and Assurance Group. These updates will be published on the partnership website.

Other governance arrangements between Partners

4.13. The Partnership is also underpinned by a series of governance arrangements specific to particular sectors (eg commissioners, acute providers, mental health providers, Councils) that support the way it works. These are described in paragraphs 4.14 to 4.29 below.

The West Yorkshire and Harrogate Joint Committee of Clinical Commissioning Groups

4.14. The nine CCGs in West Yorkshire and Harrogate are continuing to develop closer working arrangements within each of the six Places that make up our Partnership.

4.15. The CCGs have established a Joint Committee, which has delegated authority to take decisions collectively. The Joint Committee is made up of representatives from each CCG. To make sure that decision making is open and transparent, the Committee has an independent lay chair and two lay members drawn from the CCGs, and meets in public every second month. The Joint Committee is underpinned by a memorandum of understanding and a work plan, which have been agreed by each CCG.

DRAFT

4.16. The Joint Committee is a sub-committee of the CCGs, and each CCG retains its statutory powers and accountability. The Joint Committee's work plan reflects those partnership priorities for which the CCGs believe collective decision making is essential. It only has decision-making responsibilities for the West Yorkshire and Harrogate programmes of work that have been expressly delegated to it by the CCGs.

West Yorkshire Association of Acute Trusts Committee in Common

4.17. The six acute hospital trusts in West Yorkshire and Harrogate have come together as the [West Yorkshire Association of Acute Trusts](#) (WYAAT). WYAAT believes that the health and care challenges and opportunities facing West Yorkshire and Harrogate cannot be solved through each hospital working alone; they require the hospitals to work together to achieve solutions for the whole of West Yorkshire and Harrogate that improve the quality of care, increase the health of people and deliver more efficient services.

4.18. WYAAT is governed by a memorandum of understanding which defines the objectives and principles for collaboration, together with governance, decision making and dispute resolution processes. The memorandum of understanding establishes the WYAAT Committee in Common, which is made up of the Chairs and Chief Executives of the six trusts, and provides the forum for working together and making decisions in a common forum. Decisions taken by the Committee in Common are then formally approved by each Trust Board individually in accordance with their own internal procedures.

West Yorkshire Mental Health Services Collaborative

4.19. The four trusts providing mental health services in West Yorkshire (Bradford District Care Foundation Trust, Leeds Community Healthcare NHS Trust, Leeds and York Partnership Foundation Trust and South West Yorkshire Partnership Foundation Trust) have come together to form the West Yorkshire Mental Health Services Collaborative (WYMHC). The trusts will work together to share best practice and develop standard operating models and pathways to achieve better outcomes for people in West Yorkshire and ensure sustainable services into the future.

4.20. The WYMHC is underpinned by a memorandum of understanding and shared governance in the form of 'committees in common'.

4.21. Tees, Esk and Wear Valleys NHS Foundation Trust provides mental health services to the Harrogate area.

Local council leadership

4.22. Relationships between local councils and NHS organisations are well established in each of the six places and continue to be strengthened. Complementary arrangements for the whole of West Yorkshire and Harrogate have also been established:

- Local authority chief executives meet and mandate one of them to lead on

DRAFT

health and care partnership;

- Health and Wellbeing Board chairs meet;
- A Joint Health Overview and Scrutiny Committee
- West Yorkshire Combined Authority
- North Yorkshire and York Leaders and Chief Executives

Clinical Forum

4.23. Clinical leadership is central to all of the work we do. Clinical leadership is built into each of our work programmes, and our Clinical Forum provides formal clinical advice to all of our programmes.

4.24. The purpose of the Clinical Forum is to be the primary forum for clinical leadership, advice and challenge for the work of the partnership in meeting the Triple Aim: improving health and wellbeing; improving care and the quality of services; and ensuring that services are financially sustainable.

4.25. The Clinical Forum ensures that the voice of clinicians, from across the range of clinical professions and partner organisations, drives the development of new clinical models and proposals for the transformation of services. It also takes an overview of system performance on quality.

4.26. The Clinical Forum has agreed Terms of Reference which describe its scope, function and ways of working.

Local Place Based Partnerships

4.27. Local partnerships arrangements for the Places bring together the Councils, voluntary and community groups, and NHS commissioners and providers in each Place, including GPs and other primary care providers, to take responsibility for the cost and quality of care for the whole population. Each of the six Places in West Yorkshire and Harrogate has developed its own arrangements to deliver the ambitions set out in its own Place Plan.

4.28. These new ways of working reflect local priorities and relationships, but all provide a greater focus on population health management, integration between providers of services around the individual's needs, and a focus on care provided in primary and community settings.

4.29. There are seven local health and care partnerships (two in Bradford District and Craven and one in each other place) which will develop horizontally integrated networks to support seamless care for patients.

5. Mutual accountability framework

5.1. A single consistent approach for assurance and accountability between Partners on West Yorkshire and Harrogate system wide matters will be applied through the governance structures and processes outlined in Paragraphs 4.1 to 4.12 above.

Current statutory requirements

5.2. NHS England has a duty under the NHS Act 2006 (as amended by the 2012 Act) to assess the performance of each CCG each year. The assessment must consider, in particular, the duties of CCGs to: improve the quality of services; reduce health inequalities; obtain appropriate advice; involve and consult the public; and comply with financial duties. The 2012 Act provides powers for NHS England to intervene where it is not assured that the CCG is meeting its statutory duties.

5.3. NHS Improvement is the operational name for an organisation that brings together Monitor and the NHS Trust Development Authority (NHS TDA). NHS Improvement must ensure the continuing operation of a licensing regime. The NHS provider licence forms the legal basis for Monitor's oversight of NHS foundation trusts. While NHS trusts are exempt from the requirement to apply for and hold the licence, directions from the Secretary of State require NHS TDA to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate. This includes giving directions to an NHS trust where necessary to ensure compliance.

A new model of mutual accountability

5.4. Through this Memorandum the Partners agree to take a collaborative approach to, and collective responsibility for, managing collective performance, resources and the totality of population health. The partners will:

- Agree ambitious outcomes, common datasets and dashboards for system improvement and transformation management;
- work through our formal collaborative groups for decision making, engaging people and communities across WY&H; and
- identify good practice and innovation in individual places and organisations and ensure it is spread and adopted through the Programmes.

5.5. The Partnership approach to system oversight will be geared towards performance improvement and development rather than traditional performance management. It will be data-driven, evidence-based and rigorous. The focus will be on improvement, supporting the spread and adoption of innovation and best practice between Partners.

5.6. Peer review will be a core component of the improvement methodology. This will provide valuable insight for all Partners and support the identification and adoption of good practice across the Partnership.

DRAFT

5.7. System oversight will be undertaken through the application of a continuous improvement cycle, including the following elements:

- Monitoring performance against key standards and plans in each place;
- Ongoing dialogue on delivery and progress;
- Identifying the need for support through a clinically and publically-led process of peer review;
- Agreeing the need for more formal action or intervention on behalf of the partnership; and
- Application of regulatory powers or functions.

5.8. The Programmes will, where appropriate, take on increasing responsibility for managing this process. The extent of this responsibility will be agreed between each Programme and the SLE.

5.9. A number of Partners have their own improvement capacity and expertise. Subject to the agreement of the relevant Partners this resource will be managed by the Partner in a co-ordinated approach for the benefit of the overall Partnership, and used together with the improvement expertise provided by national bodies and programmes.

Taking action

5.10. The SOAG will prioritise the deployment of improvement support across the Partnership, and agree recommendations for more formal action and interventions. Actions allocated to the SOAG are to make recommendations on:

- agreement of improvement or recovery plans;
- more detailed peer-review of specific plans;
- commissioning expert external review;
- the appointment of a turnaround Director / team; and
- restrictions on access to discretionary funding and financial incentives.

5.11. For Places where financial performance is not consistent with plan, the Partnership Directors of Finance Group will make recommendations to the SOAG on a range of interventions, including any requirement for:

- financial recovery plans;
- more detailed peer-review of financial recovery plans;
- external review of financial governance and financial management;
- organisational improvement plans;
- the appointment of a turnaround Director / team;

DRAFT

- enhanced controls around deployment of transformation funding held at place; and
- reduced priority for place-based capital bids.

The role of Places in accountability

5.12. This Memorandum has no direct impact on the roles and respective responsibilities of the Partners (including the Councils, Trust Boards and CCG governing bodies) which all retain their full statutory duties and powers.

5.13. Health and Wellbeing Boards (HWB) have a statutory role in each upper tier local authority area as the vehicle for joint local system leadership for health and care and this is not revised by the Partnership. HWB bring together key leaders from the local Place health and care system to improve the health and wellbeing of their population and reduce health inequalities through:

- developing a shared understanding of the health and wellbeing needs of their communities;
- providing system leadership to secure collaboration to meet these needs more effectively;
- having a strategic influence over commissioning decisions across health, public health and social care;
- involving councillors and patient representatives in commissioning decisions.

5.14. In each Place the statutory bodies come together in local health and care partnerships to agree and implement plans across the Place to:

- Integrate mental health, physical health and care services around the individual
- Manage population health
- Develop increasingly integrated approaches to joint planning and budgeting

Implementation of agreed strategic actions

5.15. Mutual accountability arrangements will include a focus on delivery of key actions that have been agreed across the Partnership and agreement on areas where Places require support from the wider Partnership to ensure the effective management of financial and delivery risk.

DRAFT**National NHS Bodies oversight and escalation**

5.16. As part of the development of the Partnership and the collaborative working between the Partners under the terms of this Memorandum, NHS England and NHS Improvement will look to adopt a new relationship with the Partners (which are NHS Bodies) in West Yorkshire and Harrogate in the form of enacting streamlined oversight arrangements under which:

- Partners will take the collective lead on oversight of trusts and CCGs and Places in accordance with the terms of this Memorandum;
- NHS England and NHS Improvement will in turn focus on holding the NHS bodies in the Partnership to account as a whole system for delivery of the NHS Constitution and Mandate, financial and operational control, and quality (to the extent permitted at Law);
- NHS England and NHS Improvement intend that they will intervene in the individual trust and CCG Partners only where it is necessary or required for the delivery of their statutory functions and will (where it is reasonable to do so, having regard to the nature of the issue) in the first instance look to notify the SLE and work through the Partnership to seek a resolution prior to making an intervention with the Partner.

6. Decision-Making and Resolving Disagreements

6.1. Our approach to making Partnership decisions and resolving any disagreements will follow the principle of subsidiarity and will be in line with our shared Values and Behaviours. We will take all reasonable steps to reach a mutually acceptable resolution to any dispute.

Collective Decisions

6.2. There will be three levels of decision making:

- **Decisions made by individual organisations** - this Memorandum does not affect the individual sovereignty of Partners or their statutory decision-making responsibilities.
- **Decisions delegated to collaborative forums** - some partners have delegated specific decisions to a collaborative forum, for example the CCGs have delegated certain commissioning decisions to the Joint Committee of CCGs. Arrangements for resolving disputes in such cases are set out in the Memorandum of the respective Joint Committee and not this Memorandum. There are also a specific dispute resolution mechanisms for WYATT and the WYMHC.
- **Whole Partnership decisions** - the Partners will make decisions on a range of matters in the Partnership which will neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum, as set out in Paragraphs 6.3 below.

6.3. Collaborative decisions on Partnership matters will be considered by the Partnership Board. The Partnership Board has no formal powers delegated by any Partner. However, it will increasingly take on responsibility for co-ordinating decisions relating to regulatory and oversight functions currently exercised from outside the WY&H system and will look to reach recommendations and any decisions on a Best for WY&H basis. The terms of reference for the Partnership Board will set out clearly the types of decision which it will have responsibility to discuss and how conflicts of interest will be managed. The Partnership Board will initially have responsibility for decisions relating to:

- The objectives of priority HCP work programmes and workstreams
- The apportionment of transformation monies from national bodies
- Priorities for capital investment across the Partnership.
- Operation of the single NHS financial control total (for NHS Bodies)
- Agreeing common actions when Places or Partners become distressed

6.4. SLE will make recommendations to the Partnership Board on these matters. Where appropriate, the Partnership Board will make decisions of the Partners by consensus of those eligible Partnership Board members present at a quorate meeting. If a consensus decision cannot be reached, then (save for decisions on allocation of capital investment and transformation funding) it may

D R A F T

be referred to the dispute resolution procedure under Paragraph 6.6 below by any of the affected Partners for resolution.

6.5. In respect of referring priorities for capital investment or apportionment of transformation funding from the Partnership, if a consensus cannot be reached at the SLE meeting to agree this then the Partnership Board may make a decision provided that it is supported by not less than 75% of the eligible Partnership Board members. Partnership Board members will be eligible to participate on issues which apply to their organisation, in line with the scope of applicable issues set out in Annex 1.

Dispute resolution

6.6. Partners will attempt to resolve in good faith any dispute between them in respect of Partnership Board (or other Partnership-related) decisions, in line with the Principles, Values and Behaviours set out in this Memorandum.

6.7. Where necessary, Place or sector-based arrangements (the Joint Committee of CCGs, WYAAT, and WYMHC as appropriate) will be used to resolve any disputes which cannot be dealt with directly between individual Partners, or which relate to existing schemes of delegation.

6.8. The Partnership will apply a dispute resolution framework to resolve any issues which cannot otherwise be agreed through these arrangements.

6.9. As decisions made by the Partnership do not impact on the statutory responsibilities of individual organisations, Partners will be expected to apply shared Values and Behaviours and come to a mutual agreement through the dispute resolution process.

6.10. The key stages of the dispute resolution process are

- i. The SOAG will seek to resolve the dispute to the mutual satisfaction of each of the affected parties. If SOAG cannot resolve the dispute within 30 days, the dispute should be referred to SLE.
- ii. SLE will come to a majority decision (i.e. a majority of eligible Partners participating in the meeting who are not affected by the matter in dispute determined by the scope of applicable issues set out in Annex 1) on how best to resolve the dispute based, applying the Principles, Values and Behaviours of this Memorandum, taking account of the Objectives of the Partnership. SLE will advise the Partners of its decision in writing.
- iii. If the parties do not accept the SLE decision, or SLE cannot come to a decision which resolves the dispute, it will be referred to an independent facilitator selected by SLE. The facilitator will work with the Partners to resolve the dispute in accordance with the terms of this Memorandum.
- iv. In the unlikely event that the independent facilitator cannot resolve the dispute, it will be referred to the Partnership Board. The Partnership Board will come to a majority decision on how best to resolve the dispute in accordance with the terms of this Memorandum and advise the parties of its decision.

7. Financial Framework

7.1. All NHS body Partners, in West Yorkshire and Harrogate are ready to work together, manage risk together, and support each other when required. The Partners are committed to working individually and in collaboration with others to deliver the changes required to achieve financial sustainability and live within our resources.

7.2. A set of financial principles have been agreed, within the context of the broader guiding Principles for our Partnership. They confirm that we will:

- aim to live within our means, i.e. the resources that we have available to provide services;
- develop a West Yorkshire and Harrogate system response to the financial challenges we face; and
- develop payment and risk share models that support a system response rather than work against it.

7.3. We will collectively manage our NHS resources so that all Partner organisations will work individually and in collaboration with others to deliver the changes required to deliver financial sustainability.

Living within our means and management of risk

7.4. Through this Memorandum the collective NHS Partner leaders in each Place commit to demonstrate robust financial risk management. This will include agreeing action plans that will be mobilised across the Place in the event of the emergence of financial risk outside plans. This might include establishing a Place risk reserve where this is appropriate and in line with the legal obligations of the respective NHS body Partners involved.

7.5. Subject to compliance with confidentiality and legal requirements around competition sensitive information and information security the Partners agree to adopt an open-book approach to financial plans and risks in each Place leading to the agreement of fully aligned operational plans. Aligned plans will be underpinned by common financial planning assumptions on income and expenditure between providers and commissioners, and on issues that have a material impact on the availability of system financial incentives

NHS Contracting principles

7.6. The NHS Partners are committed to considering the adoption of payment models which are better suited to whole system collaborative working (such as Aligned Incentive Contracting). The Partners will look to adopt models which reduce financial volatility and provide greater certainty for all Partners at the beginning of each year of the planned income and costs.

Allocation of Transformation Funds

7.7. The Partners intend that any transformation funds made available to the Partnership will all be used within the Places. Funds will be allocated through collective decision-making by the Partnership in line with agreed priorities. The method of allocation may vary according to agreed priorities. However, funds will not be allocated through expensive and protracted bidding and prioritisation processes and will be deployed in those areas where the Partners have agreed that they will deliver the maximum leverage for change and address financial risk.

7.8. The funding provided to Places (based on weighted population) will directly support Place-based transformation programmes. This will be managed by each Place with clear and transparent governance arrangements that provide assurance to all Partners that the resource has been deployed to deliver maximum transformational impact, to address financial risk, and to meet the efficiency requirements. Funding will be provided subject to agreement of clear deliverables and outcomes by the relevant Partners in the Place through the mutual accountability arrangements of the SLE and SOAG and be subject to ongoing monitoring and assurance from the Partnership.

7.9. Funding provided to the Programmes (all of which will also be deployed in Place) will be determined in agreement with Partners through the SLE, subject to documenting the agreed deliverables and outcomes with the relevant Partners.

Allocation of ICS capital

7.10. The Partnership will play an increasingly important role in prioritising capital spending by the national bodies over and above that which is generated from organisations' internal resources. In doing this, the Partnership will ensure that:

- the capital prioritisation process is fair and transparent;
- there is a sufficient balance across capital priorities specific to Place as well as those which cross Places;
- there is sufficient focus on backlog maintenance and equipment replacement in the overall approach to capital;
- the prioritisation of major capital schemes must have a clear and demonstrable link to affordability and improvement of the financial position;
- access to discretionary capital is linked to the mutual accountability framework as described in this Memorandum.

Allocation of Provider and Commissioner Incentive Funding

7.11. The approach to managing performance-related incentive funds set by NHS planning guidance and business rules (e.g. the 2018/19 Provider Sustainability Fund and Commissioner Sustainability Fund) is not part of this Memorandum. A common approach to this will be agreed by the Partnership as part of annual financial planning.

8. National and regional support

8.1. To support Partnership development as an Integrated Care System there will be a process of aligning resources from ALBs to support delivery and establish an integrated single assurance and regulation approach.

8.2. National capability and capacity will be available to support WY&H from central teams including governance, finance and efficiency, regulation and competition, systems and national programme teams, primary care, urgent care, cancer, mental health, including external support.

9. Variations

9.1. This Memorandum, including the Schedules, may only be varied by written agreement of all the Partners.

10. Charges and liabilities

10.1. Except as otherwise provided, the Partners shall each bear their own costs and expenses incurred in complying with their obligations under this Memorandum.

10.2. By separate agreement, the Parties may agree to share specific costs and expenses (or equivalent) arising in respect of the Partnership between them in accordance with a "Contributions Schedule" to be developed by the Partnership and approved by the Partnership Board.

10.3. Partners shall remain liable for any losses or liabilities incurred due to their own or their employee's actions.

11. Information Sharing

11.1. The Partners will provide to each other all information that is reasonably required in order to achieve the Objectives and take decisions on a Best for WY&H basis.

11.2. The Partners have obligations to comply with competition law. The Partners will therefore make sure that they share information, and in particular competition sensitive information, in such a way that is compliant with competition and data protection law.

12. Confidential Information

12.1. Each Partner shall keep in strict confidence all Confidential Information it receives from another Partner except to the extent that such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised

DRAFT

disclosure by a Partner. Each Partner shall use any Confidential Information received from another Partner solely for the purpose of complying with its obligations under this Memorandum in accordance with the Principles and Objectives and for no other purpose. No Partner shall use any Confidential Information received under this Memorandum for any other purpose including use for their own commercial gain in services outside of the Partnership or to inform any competitive bid without the express written permission of the disclosing Partner.

12.2. To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Partner or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights which a Partner may have in respect of such Confidential Information.

12.3. The Parties agree to procure, as far as is reasonably practicable, that the terms of this Paragraph (Confidential Information) are observed by any of their respective successors, assigns or transferees of respective businesses or interests or any part thereof as if they had been party to this Memorandum.

12.4. Nothing in this Paragraph will affect any of the Partners' regulatory or statutory obligations, including but not limited to competition law.

13. Additional Partners

13.1. If appropriate to achieve the Objectives, the Partners may agree to include additional partner(s) to the Partnership. If they agree on such a course the Partners will cooperate to enter into the necessary documentation and revisions to this Memorandum if required.

13.2. The Partners intend that any organisation who is to be a partner to this Memorandum (including themselves) shall commit to the Principles and the Objectives and ownership of the system success/failure as set out in this Memorandum.

14. Signatures

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

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

14.3. No counterpart shall be effective until each Partner has executed at least one counterpart.

D R A F T

[INSERT SIGNATURE PAGES AFTER THIS]

Schedule 1 - Definitions and Interpretation

1. The headings in this Memorandum will not affect its interpretation.
2. Reference to any statute or statutory provision, to Law, or to Guidance, includes a reference to that statute or statutory provision, Law or Guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced.
3. Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.
4. References to Annexes and Schedules are to the Annexes and Schedules of this Memorandum, unless expressly stated otherwise.
5. References to any body, organisation or office include reference to its applicable successor from time to time.

