Harrogate and District NHS Foundation Trust

The meeting of the Board of Directors held in public will take place on Wednesday 30 January 2019 Boardroom, Harrogate District Hospital, HG2 7SX

AGENDA			
Item No.	**Item**	**Lead**	**Paper No.**
	9.00am – 9.20am		
Patient Story – Mr David Duffy, Consultant Orthopaedic Surgeon in attendance			
	9.20am – 10.30am		
1.0	**Welcome and Apologies for Absence** *To receive any apologies for absence:*	Mrs A Schofield, Chairman	-
2.0	**Declarations of Interest and Register of Interests** *To declare any interests relevant to the agenda and to receive any changes to the Register of Interests*	Mrs A Schofield, Chairman	2.0
3.0	**Minutes of the Board of Directors meeting held on 28 November 2018** *To review and approve the Minutes of the meeting*	Mrs A Schofield, Chairman	3.0
4.0	**Review Action Log and Matters Arising** *To provide updates on progress of actions*	Mrs A Schofield, Chairman	4.0
Overview by the Chairman		Mrs A Schofield, Chairman	-
5.0	**Report by the Chief Executive including Integrated Board Report and Finance Report**	Dr R Tolcher, Chief Executive	5.0
	To deliver high quality health care		
6.0	6.1 Infection Prevention and Control quarterly report	Mrs Jill Foster, Chief Nurse	6.1
	6.2 Patient and Public Participation Strategy *To receive, consider and approve the Strategy*	Mrs J Foster, Chief Nurse	6.2
	6.3 Guardian of Safe Working Hours report *To receive and consider the report*	Dr C Hall, Deputy Medical Director	6.3
	6.4 Learning from Deaths annual report *To receive and consider the report*	Mrs Jill Foster, Chief Nurse/Dr C Hall, Deputy Medical Director	6.4
	6.5 Hopes for Healthcare *To receive and comment on the Standards*	Dr Natalie Lyth, Clinical Director Children's and Countywide Community Care	6.5

You matter most

	6.6 EDS2 – Annual Self- Assessment *To receive and approve the report* 6.7 NHSI Nurse Staffing report *To receive and consider the report and response* 6.8 Consideration of IBR metrics relating to quality	Mrs Jill Foster, Chief Nurse Mrs Jill Foster, Chief Nurse	6.6 6.7 6.8
	To work with partners to deliver integrated care		
7.0	7.0 WYAAT Report 7.1 Consideration of IBR metrics relating to integrated care	Dr R Tolcher, Chief Executive Mr R Harrison, Chief Operating Officer	
10.30am – 10.40am			
Break			
10.40am – 12.30pm			
	To ensure clinical and financial sustainability		
8.0	8.0 Summary from Resources Committee meetings of 7 and 28 January 2019 (written and oral) 8.1 Operational Planning update 8.2 Clinical Workforce Strategy biannual review *To consider and note the report* 8.3 Consideration of IBR and other metrics related to workforce and other HR matters 8.4 Consideration of IBR and other metrics related to financial performance and contracts	Mrs M Taylor, Chairman of Resources Committee Mr J Coulter, Director of Finance Ms A Wilkinson, Director of Workforce and Organisational Development Ms A Wilkinson, Director of Workforce and Organisational Development Mr J Coulter, Director of Finance	8.0 8.2 8.3 8.4
	Governance		
9.0	9.0 Summary from Audit Committee meetings of 5 December 2018 and 28 January 2019 (written and oral) 9.1 Terms of Reference – Audit Committee *For approval* **[to follow after Audit Committee meeting 28 January]** 9.2 Minutes of the Council of Governors' Meeting on 1 August 2018 *For information*	Mr C Thompson, Chairman of the Audit Committee Mr C Thompson, Chairman of the Audit Committee Mrs A Schofield, Chairman	9.0 9.1 9.2
10.0	**Any other relevant business** *By permission of the Chairman*	Mrs A Schofield, Chairman	-
	Board Evaluation	Mrs A Schofield, Chairman	-
Confidential Motion – the Chairman to move: *Members of the public and representatives of the press to be excluded from the remainder of the meeting due to the confidential nature of business to be transacted, publicly on which would be prejudicial to the public interest.*			

Harrogate and District NHS Foundation Trust

BOARD OF DIRECTORS – REGISTERED DECLARED INTERESTS

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 January 2019.

Name	Position	Interests Declared
Mr Andrew Alldred	Clinical Director LTUC	None
Ms Sarah Armstrong	Non-Executive Director	Company director for the flat management company, set up to manage the property where I live Chief Executive for the Ewing Foundation
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
Ms Laura Robson	Non-Executive Director	None
Mrs Angela Schofield	Chairman	1. Volunteer with Supporting Older People (charity). 2. Chair of NHS Northern Region Talent Board
Dr David Scullion	Medical Director	1. Member of the Yorkshire Radiology Group 2. Familial linkage with Freedom to Speak Up Guardian
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
Mrs Maureen Taylor	Non-Executive Director	None

Mr Christopher Thompson	Non-Executive Director	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	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
Mrs Lesley Webster	Non-Executive Director	None
Ms Angela Wilkinson	Director of Workforce and Organisational Development	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
Mrs Joanne Harrison	Deputy Director of Workforce and Organisational Development	None
Mr Jordan McKie	Deputy Director of Finance	1. Familial relationship with NMU Ltd, a company providing services to the NHS
Mrs Alison Mayfield	Deputy Chief Nurse	None
Mr Paul Nicholas	Deputy Director of Performance and Informatics	None

NHS
Harrogate and District
NHS Foundation Trust

Report Status: Open

BOARD OF DIRECTORS MEETING

Minutes of the Board of Directors' meeting held in public on Wednesday 28 November 2018 at 9.00am in the Boardroom at Harrogate District Hospital

Present:
Ms Sarah Armstrong, Non-Executive Director
Mr Jonathan Coulter, Deputy Chief Executive/Finance Director
Mrs Jill Foster, Chief Nurse
Mr Robert Harrison, Chief Operating Officer
Ms Laura Robson, Non-Executive Director
Mrs Angela Schofield, Chairman
Dr David Scullion, Medical Director
Mr Richard Stiff, Non-Executive 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
Ms Angela Wilkinson, Director of Workforce and Organisational Development

In attendance:
Mr Andrew Alldred, Clinical Director for Long Term and Unscheduled Care
Mr Andrew Forsyth, Interim Company Secretary
Mrs Melanie Jackson (Patient Experience Team – patient story only)
Dr Kat Johnson, Clinical Director, Planned and Surgical Care
Dr Natalie Lyth, Clinical Director for Children's and County Wide Community Services
Mrs P (patient story only)

Patient Story

Mrs Schofield welcomed Mrs P and Mrs Jackson to the meeting.

Mrs P said that she had come to share her experience because it was important that two members of staff were recognised for going the extra mile in her treatment.

Mrs P had crushed her hand whilst on a canal holiday in France. Following treatment there she was referred to the fracture clinic at HDFT. This was on a Monday and she received an appointment for Thursday in the same week. She was seen by a consultant Trauma and Orthopaedic surgeon who reassured her that the wound was healing well but also recognised the emotional implications of her injury. She was very grateful to him for his care and understanding of the impact of her accident and her need to know that she would regain use of her hand. He was referred her to the hand physiotherapy team

Mrs P said that as she arrived at the Therapies Reception the hand physiotherapist was just finishing her shift. However, Mrs P said that she was seen immediately and prescribed

exercises, which at first she found difficult to do. There followed seven appointments over three months, at each of which she was encouraged and guided and supported to regain her confidence. The physiotherapist was always on time for appointments and friendly throughout, helping Mrs P to overcome the psychological effects of the accident. She described the consultant and the physiotherapist as positive, professional people to whom she was very grateful.

Thanking Mrs P for coming to tell her story, Mrs Schofield said that it had been uplifting; not all of the patient stories shared with the Board were as positive. The learning from it was that there was often an emotional aspect to physical injury and that other aspects were important to recognise. She would write to the consultant and the physiotherapist to acknowledge the impact of their care.

Mrs P and Mrs Jackson left the meeting.

Mr Harrison noted that the consultant concerned had taken the initiative in developing the specialist physiotherapy support from which Mrs P had benefitted. Dr Tolcher said that whilst Mrs P's experience had been special for her it should be nothing different from what happened for every patient.

ACTION: Mrs Schofield to write to the consultant and physiotherapist

1.0

1.1 Mrs Schofield noted there were no apologies for absence.

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

1.3 Mrs Schofield welcomed Mr Robert Cowans (Public Governor) to the meeting. She also warmly welcomed Ms Sarah Armstrong as a new Non-Executive Director, and Ms Angela Wilkinson as the new Director of Workforce and Organisational Development.

2.0 Declarations of Interest and Board Register of Interests

2.1 Dr Scullion asked that his familial connection with the Freedom to Speak Up Guardian should be formally added to the Declarations of Interest. 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), which had now adopted the trading name of Harrogate Integrated Facilities (HIF). 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 HIF.

3.0 Minutes of the meetings of the Board of Directors on 25 July 2018

The draft minutes of the meeting held on 26 September 2018 were approved with the following amendments:

- Minute 9.3 line 1: delete '*liely*' insert '*likely*'
- Minute 13.6 line 2: delete '*as clinically urgent*' insert '*in priority order*'

- Minute 14.2 line 2: delete '*confiormed'* insert '*confirmed'*
- Minute 22.0 para 4 line 7: delete '*eve'* insert '*even'*

APPROVED:
The Board of Directors approved the minutes of the meeting held on 26 September 2018 as an accurate record of proceedings, subject to four amendments.

4.0 Review of Action Log and Matters Arising

4.1 Completed actions were noted.

4.2 Action 114: Mr Coulter reported that initial planning guidance had been issued; it was expected that more detail would be available on 15 December and the Board would discuss it at the December workshop on 19 December.

4.3 Mrs Schofield asked about progress with the NHSI Nursing Review. Mrs Foster confirmed that an initial report had been received but that it was factually inaccurate in some places and NHSI had agreed to review it. She would bring a paper to the January Board but there were no immediate actions arising from the initial report.

4.4 There were no other matters arising.

ACTION: Mrs Foster to bring report on NHSI Nursing Review to January Board meeting.

APPROVED:
The Board of Directors noted completed actions.

Overview by the Chairman

Mrs Schofield noted a number of items:

- Four members of the Council of Governors (Mrs Dean, Mr Masters, Ms Metcalfe and Dr Scott) would complete their terms of office on 31 December and they had been dined out and thanked on 26 November. Elections were underway and the results would be declared on 10 December. A new Staff Governor, Ms Helen Stewart, had been elected unopposed and Mrs Schofield welcomed her as a great addition to the Council.
- The process for recruiting a new Chief Executive was underway and candidates would be shortlisted at a meeting later that day. The assessment process included a presentation, focus groups and an interview on 12 and 13 December, in which many members of the Board, and the wider staff and stakeholders, would be involved.
- Mrs Schofield reflected on the Board workshop which had been held in Scarborough in October. There had been valuable sessions on risk appetite and the development of the Strategic Plan by the working group established to take this forward. Mr Stiff said that two meetings of the working group had taken place to date and the Plan was starting to take shape. There were plans to engage the Board, Council of Governors, staff and external organisations, and there would an update at the December Board workshop. Dr Tolcher commented that the engagement would also address diversity by reaching out positively to BAME groups.
- The workshop had also reviewed and agreed the Freedom to Speak Up self-assessment. It reflected both targets and ambitions for the Trust.

- Moving to the visits which had taken place after the workshop, there was agreement that these had been informative and well-organised. Dr Scullion said that he had visited podiatry which he described as really impressive, with positive staff despite a difficult working environment. He had also been impressed with the Speech and Language Therapy team. Mrs Webster echoed this, saying that it was a small team with a huge number of contacts in difficult circumstances; they were delivering important services. Mr Harrison noted the valuable involvement with the Youth Justice system. Mr Coulter had visited Whitby hospital and had been impressed with the team work of the podiatry team, despite recruiting challenges: a new recruit was very enthusiastic about her work. Dr Tolcher had asked about 'the next big thing' in orthotics and was told about 3-D photocopying which was already being deployed in the independent sector. She had asked the Directorate to explore the potential benefits to the Trust. Co-location with North Yorkshire County Council (NYCC) staff was very helpful. Mrs Schofield had visited community dentistry and been impressed with the Looked After Children team; Mrs Foster said that there were at least 900 Looked After Children across North Yorkshire. Mr Thompson described the staff he met on his visit as grounded around their challenges; this was echoed by Ms Armstrong who said they always found a way and showed great spirit. Mr Harrison reminded the Board that podiatry and dental services were provided as far west as Settle, which demonstrated what a huge area the Trust services covered. Mrs Schofield said that the visits were proving to be valuable and would continue to be organised on the days of Board workshops.
- Mrs Schofield noted that the Trust was in the midst of the CQC inspection. The Use of Resources and Unannounced Visits had been completed and the Well-Led Review was scheduled for 4 – 6 December and would involve all Board members and Governors, as well as many members of staff. Feedback to date had been good.

5.0 Report by the Chief Executive (excluding finance matters)

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

5.2 Dr Tolcher said that she wanted to add to her report that, as part of the CQC inspection, she, Dr Wood and Mrs Leng had made a presentation on Governance to the CQC team in Leeds on 23 November.

5.3 Moving to performance, Dr Tolcher said that this had improved with Emergency Department performance above 95% across September and October bringing the year to date performance to 94.8%, just short of the 95% target for payment of the Provider Sustainability Funding (PSF). All cancer targets had been met but RTT remained around 91%, and was forecast to remain below the 92% standard in Q4. Conversations were continuing with the Harrogate and Rural District CCG (HaRD CCG) around the implications for waiting lists.

5.4 Financially the position remained extremely challenging. Variance was approximately £4m adverse and cash remained a concern. Best, worst and most likely scenarios had been modelled based on current risks. The most likely forecast based on current trajectories fell short of the control total placing PSF at risk. Mr Coulter would cover the position in more detail later in the meeting.

5.5 Dr Tolcher moved on to discuss the Community Services full Business Case which was due to be released imminently. This had been considered in detail at the System Leadership Executive Group. It involved a new way of delivering adult community services

over time and one of the milestones was for Board sign-off in December. She recommended that the Board discuss it at the workshop on 19 December and, assuming that the Board was content, she and Mrs Schofield should be delegated to approve it on behalf of the Board. A full report would then be available at the January Board meeting. Mr Harrison said that detail of the Business Case could be available at the workshop; it was about the direction of travel and reshaping the service, rather than a financial case and required approval before the end of the calendar year. Mrs Schofield said that the Resources Committee would receive it at the meeting on 7 January.

5.6 Mrs Webster asked what had held up the Business Case, to which Mr Harrison responded by confirming it was the sheer volume of work involved, including working with the CCG and NYCC, and the variation of services to be included. There were no significant issues to overcome.

5.7 Mrs Schofield sought and received approval to delegate the approval of the Business Case to herself and Dr Tolcher on completion of the Board workshop on 19 December.

5.8 Dr Tolcher drew attention to the report of the North Yorkshire Director of Public Health and his three priorities. She reminded the Board that the Trust had previously revised the description of its values and strategic objectives to reflect its Public Health responsibilities and she considered that the Trust should reaffirm its commitment to improving public health as laid out in this most recent report. This aligned also with work to address staff wellbeing, addressed within the Director of Workforce and Organisational Development report which the Board would consider later in the meeting. It should also be reflected in the Strategic Plan which was in development. Mr Harrison said that he had attended the Health and Wellbeing Board on 19 November and believed that such a reaffirmation would be well-received. Dr Tolcher said that the Trust was a good partner and strongly believed in the 'Every Contact Counts' approach. The Board agreed to reaffirm the Trust commitment to the three public health priorities.

ACTION: Strategic Plan Working Group to include public health priorities in draft Plan - Mr Coulter

5.9 Mr Thompson asked about theatre optimisation in the context of C-sections, as noted in the notes of the Senior Management Team. Dr Johnson said that this was about the decision whether to operate in the ward or main theatre. It was about safety not numbers. The issue would be followed up at the December Board workshop.

5.10 Mr Thompson asked why, under BAF 16, the progress score was recorded as 2 when the risk score was 12. Mr Coulter confirmed that this was because the plan around the Cath Lab, in particular, was making progress. Dr Tolcher drew attention to the Place report which had been noted in the IBR. Scores for the Trust had improved but remained below the national average. Much of this was due to old buildings and challenges for privacy and dignity. She warned that the Place results could grow worse until resources were available to improve the infrastructure. Mr Coulter said that the Strategic Plan would include all the strategic risks recorded in the Board Assurance Framework. The discussion on planning would include defining the priorities for funding. Mrs Schofield said that it remained a significant issue for the Trust.

5.11 Mrs Taylor asked about the point under the Senior Management Team notes for October which showed that the HaRD CCG had the second highest referral rate for two-

week waits. Dr Tolcher said that this was believed partly to result from the health optimisation approach followed by the CCG but the CCG believes that there may be an error in the tool used to calculate it. However, Mr Harrison said that new thresholds had not affected the volume of referrals and that more recent figures suggested that it now had the highest national rate.

5.12 Mr Stiff said that at a recent meeting NYCC had reported receiving more funding for social care but it was less than 1% of its existing budget and with 5000 new claims a year this would equate to just £350 a year per new case. Dr Tolcher said that funding was intended to purchase additionality, not make a step change. The greatest pressures were not in Harrogate, which was a more expensive place. However, Delayed Transfers of Care (DTOCs) were currently running at less than 2%. Mr Harrison said that there had been a clear improvement and that the money was to try and sustain the good performance already achieved. He would discuss with the CCG the 'glitch' in the pathway.

ACTION: Mr Harrison to discuss pathway with HaRD CCG.

5.13 Mrs Schofield noted the apparent contradiction in the Falls and Pressure Ulcer figures which showed a rise in month and a reduction in the year to date. Mrs Foster said that whilst it was disappointing to see an in-month increase, the figures were correct and she was investigating the reasons for the in-month increase. Mrs Webster said it would be helpful to spell out the abbreviations.

5.14 Mrs Schofield asked Board members whether members had comments on the overview of the IBR as recorded in the Executive Summary. Dr Tolcher noted that, although there had been a reduction in the results of the Friends and Family Test for recommending the Trust for care, which was disappointing, the figures remained above the national average.

To deliver high quality healthcare

6.0 Report of the Quality Committee

6.1 The reports had been circulated in advance of the meeting and were taken as read.

6.2 Ms Robson noted that the October workshop had been designed to address the heavy workload of the Committee, make it more interactive and restructure the business around quality risks. The reshaping was not yet finalised and the proposed Terms of Reference may need further refinement once the final arrangements are agreed. It had been a positive workshop. Mrs Webster, the outgoing Chairman of the Quality Committee, echoed this and said that the Committee was continuing its evolution.

6.3 Mrs Schofield thanked both Mrs Webster and Ms Robson for their effective stewardship of the Committee. Ms Robson said that the November meeting had not found any issues to escalate to the Board.

6.4 Moving to metrics in the IBR referring to quality performance issues about complaints and re-referrals had been considered by the Senior Management Team but not escalated to the Quality Committee, which she was told had been satisfied. Dr Tolcher said these had been new issues and Mr Alldred said he had raised it after an increase in complaints which had apparently been resolved being reopened. There had recently been

an increase in resolution meetings, which he found to be a positive development, although complaints should not have to reach that stage. Mrs Webster said that there had been an outstanding action around the complaints process and Mrs Foster said this was continuing, with the focus on living within the deadlines. The Trust, however, had a low rate of referrals to the Ombudsman. Mrs Webster understood that there were mitigating circumstances and that it took time to reach the root of the problems but communication with the complainant was important. Agreeing the timeline with the complainant was important. Mrs Schofield emphasised that a 37% rate of completion within the deadline was a stark figure; Mrs Foster commented that in most cases the deadline was missed by a few days, and that the quarter 2 figures were showing an improvement. Work would continue to improve the timeliness of responses.

6.5 Mr Thompson reported that he had attended a conference at NHS Resolution where it was clear that there was evidence of a growing number of claims having been 'encouraged' by NHS staff. Dr Scullion emphasised the difference between a complaint and a claim; he would prefer to hear staff advising patients to contact the Patient Experience Team, which would be better for both patients and staff. Mrs Webster noted the difference between feedback and a complaint and the different value of each. Dr Scullion wanted staff to be prepared to sort out issues immediately.

6.6 Dr Tolcher noted the comments in the narrative about Respect and end of life care. Dr Scullion responded that the Respect programme was all about advanced care planning. Implementation was proving to be very challenging because of competing interests and competing tools being used. He had held a meeting of relevant clinicians to review the local approach. He had formed a specialist advisory group to develop a system for the Trust. It was unlikely that Respect could be implemented in its current form. The new system would not be directive and would include the best elements of all processes in use as well as the Respect programme. Respect had been introduced after the controversy surrounding the Liverpool Care Pathway.

6.7 Mrs Foster said that it was important to find an appropriate Trust position which could be implemented successfully. Mrs Webster was disappointed by the time spent without making progress. She had received a presentation on the significant benefits of the Respect programme and believed that there could be variable end of life care because of a lack of a single and robust process. Mr Alldred said that the end of life care team had undertaken a huge volume of work to ensure that the best service possible was provided. There had been good feedback on the service provided and he was reassured by the combined efforts of specialist clinicians, nurses and palliative care practitioners who were delivering a good service.

6.8 Mrs Schofield said that it was reasonable for the Board to expect implementation of a single, robust process and that it should be considered by the Quality Committee as soon as it was developed. Mrs Webster wondered about the likely timing of implementation and Dr Scullion said that whilst he could not give a definite time, the quality of care being delivered at the moment was very good.

ACTION: Quality Committee to consider new end of life care process

6.9 Mrs Schofield drew attention to page 5 of the IBR which referenced the Summary of National Hip Fracture Database (NHFD) report 2018. It was noted that surgery was supervised by consultant Anaesthetists and surgeons in only 27% of cases. Dr Scullion said that the mortality review had found no concerns relating to patient safety or outcomes

and that hip fractures were receiving better support. She then asked about the Healthcare Safety Investigation Board (HSIB); Dr Johnson said that it had been set up in the wake of the report on the University Hospitals of Morecambe Bay mortality cases to provide independent oversight of birth incidents. It would investigate all incidents and started work in April 2018, although no reports had yet been published. It was likely that it would take around six months after the incident to publish the report on any investigation. It was mandated to speak to patients, staff, procedures and systems and not individuals. Ms Robson wondered whether this investigation would replace the SI investigation and report for birth incidents. She thought this would make it worse for the patients and delay learning. Mrs Foster allayed her concerns by confirming that immediate safety concerns, as identified in the 72-hour report, would still be remedied and the HCSIB had agreed that this should continue. Dr Tolcher said that the 72-hour report therefore needed to be thorough as well as timely. Dr Scullion added that any anxieties about the timescale should be more than offset by the independence of the process. It would be live from 3 December.

6.10 Mrs Schofield turned to the Place report and was reassured by Mr Harrison that the Trust had recognised the deficiencies revealed and was putting in place remedies or mitigation where feasible.

6.11 Ms Robson asked for an update on the implementation of the improved DATIX process, as the IBR commentary was disappointing. Dr Scullion said that there had been problems but these had been resolved and it was being piloted in the maternity services team.

6.12 Ms Robson then asked why the falls figures were red on the Safety Thermometer as this seemed to be at odds with the Trust figures which show an improving trend. Mrs Foster replied that the Safety Thermometer metric was based on a single day which limited its usefulness. There had been a consultation in early 2018 around amending the metrics but it had been inconclusive. The figures were measured on the day of the report and required triangulation.

6.13 The report on Infection Prevention and Control had been circulated in advance of the meeting and was taken as read. Mrs Foster said it was pleasing to see that the number of *Clostridium difficile cases* had remained static (at 12) since September. All the Root Cause Analysis of these cases had been completed and there had been only one lapse of care identified. Changes had been made in the Root Cause Analysis process to relieve staff pressures without reducing the effectiveness of the process. The number of cases of Gram negative bacteraemia cases was assessed to be the result of increased testing, although the Trust was not complacent and work to reduce them appeared to be paying off.

To work with partners to deliver integrated care

7.0 West Yorkshire Association of Acute Trusts

7.1 Dr Tolcher confirmed that there was no written report from WYAAT this month. Mrs Schofield said that the recent Committee in Common meeting had been very positive and at this meeting the Board was being asked to approve two Business Cases.

Scan4Safety

7.2 Mrs Schofield said that this was a complex business case which had been scrutinised in detail by the Chief Executive group at WYAAT and the Committee in Common had received a presentation at its last meeting. There was no financial commitment for the Trust in approving this.

7.3 Mr Harrison explained that the principle of Scan4Safety was simple. It was about tracking people/product and place in healthcare. Patient wrist bands, equipment, medication were all bar-coded with a 3D barcode. Leeds Teaching Hospital Trust had been one of the pilot sites. The simple RFID bar-coding ensured that the patient could be tracked wherever they were. It covered ordering, product-matching, infection control and allergy cross-checking, amongst other things by using everyday technology, initially in a hospital setting, although it could move into the community in due course. The pilots had shown patient safety, business and financial advantages to using the system.

7.4 The Business Case had been presented in the same way to all the WYAAT Boards but individual Business Cases will be presented when the financial commitment is needed from each Trust. On this occasion the Board was being asked to commit to the direction of travel. If the Business Case was approved then the WYAAT working group would prepare the Business Case to draw down from the £15m total funding available. Dr Earl was the Trust clinical lead for the programme.

7.5 Mrs Schofield described the project as an effective way of managing risk and improving investigations. Mrs Taylor noted that York NHS Foundation Trust was not included and wondered about the implications for the alliance which HDFT had with it. Mr Harrison said that the project was site specific at present but it was likely that all Trusts would adopt Scan4Safety in time because standardisation was a key part of the improvement programme especially around pharmacies. Learning from the Leeds pilot meant that much less work needed to be redone. As an example Mr Alldred said that the Trust had tried, unsuccessfully, to instigate a blood-tracking system based on a 2D system – Mr Harrison said this was old technology and the Scan4Safety would be a significant improvement.

7.6 Mr Thompson asked whether there were any implications for the Trust's IT strategy; Mr Harrison confirmed that Scan4Safety is a GS1 compliant system which was in line with the Trust's strategy.

APPROVED: The Board of Directors approved the Business Case for the Scan4Safety programme.

To ensure clinical and financial sustainability

8.0 Report of the Resources Committee

8.1 The reports of the Resources Committee had been circulated in advance of the meeting and were taken as read.

8.2 Mrs Taylor noted that the meeting on 26 November, of which she had provided a summary, examined month 7 in detail, including financial, workforce and the Cost Improvement Programme (CIP). The Trust had made a surplus as planned in October and

the message was to continue working as hard to year-end; it was a big ask but this would meet the annual plan target. Registered nurse expenditure had reduced in month, following the removal of incentive payments but theatres continued to overspend by around £100,000. The CIP had identified measures to achieve 96% of the savings requirement, 90% when risk-assessed although more were non-recurrent, which would put pressure on to 2019-20. Income was on track – attendances at the Emergency Department were up 6.9% year-on-year, 2500 when compared with 2017. Workforce information was good but a forward look was important.

8.3 The Committee had examined the best, medium and worst case outturns and the recovery plans needed to fill the gap. Cash remained a concern and the change to the Oracle system had caused a short term slowdown in payments to creditors, although they were continuing to be made. The Committee had taken a first look at the 2019-20 budget plans and had agreed how to tie-in the work plan to match the guidance which had been issued. She would discuss the position with the Aligned Incentive Contract (AIC) during the private meeting.

8.4 Mrs Taylor noted briefly that at the October meeting the Committee had discussed an investment proposal from a partner organisation, private patient activity and the activity generated by the newly-opened Endoscopy unit. In the case of the Endoscopy unit there were challenges in both staffing and equipment which meant that it was not yet working at full capacity.

8.5 Mr Coulter reminded colleagues that the reduced ward expenditure should be triangulated with the safe staffing report and showed no reduction in the quality of care. Whilst there remained a slight overspend this could be put down largely to sickness absence running at 1.5% above the target level. A huge effort had been made to reduce expenditure, including significant changes to enhanced care for patients and this gave him confidence going into 2019-20. A recent inter-Directorate meeting had 'converted' £1m of non-recurrent CIP to recurrent, which was a major and welcome achievement. He saw the high level risks as underfunding of the NHS Pay Award, winter pressures and the emergency contract costs and non-recurrent costs of the change of clinical waste arrangements.

8.6 On the AIC there had been a meeting between the Trust, NHS England, NHS Improvement and HaRD CCG at which there was recognition of the issues and that patients safety was the clear priority, whilst there were financial and waiting list issues which also needed to be addressed. A further meeting was planned for 10 December. Mrs Schofield said that there would need to be a good debate around this issue in the private meeting.

8.7 Dr Scullion welcomed the good news on reduced ward staffing costs, whilst Mrs Foster added that the Directorates, senior nurses and ward managers had all played a part and there had been a master class for ward managers on 21 November which had proved to be useful to them in particular.

8.8 In Mrs Schofield's opinion the financial situation remained precarious in year – she asked Mr Coulter for more details of the risk posed by the pay award. He replied that the funding which had been allocated to the Trust in July had underfunded the award by around £200,000. In addition it was expected that NHS Improvement would wish to claw back the funding for those staff that had transferred to Harrogate Healthcare Facilities Management – combined this could total around £600,000. NHS Improvement had not

committed to adjusting the Trust's control total to take account of this.

8.9 Mrs Webster asked about income from private patients. Mr Coulter said that the Trust had now switched over to a new system and that non-NHS income was not only coming from the Harrogate Harlow suite; it also included, for example, income from road traffic accident payments. This was about £100,000 behind plan. Mrs Taylor said that the shortfall of £300,000 shown was likely to reduce to £100,000 once invoicing was up to date.

9.0 Review of Strategic Key Performance Indicators

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

9.2 Mr Coulter said that the Strategic Plan working group was examining the current group of indicators to ensure that they remained valid. The reporting culture aspiration was for indicators to improve to the national average. Whilst the Trust had constrained capacity it was undertaking more work for HaRD CCG and less for other commissioners. Outreach clinics in North Leeds needed more work to achieve the planned levels. Mortality was within the appropriate ranges. Income growth was being achieved. When judging the Trust using the Reference Cost indicator this, at 94%, was the best in WYAAT. Overall he felt that the results were good, whilst remaining a work in progress.

9.3 Mr Thompson asked about the Best Practice tariff and whether administrative processes were affecting the achievement of this in the Emergency Department. Mr Harrison said that current constraints were preventing optimisation, with a loss of capacity in escalation situations, but that the new Ambulatory Care Unit was expected to improve the position. Mr Thompson said that even though the work had been done were claims not being made – Mr Harrison responded by drawing attention to the fact that patients were not all in one place, which made the process more challenging.

9.4 Ms Robson was concerned at the lack of mention of children's services in the KPIs but was reassured by Mr Harrison that these were integral to many of the IBR KPIs although not specifically itemised as such– Ms Robson felt that consideration should be given to making this more explicit. Mr Coulter noted that there had been business development around the growth of services. Development of key metrics in the IBR would continue to try and show what high quality care looks like across the Trust. – Dr Lyth suggested moving the two and half year checks into the KPIs, for example. Dr Tolcher said that the logical flow was to consider issues for inclusion in the Strategic Plan and then look at KPIs for measuring their delivery; following a suggestion from Mrs Webster that the changes to guidance from NHSI on operational planning should be noted, Mr Coulter agreed and said that the Strategic Plan would also need to take account of the forthcoming 10-year plan for the NHS. Mrs Schofield noted that a system-wide plan would need to be produced in May/June 2019, taking this into account.

10.0 Workforce and Organisational Development Strategy Update including Staff Friends and Family Test Q2

10.1 The paper and annex had been circulated in advance of the meeting and were taken as read.

10.2 Ms Wilkinson said that this was the biannual update on progress to the Board on all

five objectives. She noted that some of the core elements which she wished the Board to consider were improvements in appraisal rates and agile working. There were also updates around cultural issues including fairness, bullying and harassment and the Workforce Race Equality Standard data. There was good supporting evidence triangulating the changes. Line management across the Trust was facing challenges and needed support, and there were a number of positives to be noted.

10.1 Mrs Schofield thanked Ms Wilkinson and said that the report was a very helpful summary of the position. Ms Robson noted that there were concerns amongst the Governors about staffing issues and she suggested sharing the report, or extracts from it, with the Governors.

10.2 Dr Tolcher said that at a future meeting it would be appropriate to check the progress with the Clinical Workforce Strategy against the KPIs. Mr Thompson commented about how the Trust was intending to reduce the gender pay gap and Ms Wilkinson said that some of this related to the Clinical Excellence Awards points – Dr Tolcher said drilling down into the data showed that the Trust had a number of longer serving male consultants which skewed the data; if these were removed from the calculation then the figures showed the Trust to be better than the national average. Dr Scullion agreed, noting the male dominance across the NHS, and that a new, non-consolidated scheme being introduced would make a difference.

10.3 Mrs Taylor suggested that a forward look at the workforce could be linked with other, financial, information and Mrs Schofield agreed; looking at a wider use for the workforce information and a recovery plan for the workforce was the business of the Board, in Mr Coulter's view. Mrs Webster said that the Board needed to see that plans and actions were on track whilst Dr Tolcher said that the impact of workforce changes needed to be quantified. Ms Wilkinson said that the flow through the Workforce Efficiency Group, Senior Management Team, Resources Committee and to the Board needed to be re-examined to ensure that decisions were made at the right level.

10.4 Mrs Schofield asked about unconscious bias training for staff. Mr Thompson said that he had used an online tool and he suggested that he would forward a link for Board members to use. Dr Tolcher informed the Board that the Diversity by Design approach which she was advocating included work relating to unconscious bias.

ACTION: Ms Wilkinson to share report or extract with Governors
ACTION: Ms Wilkinson to clarify process for consideration of Clinical Workforce Strategy KPIs and other workforce reports

10.5 Moving to the Staff Friends and Family Test results, Mrs Schofield noted a reduction in the overall figures in Quarter 2. Additional Clinical Services had seen the largest reduction and this included mostly unregistered staff, including care support workers. She considered that a more detailed breakdown of the figures would have been helpful.

10.6 Mr Coulter sought clarification about the influence of staff taken on in areas new to the Trust in, for example, Gateshead and Sunderland. Mrs Schofield asked when the next figures would be available so that it could be established whether or not there was a trend, and Ms Wilkinson replied that this would be in Quarter 3 as part of the NHS Staff Survey. HR Business Partners were already taking forward the analysis of the Quarter 2 results.

10.7 Mrs Taylor questioned whether the results reflected poor management standards and in reply Dr Tolcher said she thought that there was a need to provide ongoing training and support to particularly to new and inexperienced managers. This had become clear during her recent listening events. Fifteen Fairness Champions had now been appointed and these would provide a new line of intelligence about the issues in the workforce to add to the list which included the Freedom To Speak Up Guardian, the Friends and Family Test, the NHS Staff Survey and the grievance process. She felt that despite good intentions there could be blind spots in managers which were preventing staff from speaking up if they were subsequently seen as a problem. She would be taking firm action to improve the Trust position, which was not unique to HDFT; the Trust was better than average but she was far from complacent. She cautioned the Board that in 'lifting the lid' on bullying and harassment the figures could initially rise; it would be better to judge after the results of the NHS Staff Survey. The position would be examined in the round, discussed by the Executive Directors and a programme of leadership put in place.

10.10 Mrs Webster wondered whether 644 responses from 4500 staff was a representative sample – it seemed that a very large number of staff had nothing to say. Mrs Schofield said that the full NHS Staff Survey may give more useful results. Mrs Foster added that the anecdotal evidence from the CQC debrief suggested that staff were overwhelmingly positive about the Trust. This needed to be seen as a 'good to great' matter.