Glossary of terms and acronyms

6. The following words and phrases have the following meanings in this Memorandum:

ALB	Arm’s Length Body A Non-Departmental Public Body or Executive Agency of the Department of Health and Social Care, eg NHSE, NHSI, HEE, PHE
Aligned Incentive Contract	A contracting and payment method which can be used as an alternative to the Payment by Results system in the NHS
Best for WY&H	A focus in each case on making a decision based on the best interests and outcomes for service users and the population of West Yorkshire and Harrogate
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
Committee in Common	
Confidential Information	All information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Memorandum
CQC	Care Quality Commission, the independent regulator of all health and social care services in England

DRAFT

GP	General Practice (or practitioner)
HCP	Health and Care Partnership
Healthcare Providers	The Partners identified as Healthcare Providers under Paragraph 1.1
HEE	Health Education England
Healthwatch	Independent organisations in each local authority area who listen to public and patient views and share them with those with the power to make local services better.
HWB	Health and Wellbeing Board
ICP	Integrated Care Partnership The health and care partnerships formed in each of the
ICS	Integrated Care System
JCCCG	Joint Committee of Clinical Commissioning Groups - a formal committee where two or more CCGs come together to form a joint decision making forum. It has delegated commissioning functions.
Law	any applicable statute or proclamation or any delegated or subordinate legislation or regulation; any enforceable EU right within the meaning of section 2(1) European Communities Act 1972; any applicable judgment of a relevant court of law which is a binding precedent in England; National Standards (as defined in the NHS Standard Contract); and any applicable code and “Laws” shall be construed accordingly
LWAB	Local Workforce Action Board sub regional group within Health Education England
Memorandum	This Memorandum of Understanding
Neighbourhood	One of c.50 geographical areas which make up West Yorkshire and Harrogate, in which GP practices work together, with community and social care services, to offer integrated health and care services for populations of 30-50,000 people.
NHS	National Health Service
NHSE	NHS England Formally the NHS Commissioning Board
NHS FT	NHS Foundation Trust - a semi-autonomous organisational unit within the NHS

DRAFT

NHSI	NHS Improvement - The operational name for an organisation that brings together Monitor, the NHS Trust Development Authority and other functions
Objectives	The Objectives set out in Paragraph 3.5
Partners	The members of the Partnership under this Memorandum as set out in Paragraph 1.1 who shall not be legally in partnership with each other in accordance with Paragraph 2.7.
Partnership	The collaboration of the Partners under this Memorandum which is not intended to, or shall be deemed to, establish any legal partnership or joint venture between the Partners to the Memorandum
Partnership Board	The senior governance group for the Partnership set up in accordance with Paragraphs 4.4 to 4.6
Partnership Core Team	The team of officers, led by the Partnership Director, which manages and co-ordinates the business and functions of the Partnership
PHE	Public Health England - An executive agency of the Department of Health and Social Care which exists to protect and improve the nation's health and wellbeing, and reduce health inequalities
Places	One of the six geographical districts that make up West Yorkshire and Harrogate, being Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield, and "Place" shall be construed accordingly
Principles	The principles for the Partnership as set out in Paragraph 3.2
Programmes	The WY&H programme of work established to achieve each of the objectives set out in paras 4.2,i and 4.2,ii of this memorandum
SOAG	System Oversight and Assurance Group
STP	Sustainability and Transformation Partnership (or Plan) The NHS and local councils have come together in 44 areas covering all of England to develop proposals and make improvements to health and care
System Leadership Executive or SLE	The governance group for the Partnership set out in Paragraphs 4.7 and 4.8

D R A F T

Transformation Funds	Discretionary, non-recurrent funding made available by NHSE to support the achievement of service improvement and transformation priorities
Values and Behaviours	shall have the meaning set out in Paragraph 3.3 above
WY&H	West Yorkshire and Harrogate
WYAAT	West Yorkshire Association of Acute Trusts
WYMHC	West Yorkshire Mental Health Collaborative

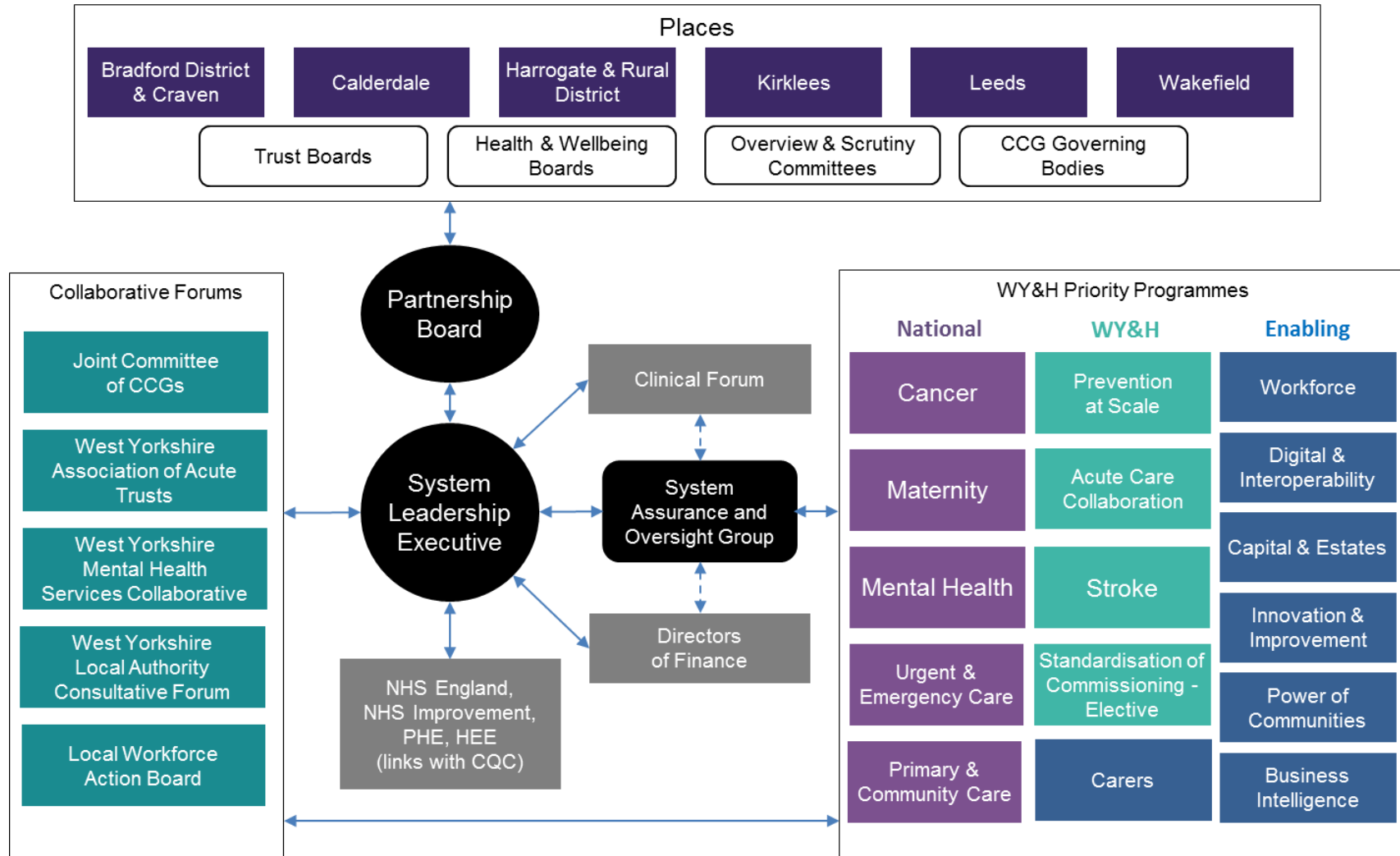
Annex 1 – Applicability of Memorandum Elements

	CCGs	NHS Providers ³	Councils	NHSE and NHI	Healthwatch	Other partners
Vision, principles, values and behaviour	✓	✓	✓	✓	✓	✓
Partnership objectives	✓	✓	✓	✓	✓	✓
Governance	✓	✓	✓	✓	✓	✓
Decision-making and dispute resolution	✓	✓	✓	✓	✓	✓
Mutual accountability	✓	✓	✓	✓		
Financial framework – financial risk management	✓	✓		✓		
Financial framework – Allocation of capital and transformation funds	✓	✓	✓	✓		
National and regional support	✓	✓	✓	✓		

³ All elements of the financial framework for WY&H, eg the application of a single NHS control total, will not apply to all NHS provider organisations, particularly those which span a number of STPs.

Locala Community Partnerships CIC is a significant provider of NHS services. It is categorised as an 'Other Partner' because of its corporate status and the fact that it cannot be bound by elements of the financial and mutual accountability frameworks. This status will be reviewed as the partnership continues to evolve.

Annex 2 – Schematic of Governance and Accountability Arrangements



Annex 3 - Terms of Reference

Part 1: Partnership Board

Part 2: System Leadership Executive

Part 3: System Oversight and Assurance Group

DRAFT



7

Partnership Board Terms of Reference

DRAFT

June 2018

Annex 3.1 Partnership Board ToR v1 180622

DRAFT

Contents

1. Introduction and context2
 Purpose2

2. How we work together in West Yorkshire and Harrogate.....3
 Our vision.....3
 Principles for our partnership3
 Our shared values and behaviour.....4

3. Role and Responsibilities4

4. Membership.....5
 Deputies.....6
 Additional attendees6

5. Quoracy and voting6

6. Accountability and reporting7

7. Conduct and Operation7
 Managing Conflicts of Interest7
 Secretariat.....7

8. Review.....8

Annex 1 – Members9

Annex 2 – Schematic of Governance and Accountability Arrangements.....11



DRAFT**1. Introduction and context**

- 1.1. West Yorkshire and Harrogate Health and Care Partnership was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs), in response to the *NHS Five Year Forward View*. It brings together all health and care organisations in our six places: Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield.
- 1.2. The Partnership is not a new organisation, but a new way of working to meet the diverse needs of our citizens and communities. NHS services have come together with local authorities, charities and community groups to agree how we can improve people's health and improve the quality of their health and care services.
- 1.3. The Partnership Board is a key element of the leadership and governance arrangements for the West Yorkshire and Harrogate Health and Care Partnership.

Purpose

- 1.4. The Partnership Board will provide the formal leadership for the Partnership. It will be responsible for setting strategic direction. It will provide oversight for all Partnership business, and a forum to make decisions together as Partners on the matters highlighted in the Partnership Memorandum of Understanding, which neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum.
- 1.5. The Partnership Board has no formal delegated powers from the organisations in the Partnership. However, over time the regulatory and oversight functions of the NHS national bodies will increasingly be enacted through collaboration with our leadership.
- 1.6. The Partnership Board will work by building agreement with leaders across Partner organisations to drive action around a shared direction of travel.
- 1.7. These Terms of Reference describe the scope, function and ways of working for the Partnership Board. They should be read in conjunction with the Memorandum of Understanding for the West Yorkshire and Harrogate Health and Care Partnership, which describes the wider governance and accountability arrangements.

DRAFT**2. How we work together in West Yorkshire and Harrogate****Our vision**

- 2.1. We have worked together to develop a shared vision for health and care services across West Yorkshire and Harrogate. All of our plans support the realisation of this vision:
- Places will be healthy - you will have the best start in life, so you can live and age well.
 - If you have long term health conditions you will be supported to self-care through GPs and social care services working together. This will include peer support and via technology, such as telemedicine.
 - If you have multiple health conditions, there will be a team supporting your physical, social and mental health needs. This will involve you, your family and carers, the NHS, social care and voluntary and community organisations.
 - If you need hospital care, it will usually mean going to your local hospital, which works closely with others to give you the best care possible
 - Local hospitals will be supported by centres of excellence for services such as cancer, stroke, and mental health.
 - All of this will be planned and paid for together, with councils and the NHS working together to remove the barriers created by planning and paying for services separately. For example community and hospital care working together.
 - Communities and staff will be involved in the development and design of plans so that everyone truly owns their health care services.

Principles for our Partnership

- 2.2. The Partnership Board operates within an agreed set of guiding principles that shape everything we do through our Partnership:
- We will be ambitious for the people we serve and the staff we employ
 - The West Yorkshire and Harrogate Partnership belongs to its citizens and to commissioners and providers, councils 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
 - We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on people's health and wellbeing.

DRAFT**Our shared values and behaviour**

2.3. Members of the Partnership Board commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our place and of West Yorkshire and Harrogate
- We support each other and work collaboratively
- We act with honesty and integrity, and trust each other to do the same
- We challenge constructively when we need to
- We assume good intentions.
- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery

3. Role and Responsibilities

3.1. The Partnership Board will provide the formal leadership for the Partnership. It will be responsible for setting strategic direction and providing strategic oversight for all Partnership business. It will make joint decisions on a range of matters which do not impact on the statutory responsibilities of individual organisations and have not been delegated formally to a collaborative forum. Its responsibilities are to:

- i. agree the broad objectives for the Partnership;
- ii. consider recommendations from the System Leadership Executive Group and make decisions on :
 - The objectives of priority Partnership work programmes and workstreams
 - The apportionment of transformation monies from national bodies
 - Priorities for capital investment across the Partnership
 - Operation of the single NHS financial control total (for NHS bodies)
 - Common actions when systems become distressed
- iii. act as a leadership cohort, demonstrating what can be achieved with strong system leadership and increased freedoms and flexibilities;
- iv. provide a mechanism for joint action and joint decision-making for those issues which are best tackled on a wider scale;
- v. oversee financial resources of NHS partners within a shared financial control total for health across the constituent CCGs and NHS provider organisations; and maximise the system-wide efficiencies necessary to manage within this share of the NHS budget;
- vi. support the development of local partnership arrangements which bring

DRAFT

- together the Councils, voluntary and community groups, and NHS commissioners and providers in each Place;
- vii. ensure that, through partnership working in each place and across WY&H, there is a greater focus on population health management, integration between providers of services around the individual's needs, and a focus on care provided in primary and community settings;
 - viii. oversee a mutual accountability framework which provides a single, consistent approach for assurance and accountability between partners;
 - ix. reach agreement in relation to recommendations made by other governance groups within the Partnership on the need to take action in relation to managing collective performance, resources and the totality of population health;
 - x. adopt an approach to making joint decisions and resolving any disagreements which follows the principle of subsidiarity and is in line with the shared values and behaviours of the partnership;

4. Membership

4.1. The membership will comprise:

- An independent, non-executive Chair
- the Partnership lead CEO
- CCG Clinical Chairs
- CCG Accountable Officers
- Council leaders
- Council chief executives
- Chairs of Health and Wellbeing Boards of each Place
- Chairs of NHS Trusts, NHS Foundation Trusts and other providers of NHS services which are formal partners
- Chief executives of NHS Trusts, NHS Foundation Trusts and other providers of NHS services which are formal partners
- One representative of NHS England
- One representative of NHS Improvement
- One representative of Health Education England
- One representative of Public Health England
- One representative of Healthwatch organisations
- The chief executive of Yorkshire and Humber Academic Health Science Network
- The chair of the WY&H Clinical Forum
- [Non-executive/Lay members – TBC]

4.2. A deputy Chair will be agreed from among the non-executive members.

DRAFT

4.3. A list of members is set out at **Annex 1**.

Deputies

4.4. If a member is unable to attend a meeting of the Partnership Board, s/he will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and sufficient understanding of the issues to be considered to represent their organisation, place or group effectively. Deputies will be eligible to vote.

Additional attendees

4.5. Additional attendees will routinely include:

- The WY&H Partnership Director
- The WY&H Partnership Finance director.

4.6. At the discretion of the Chair, additional representatives may be requested to attend meetings from time to time to participate in discussions or report on particular issues. Such additional representatives may include:

- Senior Responsible Officers and programme leads for WY&H programmes
- Representatives of Partner organisations, who are not part of the core membership.
- Members of the WY&H Partnership core team and external advisers.

5. Quoracy and voting

5.1. The Partnership Board will be quorate when 75% or more of Partner organisations are present, including at least one representative from each place. The Partnership Board will generally operate on the basis of forming a consensus on issues considered, taking account of the views expressed by members. It will look to make any decisions on a Best for WY&H basis. The Chair will seek to ensure that any lack of consensus is resolved amongst members.

5.2. Partnership Board members will be eligible to participate on issues which apply to their organisation, in line with the scope of applicable issues set out in Annex 1 of the Partnership Memorandum of Understanding. If a consensus decision cannot be reached, then (save for decisions on allocation of capital investment and transformation funding set out at 5.3 below) it may be referred to the dispute resolution procedure under Paragraph 6.6 of the Partnership Memorandum of Understanding by any of the affected Partners for resolution.

5.3. In respect of priorities for capital investment or apportionment of transformation funding from the Partnership, then the Partnership Board may make a decision provided that it is supported by not less than 75% of the eligible Partnership Board members present at a quorate meeting. In such cases, each eligible Partner organisation shall have one vote.

DRAFT**6. Accountability and reporting**

- 6.1. The Partnership Board has no formal powers delegated by Partner organisations. However, it will increasingly take on responsibility for decisions relating to regulatory and oversight functions currently exercised from outside the system.
- 6.2. The Partnership Board has a key role within the wider governance and accountability arrangements for the WY&H partnership (see **Annex 2** for a description of these arrangements). The minutes, and a summary of key messages will be submitted to all Partner organisations after each meeting.

7. Conduct and Operation

- 7.1. The Partnership Board will meet in public, at least four times each year. An annual schedule of meetings will be published by the secretariat.
- 7.2. Extraordinary meetings may be called for a specific purpose at the discretion of the Chair. A minimum of seven working days notice will be given when calling an extraordinary meeting.
- 7.3. The agenda and supporting papers will be sent to members and attendees and made available to the public no less than five working days before the meeting. Urgent papers will be permitted in exceptional circumstances at the discretion of the Chair.
- 7.4. Draft minutes will be issued within 10 working days of each meeting.

Managing Conflicts of Interest

- 7.5. Each member must abide by all policies of the organisation it represents in relation to conflicts of interest.
- 7.6. Where any Partnership Board member has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that member may participate and/or vote in meetings (or parts of meetings) in which the relevant matter is discussed.
- 7.7. Where the Chair decides to exclude a member, the relevant organisation represented by that member may send a deputy to take the place of the conflicted member in relation to that matter.

Secretariat

- 7.8. The secretariat function for the Partnership Board will be provided by the WY&H Partnership core team. A member of the team will be responsible for arranging meetings, recording notes and actions from each meeting, preparing agendas, and agreeing these with the Chair.

DRAFT

8. Review

- 8.1. These terms of reference and the membership of the Partnership Board will be reviewed at least annually. Further reviews will be undertaken in response to any material developments or changes in the wider governance arrangements of the Partnership.