Governance

11.0 Terms of Reference of the Quality Committee

11.1 Mrs Schofield said that revision of the Terms of Reference was related to changes to membership to bring it into line with other Board Committees and that they may change again. Ms Robson said that the revisions had been discussed at a workshop in October, where it was also agreed to reduce the number of meetings to 10 per annum rather than 12. Mrs Webster noted that the Infection Control annual report was no longer considered by the Quality Committee.

APPROVAL: The Board of Directors approved the revised Terms of Reference for the Quality Committee, noting that further changes may be necessary in the short term.

12.0 Business Case for VMware

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

12.2 Mr Harrison said that the replacement of the servers on the hospital site was necessary and a number of options had been examined. The selected option was to use company 2 and finance the option over five years – the alternative would have been a full capital outlay and the Trust was not in a position to afford this. Mr Coulter confirmed that although the cost will be greater over five years, the approach would be beneficial since the Trust would accrue 3½% on cash over that period. Mr Thompson asked whether the chosen option would accommodate the growth in requirement over the five-year period, citing Scan4Safety as an example. Mr Harrison said that the projected requirements had indeed been taken into account and pointed out that the current servers had held sufficient capacity for six years against their five-year planned lifespan and he was

confident that the new servers would prove to have sufficient capacity.

APPROVAL: The Board of Directors approved the proposal to adopt company 2 to replace the Trust servers over a five-year period.

13.0 Any other relevant business not included on the Agenda

There was no other relevant business.

14.0 Board Evaluation

14.1 Mr Coulter thought that it had been a good, positive meeting whilst Dr Tolcher thought that there should be some re-ordering in the various elements to ensure that the Executive Directors led on relevant business, rather than the Non-Executive Directors. Mrs Schofield considered that it was positive to see how knowledgeable the Non-Executive Directors had been shown to be.

14.2 Dr Tolcher said that much of the information on quality had been included in the Chief Executive's report and whether the Finance Director should be moved forward in the agenda to address the financial position earlier. Mrs Webster felt that there were levels of report and Mrs Taylor echoed this, saying that as Chairman of the Finance Committee she would deliver the overview and Mr Coulter would provide greater detail. Mr Coulter agreed about the different levels of report and said that there was no need to repeat everything which had been said at the Resources Committee meeting for the benefit of those who had not attended, as the Committees were delegated to deal with the detail on behalf of the Board.

14.3 Moving on to the Integrated Board Report, Mrs Webster said that the developing format, with narrative summaries, was very valuable and Mr Harrison said that the evolution of the report was allowing him to test out some elements – he welcomed comments from Board members on how these were working. Mrs Webster said that it would be helpful to segment the report to match the shape of the agenda.

14.4 Mr Harrison noted that some issues had not been raised in the discussions; for example, concerns about disproportionate referrals to such high cost specialties as orthopaedics. He reported that the November Emergency Department four-hour figures were not as good as those of October and that on 26 November the Trust had experienced its second highest ever number of admissions. The Supported Discharge Service was live from 26 November, although some elements had yet to be implemented fully, and a method for capturing data on its impact was in place. The winter plan, with associated costs, was also now in place.

14.5 In Mrs Schofield's opinion the meeting had been less hurried than previous meetings and more time had been spent on important things, with everyone contributing. Ms Wilkinson said that as this was her first meeting, she had been impressed with the range, nature and constructive engagement of the Non-Executive Directors.

15.0 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 12.05pm.

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HDFT Board of Directors Actions Schedule
Action Log
January 2019

This document logs items for action from Board of Directors meetings which remain outstanding. Board members will be asked to confirm completion of actions or give a progress update at the following Board meeting when they do not appear on a future agenda.

Ref	Meeting Date	Item Description	Director/Manager Responsible	Completion date	Detail of progress
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 CCWCC	January 2019	
102	June 2018 (minute 5.5)	Mrs Roberts (Mr Forsyth) and Mrs Webster (Ms Robson) to agree an appropriate resolution, and amend the Quality Committee Terms of Reference accordingly.	Ms Robson, Non-Executive Director & Mr Forsyth, Interim Company Secretary	November 2018	**Action complete – TsoR amended and approved**
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	January 2019	
111	July 2018 (minute 7.7)	Update the Scheme of Reservation and Delegation following review of Quality Committee Terms of Reference, when approved	Mr Forsyth, Interim Company Secretary	January 2019	Complete
112	September 2018	Patient and Public Participation Strategy – consult widely with stakeholders and take principles in framework forward to develop strategy	Mrs Jill Foster, Chief Nurse	January 2019	
116	November 2018 (Patient Story)	Write to Consultant and Physiotherapist cited by Mrs P in story	Mrs Angela Schofield, Chairman	January 2019	
117	November 2018 (minute 4.0)	Report on NHSI Nursing Review	Mrs Jill Foster, Chief Nurse	January 2019	
118	November 2018 (minute 5.8)	Strategic Plan Working Group to include public health priorities in draft plan	Mr Jonathan Coulter, Director of Finance	January 2019	
119	November 2018 (minute 5.12)	Discuss with HaRD CCG the pathway which was experiencing high referral rates	Mr Robert Harrison, Chief Operating Officer	January 2019	

120	November 2018 (minute 6.8)	Quality Committee to discuss new end of life care process	Ms Laura Robson, Non-Executive Director, Chairman of QC	January 2019	
121	November 2018 (minute 10.1)	Share Workforce and Organisational Development Strategy Update (or extract thereof) with Governors	Ms Angela Wilkinson, Director of Workforce and Organisational Development	January 2019	
122	November 2018 (minute 10.3)	Clarify process for consideration of Clinical Workforce Strategy Key Performance Indicators and other workforce reports	Ms Angela Wilkinson, Director of Workforce and Organisational Development	January 2019	

Harrogate and District NHS Foundation Trust

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Date of Meeting:	30 January 2019	**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 Andrew Forsyth, Interim Company Secretary		

Report Purpose:	**Decision**		**Discussion/ Consultation**	✓	**Assurance**	✓	**Information**	✓

Executive Summary:

- The Trust reported an operating surplus in November and December and achieved the required Q3 control total.
- For Quarter 3 the Trust's performance is below the required level for two of the operational performance metrics - the18 weeks standard and the ED 4-hour standard, although both remain relatively good compared to national means.
- The Trust's year to date performance on the ED 4 hour standard now stands at 94.5%. ED attendances are 4.8% above last year's numbers for the same period. Provider Sustainability Funding associated with this key performance metric is at risk.
- A recent 'flu outbreak has been contained. To date 56% of HDFT staff have been vaccinated.
- The NHS Plan and operational planning guidance have been published and the Trust has been notified of its 2019/20 Control total

Related Trust Objectives

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

Key implications

Risk Assessment:	Strategic and operational risks are noted in section 6. Risks associated with this report are reflected in the Board Assurance Framework: BAF 14: risk to delivery 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:	• NHS Improvement: Single Oversight Framework: https://improvement.nhs.uk/uploads/documents/Single_Oversight_Framework___update_Nov_2017_v2.pdf
Assurance:	Not applicable.

Action Required by the Board of Directors:

- 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.
- To endorse the recommendation of the WYH ICS System Leadership Executive group to support the Truth Project
- The Board is requested to **endorse** use of the Trust's seal and agreement of a license as detailed in the report.

This report should be read alongside the Trust's Integrated Board Report which contains further information on key quality, operational and finance metrics.

1.0 QUALITY, PATIENT EXPERIENCE AND OPERATIONAL PERFORMANCE

1.1 Operational Performance

Recent trends in respect of achieving the key national operational performance standards continued during November and December as illustrated in the Integrated Board Report. The Trust's performance against the A&E 4-hour standard was below 95% in November and December at 93.5% and 92.3% respectively. Emergency Department attendances were 2.9% above plan in November but fell to expected levels in December. Total ED attendances including patients assessed and streamed to the GP service are 4.8% higher YTD (year to date) than the same period last year. The Trust's year to date achievement on the A&E 4-hour standard now stands at 94.4%.

Performance against the 92% standard for incomplete referral to treatment pathways within 18 weeks also deteriorated in both months (November 90.5%; December 89.9%) delivering a YTD rate of 90.4% and is forecast to remain challenging. The total number of people waiting for non-urgent care on the Trust waiting list was 14,800 at the end of December, which is above the year-end target of 14,005. The actual number of people receiving elective in-patients or day case care is 12.1% above the same period last year (5.5% for Harrogate and Rural District patients). The Trust is in dialogue with commissioners regarding this matter. The main drivers for changes to waiting list size and performance relate to capacity and demand in Neurology and Ophthalmology and demand in excess of plan for Urology and Orthopaedics. A Locum Consultant has now been engaged in Neurology which will assist in improving the waiting times for this service.

Provisional data indicates that cancer waiting times standards were achieved for December, and despite dropping to 83.5% in November, the Trust's year to date performance at the end of Q3 is above the standard at 86%.

Typically the Trust experiences higher levels of demand for non-elective admission during winter months; higher conversion rates from the ED (admissions) and often longer lengths of stay. The Trust ran an 'Every Hour Matters' fortnight in the first two weeks of the new year in order to optimise care during this period, which historically has been very challenging. Coordinated work with system partners contributed to the Trust being in the top ten nationally for performance over this period. While admissions were above the number seen in the same period last year, site occupancy and ED performance were significantly better. Delayed transfers of care remain low at just 2.0% of occupied bed days.

Small increases in hospital and community acquired category 3 or unstageable pressure ulcers have been reported in December, and a small reduction in the safety thermometer score attributed to an unusually high number of urinary tract infections detected this month. No new cases of CDI have been reported since September and mortality indicators remain within expected ranges.

The opening of our new Clinical Assessment Team (CAT) on the ground floor adjacent to the Emergency Department has enabled significant improvements to patient dignity as well as improving flow and the working environment for staff. The discharge team and Supported Discharge Service are co-located with the CAT.

Jervaulx Ward was affected by on outbreak of 'flu early in January and was closed to admissions for a period. Eleven patients and four staff have been confirmed as affected with a significant number of staff symptomatic and absent from work.

1.2 HDFT Care Quality Commission (CQC) Inspection

The Well Led Review, which was the final stage of the inspection, went ahead on 4-6 December as planned. No concerns were raised in verbal or written feedback and the Trust was commended for a number of areas including visibility of leadership, effective governance and system working. The Trust is due to receive a draft report for factual accuracy checking by the end of January.

1.3 Harrogate Hospital and Community Charity event

I am pleased to record my thanks to the organisers of this year's Variety Performance which raised a magnificent £10,848. Particular thanks are due to former Trust Chairman Dr Albert Day.

1.4 Gamma Scanner

Following some exceptionally generous donations to the Trust we were able to formally open our new Gamma Scanner in December, an event which attracted significantly media coverage. This facility, the only one of its type outside London, will speed up diagnosis for our patients and avoid additional investigations. It also offers an improved environment in which to provide the service.

1.5 The Truth Project

The Truth Project is part of the work of the Independent Inquiry into Child Sexual Abuse (CSA). The project offers the opportunity for victims and survivors of CSA to share their experience and be respectfully heard and acknowledged. They will make recommendations about support needs, as well as challenging assumptions of child sexual abuse.

Partners in WY&H have been asked to support The Truth Project's 'I will be heard' campaign by sharing social media messaging and electronic information; displaying posters or silent screens; and inviting The Truth Project to share information at events or meetings.

The West Yorkshire and Harrogate ICS System Leaders Executive Group has agreed to support the campaign which will be led by Local Authority partners. The Board is invited to support this campaign.

2.0 FINANCIAL AND EFFICIENCY

2.1 Financial performance

The Trust reported surpluses of £583k and £1,214k in November and December which supported achievement of the agreed control total in Quarter 3, triggering payment in due course, of the third quarter's Provider Sustainability Funding (PSF). The year to date position inclusive of PSF is a deficit of £638k which although representing a continued improvement on prior months, remains £2.9m behind the Trust's internal plan. Without PSF accrued the Trust would be reporting a deficit position of £3.3m.

Achievement of CIP plans remains positive with forecast attainment close to 100%. Significant risks still remain in the overall position and all possible measures are being pursued in order to deliver the full year's control total requirement. Further details of best, worst and likely scenarios are contained in the Finance Director's report.

NHS Improvement has notified the Trust of its 2019/20 control total.

The Trust reported a use of resources rating of 3 in November which improved to 2 in December in line with the annual plan submitted to NHS Improvement. This improvement reflects the reduction in agency expenditure.

3.0 PARTNERSHIPS AND INTEGRATION

3.1 West Yorkshire and Harrogate Integrated Care System (WYH ICS)

It is pleasing to confirm that the Trust's chairman, Angela Schofield has been appointed as Vice Chair of the WYH ICS Partnership Board for the first two years in line with the Memorandum of Understanding (MoU) agreed at the HDFT Board meeting in September. The Partnership Board will ensure that the work discussed there meets the ambitions set out in the WHY ICS 'Next Steps to Better Health and Care for Everyone' whilst informing the development of the Long Term Plan for WYH.

Following publication of the NHS Long Term Plan ('The Plan', details below) and annual operating plan guidance, a number of meetings have been held across the WYH ICS to explore the opportunities and implications of the new approach to planning and updated financial arrangements across the NHS. The green paper on Social Care is awaited and the future funding arrangements for Public Health England also remain unknown. The workforce education and training budget for HEE (Health Education England) will not be known until the next comprehensive spending review in the autumn. The maturity of the WYH ICS makes it well placed to respond to the plan, the key themes in which support our shared ambition and direction of travel. The ICS PMO will be reviewing existing work streams to ensure congruence with The Plan.

3.2 West Yorkshire Association of Acute Trusts (WYAAT)

The West Yorkshire & Harrogate Pathology Case for Change & Options Appraisal was supported by the WYAAT CEO group on 22 January and is due to be considered via the WYAAT Committee in Common (CIC) this month.

NHS Improvement has set out a clear case for change for pathology services nationally and the same drivers for change apply to WY&H. WY&H Pathology Services need to work together in a single network to improve quality and productivity. Formalisation of the collaborative approach, with stronger governance and increased resources, is required for the next phase of the programme when recommendations on future organisational and commercial models and service configuration will need to be made.

3.3 Harrogate System

The NHS Plan and planning for 2019/20 were discussed at the meeting of the Harrogate System Leadership Executive Group on 24 January. A verbal update will be provided. The group is also due to approve the final business case in respect of integrated community services.

4.0 SENIOR MANAGEMENT TEAM (SMT) MEETING

The SMT met on 23 January. There was no meeting of the SMT in December. The following key areas are for noting:

- Discussed key messages in The NHS Plan
- A report on Safety Visits was discussed. Steps to increase senior clinician involvement were explored.
- Income and expenditure forecasts for Q4 were discussed. The importance of securing maximum provider sustainability funding at year end was stressed and some actions agreed.
- Risks relating to the Agenda for Change pay award applicable to staff employed in Local Authority commissioned services was discussed. The Trust will be liaising with commissioners.

- Noted a five year Dental contract with NHSE signed and County Durham contract extended by two years.
- Approved the Hopes for Healthcare recommendations.
- Received the final report from NHSI following its supportive review of nurse staffing, and supported the action plan which has been developed.
- Approved the patient and public participation strategy.

5.0 COMMUNICATIONS RECEIVED AND ACTED UPON

5.1 The NHS Long Term Plan and Operational planning guidance for 2019/20

The NHS Long Term Plan ('The Plan') was published on 7 January 2019. The Plan was commissioned in response to the five-year funding settlement announced by the Government in June 2018 and is described as 'a bold set of service re-designs' to reduce pressure across the NHS and improve care access and quality. The new settlement provides an average of 3.4% growth per annum and an additional £20.5 billion a year in real terms by 2023/24.

There are three overarching aims to The Plan as follows:

1. Making sure everyone gets the best start in life;
2. Delivering world-class care for major health problems; and
3. Supporting people to age well.

Six chapters set out how these aims will be delivered through new service models; prevention and inequalities; improving care quality; workforce; digital and value for money.

Further details of The Plan are attached to this paper and a full copy of the plan can be accessed at https://www.england.nhs.uk/long-term-plan

The Plan and the supporting guidance are currently being considered by the Trust. Some key elements of relevance to service delivery by the Trust include:

- Ensuring most women can benefit from continuity of carer through and beyond their pregnancy;
- Developing more Rapid Community Response Teams to prevent unnecessary hospital spells, and speed up discharges home;
- Digitally enabled primary and outpatient care;
- Boost out of hospital care and joining up primary and community services; a new NHS offer on urgent community response and reablement;
- Targets for reducing pressure on emergency hospital services by achieving higher rates of same day emergency care; and
- Work to reduce unjustified variation in performance.

The HDFT Strategic Plan Development Group will ensure that the future strategic direction of the Trust reflects the requirements of The Plan, as well as alignment to ICS and Harrogate system plans.

The planning guidance states that changes to the financial framework including to CCG allocations mean that in future all CCGs should be able to balance their financial position each year without additional support. Similarly, the new payment framework should mean that all well led NHS Trusts / FTs will be able to achieve financial balance by April 2020.

The plan identifies a number of efficiency priority areas including actions to improve quality and productivity of services delivered in the community, across physical and mental health, by making mobile devices and digital services available to a significant proportion of staff.

Key dates:

- 14 January - initial plan submission (activity focused), done.
- 12 February – draft 2019/20 organisation operational plans
- 19 February – draft aggregate system 2019/20 operation plan submission, system operating plan overview and STP led contract/plan alignment submission
- 21 March – deadline for 2019/20 contract signature
- 29 March – organisation Board approval of 2019/20 budgets
- 4 April – final 2019/20 organisation operational plan submission
- 11 April – final aggregate system 2019/20 operation plan submission, system operating plan overview and STP led contract/plan alignment submission

5.2 EU exit planning

Trusts received a number of communications in December 2018 from Matt Hancock, Secretary of State for Health and Social Care regarding contingency planning in respect of a potential 'no-deal' EU exit scenario. Trusts are advised to adopt a 'reasonable worst case' mind-set.