DRAFT**Annex 1 – Members****Health and Wellbeing Boards**

Bradford , Airedale and Wharfedale	✓
Calderdale	✓
Kirklees	✓
Leeds	✓
North Yorkshire	✓
Wakefield Council	✓

Local Authorities

	Leader	Chief Executive
City of Bradford Metropolitan District Council	✓	✓
Calderdale Council	✓	✓
Craven District Council	✓	✓
Harrogate Borough Council	✓	✓
Kirklees Council	✓	✓
Leeds City Council	✓	✓
North Yorkshire County Council	✓	✓
Wakefield Council	✓	✓

CCGs Clinical Chairs

	Chair	Accountable Officer
NHS Airedale, Wharfedale and Craven CCG	✓	✓
NHS Bradford City CCG	✓	✓
NHS Bradford Districts CCG	✓	✓
NHS Calderdale CCG	✓	✓
NHS Greater Huddersfield CCG	✓	✓
NHS Harrogate and Rural District CCG	✓	✓
NHS Leeds CCG	✓	✓
NHS North Kirklees CCG	✓	✓
NHS Wakefield CCG	✓	✓

DRAFT**NHS Service Providers**

	Chair	Chief Executive
Airedale NHS Foundation Trust	✓	✓
Bradford District Care NHS Foundation Trust	✓	✓
Bradford Teaching Hospitals NHS Foundation Trust	✓	✓
Calderdale and Huddersfield NHS Foundation Trust	✓	✓
Harrogate and District NHS Foundation Trust	✓	✓
Leeds and York Partnership NHS Foundation Trust	✓	✓
Leeds Community Healthcare NHS Trust	✓	✓
The Leeds Teaching Hospitals NHS Trust	✓	✓
Locala Community Partnerships CIC	✓	✓
The Mid Yorkshire Hospitals NHS Trust	✓	✓
South West Yorkshire Partnership NHS Foundation Trust	✓	✓
Tees, Esk, and Wear Valleys NHS Foundation Trust	✓	✓
Yorkshire Ambulance Service NHS Trust	✓	✓

Heath Regulator and Oversight Bodies

NHS England	✓
NHS Improvement	✓

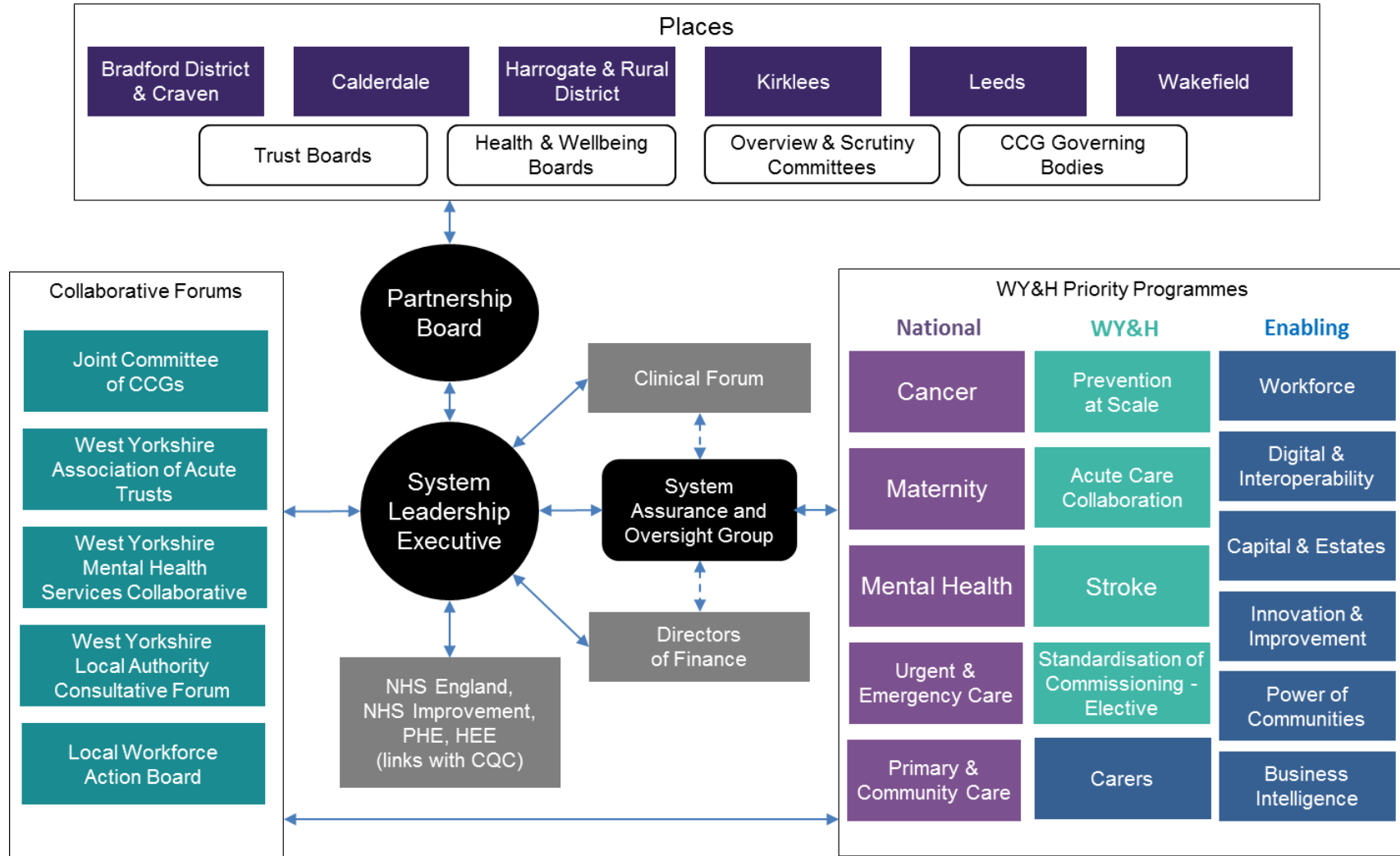
Other National Bodies

Health Education England	✓
Public Health England	✓
Care Quality Commission [TBC]	✓

Other Partners

Healthwatch representative	✓
Yorkshire and Humber Academic Health Science Network	✓

Annex 2 – Schematic of Governance and Accountability Arrangements



DRAFT

West Yorkshire and Harrogate
Health and Care Partnership



7

System Leadership Executive Group Terms of Reference

DRAFT

June 2018

Annex 3.2 SLE ToR v3 180622

DRAFT

Contents

1. Introduction and context2
 Purpose2

2. How we work together in West Yorkshire and Harrogate.....3
 Our vision.....3
 Principles for our partnership3
 Our shared values and behaviour.....4

3. Role and Responsibilities4

4. Membership.....5
 Deputies.....5
 Additional attendees6

5. Quoracy and voting6

6. Accountability and reporting6

7. Conduct and Operation7
 Managing Conflicts of Interest7
 Secretariat.....7

8. Review.....7

Annex 1 – Members8
 Local Authorities8
 NHS Commissioners8
 Healthcare Providers8
 Heath Regulator and Oversight Bodies9
 Other National Bodies.....9
 Other Partners9

Annex 2 – Schematic of Governance and Accountability Arrangements.....10



DRAFT**1. Introduction and context**

- 1.1. West Yorkshire and Harrogate Health and Care Partnership was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs), in response to the *NHS Five Year Forward View*. It brings together all health and care organisations in our six places: Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield.
- 1.2. The Partnership is not a new organisation, but a new way of working to meet the diverse needs of our citizens and communities. NHS services have come together with local authorities, charities and community groups to agree how we can improve people's health and improve the quality of their health and care services.
- 1.3. The System Leadership Executive Group ('SLE') is a key element of the leadership and governance arrangements for the West Yorkshire and Harrogate Health and Care Partnership.

Purpose

- 1.4. The SLE will support the Partnership Board to lead and direct the Partnership and will have overall executive responsibility for delivery of the Partnership plan.
- 1.5. The SLE will make decisions and recommendations to the Partnership Board on the matters highlighted in the Partnership Memorandum of Understanding, which neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum.
- 1.6. The SLE has no formal delegated powers from the organisations in the Partnership. However, over time the regulatory and oversight functions of the NHS national bodies will increasingly be enacted through collaboration with our leadership.
- 1.7. The SLE will work by building agreement with leaders across Partner organisations to drive action around a shared direction of travel.
- 1.8. These Terms of Reference describe the scope, function and ways of working for the SLE. They should be read in conjunction with the Memorandum of Understanding for the West Yorkshire and Harrogate Health and Care Partnership, which describes the wider governance and accountability arrangements.

DRAFT**2. How we work together in West Yorkshire and Harrogate****Our vision**

2.1. We have worked together to develop a shared vision for health and care services across West Yorkshire and Harrogate. All of our plans support the realisation of this vision:

- Places will be healthy - you will have the best start in life, so you can live and age well.
- If you have long term health conditions you will be supported to self-care through GPs and social care services working together. This will include peer support and via technology, such as telemedicine.
- If you have multiple health conditions, there will be a team supporting your physical, social and mental health needs. This will involve you, your family and carers, the NHS, social care and voluntary and community organisations.
- If you need hospital care, it will usually mean going to your local hospital, which works closely with others to give you the best care possible
- Local hospitals will be supported by centres of excellence for services such as cancer, stroke, and mental health.
- All of this will be planned and paid for together, with councils and the NHS working together to remove the barriers created by planning and paying for services separately. For example community and hospital care working together.
- Communities and staff will be involved in the development and design of plans so that everyone truly owns their health care services.

Principles for our Partnership

2.2. The SLE operates within an agreed set of guiding principles that shape everything we do through our Partnership:

- We will be ambitious for the people we serve and the staff we employ
- The West Yorkshire and Harrogate partnership belongs to its citizens and to commissioners and providers, councils 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
- We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on people's health and wellbeing.

DRAFT**Our shared values and behaviour**

2.3. Members of the SLE commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our place and of West Yorkshire and Harrogate
- We support each other and work collaboratively
- We act with honesty and integrity, and trust each other to do the same
- We challenge constructively when we need to
- We assume good intentions.
- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery

3. Role and Responsibilities

3.1. The SLE will take overall executive responsibility for delivery of the Partnership plan. It will make recommendations to the Partnership Board and make joint decisions on a range of matters which do not impact on the statutory responsibilities of individual organisations and have not been delegated formally to a collaborative forum. Its responsibilities are to:

- i. make recommendations to the Partnership Board on:
 - The objectives of priority Partnership work programmes and workstreams
 - The apportionment of transformation monies from national bodies
 - Priorities for capital investment across the Partnership.
 - Operation of the single NHS financial control total (for NHS bodies)
 - Agreeing common action when systems become distressed
- ii. progressively build the capabilities to manage the health of our population, keeping people healthier for longer and reducing avoidable demand for healthcare services;
- iii. act as a leadership cohort, demonstrating what can be achieved with strong system leadership and increased freedoms and flexibilities;
- iv. provide a mechanism for joint action and joint decision-making for those issues which are best tackled on a wider scale;
- v. manage financial resources of NHS partners within a shared financial control total for health across the constituent CCGs and NHS provider organisations; and maximise the system-wide efficiencies necessary to manage within this share of the NHS budget;

DRAFT

- vi. support the development of local partnership arrangements which bring together the Councils, voluntary and community groups, and NHS commissioners and providers in each Place;
- vii. ensure that, through partnership working in each place and across WY&H, there is a greater focus on population health management, integration between providers of services around the individual's needs, and a focus on care provided in primary and community settings;
- viii. oversee the development and implementation of a mutual accountability framework which provides a single, consistent approach for assurance and accountability between partners;
- ix. reach agreement in relation to recommendations made by other governance groups within the partnership on the need to take action in relation to managing collective performance, resources and the totality of population health;
- x. adopt an approach to making joint decisions and resolving any disagreements which follows the principle of subsidiarity and is in line with the shared values and behaviours of the partnership;

4. Membership

4.1. The membership will comprise:

- A Chair – the Partnership lead CEO
- CCG Accountable Officers
- Council chief executives
- Chief executives of NHS Trusts, NHS Foundation Trusts and other providers of NHS services which are formal partners
- One representative of NHS England
- One representative of NHS Improvement
- One representative of Health Education England
- One representative of Public Health England
- One representative of Healthwatch organisations
- The chief executive of Yorkshire and Humber Academic Health Science Network
- The chair of the WY&H Clinical Forum

4.2. A deputy Chair will be agreed from among nominated members. A list of members is set out at **Annex 1**.

Deputies

4.3. If a member is unable to attend a meeting of the SLE, s/he will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and sufficient understanding of the issues to be considered, to

DRAFT

represent their organisation, place or group effectively. Deputies will be eligible to vote.

Additional attendees

4.4. Additional attendees will routinely include:

- The WY&H Partnership director
- The WY&H Partnership finance director.

4.5. At the discretion of the Chair, additional representatives may be requested to attend meetings from time to time to participate in discussions or report on particular issues. Such additional representatives may include:

- Senior Responsible Officers and programme leads for WY&H programmes
- Representatives of Partner organisations, who are not part of the core membership.
- Members of the WY&H Partnership core team and external advisers.

5. Quoracy and voting

5.1. The SLE will be quorate when 75% or more of Partner organisations are present, including at least one representative from each place. The SLE will generally operate on the basis of forming a consensus on issues considered, taking account of the views expressed by members. It will look to make any decisions on a Best for WY&H basis. The Chair will seek to ensure that any lack of consensus is resolved amongst members.

5.1. Members will be eligible to participate on issues which apply to their organisation, in line with the scope of applicable issues set out in Annex 1 of the Partnership Memorandum of Understanding. If a consensus cannot be reached, then decisions will be made by 75% majority of the Group present and voting at a quorate meeting. In such cases, each eligible Partner organisation shall have one vote.

6. Accountability and reporting

6.1. The SLE will be accountable to the Partnership Board, which provides the formal leadership of the WY&H Partnership. The SLE has no formal powers delegated by Partner organisations. However, it will increasingly take on responsibility for decisions relating to regulatory and oversight functions currently exercised from outside the system.

6.2. The SLE has a key role within the wider governance and accountability arrangements for the WY&H Partnership (see **Annex 2** for a description of these arrangements). The minutes will be submitted to each meeting of the Partnership Board. The minutes, and a summary of key messages will also be submitted to all Partner organisations after each meeting.

DRAFT**7. Conduct and Operation**

- 7.1. The SLE will normally meet monthly. An annual schedule of meetings will be published by the secretariat.
- 7.2. Extraordinary meetings may be called for a specific purpose at the discretion of the Chair. A minimum of seven working days notice will be given when calling an extraordinary meeting.
- 7.3. The agenda and supporting papers will be sent to members and attendees no less than five working days before the meeting. Urgent papers will be permitted in exceptional circumstances at the discretion of the Chair.
- 7.4. Draft minutes will be issued within 10 working days of each meeting.

Managing Conflicts of Interest

- 7.5. Each member must abide by all policies of the organisation it represents in relation to conflicts of interest.
- 7.6. Where any SLE member has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that member may participate and/or vote in meetings (or parts of meetings) in which the relevant matter is discussed.
- 7.7. Where the Chair decides to exclude a member, the relevant organisation represented by that member may send a deputy to take the place of the conflicted member in relation to that matter.

Secretariat

- 7.8. The secretariat function for the SLE will be provided by the WY&H Partnership core team. A member of the team will be responsible for arranging meetings, recording notes and actions from each meeting, preparing agendas, and agreeing these with the Chair.

8. Review

- 8.1. These terms of reference and the membership of the SLE will be reviewed at least annually. Further reviews will be undertaken in response to any material developments or changes in the wider governance arrangements of the Partnership.

DRAFT**Annex 1 – Members****Local Authorities**

City of Bradford Metropolitan District Council	
Calderdale Council	
Craven District Council	
Harrogate Borough Council	
Kirklees Council	
Leeds City Council	
North Yorkshire County Council	
Wakefield Council	

NHS Commissioners

NHS Airedale, Wharfedale and Craven CCG	
NHS Bradford City CCG	
NHS Bradford Districts CCG	
NHS Calderdale CCG	
NHS Greater Huddersfield CCG	
NHS Harrogate and Rural District CCG	
NHS Leeds CCG	
NHS North Kirklees CCG	
NHS Wakefield CCG	
NHS England	

Healthcare Providers

Airedale NHS Foundation Trust	
Bradford District Care NHS Foundation Trust	
Bradford Teaching Hospitals NHS Foundation Trust	
Calderdale and Huddersfield NHS Foundation Trust	
Harrogate and District NHS Foundation Trust	
Leeds and York Partnership NHS Foundation Trust	
Leeds Community Healthcare NHS Trust	
The Leeds Teaching Hospitals NHS Trust	
Locala Community Partnerships CIC	
The Mid Yorkshire Hospitals NHS Trust	

DRAFT

South West Yorkshire Partnership NHS Foundation Trust	
Tees, Esk, and Wear Valleys NHS Foundation Trust	
Yorkshire Ambulance Service NHS Trust	

Health Regulator and Oversight Bodies

NHS England	
NHS Improvement	

Other National Bodies

Health Education England	
Public Health England	
Care Quality Commission [TBC]	

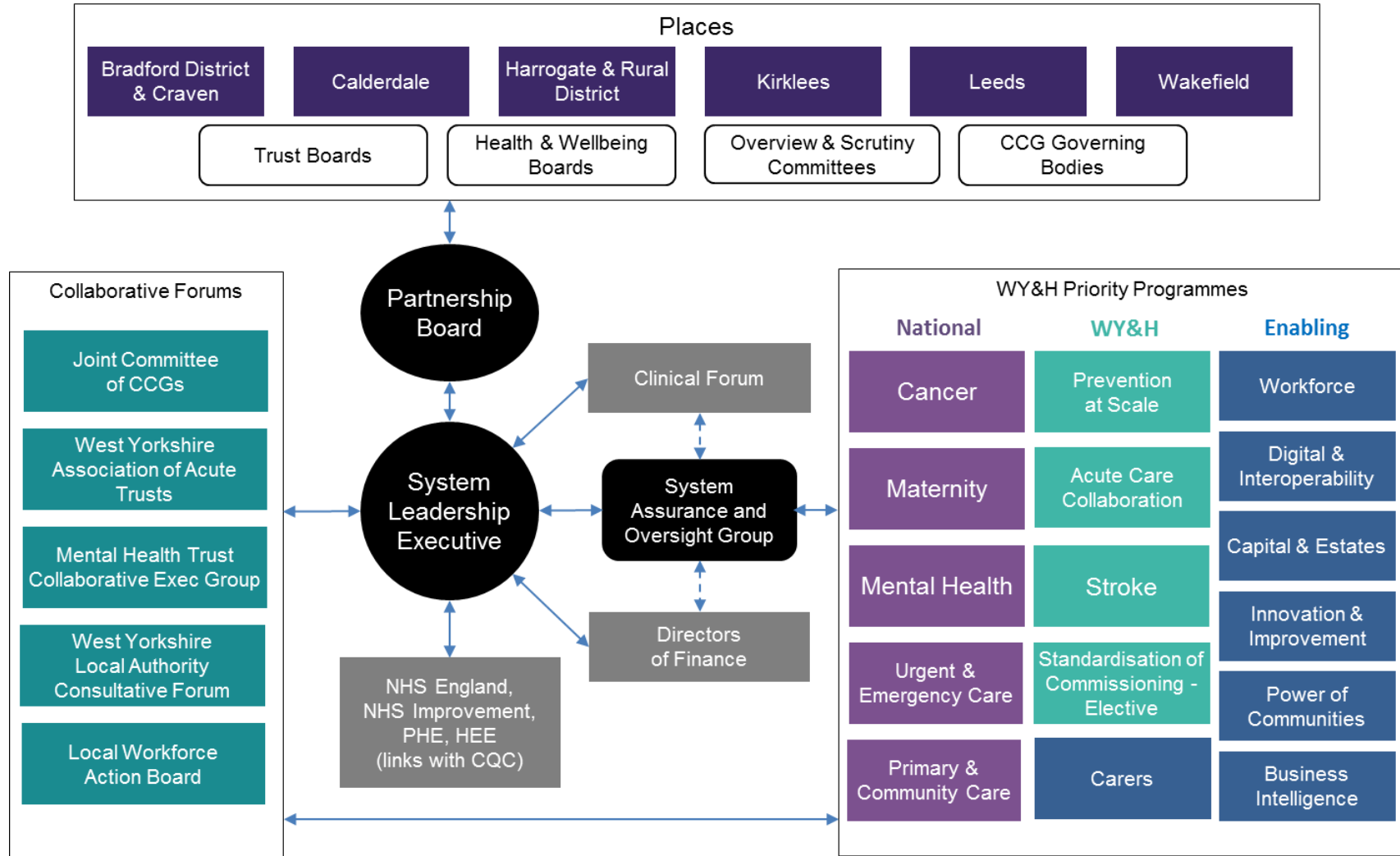
Other Partners

Clinical Forum Chair	
Healthwatch representative	
Yorkshire and Humber Academic Health Science Network	

7

DRAFT

Annex 2 – Schematic of Governance and Accountability Arrangements



DRAFT

West Yorkshire and Harrogate
Health and Care Partnership



7

System Oversight and Assurance Group Terms of Reference

DRAFT

June 2018

Annex 3.3 SOAG ToR v6 180622

DRAFT

Contents

1. Introduction and context2
 Purpose2

2. How we work together in West Yorkshire and Harrogate.....3
 Our vision.....3
 Principles for our partnership3
 Our shared values and behaviour.....4

3. Role and Responsibilities4

4. Membership.....5
 Deputies.....5
 Additional attendees6

5. Quoracy and voting6

6. Accountability and reporting6

7. Conduct and Operation7
 Managing Conflicts of Interest7
 Secretariat.....7

8. Review.....7

Annex 1 – Members8

Annex 2 – Schematic of Governance and Accountability Arrangements.....9



DRAFT**1. Introduction and context**

- 1.1. West Yorkshire and Harrogate Health and Care Partnership was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs), in response to the *NHS Five Year Forward View*. It brings together all health and care organisations in our six places: Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield.
- 1.2. The Partnership is not a new organisation, but a new way of working to meet the diverse needs of our citizens and communities. NHS services have come together with local authorities, charities and community groups to agree how we can improve people's health and improve the quality of their health and care services.
- 1.3. The System Oversight and Assurance Group is a key element of the leadership and governance arrangements for the West Yorkshire and Harrogate Health and Care Partnership.

Purpose

- 1.4. The Partnership has agreed to adopt a new integrated approach to leading performance development and culture change, encompassing operational performance, quality and outcomes, service transformation, and finance.
- 1.5. This new approach will feature:
 - a single framework, covering individual places, and West Yorkshire and Harrogate as a whole;
 - an increasing focus on making judgements about a whole place, while understanding the positions of individual organisations;
 - a strong element of peer review and mutual accountability;
 - a clear approach to improvement-focused intervention, support and capacity building.
- 1.6. The purpose of the System Oversight and Assurance Group is to be the primary governance forum to oversee the Partnership's mutual accountability arrangements. It will take an overview of system performance and progress with delivery of the Partnership's plan
- 1.7. These Terms of Reference describe the scope, function and ways of working for the System Oversight and Assurance Group. They should be read in conjunction with the Memorandum of Understanding for the West Yorkshire and Harrogate Health and Care Partnership, which describes the wider governance and accountability arrangements.

DRAFT**2. How we work together in West Yorkshire and Harrogate****Our vision**

- 2.1. We have worked together to develop a shared vision for health and care services across West Yorkshire and Harrogate. All of our plans support the realisation of this vision:
- Places will be healthy - you will have the best start in life, so you can live and age well.
 - If you have long term health conditions you will be supported to self-care through GPs and social care services working together. This will include peer support and via technology, such as telemedicine.
 - If you have multiple health conditions, there will be a team supporting your physical, social and mental health needs. This will involve you, your family and carers, the NHS, social care and voluntary and community organisations.
 - If you need hospital care, it will usually mean going to your local hospital, which works closely with others to give you the best care possible
 - Local hospitals will be supported by centres of excellence for services such as cancer, stroke, and mental health.
 - All of this will be planned and paid for together, with councils and the NHS working together to remove the barriers created by planning and paying for services separately. For example community and hospital care working together.
 - Communities and staff will be involved in the development and design of plans so that everyone truly owns their health care services.

Principles for our partnership

- 2.2. The System Oversight and Assurance Group operates within an agreed set of guiding principles that shape everything we do through our Partnership:
- We will be ambitious for the people we serve and the staff we employ
 - The West Yorkshire and Harrogate partnership belongs to its citizens and to commissioners and providers, councils 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
 - We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on people's health and wellbeing.

DRAFT**Our shared values and behaviour**

- 2.3. Members of the System Oversight and Assurance Group commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:
- We are leaders of our organisation, our place and of West Yorkshire and Harrogate
 - We support each other and work collaboratively
 - We act with honesty and integrity, and trust each other to do the same
 - We challenge constructively when we need to
 - We assume good intentions.
 - We will implement our shared priorities and decisions, holding each other mutually accountable for delivery

3. Role and Responsibilities

- 3.1. The System Oversight and Assurance Group will provide oversight, and challenge to the delivery of the aims and priorities of the Partnership. In support of this, its responsibilities are to:
- i. lead the development of a dashboard of key performance, quality and transformation metrics for the Partnership;
 - ii. take an overview of performance and transformation at whole system, place and organisation levels in relation to Partnership objectives and wider national requirements;
 - iii. take an overview of programme delivery;
 - iv. receive reports from WY&H programmes and enabling workstreams on issues which require escalation;
 - v. develop and maintain connections with other key groups and organisations which have a role in performance development and improvement, including:
 - Care Quality Commission
 - Quality Surveillance Groups
 - Place-based transformation boards
 - A&E Delivery Boards
 - WY&H Directors of Finance Group
 - WY&H Clinical Forum;
 - vi. lead the development of a framework for peer review and support for the Partnership and oversee its application;

DRAFT

- vii. make recommendations to the System Leadership Executive, in consultation with WY&H programme boards, and national NHS bodies, on the deployment of improvement support across the Partnership, and on the need for more formal action and interventions. Actions will include the requirement for:
- agreement of improvement or recovery plans;
 - more detailed peer-review of specific plans;
 - commissioning expert external review;
 - the appointment of a turnaround Director / team;
 - agreement of restrictions on access to discretionary funding and financial incentives.

4. Membership

4.1. The membership of the System Oversight and Assurance Group will include representation from each sector of the partnership, ie providers, commissioners, Councils, national bodies, Healthwatch.

4.2. The membership will comprise:

- A Chair – the Partnership lead CEO
- Acute sector – chair of WYAAT
- Mental health sector – chair of Mental Health Services Collaborative
- CCGs – nominated lead accountable officer
- A representative of community / primary care providers
- Local authorities – lead CEO for health
- One representative of NHS England
- One representative of NHS Improvement
- One representative of Healthwatch

4.3. A deputy Chair will be agreed from among nominated members. A list of members is set out at **Annex 1**.

Deputies

4.4. If a member is unable to attend a meeting of the System Oversight and Assurance Group, s/he will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and sufficient understanding of the issues to be considered, to represent their organisation, place or group effectively.

DRAFT**Additional attendees**

4.5. Additional attendees will routinely include:

- The WY&H Partnership director
- The WY&H Partnership finance director.

4.6. At the discretion of the Chair, additional representatives may be requested to attend meetings from time to time to participate in discussions or report on particular issues. Such additional representatives may include:

- Senior Responsible Officers and programme leads for WY&H programmes
- Representatives of Partner organisations, who are not part of the core membership.
- Members of the WY&H Partnership core team and external advisers.

5. Quoracy and voting

5.1. The System Oversight and Assurance Group will not be a formal decision making body. The Group will operate on the basis of forming a consensus on issues considered, taking account of the views expressed by members. The Group will not take votes and will not require a quorum of members to be present to consider any business.

5.2. The Chair will seek to ensure that any lack of consensus is resolved amongst members.

5.3. Under exceptional circumstances any substantive difference of views among members will be reported to the System Leadership Executive Group.

6. Accountability and reporting

6.1. The Group does not have any powers or functions formally delegated by the Boards or governing bodies of its constituent organisations. However, NHS England and NHS Improvement will, where appropriate, enact certain regulatory and system oversight functions through the Group.

6.2. The Group has a key role within the wider governance and accountability arrangements for the WY&H partnership (see **Annex 2** for a description of these arrangements).

6.3. The System Oversight and Assurance Group will formally report, through the Chair, to the System Leadership Executive Group. It will make recommendations, where appropriate to the System Leadership Executive Group.

DRAFT

7. Conduct and Operation

- 7.1. The Group will normally meet monthly. An annual schedule of meetings will be published by the secretariat.
- 7.2. Extraordinary meetings may be called for a specific purpose at the discretion of the Chair. A minimum of seven working days notice will be given when calling an extraordinary meeting.
- 7.3. The agenda and supporting papers will be sent to members and attendees no less than five working days before the meeting. Urgent papers will be permitted in exceptional circumstances at the discretion of the Chair.
- 7.4. Draft minutes will be issued within 10 working days of each meeting.

Managing Conflicts of Interest

- 7.5. Each member must abide by all policies of the organisation it represents in relation to conflicts of interest.
- 7.6. Where any Group member has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that member may participate and/or vote in meetings (or parts of meetings) in which the relevant matter is discussed.
- 7.7. Where the Chair decides to exclude a member, the relevant organisation represented by that member may send a deputy to take the place of the conflicted member in relation to that matter.

Secretariat

- 7.8. The secretariat function for the System Oversight and Assurance Group will be provided by the WY&H Partnership core team. A member of the team will be responsible for arranging meetings, recording notes and actions from each meeting, preparing agendas, and agreeing these with the Chair.

8. Review

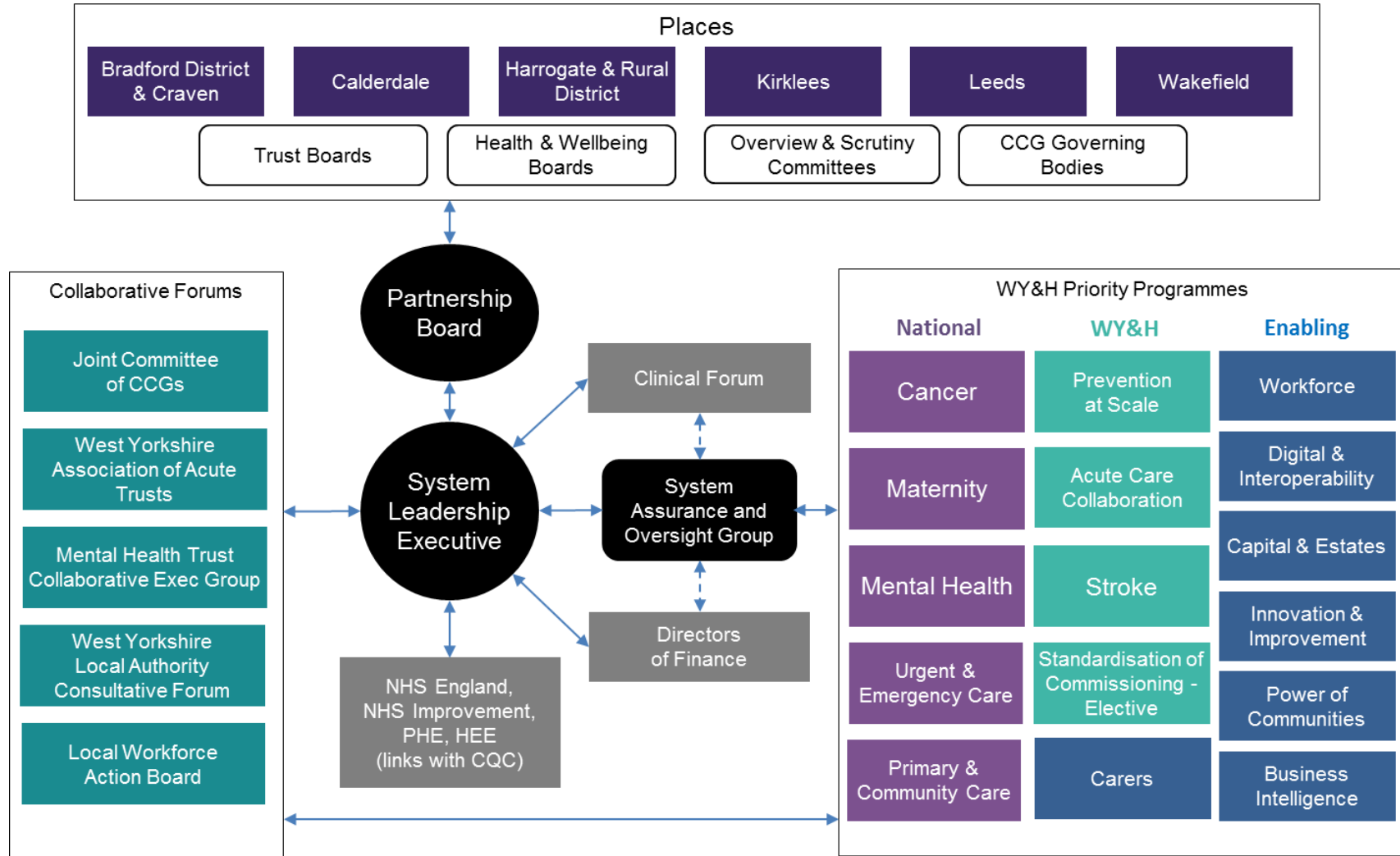
- 8.1. These terms of reference and the membership of the Group will be reviewed at least annually. Further reviews will be undertaken in response to any material developments or changes in the wider governance arrangements of the Partnership.

DRAFT

Annex 1 – Members

DRAFT

Annex 2 – Schematic of Governance and Accountability Arrangements





Clinical Forum Terms of Reference

April 2018

Annex 3.4 Clinical Forum ToR vFINAL 180430

Contents

1. Introduction and context	2
Purpose	2
2. How we work together in West Yorkshire and Harrogate.....	2
Our vision.....	2
Principles for our partnership	3
Our shared values and behaviour.....	3
3. Role and Responsibilities	4
4. Membership.....	5
Additional attendees	6
Deputies.....	6
5. Accountability and reporting	6
6. Conduct and Operation of the Clinical Forum	6
Secretariat.....	7
7. Frequency of meetings.....	7
8. Review.....	7
Annex 1 – Nominated members of the Clinical Forum	8
Annex 2 – Schematic of Governance and Accountability Arrangements.....	9



1. Introduction and context

1.1. West Yorkshire and Harrogate Health and Care Partnership was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs), in response to the *NHS Five Year Forward View*. It brings together all health and care organisations in our six places: Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield.

1.2. The partnership is not a new organisation, but a new way of working to meet the diverse needs of our citizens and communities. NHS services have come together with local authorities, charities and community groups to agree how we can improve people's health and improve the quality of their health and care services.

1.3. The Clinical Forum is a key element of leadership and governance arrangements for the West Yorkshire and Harrogate health and care partnership.

Purpose

1.4. The purpose of the Clinical Forum is to be the primary forum for clinical leadership, advice and challenge for the work of the partnership in meeting the Triple Aim: improving health and wellbeing; improving care and the quality of services; and ensuring that services are financially sustainable.

1.5. The Clinical Forum ensures that the voice of clinicians, from across the range of clinical professions and partner organisations, drives the development of new clinical models and proposals for the transformation of services. It also takes an overview of system performance on quality.

1.6. These Terms of Reference describe the scope, function and ways of working for the Clinical Forum. They should be read in conjunction with the Memorandum of Understanding for the West Yorkshire and Harrogate Health and Care Partnership [**forthcoming**], which describes the wider governance and accountability arrangements.

2. How we work together in West Yorkshire and Harrogate

Our vision

2.1. We have worked together to develop a shared vision for health and care services across West Yorkshire and Harrogate. All of our plans support the realisation of this vision:

- Places will be healthy - you will have the best start in life, so you can live and age well.
- If you have long term health conditions you will be supported to self-care through GPs and social care services working together. This will include peer support and via technology, such as telemedicine.
- If you have multiple health conditions, there will be a team supporting your

physical, social and mental health needs. This will involve you, your family and carers, the NHS, social care and voluntary and community organisations.

- If you need hospital care, it will usually mean going to your local hospital, which works closely with others to give you the best care possible
- Local hospitals will be supported by centres of excellence for services such as cancer, stroke, and mental health.
- All of this will be planned and paid for together, with councils and the NHS working together to remove the barriers created by planning and paying for services separately. For example community and hospital care working together.
- Communities and staff will be involved in the development and design of plans so that everyone truly owns their health care services.

Principles for our partnership

2.2. The Clinical Forum operates within an agreed a set of guiding principles that shape everything we do through our partnership:

- We will be ambitious for the people we serve and the staff we employ
- The West Yorkshire and Harrogate partnership belongs to its citizens and to commissioners and providers, councils 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
- We will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on people's health and wellbeing.

Our shared values and behaviour

2.3. Members of the Clinical Forum commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our place and of West Yorkshire and Harrogate
- We support each other and work collaboratively
- We act with honesty and integrity, and trust each other to do the same
- We challenge constructively when we need to
- We assume good intentions.

- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery

3. Role and Responsibilities

3.1. The Clinical Forum will provide clinical leadership, oversight, and challenge to the development and delivery of the aims and priorities of the partnership. In support of this, its responsibilities are to:

- i. lead the development of a clinical strategy and narrative for West Yorkshire and Harrogate
- ii. ensure that all plans within the West Yorkshire and Harrogate health and care partnership are clinically led, evidence based, and configured to improve patient outcomes;
- iii. ensure the voice of the patients, service users and citizens is heard and reflected in all plans;
- iv. maintain and embed clinical co-production as a core principle of the partnership;
- v. support collaboration and strengthen partnerships between clinical colleagues;
- vi. exhibit clinical leadership and galvanise professional colleagues and partner organisation to agree models of care which support delivery to close the three gaps (health, care and finance) in West Yorkshire and Harrogate
- vii. champion change and evidence-based innovation within their own organisations and Place, with peers, professional colleagues and networks;
- viii. support transition to new models of care, where appropriate.
- ix. make recommendations to the System Leadership Executive Group on proposals developed by priority workstreams and local place-based partnerships;
- x. provide oversight and alignment of all clinical initiatives across West Yorkshire and Harrogate;
- xi. support regular communication and engagement with all stakeholders;
- xii. support through review the evaluation and impact of all workstreams and plans
- xiii. provide innovative solutions to system-wide challenges, particularly where there are dependencies between workstreams (including enablers) and local plans;
- xiv. provide input and assurance to the clinical representation on each of the workstreams;

- xv. ensure a robust framework for quality impact assessment of change is established and implemented;
 - xvi. review system performance on the quality of health and care services and provide a mechanism for partner organisations to hold each other to account on quality, making appropriate links with the Quality Surveillance Forum.
- 3.2. Members of the group should ensure that all groups of clinicians within their organisations are engaged with the work of the Clinical Forum as appropriate.

4. Membership

- 4.1. The membership of the Clinical Forum will reflect the engagement of all Places and partner organisations.
- 4.2. Members will be senior clinicians (normally clinical commissioners, provider GPs, medical directors, directors of nursing, senior allied health professionals) nominated by the relevant organisation or partnership group.
- 4.3. The membership will comprise:
- A Chair
 - One clinical commissioner representative from each of the six places
 - One representative from each mental health and community trust
 - One representative from each acute Trust
 - One representative from Yorkshire Ambulance Service
 - One medical representative from NHS England and NHS Improvement
 - One Nursing and Quality Lead
 - One Allied Health Professional representative
 - One Community Pharmacist representative
 - Two representatives of primary care federations
 - One Director of Adult Social Services
 - One Director of Public Health
 - The Clinical Director for the West Yorkshire Association of Acute Trusts
 - One representative from Yorkshire Academic Health Science Network
- 4.4. A deputy Chair will be agreed from among nominated members.
- 4.5. A list of current members is set out at **Annex 1**. (Arrangements for future changes to the role of Chair and nominated members will be confirmed with the Forum).
- 4.6. Additional representatives may be requested to attend meetings of the Clinical Forum from time to time to participate in discussions or report on particular issues. Such additional representatives may include:

- clinical leads for each of the West Yorkshire and Harrogate priority programmes and enabling workstreams
- Local Medical Committee representatives.

Additional attendees

4.7. A representative of Healthwatch, members of the WY&H partnership core team, external advisers, and other individuals may be invited to attend for all or part of any meeting as and when appropriate, at the discretion of the Chair.

Deputies

4.8. If a member is unable to attend a meeting of the Clinical Forum, s/he will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and sufficient understanding of the issues to be considered, to represent their organisation, place or group effectively.

5. Accountability and reporting

5.1. The Clinical Forum will not be a formal decision making body. It does not have any powers or functions formally delegated by the Boards or governing bodies of its constituent organisations.

5.2. The Clinical Forum has a key role within the wider governance and accountability arrangements for the WY&H partnership (see **Annex 2** for a description of these arrangements).

5.3. The Clinical Forum will formally report, through the Chair, to the System Leadership Executive Group. The Chair will be a core member of this group.

5.4. The Forum will make recommendations, where appropriate to the System Leadership Executive Group.

6. Conduct and Operation of the Clinical Forum

6.1. The Forum will operate on the basis of forming a consensus on issues considered, taking account of the views expressed by members.

6.2. The Forum will not take votes and will not require a quorum of members to be present to consider any business.

6.3. The Chair will seek to ensure that any lack of consensus is resolved amongst members.

6.4. Under exceptional circumstances any substantive difference of views among members will be reported by the Chair to the System Leadership Executive Group.

Secretariat

6.5. The secretariat function for the Clinical Forum will be provided by the WY&H partnership core team. A member of the team will be responsible for arranging meetings, recording notes and actions from each meeting, preparing agendas, and agreeing these with the Chair.

6.6. The secretariat will collate papers and circulate them to members and attendees no less than five days before the meeting. Late papers will be permitted in exceptional circumstances at the discretion of the Chair.

7. Frequency of meetings

7.1. The Clinical Forum will usually meet each month. An annual schedule of meetings will be confirmed by the secretariat.

7.2. Additional or extraordinary meetings may be called for a specific purpose at the discretion of the Chair.

7.3. Members will normally be given a minimum of six weeks' notice of any meeting of the Forum.

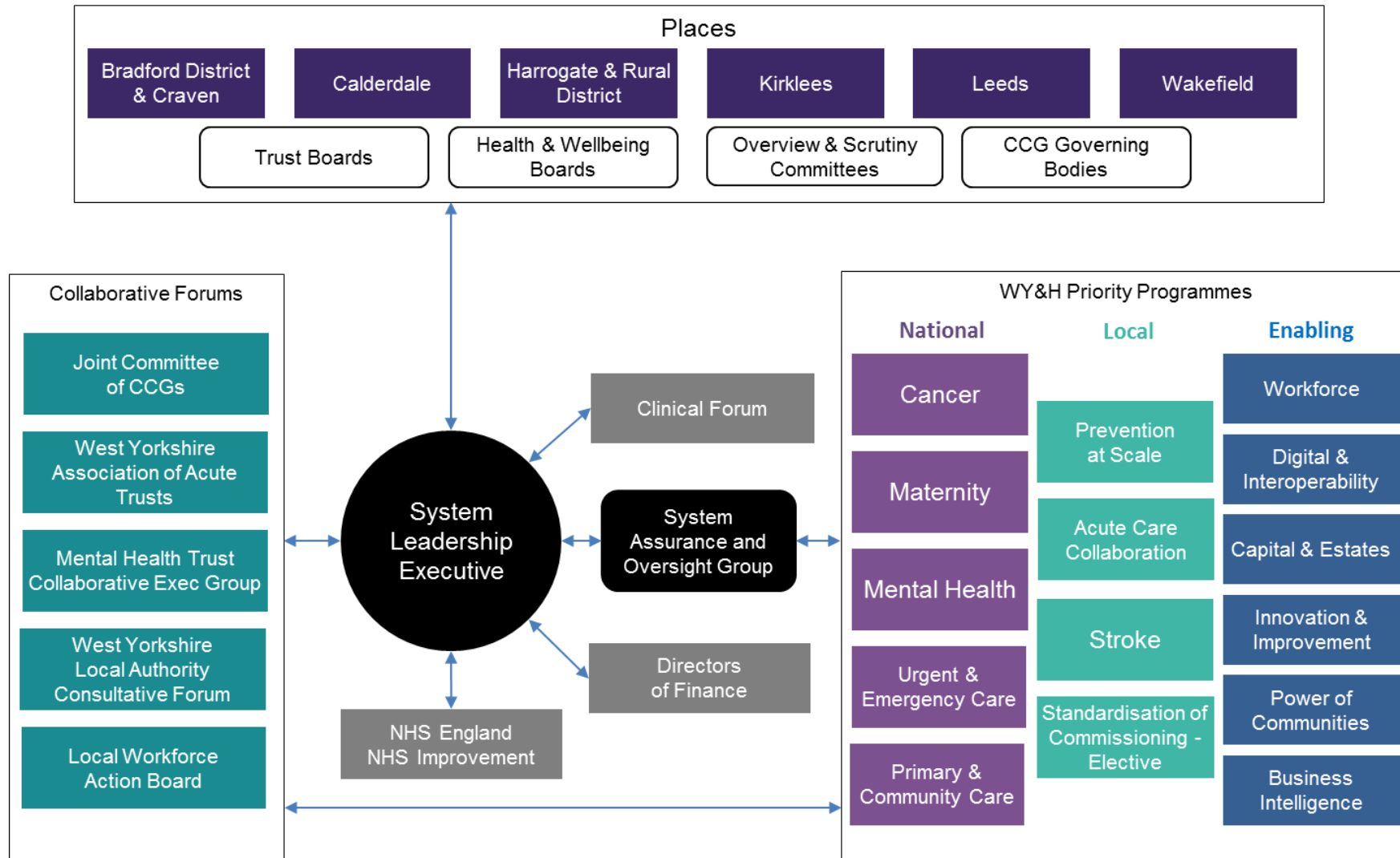
8. Review

8.1. These terms of reference and the membership of the Forum will be reviewed at least annually. Further reviews will be undertaken in response to any material developments or changes in the wider governance arrangements of the partnership.