The Department of Health and Social Care has published Operational Guidance which sets out the local actions that providers and commissioners of health and adult social care services in England should take to prepare for EU Exit, including immediate actions to manage the risks of a 'no deal' EU Exit. The Department, with the support of NHS England and Improvement, and Public Health England, has set up a national Operational Response Centre. This new centre will lead on responding to any disruption to the delivery of health and care services in England that may be caused or affected by EU Exit. NHS England and Improvement will also establish local, regional and national teams to enable rapid support on emerging local incidents and escalation of issues into the Operational Response Centre as required.

The Senior Responsible Officer for HDFT is Robert Harrison, Chief Operating Officer. A dedicated EU-Exit planning group has been set up and is currently reviewing relevant business continuity plans. Corporate risk registers and the Board Assurance Framework will be kept under continuous review as additional details become clear.

6.0 BOARD ASSURANCE AND CORPORATE RISK

6.1 Board Assurance Framework (BAF)

No new risks have been added to the BAF this month. Six risks (no change from November 2018) are currently assessed as having achieved their target risk score. The BAF has been reviewed by the Executive Directors and progress with mitigating actions and additional key controls have been noted where appropriate. Additional mitigating actions were added where appropriate. The strategic risks are as summarised 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	*Yellow 5* ↔	*Unchanged at 1*	✓

	Licence to operate			
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*	

A summary version of the Board Assurance Framework will be considered at the Board workshop in February with a view to publishing it in the papers for the public session of the Board of Directors in March 2019.

5

7.2 Corporate Risk Register (CRR)

The CRR was reviewed at the monthly meeting of the Corporate Risk Review Group on 17 January 2019. The Corporate Risk Register contains 12 risks.

Corporate Risk Register Summary

Corporate risk register summary of changes: Updated December 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*	
CR5	Risk to service delivery due gaps in registered nurses establishment	12	↔	2	*Oct-20*	
CR13	Risk to patient care, experience and quality due to a lack of capacity to support patients following discharge	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*	
CR18	Risk to provision of service and not achieving national standards in cardiology due to potential for lab equipment breaking down	12	↔	1	*Mar-19*	
CR24	Risk to patient safety, quality, experience, reputation, staff wellbeing due to reduced capacity in the Community Care teams (CCTs).	12	↔	2	*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	*Apr-19*	
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	↔	3	*Apr-19*	
CR31	Financial risk and risk of poor patient experience associated with the failure to meet the 4 hour standard	12	↔	2	*Apr-19*	
CR32	Financial risk from major sporting events due to cost of contingency arrangements and loss of income	12	↔	3	*Sep-19*	
CR34	Risk to quality of care by not meeting NICE guidance in relation to the completion of autism assessment within 3 months of referral.	12	↔	1	*TBC*	*Target date to be agreed*

Risks added to the corporate risk register

- None.

Risks removed from corporate risk register

- CR33: Risk of detrimental outcome due to extended times between treatments for existing podiatry patients due to staff shortages Harrogate & Scarborough locality teams.

Risks with amended target dates, and / or target or progress scores

- None

8.0 Quality Charter: Making a Difference and Team of the Month Awards

Congratulations to this month's Team of the Month and the Making a Difference Awards winners listed below:

Team of the Month

November: Harrogate Renal Satellite Unit
December: CT Team, Radiology

Making a Difference Awards (made since 1 November):

- Tracy Golby, Assistant Practitioner – Growing Healthy North Yorkshire
- Charlotte O'Donovan, Midwife – Pannal Ward
- Nadia Ali, Staff Nurse – Oakdale Ward
- Dr Dan Leeder, Speciality Doctor – Emergency Medicine
- Stephanie Robinson, Physiotherapy and Occupational Therapy Frailty Team Lead
- Mr Ayman Sorial, Speciality Doctor – Trauma and Orthopaedics
- Hannah Dickinson, Sister – Jervaulx Ward
- Sarah Gill, 0-19 Health Screening Technician – North Yorkshire and City of York Childhood Immunisations Service
- Dr Sean Treadwell, FY2 – Haematology and Oncology
- Dale Fothergill, Information Analyst
- Louise MacDonald, Sister – Critical Care Outreach Team
- Dr Pete Whitehead, GP – GP Out of Hours Service
- Emma Nelson, Former Parent Education Midwife
- Sam Cotgrave, Senior Urgent Care Practitioner – GP Out of Hours Service
- Sarah Dunn, Apprentice Rota Coordinator – Long Term and Unscheduled Care
- Annemarie Perry, Sister – ENT Outpatients
- Dr Dartel Norman, Specialist Registrar – Elderly Care
- Alison Sharpe, Macmillan Urology Nurse Specialist
- Debbie Elliot, Bank Ward Clerk
- Antoinette Fineberg, Care Support Worker – Byland Ward
- Dr Sarah Glover, Consultant Clinical Biochemist and Point of Care Testing Clinical Lead
- Dr Sujatha Kamala, Speciality Doctor – Obstetrics and Gynaecology
- Joanne Percival and Abigail Tidswell, Staff Nurses – ITU
- Julie Mortimer, Sister – Emergency Department
- Tina Hibbert, Clerical Officer – Audiology
- Lynda Green, Practice Development Sister – ITU/ HDU
- Eve Geldart, Practice Development Sister – ITU/ HDU
- Liz Simmons, Team Sister – Overnight Nursing Team, Adult Community Services
- Amy Phillips, Medical Secretary – Rheumatology
- Sarah Blackburn, Lead Nurse – Critical Care Outreach Team
- Dr Anthony O'Connell, Clinical Scientist – Audiology
- Lesley Wright, Macmillan Haematology Nurse Specialist
- Fiona Love, Nutritional Assistant – Granby Ward
- Jeff Walker, Blood Sciences Laboratory Manager

Dr Ros Tolcher
Chief Executive
January 2019

The NHS Long Term Plan – a summary

Find out more: **www.longtermplan.nhs.uk** | **Join the conversation:** **#NHSLongTermPlan**

Health and care leaders have come together to develop a Long Term Plan to make the NHS fit for the future, and to get the most value for patients out of every pound of taxpayers' investment.

Our plan has been drawn up by those who know the NHS best, including frontline health and care staff, patient groups and other experts. And they have benefited from hearing a wide range of views, whether through the 200 events that have taken place, and or the 2,500 submissions we received from individuals and groups representing the opinions and interests of 3.5 million people.

This summary sets out the key things you can expect to see and hear about over the next few months and years, as local NHS organisations work with their partners to turn the ambitions in the plan into improvements in services in every part of England.

What the NHS Long Term Plan will deliver for patients

These are just some of the ways that we want to improve care for patients over the next ten years:

Making sure everyone gets the best start in life	• reducing stillbirths and mother and child deaths during birth by 50% • ensuring most women can benefit from continuity of carer through and beyond their pregnancy, targeted towards those who will benefit most • providing extra support for expectant mothers at risk of premature birth • expanding support for perinatal mental health conditions • taking further action on childhood obesity • increasing funding for children and young people's mental health • bringing down waiting times for autism assessments • providing the right care for children with a learning disability • delivering the best treatments available for children with cancer, including CAR-T and proton beam therapy.
Delivering world-class care for major health problems	• preventing 150,000 heart attacks, strokes and dementia cases • providing education and exercise programmes to tens of thousands more patients with heart problems, preventing up to 14,000 premature deaths • saving 55,000 more lives a year by diagnosing more cancers early • investing in spotting and treating lung conditions early to prevent 80,000 stays in hospital • spending at least £2.3bn more a year on mental health care • helping 380,000 more people get therapy for depression and anxiety by 2023/24 • delivering community-based physical and mental care for 370,000 people with severe mental illness a year by 2023/24.
Supporting people to age well	• increasing funding for primary and community care by at least £4.5bn • bringing together different professionals to coordinate care better • helping more people to live independently at home for longer • developing more rapid community response teams to prevent unnecessary hospital spells, and speed up discharges home. • upgrading NHS staff support to people living in care homes. • improving the recognition of carers and support they receive • making further progress on care for people with dementia • giving more people more say about the care they receive and where they receive it, particularly towards the end of their lives.

How we will deliver the ambitions of the NHS Long Term Plan

To ensure that the NHS can achieve the ambitious improvements we want to see for patients over the next ten years, the NHS Long Term Plan also sets out how we think we can overcome the challenges that the NHS faces, such as staff shortages and growing demand for services, by:

1. **Doing things differently:** we will give people more control over their own health and the care they receive, encourage more collaboration between GPs, their teams and community services, as 'primary care networks', to increase the services they can provide jointly, and increase the focus on NHS organisations working with their local partners, as 'Integrated Care Systems', to plan and deliver services which meet the needs of their communities.

2. **Preventing illness and tackling health inequalities:** the NHS will increase its contribution to tackling some of the most significant causes of ill health, including new action to help people stop smoking, overcome drinking problems and avoid Type 2 diabetes, with a particular focus on the communities and groups of people most affected by these problems.

3. **Backing our workforce:** we will continue to increase the NHS workforce, training and recruiting more professionals – including thousands more clinical placements for undergraduate nurses, hundreds more medical school places, and more routes into the NHS such as apprenticeships. We will also make the NHS a better place to work, so more staff stay in the NHS and feel able to make better use of their skills and experience for patients.

4. **Making better use of data and digital technology:** we will provide more convenient access to services and health information for patients, with the new NHS App as a digital 'front door', better access to digital tools and patient records for staff, and improvements to the planning and delivery of services based on the analysis of patient and population data.

5. **Getting the most out of taxpayers' investment in the NHS:** we will continue working with doctors and other health professionals to identify ways to reduce duplication in how clinical services are delivered, make better use of the NHS' combined buying power to get commonly-used products for cheaper, and reduce spend on administration.

What happens next

Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs), which are groups of local NHS organisations working together with each other, local councils and other partners, now need to develop and implement their own strategies for the next five years.

These strategies will set out how they intend to take the ambitions that the NHS Long Term Plan details, and work together to turn them into local action to improve services and the health and wellbeing of the communities they serve – building on the work they have already been doing.

This means that over the next few months, whether you are NHS staff, a patient or a member of the public, you will have the opportunity to help shape what the NHS Long Term Plan means for your area, and how the services you use or work in need to change and improve.

To help with this, we will work with local Healthwatch groups to support NHS teams in ensuring that the views of patients and the public are heard, and Age UK will be leading work with other charities to provide extra opportunities to hear from people with specific needs or concerns.

Find out more

More information is available at www.longtermplan.nhs.uk, and your local NHS teams will soon be sharing details of what it may mean in your area, and how you can help shape their plans.

Integrated board report - December 2018

Key points this month

1. The Trust reported a surplus of £1,214k in December. This improved the year to date position to £687k, ensuring the control total for the Trust was achieved for Quarter 3. Risks still remain in the position, with the finance report outlining the best, worst and likely forecast positions.

2. HDFT's performance against the A&E 4-hour standard was below 95% in December at 92.3%.

3. The Trust's 18 weeks performance remained below the 92% standard in December with performance at 89.9%.

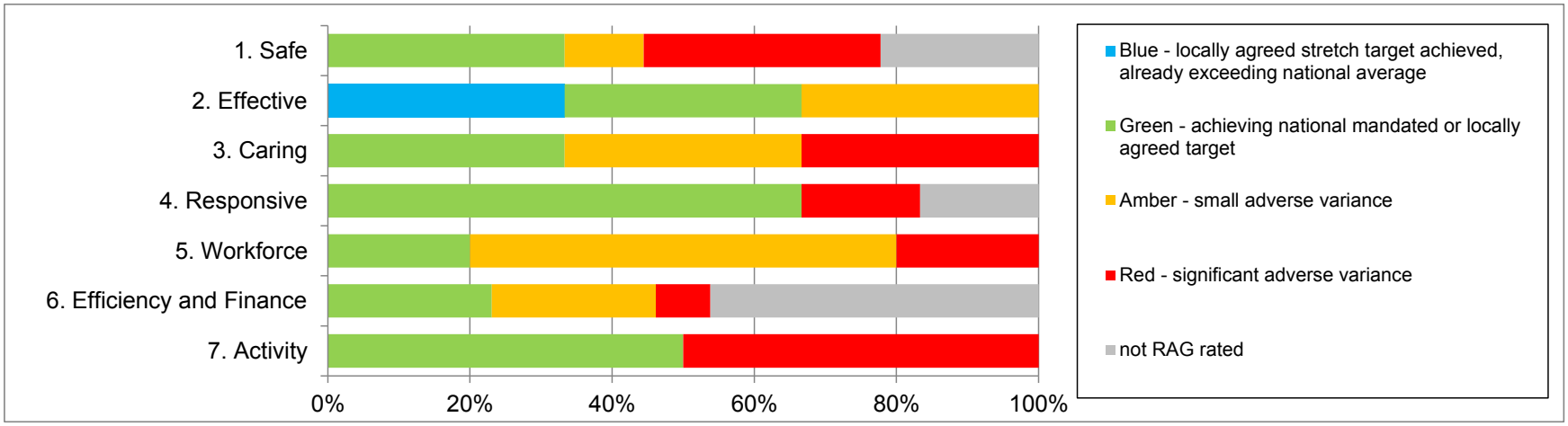
4. Provisional data indicates that all cancer waiting times standards were achieved for December.

5. The Safety Thermometer harm free percentage for December was 94.6%, a reduction on last month and below 95%.

6. The number of inpatient falls increased in December. However there were no falls reported that resulted in a fracture.

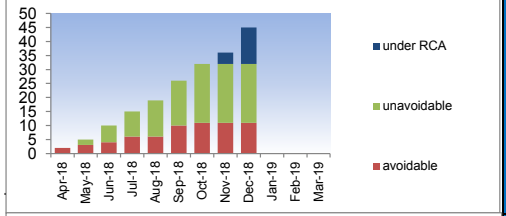
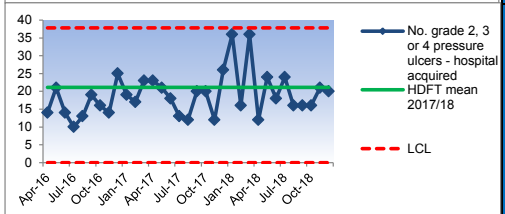
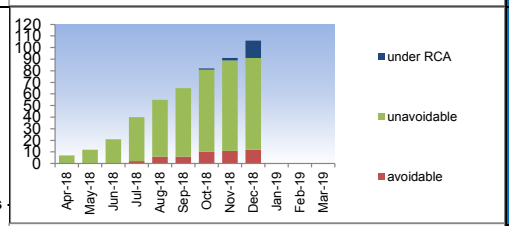
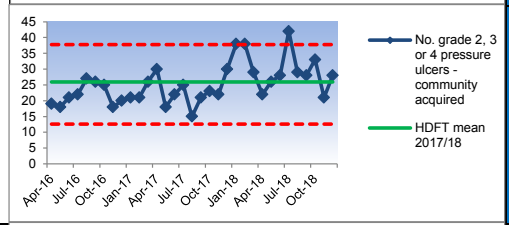
7. Delayed transfers of care remain low at just 2.0% of occupied bed days.

Summary of indicators - current month



Harrogate and District NHS Foundation Trust

Section 1 - Safe - December 2018

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.1a	DQ Pressure ulcers - hospital acquired		There were 9 hospital acquired unstageable or category 3 pressure ulcers reported in December, bringing the year to date total to 45. This is in line with last year with an average of 5 per month reported in 2017/18. For the 45 cases reported in 2018/19 to date, 11 have been assessed as avoidable, 21 as unavoidable and 13 are still under root cause analysis (RCA). No category 4 hospital acquired pressure ulcers have been reported in 2018/19 to date.
1.1b	DQ		The number of hospital acquired category 2-4 (or unstageable) pressure ulcers reported in December was 20, a decrease on last month and just below the average per month reported in 2017/18.
1.2a	DQ Pressure ulcers - community acquired		There were 15 community acquired unstageable or category 3 pressure ulcers reported in December, compared to 9 last month. The average per month reported in 2017/18 was 12. For the 106 cases reported in 2018/19 to date, 12 have been assessed as avoidable, 79 as unavoidable and 15 are still under root cause analysis (RCA).
1.2b	DQ		The number of community acquired category 2-4 (or unstageable) pressure ulcers reported in December was 28, an increase on last month and above the average per month reported in 2017/18.