Annex 1 – Nominated members of the Clinical Forum

	Nominee
Chair	Dr Andy Withers
CCGs / Places	
Bradford District and Craven	Dr James Thomas
Calderdale	Dr Steven Cleasby
Harrogate and Rural District	Dr Bruce Willoughby
Leeds	Dr Gordon Sinclair
North Kirklees and Greater Huddersfield	Dr David Kelly
Wakefield	Dr Phil Earnshaw
Acute Trusts	
Airedale NHS Foundation Trust	Jill Asbury
Bradford Teaching Hospitals NHS Foundation Trust	Dr Bryan Gill (Deputy Chair)
Calderdale and Huddersfield NHS Foundation Trust	Brendan Brown
Harrogate and District NHS Foundation Trust	David Scullion
The Leeds Teaching Hospitals NHS Foundation Trust	Dr Yvette Oade
The Mid Yorkshire Hospitals NHS Foundation Trust	David Melia
Mental Health and Community Providers	
Bradford District Care NHS Foundation Trust	Dr Andy McElligott
Leeds and York Partnership NHS Foundation Trust	TBC
South West Yorkshire Partnership NHS Foundation Trust	Tim Breedon
Leeds Community Healthcare NHS Trust	Marcia Perry
Others	
NHS England	Dr Yasmin Khan
Allied Health Professional	TBC
Community Pharmacist	Ruth Buchan
GP Providers x 2	TBC
Social Care	TBC
Public Health representative	Andrew O'Shaughnessy
WYAAT Clinical Lead	Robin Jeffrey
Yorkshire Ambulance Service	Julian Mark
Nursing & Quality Lead (and QSG link)	Jo Harding
AHSN	Mike Potts (interim)

Annex 2 – Schematic of Governance and Accountability Arrangements



Board Committee report to the Board of Directors

Committee Name:	Finance Committee
Committee Chair:	Mrs Maureen Taylor
Date of last meeting:	3 September 2018
Date of Board meeting for which this report is prepared	26 September 2018

Summary of live issues and matters to be raised at Board meeting:
<ol style="list-style-type: none"> 1. The Committee received an update on the latest financial position for 2018/19. Mr Coulter confirmed that the Trust achieved a surplus position in July improving the year to date deficit to £3,012k. This is within the external plan but significantly behind the plan set internally which was for a deficit of £152k. 2. There was an improvement to ward staffing spend in July, however it remains a significant area of overspend. Theatre staffing continues to overspend at a consistent rate and needs to be addressed, either through additional savings elsewhere or through actions within Theatres. 3. The nurse staffing review which will compare staffing levels with other Trusts and was planned for July will now take place in September. This review will be undertaken with NHS Improvement. 4. It has been assumed that Provider Sustainability Funding for Q1 for both financial performance and A&E performance will be received. Discussions have taken place about the A&E performance element and to date this has not been agreed and is therefore at risk. 5. Plans in place to deliver CIP, after risk adjustment, stand at 86%. A number of plans have been actioned, however, at the same time a number of schemes have been rationalised and the anticipated benefit is lower. Further work is needed to close this gap. 6. Although specific areas of capacity remain challenged, acute clinical income is generally at planned levels. The phasing of income throughout the year means an increase in activity and income is expected in the second part of the year. 7. Outturn forecasts were presented based on the best, medium and worse case positions and these range from achieving a £4m surplus to a £11m deficit. 8. An internal recovery plan process has been initiated around the following: <ol style="list-style-type: none"> a) Ward spending b) Theatre spend c) CIP d) Medical staffing e) Income under the Aligned Incentive Contract 9. In addition a review is being undertaken of discretionary spend, with a view to reducing costs and consideration is being given to any technical areas/adjustments that could benefit the Trust's financial position. 10. The cash position continues to be a concern. All Provider Sustainability Funding relating to 2017/18 has now been received. Following years of consistent

<p>performance, the Trust is falling further behind the performance expected by the Better Payment Practice Code.</p> <p>11. Mr Coulter gave a confidential update on progress with the Aligned Incentive Contract and in particular about discussions with HaRD CCG as to how measures can be taken to meet elective demand, waiting list size and winter pressures whilst keeping the contract within the £94m agreed.</p> <p>12. The Committee received an update on the Carbon Energy Fund Project after its first operational year. Savings are marginally ahead of expectations in year one due to early savings (during the construction period) which will not apply to later years. If these early savings are excluded there is a shortfall in savings expected of £113k. The contractor has found implementing the operational phase very challenging and have failed to hit some performance targets. These have not impacted on operations within the hospital but the Trust has been able to make deductions to the contract payment for non-achievement.</p> <p>13. The Committee was updated on the new arrangements and role for the Finance Committee together with the revised draft work-plan.</p>
<p>Are there any significant risks for noting by Board? (list if appropriate)</p> <ul style="list-style-type: none"> • The financial position remains £3m behind our internal plan and work on the recovery plan is needed to address this; • There is a risk that elective demand and winter pressures cannot be contained within the £94m agreed HaRD CCG contract. Measures need to be agreed to control activity to ensure the Trust can respond to winter demand; and • Focus on outstanding debts is needed to improve the Trust’s cash position. There is a risk to the Trust’s reputation if we continue to fall behind the Better Payment Practice Code.
<p>Matters for decision</p> <p>None.</p>
<p>Action Required by Board of Directors: The Board of Directors is asked to approve the updated Terms of Reference for Finance Committee.</p>

Terms of Reference

Resources Finance Committee

1. **Accountable to:** Board of Directors

2. **Purpose of the group**

The Finance-Resources Committee is a committee of the Board of Directors of Harrogate and District NHS Foundation Trust, with oversight of the development and delivery of the financial plan of the organization.

3. **Responsibilities**

The key responsibilities of the group are:

Scrutiny and Efficiency

- ~~To s~~Support the Board ~~in~~ by scrutinising the Trust's monthly financial performance position including and operational activity levels (excluding performance against operational standards) and the workforce plan.
- Scrutinise of financial performance against the annual Cost Improvement Programme and ~~review~~ the impact on the Trust
- ~~To s~~Scrutinise the Trust budget prior to approval by the Board.
- ~~To s~~Scrutinise and ensure appropriate due diligence is undertaken in relation to any significant transactions, as defined by NHS Improvement.
- ~~To carry out detailed reviews of financial risks within the Board Assurance Framework~~
- ~~To s~~Scrutinise and endorse assumptions in significant major business cases prior to consideration by the Trust Board

Financial Strategy

- ~~To s~~Scrutinise the development of the Trust's financial and commercial strategy, both revenue and capital.
- ~~To s~~Scrutinise the assumptions and methodology used in developing the financial strategy, including activity modelling and efficiency assumptions.
- ~~To e~~nsure that the annual financial plan is consistent with the financial strategy
- ~~To r~~Review the capital programme in line with the financial plan.
- To make recommendations to the Board of Directors on the Trust's the financial plan prior to submission to NHS Improvement.

Formatted: No bullets or numbering, Tab stops: 0", Left

Formatted: English (U.K.)

8.1

Financial Performance

- ~~To r~~Review the activity plans in line with the financial planning assumptions
- ~~To r~~Review the ~~quarterly-monthly~~ financial performance ~~submitted before submission~~ to ~~Monitor~~ NHS Improvement
- ~~To a~~Assess the impact of financial performance on the Use of Resources Financial Services-Risk Rating
- ~~To o~~Oversee ~~ing how initiatives highlighted by use of the Model Hospital benchmarking are being implemented within the Trust~~the implementation of benchmarking initiatives including service line reporting.
- ~~To r~~review service line information, profitability of service lines and the impact of activity delivery on financial performance.
- ~~To s~~Scrutinise proposals for significant projects prior to formulation of business case s and business plans.
- ~~To u~~Undertake any relevant matter as requested by the Board of Directors

Formatted: Highlight

4. Audit Committee

The Audit Committee will maintain full oversight of the Annual Accounts process and ~~also~~ Treasury Management policy, as well as areas such as Standing Financial Instructions (SFIs) which are part of the Trust's system of control.

5. Membership

The membership comprises:

- Non-Executive Director (~~Mrs Maureen Taylor~~) (Chair)
- ~~Non-Executive Director (Mr Ian Ward)~~
- Non-Executive Director (~~Mrs Lesley Webster~~)
- Director of Finance
- ~~Chief Operating Officer~~
- Director of Workforce and Organisational Development

Ad hoc attendance may be by invitation of the Chair.

The Non-Executive Director who serves as Chair of the Audit Committee will be standing observer to the Audit Committee.

A Trust Governor may be in attendance as an observer

The Deputy Director of Performance and Informatics, Deputy Director of Finance and Company Secretary will be in attendance at meetings of the ~~Finance~~Resources Committee.

6. Quorum

Quorum will be 3 members of the Committee, with at least 2 Non-Executive and 1 Executive Director at each meeting.

7. Administrative support

Administrative support to the ~~Finance~~Resources Committee will be provided by the Corporate Support team.

8. Frequency of meetings

The Committee will meet ~~6-12~~ times per year.

Additional meetings may be scheduled if necessary and agreed by the Chair of the Committee.

The Chair of the Resources Committee will submit a summary report to the next meeting in public of the Board of Directors and the approved Minutes of meetings will be submitted to the subsequent meeting in private.

Minutes will be reported to the Board of Directors, and copied to the Audit Committee.

9. Date terms of reference approved

These Terms of Reference will be approved by the Board of Directors and reviewed at least annually.

DRAFT ~~April-September~~ 2018

Formatted: Font: Not Bold

Formatted: Indent: Left: 0.5"

Formatted: Font: Not Bold

8.1

Terms of Reference

Resources Committee

1. Accountable to: Board of Directors

2. Purpose of the group

The Resources Committee is a committee of the Board of Directors of Harrogate and District NHS Foundation Trust, with oversight of the development and delivery of the financial plan of the organisation.

3. Responsibilities

The key responsibilities of the group are:

Scrutiny and Efficiency

- Support the Board by scrutinising the Trust's monthly financial position including operational activity levels (excluding performance against operational standards) and the workforce plan.
- Scrutinise financial performance against the annual Cost Improvement Programme and the impact on the Trust
- Scrutinise the Trust budget prior to approval by the Board.
- Scrutinise and ensure appropriate due diligence is undertaken in relation to any significant transactions, as defined by NHS Improvement.
- Scrutinise and endorse assumptions in significant business cases prior to consideration by the Trust Board

Financial Strategy

- Scrutinise the development of the Trust's financial and commercial strategy, both revenue and capital.
- Scrutinise the assumptions and methodology used in developing the financial strategy, including activity modelling and efficiency assumptions.
- Ensure that the annual financial plan is consistent with the financial strategy
- Review the capital programme in line with the financial plan.
- To make recommendations to the Board of Directors on the Trust's financial plan prior to submission to NHS Improvement.

Financial Performance

- Review the activity plans in line with the financial planning assumptions
- Review the monthly financial performance submitted to NHS Improvement
- Assess the impact of financial performance on the Use of Resources Risk Rating
- Oversee how initiatives highlighted by use of the Model Hospital benchmarking are being implemented within the Trust.
- Scrutinise proposals for significant projects prior to formulation of business cases and business plans.
- Undertake any relevant matter as requested by the Board of Directors

4. Audit Committee

The Audit Committee will maintain full oversight of the Annual Accounts process and Treasury Management policy, as well as areas such as Standing Financial Instructions (SFIs) which are part of the Trust's system of control.

5. Membership

The membership comprises:

- Non-Executive Director (Chair)
- Non-Executive Director
- Non-Executive Director
- Director of Finance
- Chief Operating Officer
- Director of Workforce and Organisational Development

Ad hoc attendance may be by invitation of the Chair.

The Non-Executive Director who serves as Chair of the Audit Committee will be a standing observer to the Audit Committee.

A Trust Governor may be in attendance as an observer. The Deputy Director of Performance and Informatics, Deputy Director of Finance and Company Secretary will be in attendance at meetings of the Resources Committee.

6. Quorum

Quorum will be three members of the Committee, with at least two Non-Executive and one Executive Director at each meeting.

7. Administrative support

Administrative support to the Resources Committee will be provided by the Corporate Support team.

8. Frequency of meetings

The Committee will meet 12 times per year.

Additional meetings may be scheduled if necessary and agreed by the Chair of the Committee.

The Chair of the Resources Committee will submit a summary report to the next meeting in public of the Board of Directors and the approved Minutes of meetings will be submitted to the subsequent meeting in private.

9. Date terms of reference approved

These Terms of Reference will be approved by the Board of Directors and reviewed at least annually.

DRAFT September 2018

Date of Meeting:	26 September 2018	Agenda item:	8.2
Report to:	Board of Directors		
Title:	Transformation and Improvement Strategy bi-annual report		
Sponsoring Director:	Joanne Harrison, Interim Director of Workforce and Organisational Development		
Author(s):	David Plews, Deputy Director of Improvement and Transformation		
Report Purpose:	Decision	Discussion/ Consultation	Assurance <input checked="" type="checkbox"/> Information
Executive Summary:	<ul style="list-style-type: none"> • New governance arrangements are in place for the delivery of the Improvement and Transformation agenda. Work to realise the transformation necessary to deliver the Aligned Incentive Contract (AIC) continues through the system-wide Planned and Unplanned Care Groups. Work has been prioritised to focus on projects that realise cost improvements that are transactable in the short-term. • Planned and responsive quality improvement activity is delivering measurable gains to support system-wide transformation efforts. Consultation on the next annual programme of work is now “live”. The Trust’s approach to quality improvement and clinical transformation continues to be supported and augmented by the work of our growing band of over 280 Quality of Care Champions. • Key highlights from the improvement programme are available to view on the accountability board directly outside the Board Room. 		
Related Trust Objectives			
To deliver high quality care	<input checked="" type="checkbox"/>	To work with partners to deliver integrated care:	<input checked="" type="checkbox"/> To ensure clinical and financial sustainability: <input checked="" type="checkbox"/>
Key implications			
Risk Assessment:	Improvement and Transformation work helps to mitigate risks on the corporate register, specifically: - risk to the delivery of annual plan: 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. - risk to quality care as a result of failing to meet locally agreed waiting standards and targets.		
Legal / regulatory:	None identified.		
Resource:	None identified.		
Impact Assessment:	Further work on quality and equality impact assessments is likely to be required for some transformation projects, many of which have already undergone an initial screening process.		

8.2



Conflicts of Interest:	None identified.
Reference documents:	<ul style="list-style-type: none"> - Rapid Process Improvement Workshops (RPIW) Update – Q1 2018/19 update for HaRD CCG. - Strategic Oversight and Management Board update from Delivery Groups, July 2018.
Assurance:	The SMT receive twice-yearly updates on improvement programme delivery and monthly updates on Finance. Strategic Oversight and Management Board (HDFT and CCG) meet monthly to oversee transformational work to support delivery of the AIC.
Action Required by the Board of Directors:	
It is recommended that the Board notes the items included within the report.	



Delivering Improvement and Transformation (April-September 2018)

Changing Context

In the last six months a new system-wide governance structure focused on the delivery of the business transformation needed to deliver the Aligned Incentive Contract has been put in place. This replaces the Clinical Transformation Board. Oversight in the new arrangements is by the Strategic Oversight and Management Board. Work proceeds through the Planned and Unplanned Care Delivery Groups; and overviews of the current status of the work are given here. The financial reporting for the transformation work that this report describes is covered separately in the Director of Finance's report.

A programme of improvement projects to support our transformation activity has been delivered according to a planned schedule. This has been augmented with responsive work to tackle emerging issues. In parallel with this our Quality of Care Champions are continuously working to deliver quality improvements in their own areas.

Together, this improvement and transformation activity supports the achievement of the Trust's strategic objectives:

- To deliver high quality health care
- To work with partners to deliver integrated care
- To ensure clinical and financial sustainability.

Status Update: Transforming Unplanned Care

The Transforming Unplanned Care Delivery Group manages the delivery of the programme described in appendix 1 (identity code: UC). The projects span across delivery themes relating to:

1. Cost management and repatriation
2. Demand management
3. Pathway improvements
4. Bed reductions
5. Medicines management
6. Mental health
7. Ripon Hospital
8. Out-of-hours GP services

Some of the projects in the programme are still in development due to their more recent inception in response to the Trust's financially challenging position. The table in appendix 1 describes the current state of the programme and shows that efforts are focused on delivering high priority projects that are more likely to be able to transact cost improvements during 2018/19.

Status Update: Transforming Planned Care

The Transforming Planned Care Delivery Group manages the delivery of the programme described in appendix 1 (see identity code: PC). The projects focus on increasing productivity and span across five main schemes:

1. Productive Theatres

2. Productive Outpatients
3. Productive Ophthalmology
4. Productive Wards
5. Productive Endoscopy

Review of Planned Improvement Work

To support these transformation schemes, a rolling programme of rapid quality improvement activity is in train. The report below shows highlights from the last six months.

Rapid Process Improvement Workshop (RPIW): Incidents: pathways and learning

This RPIW, which was co-sponsored by Jill Foster (Chief Nurse) and Dr David Scullion (Medical Director), was held during week of 20th November, 2017. Co-workshop leaders were Platinum Quality of Care Champion and Lead Allied Health Professional, Claire Arditto, and Improvement Facilitator and Gold Quality of Care Champion, Mark Fuller.

Since April 2018, there have further sponsor report-outs. Progress has included:

- Issue of the first quarterly #Chattermatters newsletters as one of various mechanisms introduced to keep staff informed of progress.
- Completion of “plan, do, study, act” cycles to test a simplified incident reporting form.
- Further reductions to open historical incidents, achieved by focusing on quick review and closure of low/no harm incidents.
- Agreement from Co-sponsors to fund initial implementation of changes to the incident reporting system which will be made on 26th and 27th September, 2018.
- Further development of standard operations for reporting high volume categories of incident.
- Planned test areas in acute and community services for implementation in October 2018.

Long-anticipated changes to the reporting system will be followed-up with the training of key colleagues to help embed the new, simplified approach.

RPIW: Theatres Scheduling

This RPIW was held in May 2017 to improve the productivity of our theatre schedule to ensure the efficient use of Trust resources. It was sponsored by Jonathan Coulter (Deputy Chief Executive) and led by David Plews (Deputy Director of Improvement and Transformation). Process Owners were Consultants, David Copas and Sarah Sherliker, and Operational Director, Jonny Hammond.

Regular reports-out to the Project Sponsor continue to take place. The focus of the work has now moved onto rolling out and then sustaining the new arrangements for pre-operative assessment. Over 60% of Consultant Surgeons’ patients are now pre-operatively assessed under the new approach. Further training, flow modelling and job role remodelling in the pre-operative assessment team is being developed in order to move towards the target of 100%.

A workshop has been held earlier this month to:

- fully understand demand and capacity
- understand the risks of and blocks to further roll-out
- explore development of skills matrices to better align the skills of workers to steps in the pathway.

RPIW: Podiatry

Platinum Quality of Care Champions Beth Barron (Private Patients Manager) and Robin Pitts (Clinical IT Manager) co-led the RPIW which was sponsored by Operational Director – Children’s and Countywide Community Care, Richard Chillery. General Manager Robin Hull was the Process Owner. The five day workshop was held during week of 5th February 2018.