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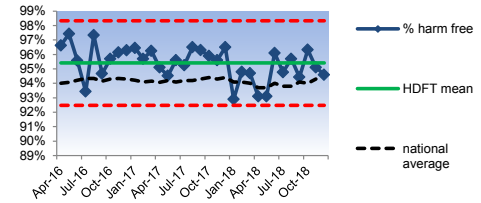
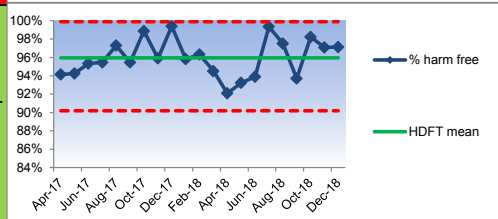
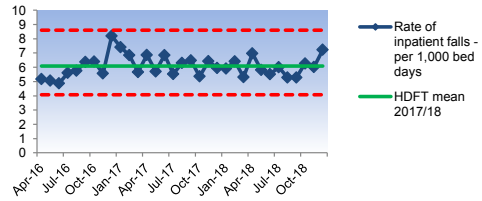
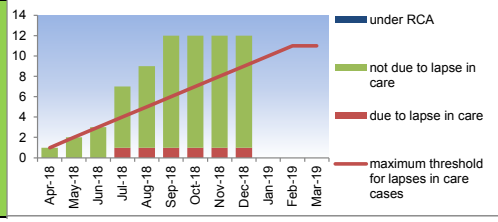
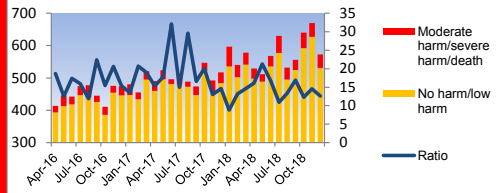
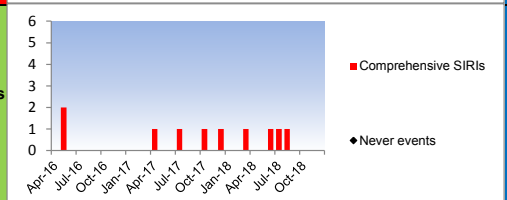
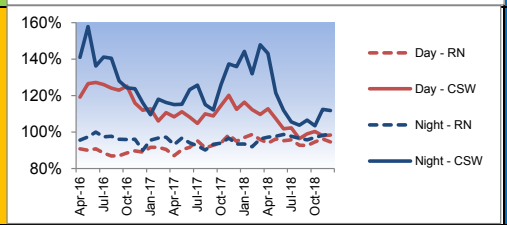
Section 1 - Safe - December 2018

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.3	Safety Thermometer - harm free care DQ		The harm free percentage for December was 94.6%, a reduction on last month and below 95%. 5 new urinary tract infections for patients with catheters were reported in this month's survey – this is the highest number reported in any single month this year.
1.4	Safety thermometer - harm free care - Community Care Teams DQ		The harm free percentage for December was 97.2%, no change on last month and remaining well above 95%.
1.5	Falls DQ		The rate of inpatient falls was 7.23 per 1,000 bed days in December, an increase on last month and above the average HDFT rate for 2017/18. However, there were no falls resulting in a fracture this month.
1.6	Infection control DQ		There were no cases of hospital apportioned C. difficile reported in December, with the year to date total remaining at 12 cases. All 12 cases have had root cause analysis completed and shared with HARD CCG. The outcome for 11 out of 12 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. No hospital apportioned MRSA cases have been reported in 2018/19 to date.

Harrogate and District NHS Foundation Trust

Section 1 - Safe - December 2018

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.7	Incidents - all DQ		The latest published national data (for the period Oct 17 - Mar 18) shows that Acute Trusts reported an average ratio of 47 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 17, a reduction on the last publication and remaining in the bottom 25% of Trusts nationally. HDFT's latest local data gives a ratio of 13, a further 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.
1.8	Incidents - SIRIs and never events DQ		There were no comprehensive SIRIs reported in December. No Never Events were reported in 2017/18 or in 2018/19 to date.
1.9	Safer staffing levels DQ		Overall staffing compared to planned was at 98.5% in December. 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.

Narrative

Joint Targeted Area Inspection (JTAI)

Between 9 and 13 July 2018, Ofsted, the Care Quality Commission, Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) and HMI Probation undertook a Joint Targeted Area Inspection (JTAI) of the multi-agency response to domestic abuse in Durham. This inspection included a 'deep dive' focus on the response to children of all ages living with domestic abuse. A report of the findings of the multi-agency JTAI inspection was published on 24 August 2018 and contained 42 recommendations. No overall grade was given, however inspectors did identify a number of key strengths and areas they wished partners to improve upon in relation to their practice and support for children and families who experience Domestic Abuse.

The Corporate Director of Children's Services for Durham County Council is the lead officer and was required to work with Chief Officers of the Local Safeguarding Children's Board (LSCB) to provide a response to the letter by 3 December 2018 with a written statement of proposed actions to the findings. The Chief Officer Group met on 19th November and approved the JTAI Improvement Action Plan for final submission to the Joint Inspectorate. Staff in the Children's and County Wide Directorate are fully engaged in this work and the small number of recommendations for which the Trust has direct responsibility are all progressing as planned. The Accountable Officers group acknowledged the need to build in some independent scrutiny as part of a dedicated multi-agency assurance framework and this will be developed in the coming weeks.

The Board is asked to note the outcome of the inspection and actions agreed as set out in the action plan.

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Section 1 - Safe - December 2018

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation

Stroke services

The Trust is continuting discussions with Leeds and York about the move of Hyper Acute Stroke from the 3rd April. We have reached broad agreement around clinical pathways but there are still a couple of areas that are not yet decided that need further conversation. The most significant of these is around access to TIA services on weekends to ensure patients can be seen within 24 hours of presentation. We would not be able to provide this service from April and currently York and Leeds feel that they do not have the capacity to pick this up.

Oncology Services

There is concern regarding severe pressures currently being experienced by other local Trusts' oncology services and the potential impact this may have on HDFT. Hull Trust may have to withdraw their support to Scarborough Hospital which would have implications for both HDFT and York as this support may need to be provided by York. This would impact on the case we have had approved to enhance specialist oncology nursing to deliver acute oncology which relies on good access to visiting oncologists. A follow up call has been arranged to discuss possible solutions with Leeds, York and Hull.

Safer staffing

A summary of the December safer staffing results is presented below. 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 December was 7.82 care hours per patient per day.

	Dec-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	97.6%	92.2%	100.0%	106.5%	4.41	2.63	7.04
Byland	88.7%	97.6%	92.9%	114.5%	2.67	3.38	6.05
CATT	88.9%	109.7%	105.2%	104.0%	4.76	3.02	7.78
Farndale	97.1%	83.3%	100.0%	119.6%	3.10	2.84	5.94
Granby	111.5%	130.6%	100.0%	101.6%	3.15	3.00	6.15
Harlow	102.4%	100.0%	100.0%	-	7.53	3.26	10.79
ITU/HDU	98.9%	-	103.9%	-	24.16	0.94	25.10
Jervaulx	94.8%	96.8%	95.5%	124.7%	2.81	3.47	6.28
Lascelles	103.3%	94.2%	100.0%	103.2%	4.48	3.88	8.36
Littondale	92.9%	98.9%	98.9%	132.3%	4.21	2.74	6.95
Maternity Wards	99.6%	91.9%	95.0%	82.3%	20.59	5.69	26.28
Nidderdale	100.1%	94.1%	103.2%	96.8%	3.77	2.10	5.88
Oakdale	88.0%	95.2%	96.8%	116.1%	4.07	2.55	6.62
Special Care Baby Unit	92.2%	34.5%	90.3%	-	13.75	1.32	15.07
Trinity	98.6%	105.8%	100.0%	100.0%	3.23	3.79	7.02
Wensleydale	87.5%	112.9%	103.2%	111.3%	3.73	2.80	6.53
Woodlands	79.4%	96.8%	95.7%	96.8%	8.52	2.77	11.29
Trust total	**94.6%**	**98.4%**	**99.0%**	**111.7%**	**4.84**	**2.98**	**7.82**

Section 1 - Safe - December 2018

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation

Further information to support the December safer staffing data

On the wards CATT, Oakdale, Byland and Jervaulx, 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.

On Granby and Trinity wards, the increase in day duty RN hours (Granby) and day duty CSW hours (Trinity) above plan was to support the opening of additional escalation beds in December, as required.

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 December, however a professional assessment was made on a shift by shift basis to ensure that nurse staffing numbers matched the activity.

In some wards, the actual care staff hours show additional hours used for enhanced care for those patients who require intensive support. In December, this is reflected on the wards Byland, Farndale, Jervaulx, Oakdale, Lascelles and Littondale.

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

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 and care staff hours are less than planned in December, however the ward occupancy levels vary considerably which means that particularly in this area that the number of planned and actual nurses is kept under constant review.

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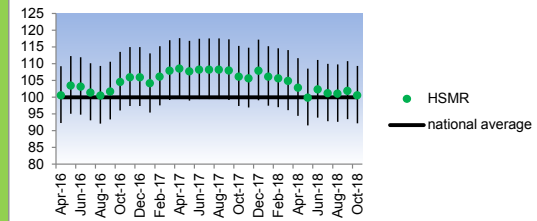
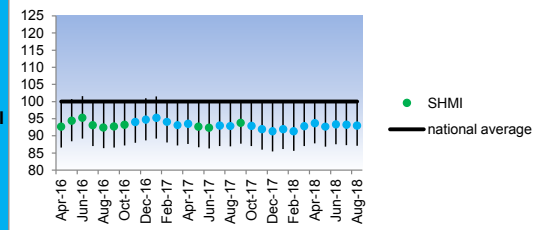
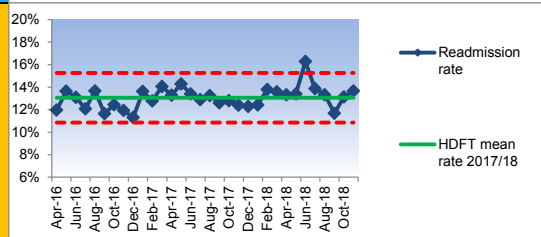
Section 2 - Effective - December 2018

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
2.1	Mortality - HSMR DQ		HDFT's HSMR for the rolling 12 months ending October 2018 was 100.51, a decrease on last month and remaining within expected levels. At specialty level, 4 specialties have a higher than expected standardised mortality rate - General Medicine, Geriatric Medicine, Trauma & Orthopaedics and Endocrinology.
2.2	Mortality - SHMI DQ		SHMI data is now available on HED up to end August 2018. HDFT's SHMI for the most recent rolling 12 months (September 2017 to August 2018) was 92.98. This remains below expected levels. At specialty level, 3 specialties (Geriatric Medicine, Respiratory Medicine and General Medicine) have a standardised mortality rate above expected levels.
2.3	Readmissions DQ		The number of emergency readmissions in November (after PbR exclusions are applied) was 270. This equates to 13.7% when expressed as a percentage of all emergency admissions. This is an increase on last month and just HDFT average for 2017/18.

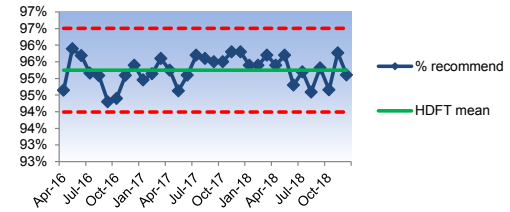
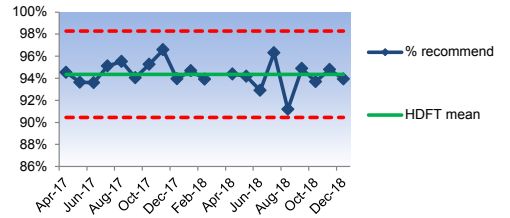
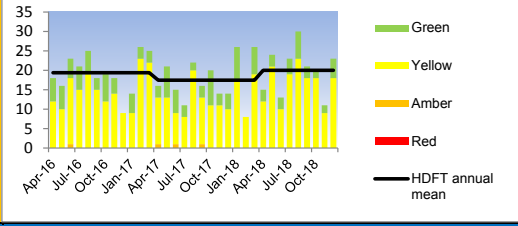
Narrative

UNICEF Baby Friendly Initiative

In December 2018, the Maternity Unit undertook the reassessment process to remain accredited at gold standard for being baby friendly. The Maternity Unit has maintained gold standard practice. It is notable, in addition to Harrogate having the highest breast feeding rate at initiation in Yorkshire and Humber, that the team have also achieved an improvement in the number of babies still being breastfed at 10-14 days from 54.4% in 2014 to 70.5% in 2018.

Harrogate and District NHS Foundation Trust

Section 3 - Caring - December 2018

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
3.1	Friends & Family Test (FFT) - Patients DQ		95.1% of patients surveyed in December would recommend our services, a reduction on last month but remaining above the latest published national average (93.6%). Around 3,500 patients responded to the survey this month. This is lower than recent months and may be partly due to reduced activity during the Christmas period.
3.2	Friends & Family Test (FFT) - Adult community services DQ		93.9% of patients surveyed in December would recommend our services, a decrease on last month and remaining below the national average performance for community services (95.9%). 350 patients from adult community services responded to the survey this month. This indicator is based on the FFT for Rehabilitation & Therapy Services, Children & Family Services and GPOOH. The only service of these three which is below the national average is GPOOH at 73.3%. When reviewing the narrative, it appears that the main reasons for users not recommending the service are due to the waiting times to be seen and the information shared around waits. This is being picked up with the service to agree how we might improve the information given to patients around expected waits in GPOOH and how we might use other services (such as Extended Access) to support capacity issues in the service.
3.3	Complaints DQ		23 complaints were received in December, an increase on last month and above the average for 2018/19. 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 about delay or failure in treatment or procedure.

Narrative

Complaints

From April - December 2018, the Trust has received 178 formal complaints. This compares to 150 formal complaints in the same period last year, representing an increase of 16%. The Patient Experience Team are preparing further analysis.

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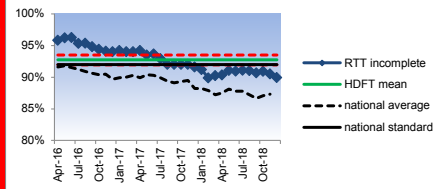
Section 4 - Responsive - December 2018

NHS Improvement Single Oversight Framework

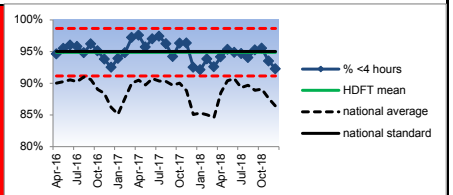
4.1 **NHS Improvement Single Oversight Framework** DQ

Standard	Q1	Q2	Q3	Q4	YTD
RTT incomplete pathways	90.8%	90.9%	90.4%		90.7%
A&E 4-hour standard	94.8%	94.6%	93.8%		94.4%
Cancer - 62 days	87.3%	85.3%	85.5%		86.0%
Diagnostic waits	98.4%	99.0%	99.5%		98.96%
Dementia screening - Step 1	95.6%	93.0%	93.0%		93.8%
Dementia screening - Step 2	95.7%	100.0%	98.1%		97.8%
Dementia screening - Step 3	97.4%	100.0%	96.8%		97.8%

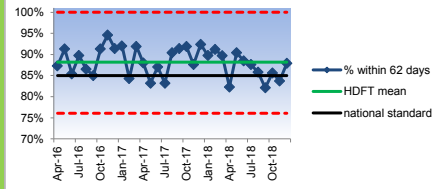
4.2 **RTT Incomplete pathways performance** DQ



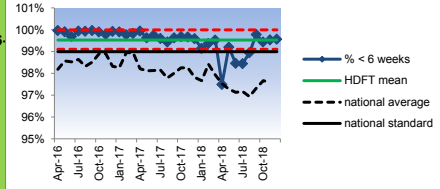
4.3 **A&E 4 hour standard** DQ



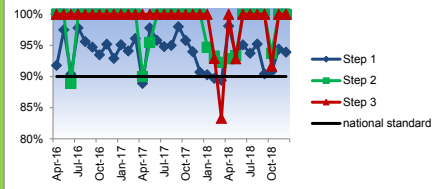
4.4 **Cancer - 62 day wait for first treatment from urgent GP referral to treatment** DQ



4.5 **Diagnostic waiting times - 6-week standard** DQ



4.6 **Dementia screening** DQ



Narrative

In Quarter 3, HDFT's performance is below the required level for 2 of the operational performance metrics - the18 weeks standard and the A&E 4-hour standard. RTT performance was at 89.9% in December, a further deterioration on the previous month. The total RTT waiting list size increased in December to 14,800 and remains above the position reported at the end of 2017/18 (14,005).

For the A&E 4-hour standard, HDFT's Trust level performance for December was 92.3%, a further deterioration on recent months. This includes data for the Emergency Department at Harrogate and Ripon MIU. A new Task and Finish group has been established to focus on improving performance to back above 95% between now and year end. It is anticipated this will ensure the delivery of the performance required to meet the PSF requirements for Quarter 4.

Performance against the 62 day cancer standard has improved and is now above the 85% standard for December and for Quarter 3 overall.

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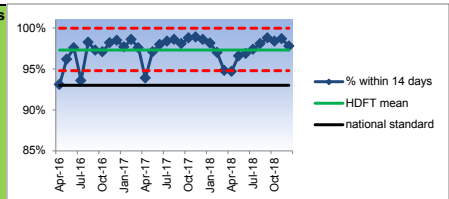
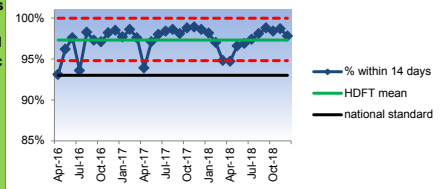
Section 4 - Responsive - December 2018

Cancer waiting times standards

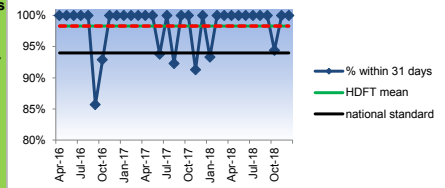
4.7 Cancer - 14 days max wait from urgent GP referral for suspected cancer — DQ



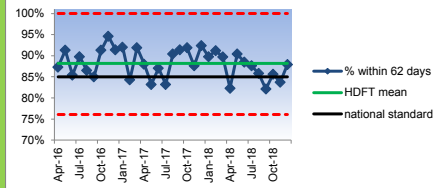
4.8 Cancer - 14 days maximum wait from GP referral for symptomatic breast patients — DQ



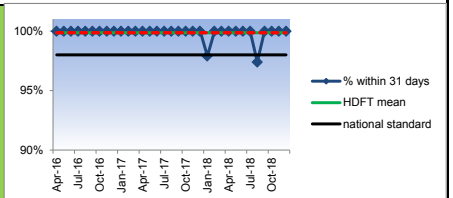
4.9 Cancer - 31 days maximum wait from diagnosis to treatment for all cancers — DQ



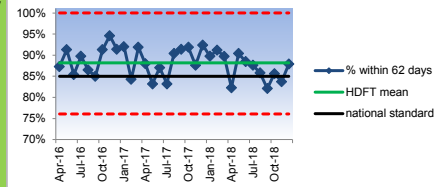
4.10 Cancer - 31 day wait for second or subsequent treatment: Surgery — DQ



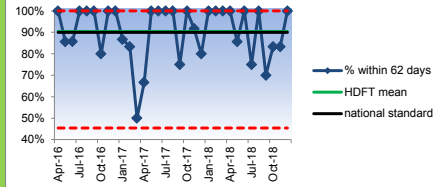
4.11 Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug — DQ



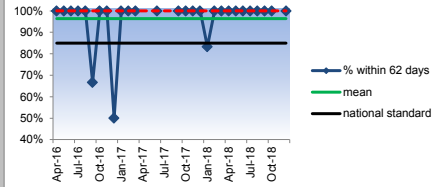
4.12 Cancer - 62 day wait for first treatment from urgent GP referral to treatment — DQ



4.13 Cancer - 62 day wait for first treatment from screening service — DQ



4.14 Cancer - 62 day wait for first treatment from consultant upgrade — DQ



Narrative

Provisional data indicates that all cancer waiting times standards were achieved for December. All standards were also achieved for Quarter 3 overall with the exception of the 62 day screening standard where performance was at 88.9% for the quarter against the 90% minimum standard. With 13.5 accountable pathways in the quarter, this is above the de minimis level for reporting performance.