60 and 90 day report-outs have since been held and have demonstrated, in the Sponsor’s words, “fantastic progress” with a number of actions delivered:

- Audits are now being regularly carried out to monitor achievement against the target of 95% of home visits being carried out by their due date – this currently stands at around 89.3%.
- 94.72% of high risk patients were seen by the due date and the majority that were late were only late by 1-2 days. This provides good assurance of a safe service.
- Where previously home visits were organised differently in each locality, all localities are now using a waiting list function on SystemOne, which has greatly improved governance and reduces the chance of patient follow-ups being missed.
- Timings and visit intervals have been standardised, to help manage capacity and demand, ensure equity of work load for staff and improve consistency. A home visits calculator has been created to calculate the amount of home visits that can be carried out in a day, helping to eliminate much of the unwarranted variation previously seen.
- A business case has been agreed in principle for additional mobile working devices, with the aim being to equip all Podiatry staff who undertake home visits with a mobile device.
- Following a successful trial, the protocol for referral reply letters has changed and tasks are now being sent to the referrer on SystemOne. All staff are to be briefed and trained so that this new process can be followed for all GPs on SystemOne. This will have a number of benefits, including more in-depth clinical information available to GPs and time savings for Podiatrists.

RPIW: Improve Earlier Diagnosis in Cancer – across multiple pathways

The RPIW, delivered week of 30th July, is sponsored by Mike Forster (Operational Director of Unplanned Care) and led by Mark Fuller (Improvement Facilitator) and Lorraine Cole (Service Improvement Facilitator). The Process Owner is Aditi Bandyopadhyay (Programme Manager & Developer - Early Diagnosis of Cancer Project). Strong progress, including the following, has been made so far:

- A vague symptoms clinical pathway has been developed in collaboration between secondary and primary care clinicians. Communication and roll-out follows over the next 90 days.
- Following an audit, plans are now in place to increase provision of patient information by 75% by December 2018. This will ensure that all patients who are on a two week referral pathway understand this.
- Plans to test the triage of two week wait patients (except breast and upper GI) are in place. Work with radiology to highlight patients in two week wait pathways is in progress.
- Plans to avoid delays to patients on two week wait pathways by the better management of activity due to take place on Bank Holidays are now being delivered by clinical directorates. This is likely to involve the provision of more “mini-MDTs” either side of the Bank Holiday. There will be a review in 50 days’ time.

- Work is ongoing to consider the further use of pooled appointments and surgeries with a view to reducing delays to the 62 day pathway.

Review of Reactive Improvement Work: highlights only

Quality Improvement Event: Community Therapy Services Redesign

In May a one day workshop was held to review current service provision led by Improvement Facilitator, Mark Fuller and Physiotherapist, Marguerite Wright. After identifying challenges and current good practice the team undertook some process mapping to identify some of the delays, barriers, wastes and inefficiencies within the current way of working. A number of themes and priorities were identified from the day and workstreams established, with each producing a project charter and action plan. Progress is to be regularly reviewed.

Quality Improvement Events:

1. Improving Flow in Community Children’s Services
2. Improving the Administration of Education, Health and Care Plans (EHCPs)

These linked one day workshops in early July have led to some really valuable progress:

A SystemOne EHCP module is in development. It will simplify the administrative pathway significantly for those using paper systems, saving administrators and clinicians valuable time and avoiding wasted effort. It will also facilitate more accurate and timely tracking of cases and remove reliance on the commissioner’s interpretation of our data. Training plans are in development to be rolled out following the building of the module. Work has been completed to separate out HDFT performance from the performance of other healthcare providers in respect of EHCPs across North Yorkshire so that commissioners and providers can see a picture which better facilitates accountability across different providers.

8.2

Parkinson’s Disease (PD) Medication Improvement Project

This project aims to ensure that 100% of patients with PD who are admitted to Harrogate District Hospital, receive their medication on time whilst in our care. Led by Consultant Neurologist, Dr Rosario Buccoliero and Dr Ip Scarrott, Consultant Geriatrician, the project is delivering action to improve from the most recently audited position, when over the previous twelve months 42.9% of medication was over one hour late.

Work is in progress to:

- Reduce delay between the time medication is prescribed for administration and actually given to the patient
- Improve the documentation regarding side-effects of PD medication
- Ensure more staff in all relevant clinical roles are engaged in continuing professional development in relation to PD
- Undertake “activities of daily living” assessments and screen for non-motor symptoms for all PD patients

Standardising Outpatient Flow

Work has started to better plan routine “plan, do, study, act” cycles in the delivery of improvement in Planned Care Outpatients services. This will be facilitated by the



development of a flow tool which identifies practical standard approaches to tackle different commonly seen barriers and challenges. The tool will help service managers to

- Reduce DNA rates
- Reduce long waits for new and/or follow-up appointments
- Manage variation in referral rates
- Reduce delays for staff and patients
- Speed the flow of information needed in the delivery of OP clinics.

Next Steps

Delivery of transformation schemes will continue through the Planned and Unplanned Delivery Groups in collaboration with Harrogate and Rural District CCG. Consultation is currently “live” on the development of a programme of rapid improvement activity to support the delivery of transformation schemes over the coming 12 months. To help enable this, plans are being made to train a new cohort of Platinum Quality of Care Champions in 2018/19. They will expand our existing band of over 280 Quality of Care Champions, all of whom are actively engaged in proposing, delivering, facilitating or advising on improvement activity. This will help to develop wider capability among existing staff to facilitate the delivery of rapid improvement activity. The syllabus and training materials are being revised and updated to reflect the latest research and best practice in the field of quality improvement in health care systems.

Recommendation

It is recommended that the Board notes the content of the report, commenting upon its scope and format as required.

APPENDIX 1

ID	Delivery themes	Name	Initial Priority	Risk of Non delivery in 18/19	Timescale	Impact	Progress
PC1	Cost management	Waiting list management	High	High	2018/19/20	Not yet known	Further analysis to understand impact on key specialties, RTT & 52 w/w
PC2	Cost management	Repatriation of appropriate specialities	High	High	2018/19/20	Not yet known	Initial work undertaken to be refreshed to look at full year 17/18 opportunity. Working with PWC to support the initial scoping.
PC3	Demand Management	Gynaecology: Direct Hysteroscopy	High	Low	November '18 TBC	c200 1 st OPA per year	HDT to understand changes to clinic templates. Agree new clinical pathway and implement
PC4	Demand Management	Gastro: Local consultant triage of referrals	High	Low	October '18	c260 OPA per year	eRS and booking process not yet agreed. Information required from NHS Digital and then agree new process
PC16	Demand Management	Urology: Local consultant triage	High	Medium	Not yet known	Not yet known	Agreement with Consultant team required
PC7	Demand Management	MSK Programme: First Contact Practitioner (FCP)	High	Medium	Not yet known	Not yet known	HDFT developing pilot proposal for 2 practices. Potential start date November
PC10	Demand Management	Dermatology: Non 2ww HCA photo capture clinic	Medium	High	Not yet known	Not yet known	Plan not yet agreed. Need to agree process and estimate activity saving
PC12	Demand Management	Pre-Assessment triage	Medium	Medium	In place. Potential to further develop.	Not yet known	Internal HDFT pathway improvement
PC5	Pathway	Fibroscan	High	Medium	Not yet known	Not yet Known	Internal HDFT business case in development

PC8	Pathway	MSK - spinal pathway	High	Medium	Q4 '18/19	Not yet known	Requires sign off from spinal consultant. Links with WY&H ICS programme. Could be implemented locally ahead of ICS.
UPC1	Bed reduction	Out of hospital beds - rehab / re-ablement & CHC transfer to assess	High	Low	In place	Reduced DTOC and Stranded Patients	In implementation and refinement stage
UPC2	Bed reduction	Integrated discharge hub	High	Low	November 2018	Earlier discharge and reduced LOS	Location identified
UPC3	Bed reduction	Ambulatory Care Unit	High	Low	November 2018	Reduced zero LOS. Reduced admissions (c3 patients per day)	BC being developed to allow it to be a joint surgical and medical ambulatory unit - reliant on capital
UPC4	Bed reduction	Enhanced Supported Discharge Service	High	Low	November 2018	15 beds of activity per day in the community	Case approved and recruitment commenced with plan to be in place by November 18.
UPC5	Bed reduction	Transport - reducing unnecessary admissions and prevents delayed discharges	High	Low	In place. Needs further resilience for winter.	5/6 patients per day	Ongoing discussions with YAS. CCG paying for additional transport outside of PTS contract. Still occasions when patients admitted / kept in hospital due to lack of on the day transport.
UPC17	Bed reduction	Use of paramedics to support home visits for GPOOH service	High	High	C3-6 months to pilot	Release GP time. Reduce costs for OOH. Costs not yet known	1st meeting held August '18. Use learning from HRW pilot. Will require full project plan, stakeholder engagement and business case.
UPC7	Demand Management	Reinstate (CATT) advice and guidance line	High	Medium	Partial implementation for Winter '18	Reduce admissions/ Outpatient referrals. Full impact not known	Linked to recruitment of 2nd acute medicine consultant to provide capacity for advice line for Medical Admissions. Not yet able to recruit to consultant post.



UPC8	Demand Management	Frailty assessment in ED / Ambulatory Care	Medium	Low	November '18	Reduce admissions. Full impact not known	Linked to development of SDS service and increased ambulatory care capacity.
UPC9	Demand Management	Cardiology: Triage and allocation	Medium	High	Not known	Not known	Requires move away from C&B to allow allocation of appointment to most appropriate individual / intervention.
UPC10	Demand Management	Cardiology: Referral pathways/guidance	Low	Low	3 months	Reduced outpatient referrals	Development of GP guidance for referral
UPC14	Medicines Management	Freestyle Libre	Low	Low	Start date TBC	Small saving from reduced use of consumables	Implementation agreed. Start date TBC
UPC20	Repatriation / Cost management	Ventilated patients - repatriate to Lascelles	Medium	High	Not known	Reduced tariff costs at LTHT. Savings not yet known	Business case to be developed to identify cost of repatriation of patients from Leeds.
UPC16	Mental Health	Mental health - CRISIS / AHMPs & inpatient admissions	Medium	High	Not known	Not yet identified.	Joint work between HDFT and TEWV to develop alternative pathways for mental health patients to avoid admission to hospital.
UPC6	Ripon	MIU Ripon - urgent treatment centre (links to GP extended hours)	Medium	High	Not known	Not yet identified.	Work stream under Integrated Urgent Care. Links with Primary Care Hub work.
UPC18	OOH	Reducing duplication between extended access & GPOOH	Medium	High	6 – 12 months	Savings not yet identified	Work stream under Integrated Urgent Care. Unlikely to impact in 18/19

Date of Meeting:	26 September 2018	Agenda item:	8.3
Report to:	Board of Directors		
Title:	Operational Plan 2019/20		
Sponsoring Director:	Jonathan Coulter, Deputy Chief Executive/Finance Director		
Author(s):	Angie Gillett, Deputy Director of Planning and Business Development		
Report Purpose:	Decision	Discussion/ Consultation	Assurance
			Information
			✓
Executive Summary:	<ul style="list-style-type: none"> The Board of Directors is required to approve the Operation Plan for 2019/20 later in the financial year; A WY&H planning session was held recently, but we are awaiting the specific timetable for submission; Work has been initiated in respect of demand, capacity, workforce, financial and capital planning; and The Board will continue to be involved in the development of the Operational Plan over the coming months. 		
Related Trust Objectives			
To deliver high quality care	✓	To work with partners to deliver integrated care:	✓
		To ensure clinical and financial sustainability:	✓
Key implications			
Risk Assessment:	Current risk on the CRR related to delivery of the operational plan		
Legal / regulatory:	It is an NHSI requirement for the Trust to submit an Operational Plan		
Resource:	Board and managerial input		
Impact Assessment:	Not Applicable		
Conflicts of Interest:	None identified		
Reference documents:	Specific guidance for 2019/20 awaited from NHSI		
Action Required by the Board of Directors:			
The Board is asked to note the report and associated input required.			

1 Introduction

1.1 The Board of Directors has the responsibility for signing off the final Operational Plan before submission to NHSI, The purpose of this paper is to set out the process to be followed and provide assurance to the Board in relation to the development of the Operational Plan for 2019/20.

1.2 Regular weekly meetings have been scheduled with the Corporate and Clinical Directorates to enable completion of the draft Operational Plan by the end of December 2018. However the Board should note that there may some flexibility in this date, as guidance has still to be received from NHSI regarding the date for submission.

2. Planning Environment and Guidance

2.1 A West Yorkshire and Harrogate Health and Care Partnership 2019/20 Planning Workshop was held in August with representatives from Business Planning, Finance and Information Services attending from across the patch. The workshop outlined the process for completion of the plan and indicated that detailed guidance would be issued in November 2018 following the budget. At this stage it is unclear as to whether the Trust will be required to complete a one year Operational Plan as in previous years, or a Plan covering a five to ten year period.

3. Current Position

3.1 Capacity Planning templates have been issued to the Clinical Directorates to populate for wider discussion in October, along with anticipated demand. In addition, work has also commenced to identify service priorities with the Clinical and Corporate Directorates and assess capital requirements and resource availability.

4. Timetable and Process

4.1 Based on the guidance issued last year, it is assumed that the Operational Plan will need to be completed by the end of December 2018.

4.2 Work has started internally to review the following:-

- Capacity Planning
- Anticipated demand from the CCG
- Review of services developments and capital requirements and resources availability
- Future workforce requirements
- Physical capacity requirements
- Quality Priorities
- Risks
- Development of an efficiency programme

4.3 The timescale is challenging but it is recognised that further work will be required following submission of the Operational Plan to provide further details in these areas.

You matter most

4.4 A detailed timetable of the key tasks to be taken forward over the planning period is at the end of this report at **Appendix A**.

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

5.1 A Governor Working Group has been established, with regular meetings scheduled to update Governors on the development of the Operational Plan.

5.2 Regular updates on process will be given to the Board of Directors and Finance Committee over the coming weeks, with a view to a more detailed discussion and review of the draft operational plan taking place at the Board of Directors workshop in December.

5.3 It should be noted that detailed budgets that reflect the Operational Plan will be prepared as usual for final approval at the Board of Directors in March 2019.

6. Conclusion

6.1 The Board of Directors is asked to:-

- Note the work that is ongoing with the development of the Operational Plan for 2019/20 and the associated timescales and
- Note the Board of Directors input into the process over the coming months

Appendix A - OPERATIONAL PLAN 2019/20 - TIMELINE:

Date	Actions/discussions
Sep 18	<ul style="list-style-type: none"> • Introduce the Annual Business Planning Process for 2019/20 • Introduce the capacity planning templates for completion • Report to Board of Directors • Initial meeting with Governors 26 September 2018
Oct 18	<ul style="list-style-type: none"> • Agree process for service and capital developments • Receipt and discussion of capacity plans • Agreement of large efficiency schemes • Activity demand plans to be estimated for discussion • Draft Efficiency Programme produced • Anticipated demand from CCG review with Clinical Directorates
Nov 18	<ul style="list-style-type: none"> • Confirm capacity plans • Confirm activity plans and impact in relation to demand • Identify potential service developments • Assess capital requirements and resource availability • Identify quality priorities • Develop workforce plans • Tariff and planning guidance to be issued • Report to Board of Directors to update progress • Finance Committee paper to review progress • Finalise Efficiency Programme
Dec 18	<ul style="list-style-type: none"> • QIA Completed with Directorate, Medical Directors and Chief Nurse • Sign off activity and capacity plans (ALL) • Sign off Workforce plan • Sign off Efficiency Programme delivery • Sign off capital and service priorities • SMT to agree draft Operational Plan • Finance Committee Review • Meeting with Governors • BoD Workshop discussion and review of draft Operation Plan
Jan 19	<ul style="list-style-type: none"> • Anticipate NHSI Financial templates to be issued • Update on Efficiency Programmes • Outline key messages included in the plan • Meeting with the Governors • Contract negotiations
Feb 19	<ul style="list-style-type: none"> • Budgets signed off and financial plans finalised • Sign off Directorate business plans • Sign off quality priorities • SMT review of progress • Finance Committee review • Report to Board of Directors to update progress • Meeting with the Governors
Mar 19	<ul style="list-style-type: none"> • Quality Committee review and confirmation of priorities • Board of Directors to sign off budgets for 2018/19 • Meeting with Governors

8.3



Date of Meeting:	26 September 2018	Agenda item:	9.0
Report to:	Board of Directors		
Title:	Medical Revalidation Annual Statement of Compliance		
Sponsoring Director:	Dr David Scullion, Medical Director		
Author(s):	Andrew Forsyth, Interim Company Secretary		
Report Purpose:	Decision	✓	Discussion/ Consultation
		✓	Assurance
		✓	Information
			✓
Executive Summary:	<ul style="list-style-type: none"> The Trust is required by NHS England to complete an annual Statement of Compliance with regulatory procedures. The Trust remains fully compliant with all the requirements of a Designated Body. 		
Related Trust Objectives			
To deliver high quality care	✓	To work with partners to deliver integrated care:	✓
		To ensure clinical and financial sustainability:	✓
Key implications			
Risk Assessment:	Failure to comply with the requirements of annual medical appraisal and revalidation would place the Trust at risk of medical staff losing their Licence to practise medicine in England and the Trust losing status as a Designated Body under the General Medical Council.		
Legal / regulatory:	A failure to employ a Responsible Officer, as required under the terms of the Medical Profession (Responsible Officers) Regulations 2011, would lead to loss of status as a Designated Body		
Resource:	The Trust employs a part-time Responsible Officer and administrative support for medial appraisal and revalidation		
Impact Assessment:	Not applicable		
Conflicts of Interest:	None identified.		
Reference documents:	Not applicable		
Assurance:	Not applicable		
Action Required by the Board of Directors:			
It is recommended that the Board: <ul style="list-style-type: none"> Notes items included within the report Authorises the Chairman and Chief Executive to sign-off the Statement 			

OFFICIAL



9

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex E - Statement of Compliance

OFFICIAL

Statement of Compliance

Version number: 2.0

First published: 4 April 2014

Updated: 22 June 2015

Prepared by: Gary Cooper, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Publications Gateway Reference: 03432

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

OFFICIAL

Designated Body Statement of Compliance

The board / executive management team – HARROGATE AND DISTRICT NHS FOUNDATION TRUST can confirm that

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

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

YES

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

YES

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

YES

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers¹ or equivalent);

YES

5. All licensed medical practitioners² either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

YES

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners¹ (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for doctors to include at their appraisal;

YES

7. There is a process established for responding to concerns about any licensed medical practitioners¹ fitness to practise;

YES

8. There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's

¹ <http://www.england.nhs.uk/revalidation/ro/app-syst>

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

OFFICIAL

responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works;³

YES

9. The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners⁴ have qualifications and experience appropriate to the work performed;

YES

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

YES

Signed on behalf of the designated body

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

Name: Angela Schofield

Signed:

Role: Chairman of the Board

Name: Dr Ros Tolcher

Signed:

Role: Chief Executive

Date: 26 September 2018

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

Date of Meeting:	26 September 2018	Agenda item:	9.0
Report to:	Board of Directors		
Title:	Non-Executive Director Responsibilities		
Sponsoring Director:	Angela Schofield, Chairman		
Author(s):	Angela Schofield, Chairman		
Report Purpose:	Decision ✓	Discussion/ Consultation	Assurance ✓ Information
Executive Summary:	<ul style="list-style-type: none"> To approve the appointment of the Senior Independent Director To note the revised membership of Board Committees 		
Related Trust Objectives			
To deliver high quality care	✓	To work with partners to deliver integrated care:	✓ To ensure clinical and financial sustainability: ✓
Key implications			
Risk Assessment:	Very low risk		
Legal / regulatory:	The Senior Independent Director is also the Non Executive Director with responsibility for whistleblowing.		
Resource:	None Identified.		
Impact Assessment:	Not applicable.		
Conflicts of Interest:	None identified.		
Reference documents:			
Assurance:	As required by the Trust's Constitution, the Council of Governors have been consulted on the appointment of the Senior Independent Director.		
Action Required by the Board of Directors:			
<ul style="list-style-type: none"> To approve the appointment of the Senior Independent Director and To note the revised membership of Board Committees. 			

9.1



1. Background

The resignation of Ian Ward, Non Executive Director, at the end of two terms of office at the end of September 2018 requires the appointment of a replacement Senior Independent Director (SID) and the review of the membership of Board committees. Two new Non Executive Directors have been appointed – Richard Stiff, from May 2018 and Sarah Armstrong, who will commence on 1 October 2018.

2. Senior Independent Director

The Board is requested to approve the appointment of Mrs Lesley Webster as SID from 1 October 2018. The Board have informally discussed the appointment and the Council of Governors gave their support at their meeting on 1 August 2018. As the SID, Mrs Webster takes on the role of Non Executive Director with responsibility for whistleblowing. Mrs Webster will cease to be the Chairman of the Quality Committee from 1 October 2018.

3. Board Committee Membership

The Non Executive Directors have reviewed membership of the Board's Committees as from 1 October; this will be as follows:

Audit Committee

Chris Thompson (Chairman)
Maureen Taylor
Richard Stiff
Lesley Webster

Quality Committee*

Laura Robson (Chairman)
Richard Stiff
Sarah Armstrong
Lesley Webster (until end of December at the latest)

Finance Committee*

Maureen Taylor (Chairman)
Lesley Webster
Angela Schofield
Chris Thompson – ex officio (Chairman of Audit Committee)

Remuneration and Nominations Committee

All Non Executive Directors

Charitable Funds Committee*

Angela Schofield
Laura Robson
Sarah Armstrong

*Designated Executive Directors are also members of these committees.

4. Vice Chairman

Chris Thompson will continue to be the Vice Chairman.

Council of Governors' Meeting

Minutes of the public Council of Governors' meeting held on 2 May 2018 at 17:45 hrs
at St. Aidan's Church of England High School, Oatlands Drive, Harrogate, HG2 8JR

Present:

- Mrs Angela Schofield, Chairman
- Ms Pamela Allen, Public Governor/Deputy Chair of Council of Governors
- Dr Pam Bagley, Stakeholder Governor
- Mrs Cath Clelland, Public Governor
- Mrs Angie Colvin, Corporate Affairs and Membership Manager
- Mr Jonathan Coulter, Finance Director/Deputy Chief Executive
- Mrs Liz Dean, Public Governor
- Miss Sue Eddleston, Public Governor
- Mrs Emma Edgar, Staff Governor
- Mrs Jill Foster, Chief Nurse
- Mr Rob Harrison, Chief Operating Officer
- Ms Carolyn Heaney, Stakeholder Governor
- Mrs Pat Jones, Public Governor
- Mrs Mikalie Lord, Staff Governor
- Mrs Rosemary Marsh, Public Governor
- Mr Andy Masters, Staff Governor
- Mr David Plews, Deputy Director of Improvement and Transformation
- Mrs Katherine Roberts, Company Secretary
- Mrs Laura Robson, Non-Executive Director
- Dr Daniel Scott, Staff Governor
- Dr David Scullion, Medical Director
- Mrs Maureen Taylor, Non-Executive Director
- Mr Chris Thompson, Non-Executive Director
- Dr Ros Tolcher, Chief Executive
- Mr Ian Ward, Non-Executive Director
- Mrs Lesley Webster, Non-Executive Director

In attendance:

- Eight members of the public
- Mr Richard Chillery, Operational Director, Children's and County Wide Community Care Directorate
- Ms Amanda Paley, Lancashire Teaching Hospital, Nye Bevan Programme

9.2

1. Welcome and apologies for absence

Mrs Schofield was delighted to see members of the public at the meeting and offered them a warm welcome. She hoped they would find the meeting interesting and informative and welcomed questions for Governors, or any member of the Board, in attendance. She asked that any questions for item 10.0 on the agenda to be submitted during the break.

She introduced Mr Plews who was attending on behalf of Mr Marshall and Ms Paley from Lancashire Teaching Hospital who was shadowing Mr Harrison as part of the Nye Bevan Programme.

Apologies were received from Mr Tony Doveston, Public Governor, Mrs Beth Finch, Stakeholder Governor, Dr Sheila Fisher, Public Governor, Cllr. Phil Ireland, Stakeholder Governor, County Councillor John Mann, Stakeholder Governor, Mr Phillip Marshall, Director of Workforce and Organisational Development, Mrs Zoe Metcalfe, Public Governor, Mr Steve Treece, Public Governor and, Dr Jim Woods, Stakeholder Governor.

2. Minutes of the last meeting, 3 February 2018

The minutes of the last meeting on 3 February were agreed as a true and accurate record subject to the following amendments requested by Mrs Clelland:

Page 8, 3rd paragraph would be amended to read –

Mrs Clelland expressed concerns regarding the timing of this matter; dealing with a pay increment for Mr Thompson before the new company had been set up and could demonstrate its benefits.

Page 9, penultimate paragraph would be amended to read –

Mrs Clelland made further comments regarding representation from a Trust Governor on the Harrogate Healthcare Facilities Management (HHFM) Board, workforce terms and conditions, and tax benefits.

It was noted that the creation of HHFM, and the transfer of assets and staff to the new company, would not be a significant or material transaction and did not therefore require approval by the Council of Governors. This had been confirmed following consideration of the Trust's Constitution, the Trust's legal advisers, and also by NHS Improvement.

3. Matters arising and review of action log

Item 1 – Mr Plews provided a further update on the Global Health Exchange Programme.

The Trust would soon be welcoming a further three nurses in May taking the programme workforce to a total of nine.

To date, the Trust had successfully supported four nurses to gain their Nursing and Midwifery Council (NMC) registration and was currently preparing two nurses for their objective structured clinical examination (OSCE), scheduled to take place in the coming weeks.

The programme continued to grow in strength and members of the theatres department had recently completed interviews via Skype, successfully appointing four theatre nurses. Conditional offers had been issued and members of the resourcing team were supporting the nurses to complete the required NMC processes before arriving in the UK later this year.

Following a recent visit by colleagues from Health Education England, during which members of the Trust were interviewed for a promotional video regarding the programme, the final edit was currently taking place before its official launch. The video would then be used to promote the programme and the Trust's involvement to NHS trusts throughout the UK and would be shown to nurses across the world to encourage them to consider the NHS as a place to work. A link to the video would be shared with Governors when it was available.

Finally, Mr Plews suggested that further updates would be provided to Governors by exception rather than at each meeting; this was agreed and the action would be marked as complete.

At this stage in the meeting, Mrs Schofield took a question from Mrs Dean, Public Governor:

'There have been news stories regarding visas and sponsorship licences being a problem for doctors. How is this affecting the Global Health Exchange Programme and the employment of other employees? Can you give assurance that staffing levels are being affected?'

Mr Plews confirmed the Trust was aware of these issues. The Trust had a Brexit communication plan drawn up however, clearly there were issues around immigration not related to Brexit. The Trust would continue to await formal announcements from the Government.

Dr Tolcher added that these issues were primarily impacting on medical staff however, NHS Employers had a strong voice and was lobbying to Government to put nurses on the exemption list.

Mrs Schofield thanked Mr Plews for his update.

There were no other matters arising.

ACTION:

- ***Share link to the Global Health Exchange Programme promotional video with Governors.***

4. Declaration of interests

Mrs Schofield relayed an additional declaration of interest from Mr Doveston to Paper 4.0 which had been circulated prior to the meeting. Mr Doveston had declared that he was now a Director of Oakdale Golf Club Limited with effect from Wednesday 14th March 2018.

It was noted Mr Coulter and Mr Thompson were directors of Harrogate Healthcare Facilities Management. No agenda items were planned which would present a conflict of interest. It was however agreed that Mr Coulter and Mr Thompson could participate fully in any items which included reference to Harrogate Healthcare Facilities Management.

5. Chairman's verbal update

Mrs Schofield paid tribute to Mr McLean who, having moved away from the area, had left the Trust at the end of April, for his enormous commitment as Non-Executive Director. New Non-Executive Director appointments were in progress including a replacement for Mr Ward who would be leaving the Trust at the end of September.

Council of Governors' Notice of Election would go live on 9 May and information sessions for people interested in the role of a Governor had been arranged for 9 and 14 May; further details were available in Ms Allen's report at item 6.2 on the agenda. A Stakeholder Governor from HHFM would also be progressed in line with the elections timetable however this was a separate process to the elections for public and staff Governors.

Mrs Schofield was delighted to welcome staff delivering the 0-19 Healthy Child Programme and other children's services in Stockton-on-Tees. Initial feedback received confirmed the staff were pleased to be part of the Trust.

Mrs Schofield thanked staff from the Infection, Prevention and Control team for their interesting and informative 'Medicine for Members' Event held at the beginning of April.

Moving on to the Trust's performance, which Dr Tolcher would be presenting in further detail later in the meeting, Mrs Schofield highlighted the excellent performance in 2017/18; one of the few Trusts in the country who had met all the required national targets. The Trust however, did not meet its financial control total and this would have an impact on the financial plan for 2018/19. The new Endoscopy Suite was due to open in late June and developments had commenced in the Emergency Department. Financial challenges remained and there continued to be risks associated with recruitment of medical, nursing and clinical staff.

Mrs Schofield stated she had been at the Trust now for six months and was extremely proud to be part of such an excellent organisation. She acknowledged the hard work and commitment of all the staff and thanked each and every one for their professional and enthusiastic approach.

Finally, Mrs Schofield highlighted one of the most enjoyable parts of her role; awarding staff with a 'Making a Difference Award' and 'Team of the Month' alongside

Dr Tolcher. Three such awards were given out the previous day demonstrating the incredible lengths staff go to in order to provide high quality care to patients and support for their colleagues.

There were no questions for Mrs Schofield.

6. Governor Sub-Committee Reports

Mrs Schofield moved on to clarify the role of the two formal sub committees and the Patient and Public Involvement, Learning from Patient Experience Group. She said how important it was for the general public to hear about the work of these sub-committees and thanked Governors for their commitment and involvement.

6.1 Volunteering and Education

The report from the Volunteering and Education Governor Working Group, chaired by Mrs Jones, had been circulated prior to the meeting and was taken as read.

Mrs Jones was delighted to confirm that the Trust had 608 active volunteers who gave so many hours to the hospital and services across the community. She also highlighted the work of the End of Life Support Volunteers; Governors had received a recent talk from one of the volunteers which was incredibly moving and she reiterated her thanks for their care and support.

There were no questions for Mrs Jones.

6.2 Membership Development and Communications

The report from the Membership Development and Communications Governor Working Group, chaired by Ms Allen, had been circulated prior to the meeting and was taken as read.

Ms Allen highlighted the forthcoming Council of Governors' Elections and promoted the information sessions being held for people interested in standing to be a Governor.

She also commented on the Annual Members' Meeting (AMM) scheduled to take place on 25 July.

Mrs Dean asked why there had been a change to the timing of the AMM which had been previously held in September; she commented that July was holiday season, the first week of school holidays, and felt this could impact on the number of attendees.

Mrs Schofield explained the AMM should be convened within a reasonable timescale after the end of the financial year but must not be before the Annual Report and Accounts had been laid before Parliament.

Ms Allen supported holding the AMM in July.

Dr Scott agreed with Mrs Dean's comments and asked the Chairman to avoid holding the AMM in school holidays.

Mrs Schofield asked for a general consensus from Governors and it was agreed to change the meeting back to September.

There were no questions for Ms Allen.

ACTION:

- ***Re-arrange AMM in September.***

6.3 Patient and Public Involvement – Learning from Patient Experience

The report from Miss Eddleston, on the last meeting of the Learning from Patient Experience Group, had been circulated prior to the meeting and was taken as read.

Miss Eddleston highlighted the successful recruitment event held on Saturday 3 February.

There were no questions for Miss Eddleston.

6.4 Annual Business Plan 2018/19-2019/20

Ms Allen summarised the Governor involvement in the annual Business Plan meetings led by Mrs Gillet, Deputy Director of Planning and Mr McKie, Deputy Director of Finance. The Group performs a key function on the Trust's annual business planning process; a requirement of the Health and Social Care Act 2012 that in preparing the Trust's forward plan, the Board of Directors must have regard to the views of the Council of Governors.

Recent meetings had been held on 19 February, 12 March and 30 April. Governors had received updates regarding the financial, operational performance and workforce elements of the draft plan. Governors were also briefed about other potential sources of income including information regarding plans to further develop the Trust's private patient income, although it was noted that this was below the level (i.e. 5% or more of the proportion of its total income in any financial year) at which the Governors would need to approve the plans. The Operational Plan 2018/19 was submitted to NHS Improvement on 30 April 2018.

There were no questions for Ms Allen and Mrs Schofield thanked Governors for attending the meetings.

7. Quality Priorities for 2018/19

The Quality Priorities report had been circulated prior to the meeting and was taken as read.

Mrs Foster outlined the purpose of the Quality Account, an integral part of the Annual Report and Account, which reflected both on the highest priorities of the Trust for the forthcoming year and reported on progress made in the past year.

Mrs Foster highlighted the importance of stakeholder engagement in producing the Quality Account and the priorities for improvement in 2018/19 would be:

- Ensuring effective learning from incidents, complaints and good practice.
- Reducing the morbidity and mortality related to sepsis.
- Improving the clinical model of care for acute services.
- Increasing patients and the public participation in the development of services.
- Promoting safer births, with a specific focus on reducing stillbirths.

Progress made on the first two priorities was being continued from last year and the fourth priority was an extension from last year, building on the excellent involvement with the Youth Forum.

There were no questions for Mrs Foster.

8. Presentation – Harrogate and District NHS Foundation Trust – the largest provider of Healthy Child Services in the Country

Mr Chillery provided an overview of the Trust's Healthy Child Services detailing existing and new contracts across North Yorkshire, Middlesbrough, Darlington, County Durham, Stockton-on-Tees, Gateshead and Sunderland.

He confirmed that a further 379 community based staff would be transferring to the Trust between April and July 2018 to deliver these new contracts to join the existing 1,432 community based workforce.

Mr Chillery outlined the latest commissioning guidance and acknowledged that staff were often working in deprived communities.

He referred to national outcomes; ensuring that every child had the best start in life, ready to learn at two, and ready for school at five. Research had shown that children undergo huge brain development as well as their social, emotional and cognitive development in the first two years of life and Health Visitors were focussed on collaborative working to deliver this vision.

Mr Chillery explained how the Trust was becoming a key partner in strategic discussions and influence across these areas to deliver the core public health offer for all children.

Finally, Mr Chillery summarised the aims of the 0-19 programme; a suite of services provided by the Trust, with examples including:

- Helping parents develop and sustain a strong bond with children.
- Supporting parents in keeping children healthy and safe and reaching their full potential.
- Protecting children from serious disease, through screening and immunisation.

- Reducing childhood obesity by promoting healthy eating and physical activity.

Mr Chillery confirmed that providing Healthy Child Services across such a wide geographical area was a significant challenge but an exciting development for the Trust and he acknowledged the Youth Forum for their creative and passionate involvement in developing 'Our Hopes for Healthcare'; making healthcare accessible to children and young people. ¹

Mrs Schofield opened up the floor for questions.

Mrs Marsh referred to the challenges and asked how community-based staff were made to feel part of the Trust.

Mr Chillery confirmed that he had received excellent feedback from staff and they were particularly delighted that the Chairman had paid them a visit. He expressed the importance of articulating the Trust as a community and acute provider of services.

Mrs Clelland asked if the Directorate's remit included mental health.

Mr Chillery confirmed that a tier 1 level of the 0-19 service offered some early intervention work, but more complex needs were signposted to the relevant services in the appropriate area.

Mrs Lennon, Chair of the Patient Voice Group (PVG) commented that the Group were currently working closely with the Children's and County Wide Community Care Directorate to listen to the voice of the child. They were going to Beamish in County Durham and visiting two local schools in North Yorkshire to talk to children, listen to what they thought about healthcare, and promote the 'Hopes for Healthcare' consultation.

There were no further questions for Mr Chillery.

Mrs Schofield thanked Mr Chillery for an informative and interesting presentation and commented that Governors would be keen to hear more about future developments. She confirmed the Board would be focussing on these services at a seminar in June.

Mr Chillery referred to the significant amount of key performance indicators associated with each service contract and how the data would provide the Board and the Council of Governors with further detailed information. He highlighted the positive relationship the Trust had with commissioners in each area and the Directorate was working hard to provide a high quality service.

Further details about children's services could be found on the Trust's website. ²

9. Chief Executive's Strategic and Operational Update, including Integrated Board Report (IBR) and Operational Plan 2018/19

Dr Tolcher presented the following headlines:

Operational Performance in 2017/18

Dr Tolcher highlighted that April marked the start of a new year; her timely presentation looked back over the previous 12 months and looked at plans for the coming year. She described the last 12 months as one to go down in history for the NHS as well as being exceptionally demanding for the Trust. More people than ever had been treated during this time and nationally it was becoming harder for the NHS to sustain high quality care and retain/recruit its workforce. She went on to thank all staff across the Trust and HHFM for their hard work over the last 12 months and thanked Governors and all volunteers for their continued support.

Taking a snapshot from the March 2018 Integrated Board Report (IBR), Dr Tolcher confirmed the good news that the Trust had achieved all of the key national standards for the full year 2017/18 however, it was becoming harder to meet the 4-hour A&E target and the 18 week referral to treatment standard. The slide in her presentation demonstrated how, in line with the rest of the country, the Trust was struggling to maintain these standards and the biggest area of concern was the non-elective demand, i.e. emergencies.

Referring to the Mr Chillery's presentation earlier, Dr Tolcher was delighted to highlight two areas from the IBR; children's services – 10-14 day new birth visit and 2.5 year review – both excellent performances from Children's Services.

Moving on to finance, Dr Tolcher highlighted that the Trust had reported a £1.1m surplus after receiving Sustainability and Transformation funding, which was £4.5m less than planned. While this was positive, bearing in mind not many Trusts had reported a surplus, it was important to understand that the underlying position was a loss of £2.4m which was very concerning. Dr Tolcher explained that the cash position remained a concern and there was a lot of work ongoing to carefully manage this position as this would have an impact on capital investment opportunities.

Dr Tolcher talked about other notable achievements for the Trust during the last 12 months including the 2017 NHS Staff Survey results; the scores of which remained in the upper quartile against similar organisations. She was pleased to report that, although there had been a significant increase in activity, there had been a 10% reduction in the number of complaints received. There had been a big reduction in C.Difficile cases; seven in 2017/18, of which a lapse in care contributed to the outcome in two. Other highlights included the opening of the new Sterile Services Suite, new contracts for Children's Services worth £16m, and the creation of HHFM. Three hundred and twenty colleagues had now transferred to HHFM including catering, porters and estates staff and their focus was to continue to deliver high quality services to the Trust.

Whilst there had been lots of positive achievements, Dr Tolcher did refer to the ongoing challenges for the future including the need to address was the adverse spending position and how acute hospital beds would be used. The Trust had relatively high rates of patients with longer lengths of stay (more than seven or 21 days), in particular patients aged over 85. Over the last 12 months, delayed transfers of care had been higher than the previous year despite a considerable effort in this area. The total number of falls had been similar to 2016/17 however, the number of falls causing harm had increased slightly to 21 cases; these were not all inpatient falls and included falls in the car park, so again this year this would be a key area of focus. Close monitoring of falls had shown a spike in one particular area in

November/December so targeted work, led by the Chief Nurse and the intervention of falls huddles, was starting to show improvements.

Dr Tolcher referred to the top scoring risks in April 2018 taken from the Board Assurance Framework and Trust Corporate Risk Registers. Both financial and operational risks were linked closely to the workforce and concerns remain around the ability to recruit medical, nursing and clinical staff. A new risk highlighted was the risk that critical infrastructure was not fit for purpose following a piece of work over the last 12 months to look at the future inpatient bed requirement based on historical trends, population growth, and workforce to meet such demands.

Planning for 2018/19

Dr Tolcher confirmed that the Board and the organisation's ambition would be to focus on:

- Having the right people.
- Delivering care in the right place.
- Enabling the right caseload.
- Right values and behaviours.

Dr Tolcher described the focus on the Trust continuing to be a great employer; "if we get it right for our people we get it right for our patients."

Summarising a number of plans, Dr Tolcher explained that in order to receive the additional incentive funding of £4m the Trust would need to 'balance the books' requiring a savings plan of £10.2m for 2018/19. Work was ongoing with the Trust's main commissioner, Harrogate and Rural District Clinical Commissioning Group (HaRD CCG), to deliver a new contract different to the previous payment by results system. It would also be a transitional year for adult community services in Harrogate following the end of the national vanguard; aimed to transform the way care is provided locally with GPs, community services, hospitals, mental health and social care staff working together to support people to remain independent, safe and well at home. There would also be the mobilisation of additional Children's Community services in Gateshead, Sunderland and Stockton.

Mrs Schofield thanked Dr Tolcher for her update and opened up questions from the floor.

Mr Crawley, member of the public, commented on Dr Tolcher's reference to future planning in relation to demographics and increased pressure on the Trust in achieving targets and bed capacity.

Mrs Edgar asked if Dr Tolcher would be able to explain the new contract arrangements at a future meeting; it was hoped this would be included in Dr Tolcher's presentation on 1 August.

Mrs Clelland confirmed that Dr Tolcher's presentation had addressed a question she had submitted on falls and she was pleased to hear that the falls huddles were improving the situation. She was still concerned however by the reported falls causing harm up by 34% and asked what measures were being taken to address what was causing such falls, including those in the hospital car park.

Mrs Clelland was also pleased to hear about positive engagement with staff however, she referred to the relatively high levels of sickness absence.

Dr Tolcher confirmed that sickness absences were monitored very closely and it was recognised that sickness throughout the NHS was higher than that in private business. She acknowledged the variety of reasons for staff being off sick and confirmed that the Trust continued to focus on a range of health and wellbeing measures to support staff to stay well and return to work. Overall the Trust performed relatively well regarding sickness absence compared to other organisations, but a spike in January 2018 was related to infectious diseases, respiratory illness and individual resilience. Dr Tolcher clarified that staff off work with diarrhoea and vomiting should not return to work until they were 48 hours clear of symptoms.