Looking forward into Quarter 4, the 62 day standard for January will be challenging to deliver due to capacity constraints over the Christmas period and patient choice of appointments during that period. This has also affected the 14 day breast standard for January.

For the main 62 day standard, of the 11 tumour sites, 4 had performance below 85% in December - haematological (1.0 breach), other (0.5), upper gastrointestinal (2.0) and urological (2.5). 3 patients waited over 104 days in December. The reasons for the delays were availabilty of elective capacity at other local providers and patient choice.

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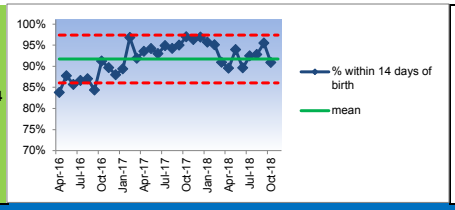
Section 4 - Responsive - December 2018

Children's Services metrics

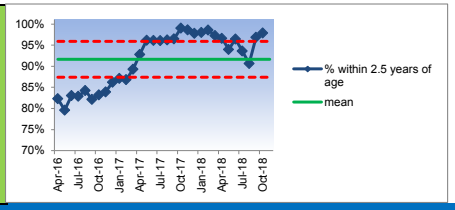
4.15 **Children's Services - 10-14 day new birth visit**

DQ



4.16 **Children's Services - 2.5 year review**

DQ



Narrative

The charts present a combined performance position for all Children's Services contracts. The data is reported a month in arrears so that the validated position can be shared. Data for Gateshead and Sunderland is now included from July 2018 onwards.

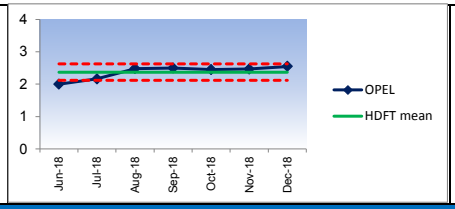
In November, the validated performance position for new birth visits is that 93% of babies were recorded on Systmone as having had a new birth visit within 14 days of birth. Performance in November in the different localities varies from 88% in Darlington to 95% in Durham and Middlesborugh. The validated performance position for 2.5 year reviews is that 97% of children were recorded on Systmone as having had a 2.5 year review. Performance in November in the different localities varies from 79% in Gateshead to 100% in Stockton and Sunderland.

Work is ongoing to develop additional metrics for Children's Services for inclusion in this report going forward.

Adult Community Services metrics

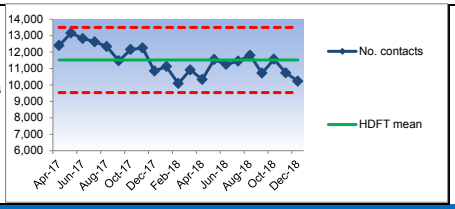
4.17 **OPEL level - Community Care Teams**

DQ



4.18 **Community Care Teams - patient contacts**

DQ



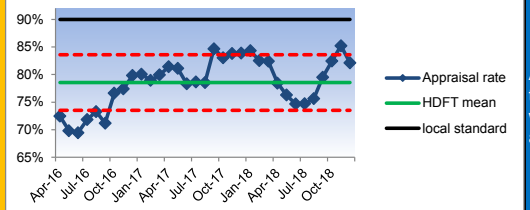
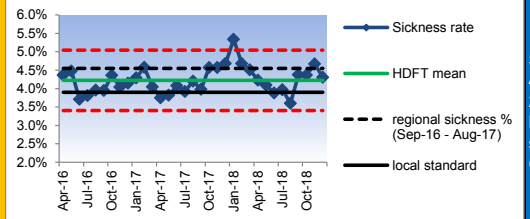
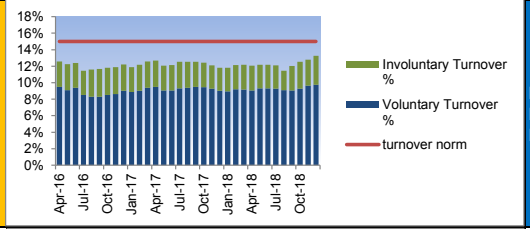
Narrative

During December, the average community OPEL level reported was 2.54, a minor increase on last month. OPEL 3 was reported on 19 out of 31 days during the month.

Following the work to review the caseload in Adult Community Services and the introduction of the clinical triage process for new referrals, patient contacts have stabilised within the funded establishment. The development and transition to single integrated Health and Social Care locality teams continues to progress and it is anticipated that the final plans will be ready by January 2019 to bring to Board to enable Phase 1 to progress from April 2019.

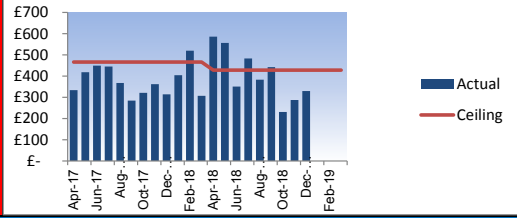
Harrogate and District NHS Foundation Trust

Section 5 - Workforce - December 2018

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
5.1	Staff appraisal rates DQ		Appraisal compliance is reported at 82.1% in December 2018, this is a decline when compared to November's 85.2% position. This is to be expected as we are now outside our appraisal window which ended in September 2018. We are making arrangements to re-launch the appraisal period in March 2019.
5.2	Mandatory training rates DQ	Competence Name / Compliance %: Data Security Awareness 91% Equality, Diversity and Human Rights 92% Fire Safety 84% Infection Control 98% Safeguarding Children & Young People Level 1 92% Risk Awareness 98% Health & Safety Elearning 96% Manual Handling eLearning 92%	The data shown is for the end of December and excludes the Harrogate Healthcare Facilities Management (HHFM) staff who transferred into the new organisation on the 1st March 2018 and excludes Stockton who Tupe transferred into the Trust on 1st April 2018 and Gateshead and Sunderland who Tupe transferred into the Trust on 1st July 2018. The overall training rate for mandatory elements for substantive staff is 93% and has stayed the same since the last reporting cycle.
5.3	Sickness rates DQ		Staff sickness has seen a marginal reduction in December, reporting 4.3% in comparison to 4.7% in November 2018. The Trust remains above the 3.9% target, but is lower than December 2017 and remains in line with the higher rates usually experienced over the winter period. There has been a focus of increasing return to work compliance across the Trust with a new streamlined return to work document, which is currently being trialled in a number of areas. Occupational Health referral documentation has also been revised and is now live.
5.4	Staff turnover rate DQ		Labour turnover has shown a slight increase in December at 13.3% compared with 12.8% in November 2018. The split between voluntary and involuntary turnover has remained static in December, however the involuntary figure is slightly higher compared to the last 7 months.

Harrogate and District NHS Foundation Trust

Section 5 - Workforce - December 2018

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
5.5	Agency spend in relation to pay spend DQ		Agency expenditure continues to increase at a similar trend, which is slightly adverse to the agency ceiling position.

Narrative

Launch of Rapid Access MSK Service

The HDFT Occupational Health Department is pleased to announce that the Trust has launched a new Rapid Access MSK (Musculoskeletal) Service, delivered through PhysioMed for a 12 month pilot. HDFT employees may be referred to PhysioMed by their manager, via Occupational Health, if they have a musculoskeletal related concern which affects their ability to perform their job. A specialist clinician from PhysioMed will subsequently undertake a telephone assessment with the employee and appropriate treatment/advice will be offered in accordance with PAL (Patient Advice Line) pathways. Occupational Health will triage referrals to the physiotherapy service. MSK related absence represents about 20% of the Trust's overall sickness absence and is the second highest reason for absence across the Trust. This is a really positive development in the Trust's health and wellbeing offer.

Flu

We have now vaccinated 2,556 HDFT staff out of a total workforce of 4,603 since the commencement of the flu campaign on the 1 October 2018, equating to 56% of our total workforce being vaccinated. The individual directorate compliance rates are as follows:

Directorate	Headcount	Vaccinated	Percentage
Children's & County Wide	1,585	746	47%
Corporate	429	267	62%
Long Term and Unscheduled Care	1,510	906	60%
Planned and Surgical	1,079	637	59%
Total HDFT	**4,603**	**2,556**	**56%**
HHFM	319	142	45%
Total Inc. HHFM	**4,922**	**2,698**	**55%**

The breakdown of clinical staff and the numbers vaccinated are below:

Staff Group	Headcount	Vaccinated	Percentage
All Doctors	494	279	56%
Qualified Nurse	1,762	961	55%
Qualified Other	576	352	61%
Support to Clinical	936	496	53%
Total	**3,768**	**2,088**	**55%**

Section 5 - Workforce - December 2018

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation

In the last week we have seen a significant outbreak of flu on one of our medical wards and a number of communications have been sent to encourage those not yet vaccinated to do so. Colleagues have also been asked to complete a form for Occupational Health if there is no record of them having the vaccination yet and to confirm if they are unfit to receive the vaccination or are declining to have it and if so, on what grounds. The data from this is currently being inputted onto our system and from this we will be able to follow up with individuals where no response has yet been received. Analysis will also take place of the reasons colleagues have provided for not having the jab which will inform the communications plan for 2019/20 flu campaign.

Job Planning Compliance

The December job planning figures show an improvement in the rate of completed consultant doctor's job plans from 79.9% to 81.3% and a decrease in completed SAS doctor's job plans from 58.9% to 57.9%. Despite the demonstrated improvements, the target of reaching 100% compliance in December 2018 was unfortunately not reached.

DECEMBER 2018 JOB PLANNING CENTRAL REPORT - CONSULTANTS

Directorate	Number of Consultants	Current Job Plans (ie < 12 months)	%	Job Plans older than 12 months	%	Number of Consultant with no Job Plans recorded	%	In progress	Previous month current JPs	RAG
C & CWCC	10	9	90.00%	0	0.00%	1	10.00%	0	90.00%	
C & CWCC - Dental	2	2	100.00%	0	0.00%	0	0.00%	0	100.00%	
LT & UC	54	44	81.48%	10	18.52%	0	0.00%	0	83.33%	
P & SC	68	54	79.41%	9	13.24%	5	7.35%	0	75.00%	
Total	**134**	**109**	**81.34%**	**19**	**14.18%**	**6**	**4.48%**	0	**79.85%**	

DECEMBER 2018 JOB PLANNING CENTRAL REPORT - SAS GRADES

Directorate	Number of SAS Doctors	Current Job Plans (ie < 12 months)	%	Job Plans older than 12 months	%	Number of SAS Doctors with no Job Plans recorded	%	In progress	Previous month current JPs	RAG
C & CWCC	6	3	50.00%	0	0.00%	3	50.00%	0	60.00%	
LT & UC	11	2	18.18%	8	72.73%	1	9.09%	0	18.18%	
P & SC	40	28	70.00%	3	7.50%	9	22.50%	0	70.00%	
Total	**57**	**33**	**57.89%**	**11**	**19.30%**	**13**	**22.81%**	0	**58.93%**	

Excludes locums, maternity leave, bank; new starters u/6 months

Change from previous month (current JPs)

Improved **No change** **Deteriorated**

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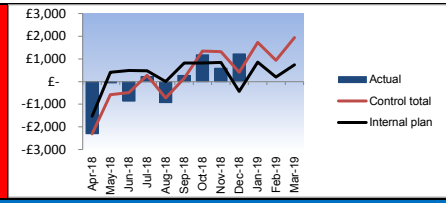
Section 6 - Efficiency and Finance - December 2018

Finance

6.1 Surplus / deficit and variance to plan DQ



6.2 NHS Improvement Single Oversight Framework - Use of Resource Metric DQ

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

6.3 Capital spend DQ

Narrative

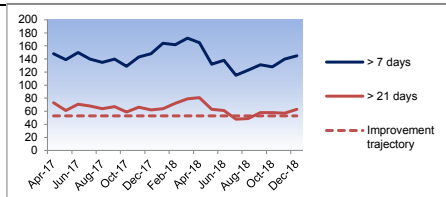
The Trust reported a surplus of £1,214k in December. This improved the year to date position to £687k, ensuring the control total for the Trust was achieved for Quarter 3. Risks still remain in the position, with the finance report outlining the best, worst and likely forecast positions.

The Trust continues to report a UoR rating of 3. While this is at the current plan, this remains a challenging position as a result of I&E performance.

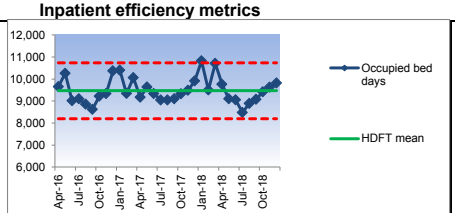
While resource for capital remains a risk, expenditure is exceeding planned levels.

Inpatient efficiency metrics

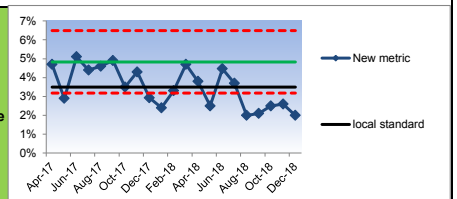
6.4 Long stay patients



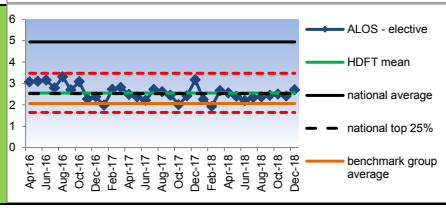
6.5 Occupied bed days



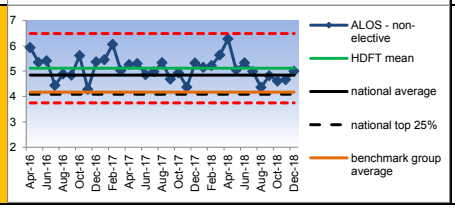
6.6 Delayed transfers of care DQ



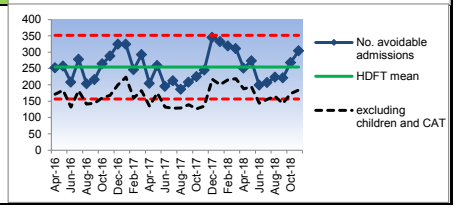
6.7 Length of stay - elective



6.8 Length of stay - non-elective



6.9 Avoidable admissions DQ



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Section 6 - Efficiency and Finance - December 2018

Narrative

The number of long stay patients (>21 days) at HDFT increased to 63 in December. NHS Improvement has set improvement trajectories for Trusts to reduce the number of super-stranded patients by around 25% by Quarter 4 2018/19. 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.

In December, there were 9,800 occupied bed days, an increase on last month but below the level reported last December (9,900).

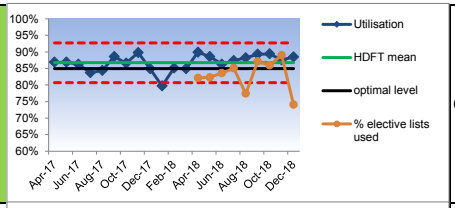
HDFT's average elective length of stay for December was 2.7 days, an increase on last month. HDFT remains in the top 25% (best) of Trusts nationally in the most recently available benchmarking data. HDFT's average non-elective length of stay for December was 5.0 days, an increase on last month but lower than December last year. The Trust remains in the middle 50% of Trusts nationally when compared to the most recently available benchmarking data.

Provisional data indicates that there were 304 avoidable admissions in November, an increase on last month and above the level reported in November last year. Adult avoidable admissions (excluding CAT attendances) also increased this month.

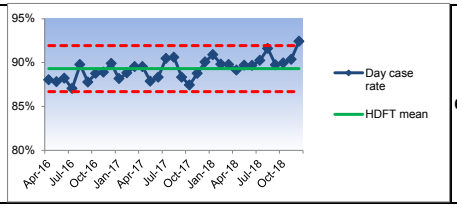
In December, 2.0% of bed days were lost due to delayed transfers of care, a decrease on last month and remaining below the local standard of 3.5%.

Productivity metrics

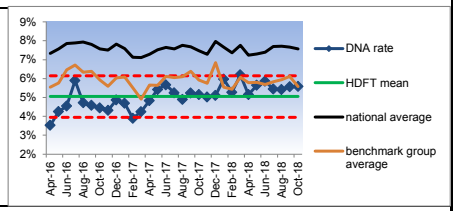
6.10 **Theatre utilisation**



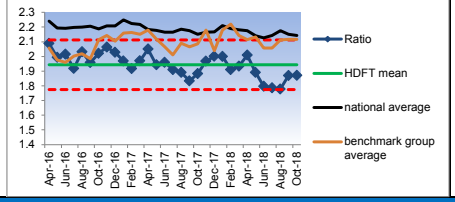
6.11 **Day case rate** DQ



6.12 **Outpatient DNA rate** DQ



6.13 **Outpatient new to follow up ratio** DQ



Narrative

Elective theatre utilisation was at 88.5% in December, an increase on last month and remaining above the 85% optimal level. This utilisation only reflects the elective lists that took place as planned. An extra line has been added to the chart to show the percentage of planned elective lists that took place each month. This is the first time that we have presented this additional metric. Further work will be done in the coming weeks to ensure that it accurately reflects list utilisation. In December, 74% of elective lists were used. This is lower than recent months but is reflective of the number of bank holidays during the month and the reduced need for elective lists over the Christmas holiday period.

The day case rate was 92.4% in December, a significant increase on last month - this is partly reflective of a planned reduction in the number of elective inpatient admissions during December to enable maximium bed availability for non-elective admissions during the winter period.

HDFT's DNA rate was 5.6% in October, no significant change on recent months. This remains below the level reported by the benchmarked group of trusts and below the national average.

The clinical teams continue to implement opportunities to reduce follow up activity through the use of appropriate alternatives. This work is being managed through the Planned Care Board which oversees work in relation to the Aligned Incentive Contract. HDFT's new to follow up ratio was 1.87 in October, no change on last month 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.

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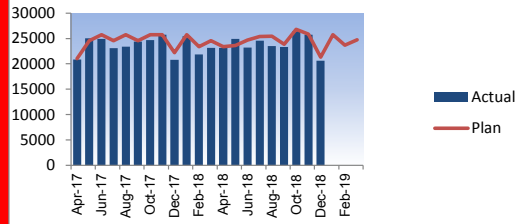
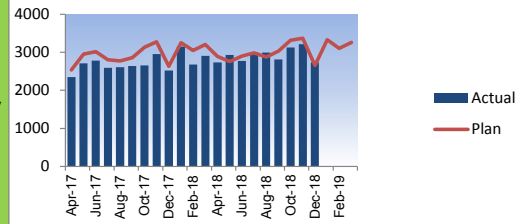
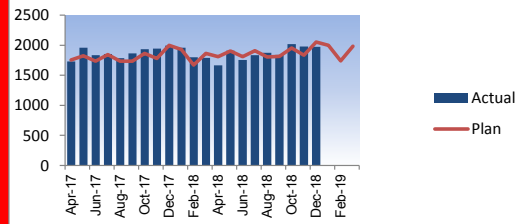
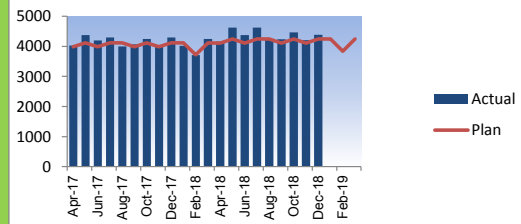
Section 7 - Activity - December 2018

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
7.1	Outpatient activity against plan DQ		Outpatient activity was 3.5% below plan in December and remains 2.2% below plan year to date.
7.2	Elective activity against plan DQ		Elective activity was 2.8% above plan in December, but remains 1.7% below plan year to date.
7.3	Non-elective activity against plan DQ		Non-elective activity was 3.7% below plan in December and 0.3% below plan year to date.
7.4	A&E activity against plan DQ		A&E attendances were 3.2% above plan in December. The year to date position is 4.3% above plan. The figures presented include patients streamed to primary care.

Section 7 - Activity - December 2018

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation

Narrative

The specialities continue to deliver above plan for new outpatient activity and below for follow ups. This reflects the ongoing work to modify clinical pathways to reduce follow ups. It continues to be of concern that activity for HaRD CCG remains above plan and although agreement has been reached to cover the costs this year, work continues to seek to resolve this going into next year. There also continues to be a focus on recovery of day case activity against plan for endoscopy following the opening of the new unit, however it should be noted that activity in the Wharfedale unit is now achieving plan following work to improve utilisation of lists with Leeds Teaching Hospitals.

The tables below summarise the activity position for the Trust overall and for HARD CCG.

Activity Summary - Trust total

	Nov-18			Dec-18			Dec-18 YTD			Dec-17 YTD		
Activity type	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
New outpatients	9024	8656	4.3%	7284	7175	1.5%	75560	73803	2.4%	72518	73112	-0.8%
Follow-up outpatients	16725	17195	-2.7%	13374	14169	-5.6%	139985	146592	-4.5%	140366	146633	-4.3%
Elective inpatients	312	331	-5.9%	208	257	-18.9%	2551	2692	-5.2%	2615	2916	-10.3%
Elective day cases	2903	3041	-4.5%	2524	2402	5.1%	23756	24081	-1.4%	21191	23069	-8.1%
Non-electives	1977	1835	7.7%	1972	2050	-3.8%	16845	16894	-0.3%	16906	16268	3.9%
A&E attendances	4210	4108	2.5%	4380	4245	3.2%	39282	37657	4.3%	37499	36546	2.6%

Activity Summary - HARD CCG

	Nov-18			Dec-18			Dec-18 YTD			Dec-17 YTD		
Activity type	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
New outpatients	5969	5720	4.4%	4956	4745	4.4%	50865	48776	4.3%	49478	45408	9.0%
Follow-up outpatients	11838	11241	5.3%	9478	9258	2.4%	98837	95859	3.1%	98968	88140	12.3%
Elective inpatients	192	207	-7.4%	144	161	-10.3%	1621	1672	-3.1%	1638	1621	1.0%
Elective day cases	1926	1789	7.7%	1638	1407	16.4%	15473	14268	8.4%	14663	13478	8.8%
Non-electives	1511	1363	10.9%	1498	1523	-1.6%	12851	12544	2.5%	12735	12077	5.5%
A&E attendances	3094	3033	2.0%	3207	3134	2.3%	28376	27803	2.1%	27177	26346	3.2%

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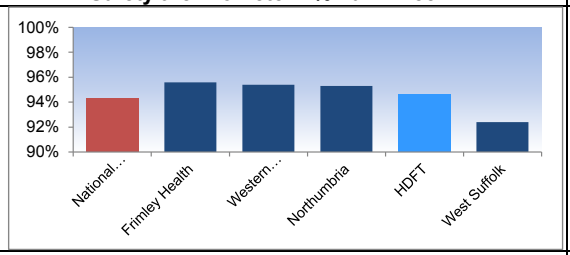
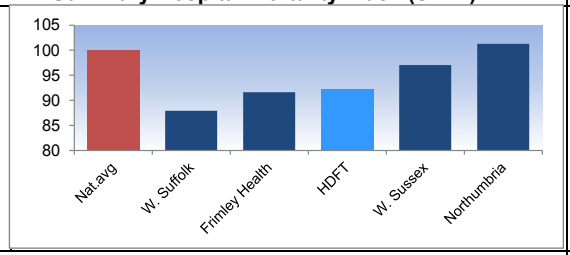
Section 8 - Benchmarking - December 2018

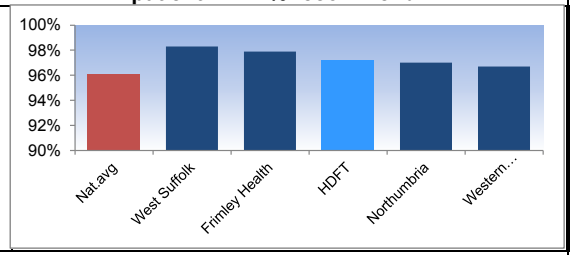
8.1 Safety thermometer - % harm free



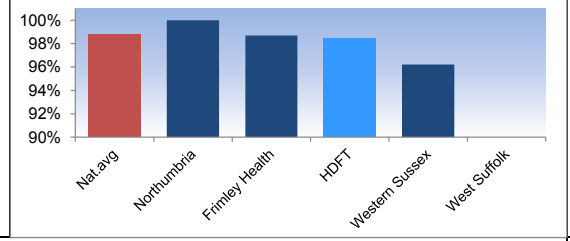
8.2 Summary Hospital Mortality Index (SHMI)



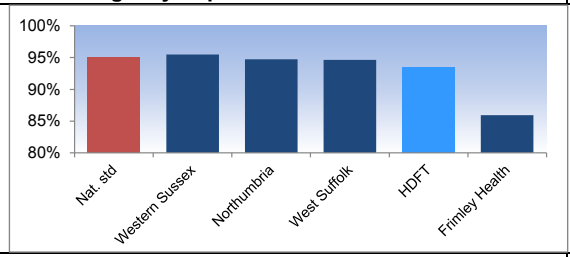
8.3 Inpatient FFT - % recommend



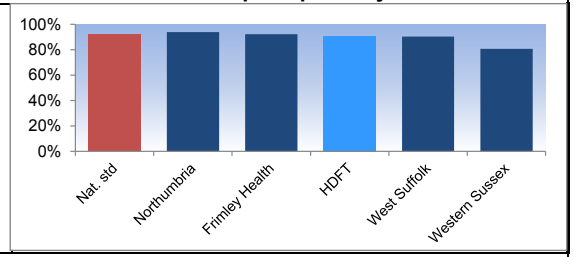
8.4 Maternity FFT - Q2 Birth - % recommend



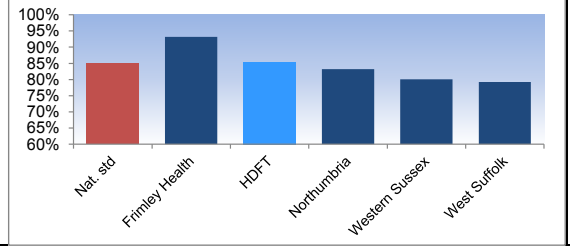
8.5 Emergency Department 4 hour standard



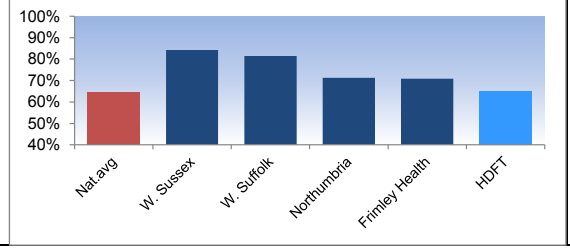
8.6 RTT incomplete pathways



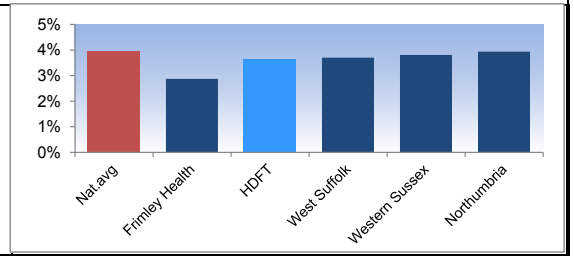
8.7 Cancer 62 days



8.8 Staff FFT - % recommend (place to work)



8.9 Sickness absence

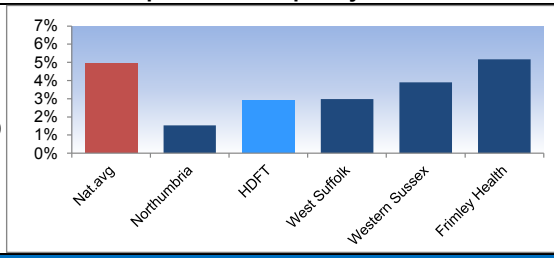


Section 8 - Benchmarking - December 2018

Harrogate and District NHS Foundation Trust

Proportion of temporary staff

8.10



Narrative

The charts above show HDFT's latest published performance benchmarked against small Trusts with an outstanding CQC rating. The metrics have been selected based on a subset of metrics presented in the main report where benchmarking data is readily available. For the majority of the metrics, the information has been sourced from the Model Hospital website.

As can be seen from the charts, HDFT performs better than average for the cancer 62-day standard, staff sickness absence and the proportion of temporary staffing. Conversely, HDFT performs worst for the staff Friends & Family Test (% staff recommending the Trust as a place to work) .

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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** 	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. The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. 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.
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.

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Indicator traffic light criteria

Indicator number	Domain	Indicator	Description	Traffic light criteria	Rationale/source of traffic light criteria
1.1	Safe	Pressure ulcers - hospital acquired	The chart shows the number of category 2, 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.	tbc	tbc
1.2	Safe	Pressure ulcers - community acquired	The chart shows the number of category 2, 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.	tbc	tbc
1.3	Safe	Safety thermometer - harm free care	Measures the percentage of patients receiving harm free care (defined as the absence of pressure ulcers, harm from a fall, urine infection in patients with a catheter and new VTE) in the Safety Thermometer audits conducted once a month. The data includes hospital and community teams. A high score is good. Whilst there is no nationally defined target for this measure, a score of 95% or above is considered best practice.	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%.
1.4	Safe	Safety thermometer - harm free care - community care teams	As above but including data for community teams only.		
1.5	Safe	Falls	The number of inpatient falls expressed as a rate per 1,000 bed days. The data includes falls causing harm and those not causing harm. A low rate is good.	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.
1.6	Safe	Infection control	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.	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
1.7	Safe	Incidents - all	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	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.
1.8	Safe	Incidents - comprehensive SIRIs and never events	The number of Serious Incidents Requiring Investigation (SIRIs) and Never Events reported within the Trust each month. The data includes hospital and community services. Only comprehensive SIRIs are included in this indicator, as concise SIRIs are reported within the presure ulcer / falls indicators above.	Green if none reported in current month; Red if 1 or more never event or comprehensive reported in the current month.	
1.9	Safe	Safer staffing levels	Trusts are required to publish information about staffing levels for registered nurses/midwives (RN) and care support workers (CSW) for each inpatient ward. The chart shows the overall fill rate at HDFT for RN and CSW for day and night shifts. The fill rate is calculated by comparing planned staffing with actual levels achieved. A ward level breakdown of this data is provided in the narrative section and published on the Trust website.	Green if latest month overall staffing >=100%, amber if between 95% and 100%, red if below 95%.	The Trusts aims for 100% staffing overall.
2.1	Effective	Mortality - HSMR	The Hospital Standardised Mortality Ratio (HSMR) looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care. A low figure is good.	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.
2.2	Effective	Mortality - SHMI	The Summary Hospital Mortality Index (SHMI) looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care. A low figure is good.		
2.3	Effective	Readmissions	% of patients readmitted to hospital as an emergency within 30 days of discharge (PbR exclusions applied). To ensure that we are not discharging patients inappropriately early and to assess our overall surgical success rates, we monitor the numbers of patients readmitted. A low number is good performance. This data is reported a month behind so that any recent readmissions are captured in the data.	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.
3.1	Caring	Friends & Family Test (FFT) - Patients	The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of hospital and community services including inpatients, day cases, outpatients, maternity services, the emergency department, some therapy services, district nursing, community podiatry and GP OOH. A high percentage is good.	Green if latest month >= latest published national average, Red if < latest published national average.	Comparison with national average performance.
3.2	Caring	Friends & Family Test (FFT) - Adult Community Services	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.		

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Indicator number	Domain	Indicator	Description	Traffic light criteria	Rationale/source of traffic light criteria
3.3	Caring	Complaints	The number of complaints received by the Trust, shown by month of receipt of complaint. The criteria define the severity/grading of the complaint with green and yellow signifying less serious issues, amber signifying potentially significant issues and red for complaints related to serious adverse incidents. The data includes complaints relating to both hospital and community services.	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.
4.1	Responsive	NHS Improvement governance rating	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 perfromance forms part of this assessment.	As per defined governance rating	
4.2	Responsive	RTT Incomplete pathways performance	Percentage of incomplete pathways waiting less than 18 weeks. The national standard is that 92% of incomplete pathways should be waiting less than 18 weeks. A high percentage is good.	Green if latest month >=92%, Red if latest month <92%.	NHS England
4.3	Responsive	A&E 4 hour standard	Percentage of patients spending less than 4 hours in Accident & Emergency (A&E). The operational standard is 95%. The data includes all A&E Departments, including Minor Injury Units (MIUs). A high percentage is good.	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%.
4.4	Responsive	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.	Green if latest month >=85%, Red if latest month <85%.	NHS England, NHS Improvement and contractual requirement
4.5	Responsive	Diagnostic waiting times - 6-week standard	Percentage of patients waiting 6 weeks or less for a diagnostic test. The operational standard is 99%. A high percentage is good.	Green if latest month >=93%, Red if latest month <93%.	NHS England, NHS Improvement and contractual requirement
4.6	Responsive	Dementia screening	The proportion of emergency admissions aged 75 or over who are screened for dementia within 72 hours of admission (Step 1). Of those screened positive, the proportion who went on to have an assessment and onward referral as required (Step 2 and 3). The operational standard is 90% for all 3 steps. A high percentage is good.	Green if latest month >=90% for Step 1, Step 2 and Step 3, Red if latest month <90% for any of Step 1, Step 2 or Step 3.	NHS England, NHS Improvement and contractual requirement
4.7	Responsive	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%. A high percentage is good.	Green if latest month >=93%, Red if latest month <93%.	NHS England, NHS Improvement and contractual requirement
4.8	Responsive	Cancer - 14 days maximum wait from GP referral for symptomatic breast patients	Percentage of GP referrals for breast symptomatic patients seen within 14 days. The operational standard is 93%. A high percentage is good.	Green if latest month >=93%, Red if latest month <93%.	NHS England, NHS Improvement and contractual requirement
4.9	Responsive	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.	Green if latest month >=96%, Red if latest month <96%.	NHS England, NHS Improvement and contractual requirement
4.10	Responsive	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.	Green if latest month >=94%, Red if latest month <94%.	NHS England, NHS Improvement and contractual requirement
4.11	Responsive	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.	Green if latest month >=96%, Red if latest month <96%.	NHS England, NHS Improvement and contractual requirement
4.12	Responsive	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.	Green if latest month >=85%, Red if latest month <85%.	NHS England, NHS Improvement and contractual requirement
4.13	Responsive	Cancer - 62 day wait for first treatment from consultant screening service referral	Percentage of cancer patients starting first treatment within 62 days of referral from a consultant screening service. The operational standard is 90%. A high percentage is good.	Green if latest month >=90%, Red if latest month <90%.	NHS England, NHS Improvement and contractual requirement
4.14	Responsive	Cancer - 62 day wait for first treatment from consultant upgrade	Percentage of cancer patients starting first treatment within 62 days of consultant upgrade. The operational standard is 85%. A high percentage is good.	Green if latest month >=85%, Red if latest month <85%.	NHS England, NHS Improvement and contractual requirement
4.15	Responsive	Children's Services - 10-14 day new birth visit	The percentage of babies who had a new birth visit by the Health Visiting team within 14 days of birth. A high percentage is good. Data shown is for North Yorkshire, Darlington, Co. Durham, Middlesbrough, Stockton, Gateshead and Sunderland. A high percentage is good.	Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%.	Contractual requirement
4.16	Responsive	Children's Services - 2.5 year review	The percentage of children who had a 2.5 year review. A high percentage is good. Data shown is for North Yorkshire, Darlington, Co. Durham, Middlesbrough, Stockton, Gateshead and Sunderland. A high percentage is good.	Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%.	Contractual requirement
4.17	Responsive	OPEL level - Community Care Teams	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.	tbc	Locally agreed metric
4.18	Responsive	Community Care Teams - patient contacts	The number of face to face patient contacts for the community care teams.	tbc	Locally agreed metric
5.1	Workforce	Staff appraisal rate	Latest position on no. staff who had an appraisal within the last 12 months. The Trusts aims to have 90% of staff appraised. A high percentage is good.	Annual rolling total - 90% green. Amber between 70% and 90%, red<70%.	Locally agreed target level based on historic local and NHS performance
5.2	Workforce	Mandatory training rate	Latest position on the % substantive 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
5.3	Workforce	Staff sickness rate	Staff sickness rate - includes short and long term sickness. The Trust has set a threshold of 3.9%. A low percentage is good.	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