Mrs Foster thanked Mrs Clelland for her question about falls and was pleased to report that in the last four years there had been a 30% reduction in falls on a background of increasing capacity and a time when patients were at their most vulnerable. She did however state that the figure this year was disappointing and, following a root cause analysis, this showed that 13 out of 14 falls were unavoidable. There had been a number of initiatives introduced to promote a safe stay in hospital including a new information mat on the patient's bedside table. This including useful information such as visiting times, a uniform guide to who's who, and six simple steps to keep patients safe during their stay in hospital. Finally, Mrs Foster described how national falls reporting guidance had changed and fractured hips as a result of a fall, previously reported as moderate, would now be reported as severe. Mrs Foster wanted to bring this to the attention of Governors as this could appear to increase the number of severe falls.

Mrs Heaney commented on sustainability and transformation funding and the inability to invest. She asked Dr Tolcher to provide the implications of this.

Mr Coulter explained that last year the Trust had missed out on some of the sustainability and transformation funding to the tune of £2.5 - £3m. Some projects would be completing this year, including the upgrade in the Emergency Department, however there were other projects which required significant funds that the Trust could not commit to.

Dr Tolcher also added that tangible changes were occurring across the system in West Yorkshire and Harrogate including a range of clinical priority programmes such as stroke and vascular services. It was hoped that the transition to an Integrated Care System would take place in the next 12 months and a public announcement would be expected soon. She confirmed that huge progress was being made however, this was not particularly visible as yet at a patient level or with all staff. Another review in 12 months would enable the public to see how much has been achieved.

A member of the public asked for clarity on the services provided in the Endoscopy Suite. Mr Harrison confirmed that currently the Trust had two procedure rooms undertaking different types of scopes seven days per week. These rooms were fully utilised and, as national screening across the country continued to grow, the Trust developed a business case two years ago to extend these services. The new suite

would include five procedure rooms in total; three of which would be used upon opening the new suite and further rooms would be used in line with demand. The Endoscopy Suite would also be supported by the new Sterile Services Suite built last year which now provides much better space and environment and the ability to clean and process the scopes.

There were no further questions for Dr Tolcher.

ACTION:

- ***Include the new contract arrangements with HaRD CCG at the next public Council of Governors' meeting on 1 August.***

10. Question and Answer session for members of the public and Governors

Mrs Schofield moved to the tabled questions submitted prior to the meeting and during the break.

Mrs Jones, Public Governor, had submitted the following question:

“Harrogate and District NHS Foundation Trust work with many young people in the Youth Forum and also with the apprenticeships, might it be a good idea to co-op a young person on to our Council of Governors' so that they could attend our meetings as it would be interesting to hear their views and have their input?”

Mrs Colvin confirmed that the excellent work of the Youth Forum was reported through the Governor Working Group, Membership Development and Communication; a sub-committee of the Council of Governors. The Youth Forum received an invitation to each public Council of Governors' meeting. She also clarified that any member of the Trust could nominate themselves to stand as a Governor in an election with a vacant seat where they reside. Elections were widely promoted to all members from the age of 16 and the general public across a variety of communication forums. The Trust currently had over 600 members aged between 16-21.

Dr Tolcher thanked Mrs Jones for her question and would welcome the Youth Forum having seats at the public Council of Governors' meeting. There was also going to be a review of the Constitution and this could be considered at the same time.

Mrs Clelland, Public Governor, had submitted the following questions:

“At the Governor meeting in August 2017, I think, we had a presentation describing a new initiative aimed at getting teams of staff communicating and working together better to reduce such as “falls resulting in harm”. We were led to believe this would improve our performance and most importantly patient outcomes.

Our performance on falls has not improved but would seem to have worsened what conclusion should governors reach?”

Mrs Clelland felt that her question on the subject of falls had been suitably answered within the presentations and discussion already held in the meeting.

“Complaints – how many complaints relate to the café in reception area and what is the theme in those complaints?”

Mr Harrison confirmed that the Trust had received comments about the café, but no formal complaints. Unfortunately, there had been some staffing issues which had meant the café had closed at 3pm instead of 4pm over the period of time in question. A decision had been made not to leave agency staff running the café on their own without the support from HHFM staff who were responsible for the running of the café.

Mr Harrison was pleased to report that, following a discussion with the Managing Director of HHFM, recruitment for more staff was in progress and they were working on extending the café opening hours. Mr Harrison also clarified that due to the financial situation, this had impacted on the proposed upgrade to the café however, this was now for the HHFM Board to take forward as part of their contract to manage this service.

Mrs Clelland commented that she had observed the café being closed longer rather than closing early.

Mrs Schofield thanked Mr Harrison for his update and was pleased that work was in progress to improve such an important resource used by many people, both visitors and staff.

Mr Kenneth Crawley, member of the public, had submitted a lengthy detailed question regarding problems relating to transition from hospital to other care arrangements.

Mrs Schofield summarised Mr Crawley's question and highlighted key points. Mr Crawley confirmed he would be happy to await a written response outside of the meeting.

There were no further questions.

ACTION:

- ***Consider Youth Forum involvement at public Council of Governors' meetings and within Constitutional review.***
- ***Written response to be sent to Mr Crawley.***

11. Update on the Quality Committee

Mrs Webster provided a detailed update on the purpose and responsibilities of the Quality Committee; a committee accountable to the Board of Directors to oversee arrangements for quality governance, seek assurances on the delivery of high quality care, and regulatory compliance.

Supported by the Chief Nurse, Deputy Director of Governance and Company Secretary, Mrs Webster described how the work of the Quality Committee evolved each year. A Governor attended each meeting on a rota basis. The agenda was structured with six key headings including current concerns, quality reports, patient safety, patient experience, effective care and outcomes, and regulatory compliance and governance.

At each meeting the committee would review hot spots to identify current concerns. This would allow members to look at specific areas in more details and discuss issues which may affect quality such as the financial recovery plan.

The committee would also look at the integrated board report quality areas in fine detail, review progress of the Trust's quality priorities set out in the Quality Account and receive a wealth of external reports including clinical effectiveness and audit.

Mrs Webster encouraged people to read the Quality Account and acknowledged the tremendous effort by all staff towards the quality initiatives detailed in the report.

Finally, Mrs Webster confirmed the committee had recently undertaken an effectiveness survey which had highlighted a number of areas for improvement going forward and each member of the committee was aiming to become a bronze level Quality of Care Champion.

There were no questions for Mrs Webster.

Mrs Schofield thanked Mrs Webster for chairing the Quality Committee and everyone who attended such a busy and effective committee.

12. Any other relevant business not included on the agenda

There were no further items of business.

13. Member Evaluation

Mrs Schofield sought views about the meeting.

The general consensus was that the new layout was preferred however, not ideal for acoustics and a review of the public seating was required.

Mrs Edgar commented on the responsibility of Governors to hold Non-Executive Directors to account and requested increased involvement from Non-Executive Directors throughout the meeting. She also highlighted that Governors could use the Informal Governors' meeting forum to decide on questions and themes to raise with Non-Executive Directors at future public Council of Governors' meetings.

Mr Ward acknowledged Mrs Edgar's point and agreed that it would improve the experience of the meeting for Non-Executive Directors if they could be involved more by commenting or taking questions.

On reflection, Mrs Dean stated that questions for Non-Executive Directors often came out of discussion so she would prefer to hear from Non-Executive Directors first.

Mrs Clelland also added that Non-Executive Directors provide a brief for Governors in response to concerns or challenges via the Governor and Non-Executive Director meetings.

Mrs Webster felt it would be useful for Non-Executive Directors to add comment where appropriate to Executive Director's updates throughout the meeting.

Mrs Schofield thanked everyone for their comments and asked everyone to think of ways in which we all contribute to the discussion.

In response to a comment made by a member of the public about the earlier question regarding the café in the hospital reception area, Mrs Schofield confirmed that there would be a Stakeholder Governor to represent HHFM however, it was appropriate for Mr Harrison to respond as Executive Lead with responsibility for managing the contract with HHFM.

There were no further comments.

ACTION:

- ***Review public seating layout at future meetings.***
- ***Review structure of Council of Governors meeting re NED involvement.***

14. Close of meeting

Mrs Schofield closed the meeting. She thanked everyone for attending and confirmed the next meeting would take place on Wednesday, 1 August at 5.45 – 8.00pm

1. <https://www.hdfn.nhs.uk/about/council-of-governors/youth-forum/hopes-for-healthcare/>
2. <https://www.hdfn.nhs.uk/services/childrens-services/>

Board Committee report to the Board of Directors

Committee Name:	Audit Committee
Committee Chair:	Chris Thompson
Date of last meeting:	Thursday 6 th September 2018
Date of Board meeting for which this report is prepared	Wednesday 26 th September 2018

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

1. The Audit Committee undertook its regular programme of work and review during the course of the meeting. This has included reviews of the minutes of Corporate Risk Review Group and the Quality Committee.
2. The most recent version of the Corporate Risk Register was reviewed, with the Committee noting the most recent set of changes that had been made to the Register, confirming that the detailed analysis was consistent with the information most recently provided to the Trust Board of Directors. There was some discussion around the way in which registers are considered at Directorate level, which is generally very well done, although it was noted that there are some issues at specialty / department level which are currently being addressed. The Committee also reviewed the most recent version of the Business Assurance Framework and can confirm that it does not believe that there are any exceptional changes required to the risk scores in the Board Assurance Framework.
3. The Committee confirms that there are no matters relating to regulatory compliance to be brought to the attention of the Board
4. The Periodic Internal Audit Report considered at the meeting contained details of 4 audits that had been finalised during the period under review. Of these audits, one was an advisory audit that benchmarked the approach to Risk Registers adopted across a range of trusts. Of the 3 audits finalised, all reported a Significant Assurance opinion which was welcomed by the Committee. There was early notification in respect of 4 audit reports that have been issued in draft – of these, 3 are currently recording a Limited Assurance opinion. One of these is in respect of Post Project Evaluations. The Committee reviews the minutes of the PPE Group and has regularly noted a lack of diligence in the preparation and submission of PPE's – it is hoped that, under the direction of the SMT, a keener focus is brought to bear on this very important area of control.
5. It was agreed that in view of the 6 monthly reports being presented to the Board in respect of the Speaking Up Policy, it was no longer appropriate for a

formal presentation to be made to the Committee in future, although the Committee will continue to provide oversight of the process and identify any relevant matters arising of concern at its next meeting following the relevant Board meeting.

6. The Committee considered and noted / approved the following reports / documents:
 - a. Treasury Management Policy & Annual Report on Treasury Activity
 - b. Annual Procurement Savings Report
 - c. Internal Audit Charter
 - d. Internal and External Audit Working Together Protocol
 - e. External Audit Technical Update

7. This was the last meeting to be attended by Ian Ward and Laura Robson, and they were both thanked for their valuable contributions to the work of the Committee. It was noted that following Ian Ward's departure from the Board, there will be a requirement for an alternative NED to attend the Security Forum, if this is still considered to be appropriate.

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

There were no new risks identified and discussed by the Committee which are to be brought to the attention of the Board.

Matters for decision

In accordance with the Constitution of the Trust, at its meeting on 2nd November 2016, the Governors recommend the appointment of KPMG as External Auditors for the Trust for a three year term of office commencing 1st December 2016, with an option to extend for a further two years, subject to satisfactory service and performance to be reviewed on an annual basis. The Committee undertakes a full assessment of the performance of the external auditors on an annual basis. The Committee considered the performance of KPMG over the previous year at its meeting on 3rd May and concluded that there were no issues of concern with the performance. On this basis the Committee recommends that the Board reappoints KPMG as the Trust's External Auditors for the 2018/19 financial year.

Action Required by Board of Directors:

The Board is asked to note the considerations that took place at the meeting of the Audit Committee on the 6th September, and also the recommendation made by the Committee in respect of the re-appointment of the external auditors.

**HARROGATE AND DISTRICT NHS FOUNDATION TRUST
GLOSSARY OF ABBREVIATIONS**

A

A&E	<i>Accident and Emergency</i>
AfC / A4C	<i>Agenda for Change</i>
AHPs	<i>Allied Health Professionals</i>
AIC	<i>Aligned Incentive Contract</i>
AMM	<i>Annual Members' Meeting</i>
AMU	<i>Acute Medical Unit</i>
AQP	<i>Any Qualified Provider</i>

B

BAF	<i>Board Assurance Framework</i>
BME	<i>Black and Minority Ethnic</i>
BoD	<i>Board of Directors</i>

C

CATT	<i>Clinical Assessment, Triage and Treatment Ward</i>
C.Diff	<i>Clostridium difficile</i>
CCCC	<i>Children's and County Wide Community Care Directorate</i>
CCG	<i>Clinical Commissioning Group</i>
CCTs	<i>Community Care Teams</i>
CCU	<i>Coronary Care Unit</i>
CE / CEO	<i>Chief Executive Officer</i>
CEA	<i>Clinical Excellence Awards</i>
CEPOD	<i>Confidential Enquiry into Perioperative Death</i>
CIP	<i>Cost Improvement Plan</i>
CLAS	<i>Children Looked After and Safeguarding Reviews</i>
CNST	<i>Clinical Negligence Scheme for Trusts</i>
CoG	<i>Council of Governors</i>
COO	<i>Chief Operating Officer</i>
CORM	<i>Complaints and Risk Management</i>
CQC	<i>Care Quality Commission</i>
CQUIN	<i>Commissioning for Quality and Innovation</i>
CRR	<i>Corporate Risk Register</i>
CSW	<i>Care Support Worker</i>
CT	<i>Computerised Tomography</i>
CT DR	<i>Core trainee doctor</i>

D

Datix	<i>National Software Programme for Risk Management</i>
DBS	<i>Disclosure and Barring Service</i>

You matter most

DNA	<i>Did not attend</i>
DoH	<i>Department of Health</i>
DoLS	<i>Deprivation of Liberty Safeguards</i>
Dr Foster	<i>Provides health information and NHS performance data to the public</i>
DSU	<i>Day Surgery Unit</i>
DToC	<i>Delayed Transfer of Care</i>

E

E&D	<i>Equality and Diversity</i>
eNEWS	<i>National Early Warning Score</i>
ENT	<i>Ear, Nose and Throat</i>
EoLC	<i>End of Life Care</i>
ERCP	<i>Endoscopic Retrograde Cholangiopancreatography</i>
ESR	<i>Electronic Staff Record</i>
EU	<i>European Union</i>
EWTD	<i>European Working Time Directive</i>

F

FAQ	<i>Frequently Asked Questions</i>
FFT	<i>Friends and Family Test</i>
FC	<i>Finance Committee</i>
FNP	<i>Family Nurse Partnership</i>
FOI	<i>Freedom of Information</i>
FT	<i>NHS Foundation Trusts</i>
FTSU	<i>Freedom to Speak Up</i>
FY DR	<i>Foundation Year doctor</i>

G

GIRFT	<i>Get it Right First Time</i>
GPOOH	<i>GP Out of Hours</i>
GWG MD&C	<i>Governor Working Group – Membership Development and Communications</i>
GWG V&E	<i>Governor Working Group – Volunteering and Education</i>

H

H@N	<i>Hospital at Night</i>
HaRD CCG	<i>Harrogate and Rural District Clinical Commissioning Group</i>
HaRCVS	<i>Harrogate and Ripon Centres for Voluntary Service</i>
HBC	<i>Harrogate Borough Council</i>
HCP	<i>Health and Care Partnership</i>
HDFT	<i>Harrogate and District NHS Foundation Trust</i>
HDU	<i>High Dependency Unit</i>
HED	<i>Hospital Episodic Data</i>
HEE	<i>Health Education England</i>
HFMA	<i>Healthcare Financial Management Association</i>
HHFM	<i>Harrogate Healthcare Facilities Management Ltd</i>
HR	<i>Human Resources</i>
HSIB	<i>Healthcare Safety Investigation Branch</i>
HSE	<i>Health & Safety Executive</i>

You matter most

HSMR	<i>Hospital Standardised Mortality Ratios</i>
I	
ICU or ITU	<i>Intensive Care Unit or Intensive Therapy Unit</i>
IG	<i>Information Governance</i>
IBR	<i>Integrated Board Report</i>
IT or IM&T	<i>Information Technology or Information Management & Technology</i>
K	
KPI	<i>Key Performance Indicator</i>
KSF	<i>Knowledge & Skills Framework</i>
L	
L&D	<i>Learning & Development</i>
LAS DR	<i>Locally acquired for service doctor</i>
LAT DR	<i>Locally acquired for training doctor</i>
LCFS	<i>Local Counter Fraud Specialist</i>
LEPs	<i>Local Education Providers</i>
LMC	<i>Local Medical Council</i>
LNC	<i>Local Negotiating Committee</i>
LoS	<i>Length of Stay</i>
LPEG	<i>Learning from Patient Experience Group</i>
LSCB	<i>Local Safeguarding Children Board</i>
LTUC	<i>Long Term and Unscheduled Care Directorate</i>
LWAB	<i>Local Workforce Action Board</i>
M	
MAC	<i>Medical Advisory Committee</i>
MAPPA	<i>Multi-agency Public Protection Arrangements</i>
MARAC	<i>Multi Agency Risk Assessment Conference</i>
MASH	<i>Multi Agency Safeguarding Hub</i>
MDT	<i>Multi-Disciplinary Team</i>
Mortality rate	<i>The ratio of total deaths to total population in relation to area and time.</i>
MOU	<i>Memorandum of Understanding</i>
MRI	<i>Magnetic Resonance Imaging</i>
MRSA	<i>Methicillin Resistant Staphylococcus Aureus</i>
MTI	<i>Medical Training Initiative</i>
N	
NCEPOD	<i>NCEPOD (National Confidential Enquiry into Perioperative Death)</i>
NED	<i>Non-Executive Director</i>
NHSE	<i>National Health Service England</i>
NHSI	<i>NHS Improvement</i>
NHSR	<i>National Health Service Resolution</i>
NICE	<i>National Institute for Health & Clinical Excellence</i>
NMC	<i>Nursing and Midwifery Council</i>
NPSA	<i>National Patient Safety Agency</i>
NRLS	<i>The National Reporting and Learning System</i>

NVQ *National Vocational Qualification*
NYCC *North Yorkshire County Council*

O

OD *Organisational Development*
ODG *Operational Delivery Group*
ODP *Operating Department Practitioner*
OPEL *Operational Pressures Escalation Levels*
OSCE *The Objective Structured Clinical Examination*

P

PACS *Picture Archiving and Communications System – the digital storage of x-rays*
PbR *Payment by Results*
PEAT *Patient Environment Action Team*
PET *Patient Experience Team*
PET SCAN *Position emission tomography scanning system*
PHSO *Parliamentary and Health Service Ombudsman*
PMO *Project Management Office*
PPU *Private Patient Unit*
PROM *Patient Recorded Outcomes Measures*
PSC *Planned and Surgical Care Directorate*
PST *Patient Safety Thermometer*
PSV *Patient Safety Visits*
PVG *Patient Voice Group*

Q

QC *Quality Committee*
QIA *Quality Impact Assessment*
QIPP *The Quality, Innovation, Productivity and Prevention Programme*
QPR *Quarterly Performance Review*

R

RCA *Route Cause Analysis*
RN *Registered Nurse*
RTT *Referral to Treatment. The current RTT Target is 18 weeks.*

S

SALT *Speech and Language Therapy*
SAS DR *Speciality and Associate specialist doctors*
SCBU *Special Care Baby Unit*
SHMI *Summary Hospital Mortality Indicator*
SHU *Sheffield Hallam University*
SI *Serious Incident*
SID *Senior Independent Director*
SIRI *Serious Incidents Requiring Investigation*
SLA *Service Level Agreement*
SMR *Standardised Mortality rate – see Mortality Rate*

SMT	<i>Senior Management Team</i>
SPF	<i>Social Partnership Forum</i>
SpR	<i>Specialist Registrar – medical staff grade below consultant</i>
ST DR	<i>Specialist trainee doctors</i>
STEIS	<i>Strategic Executive Information System</i>
STP	<i>Sustainability and Transformation Plan/Partnerships</i>
 T	
TARN	<i>Trauma Audit Research Network</i>
TOR	<i>Terms of Reference</i>
TU	<i>Trade Union</i>
TUPE	<i>Transfer of Undertakings (Protection of Employment) Regulations 2006</i>
 V	
VC	<i>Vice Chairman</i>
VSM	<i>Vey Senior Manager</i>
VTE	<i>Venous Thromboembolism</i>
 W	
WTE	<i>Whole Time Equivalent</i>
WY&H HCP	<i>West Yorkshire and Harrogate Health Care Partnership</i>
WYAAT	<i>West Yorkshire Association of Acute Trusts</i>
 Y	
YTD	<i>Year to Date</i>

Further information can be found at:

NHS Providers – Jargon Buster –

<http://nhsproviders.org/programmes/governwell/information-and-guidance/jargon-buster/>

June 2018