Indicator number	Domain	Indicator	Description	Traffic light criteria	Rationale/source of traffic light criteria
5.4	Workforce	Staff turnover	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.	Green if remaining static or decreasing, amber if increasing but below 15%, red if above 15%.	Based on evidence from Times Top 100 Employers
5.5	Workforce	Agency spend in relation to pay spend	Expenditure in relation to Agency staff on a monthly basis as a percentage of total pay bill. The Trust aims to have less than 3% of the total pay bill on agency staff.	Green if <1% of pay bill, amber if between 1% and 3% of pay bill, red if >3% of pay bill.	Locally agreed targets.
6.1	Efficiency and Finance	Surplus / deficit and variance to plan	Monthly Surplus/Deficit (£'000s). In some months, a deficit is planned for. This indicator reports positive or adverse variance against the planned position for the month.	Green if on plan, amber <1% behind plan, red >1% behind plan	Locally agreed targets.
6.2	Efficiency and Finance	NHS Improvement Financial Performance Assessment	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.	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
6.3	Efficiency and Finance	Capital spend	Cumulative Capital Expenditure by month (£'000s)	Green if on plan or <10% below, amber if between 10% and 25% below plan, red if >25% below plan	Locally agreed targets.
6.4	Efficiency and Finance	Long stay patients	This indicator shows the average number of patients that were in the hospital with a length of stay of over 7 days (previously defined as stranded patients by NHS Improvement) or over 21 days (previously super-stranded patients). The data excludes children, as per the NHS Improvement definition. A low number is good.	tbc	as defined by NHS Improvement
6.5	Efficiency and Finance	Occupied bed days	Total number of occupied bed days in the month.	tbc	Locally agreed targets.
6.6	Efficiency and Finance	Delayed transfers of care	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. The maximum threshold shown on the chart (3.5%) has been agreed with HARD CCG.	Red if latest month >3.5%, Green <=3.5%	Contractual requirement
6.7	Efficiency and Finance	Length of stay - elective	Average length of stay in days for elective (waiting list) patients. The data excludes day case patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.	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.
6.8	Efficiency and Finance	Length of stay - non-elective	Average length of stay in days for non-elective (emergency) patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.		
6.9	Efficiency and Finance	Avoidable admissions	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.	tbc	tbc
6.10	Efficiency and Finance	Theatre utilisation	The percentage of time utilised during elective theatre sessions (i.e. those planned in advance for waiting list patients). The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. A higher utilisation rate is good as it demonstrates effective use of resources. A utilisation rate of around 85% is often viewed as optimal.	Green = >=85%, Amber = between 75% and 85%, Red = <75%	A utilisation rate of around 85% is often viewed as optimal.
6.11	Efficiency and Finance	Day case rate	The proportion of elective (waiting list) procedures carried out as a day case procedure, i.e. the patient did not stay overnight. A higher day case rate is preferable.		
6.12	Efficiency and Finance	Outpatient DNA rate	Percentage of new outpatient attendances where the patient does not attend their appointment, without notifying the trust in advance. A low percentage is good. Patient DNAs will usually result in an unused clinic slot.		
6.13	Efficiency and Finance	Outpatient new to follow up ratio	The number of follow-up appointments per new appointment. A lower ratio is preferable. A high ratio could indicate that unnecessary follow ups are taking place.	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.
7.1	Activity	Outpatient activity against plan (new and follow up)	The position against plan for outpatient activity. The data includes all outpatient attendances - new and follow-up, consultant and non-consultant led.		Locally agreed targets.
7.2	Activity	Elective activity against plan	The position against plan for elective activity. The data includes inpatient and day case elective admissions.		Locally agreed targets.
7.3	Activity	Non-elective activity against plan	The position against plan for non-elective activity (emergency admissions).		Locally agreed targets.
7.4	Activity	Emergency Department attendances against plan	The position against plan for A&E attendances at Harrogate Emergency Department. The data excludes planned follow-up attendances at A&E and pateints who are streamed to primary care.	Green if on or above plan in month, amber if below plan by < 3%, red if below plan by > 3%.	Locally agreed targets.

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

Harrogate and District NHS Foundation Trust

Indicator number	Domain	Indicator	Description	Traffic light criteria	Rationale/source of traffic light criteria
	Red	major data quality issue with no improvement as yet/ data confidence low/ figures not			

December 2018 Financial Position

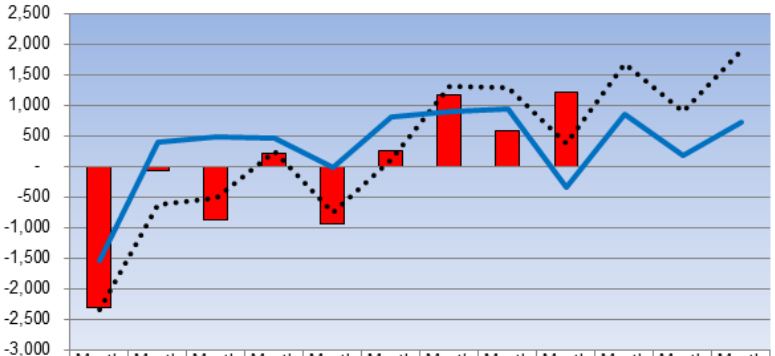
- The following slides summarise the Trustwide financial position as at December 2018.
- These should be read alongside the Resource Committee Chairs report for the meeting dated 28/01/2019.
- The Resources Committee discussed this position in more detail, supported by further analysis of –
    - In Month and Year to date drivers
    - Activity and Income
    - Workforce
    - Capital Expenditure
- This was also accompanied with Directorate level positions.

December 2018 Financial Position

Financial Performance

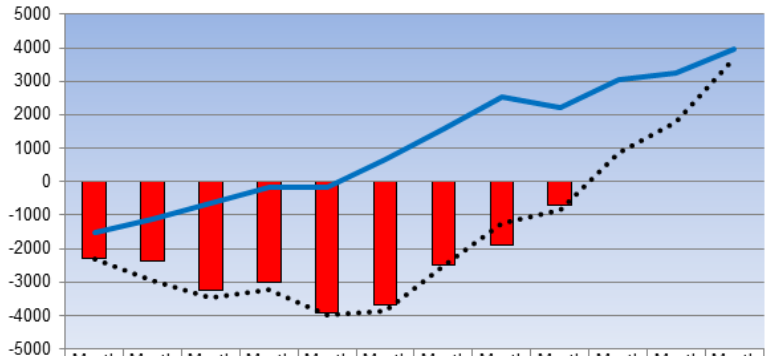
- The Trust reported a surplus of £1,214k in December. As with October and November this in month performance appears positive, and while it has supported achievement of the control total in quarter 3 we remain £2.9m behind the Trusts internal plan. Monthly and cumulative performance is highlighted below.

HDFT Monthly Financial Performance (£'000s)



	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Actual	-2,303	-59	-869	219	-925	270	1,183	583	1,214			
External Plan	-2,328	-611	-514	246	-754	119	1,326	1,290	381	1,702	910	1,916
Internal Plan	-1,526	409	486	479	-	812	917	950	-330	860	192	734

HDFT Cumulative Financial Performance (£'000s)



	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Actual	-2303	-2,362	-3231	-3012	-3936.7	-3666.5	-2483.6	-1900.6	-687			
External Plan	-2,328	-2,939	-3,453	-3,207	-3,961	-3,842	-2,516	-1,226	-845	857	1,767	3,683
Internal Plan	-1526	-1,117	-631	-152	-152	660	1,577	2,527	2,197	3,057	3,249	3,983

- The positions above include PSF funding at the planned level of £2.6m. Without this the Trust would be reporting a deficit position of £3.3m.

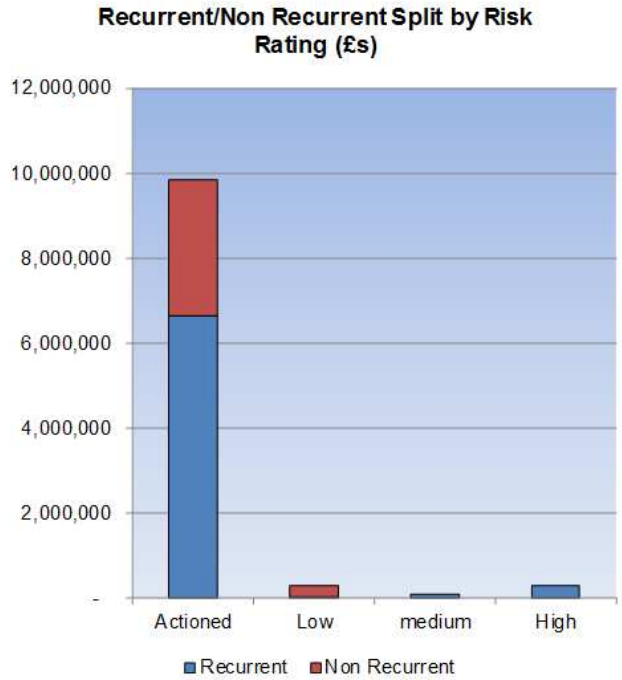
- In order to achieve the control total for quarter 4 the Trust will be required to have a surplus of £3.3m for the period. The Trust will then receive an additional £1m PSF funding, as well as a further £0.4m if we achieve the A&E standard. The cash as a result of this will be extremely beneficial to the Trusts current cash position.

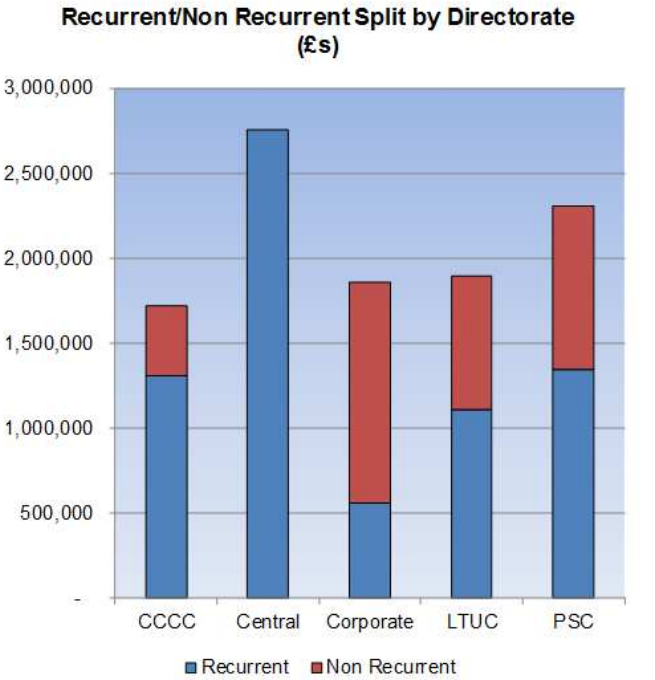
December 2018 Financial Position - CIP

- The Trustwide CIP programme continues its development and implementation, with 98% of plans in place against the £10.7m target. This reduces to 96% following risk adjustment.

Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Trustwide Summary	10,700	9,833	295	107	300	10,535	98%	10,259	96%
		% age of target	3%	1%	3%				

Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Children's and Countywide	1,733	1,686	13	0	20	1,719	99%	1,702	98%
Corporate	1,750	1,719	144	0	0	1,863	106%	1,856	106%
Other and/or Central Schen	2,667	2,613	0	49	94	2,756	103%	2,671	100%
Long Term and Unschedule	2,245	1,511	138	58	186	1,893	84%	1,726	77%
Planned and Surgical Care	2,305	2,304	0	0	0	2,304	100%	2,304	100%

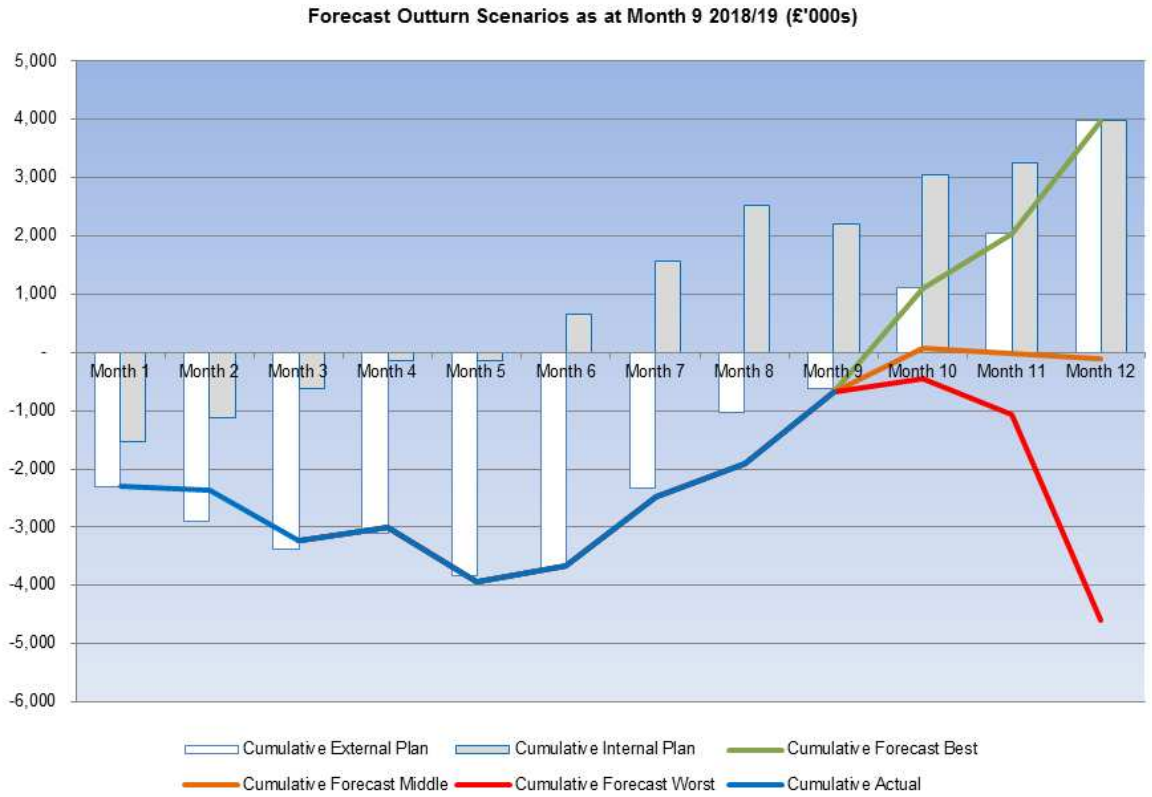




December 2018 Financial Position

Financial Performance Cont.

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



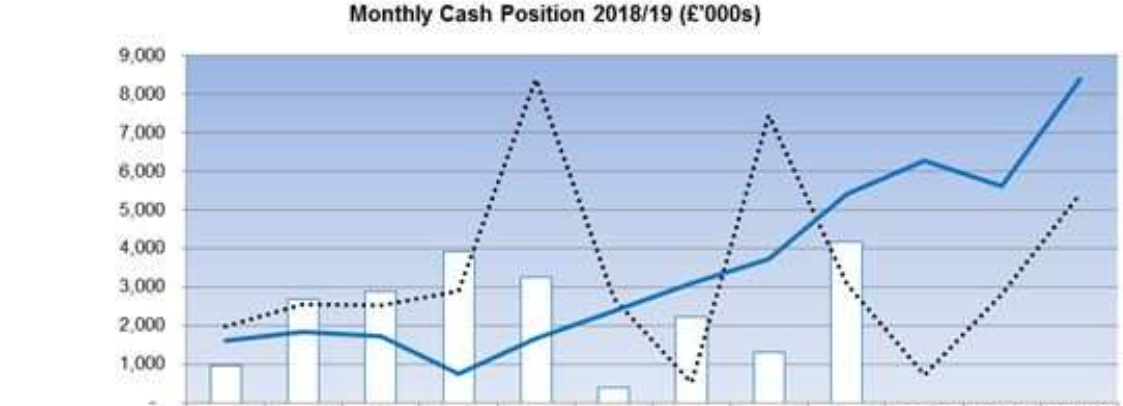
- The current likely scenario is a £0.2m deficit after PSF funding, £3m deficit before PSF funding. This assumes that while the underlying position improves, pressures such as ward expenditure, theatres, etc will continue.

- The decline in position in Month 12 as part of the worst case scenario shows the impact of PSF funding not being received for Q4 and if the Trust does not receive the element linked to A&E performance.

December 2018 Financial Position

Cash and Capital resource

- The December position improved significantly for the group, however, this is a consolidated position and the majority of this is currently with HHFM.



	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Actual	976	2,674	2,878	3,905	3,257	395	2,243	1,312	4,171			
17/18 Actual	1,989	2,563	2,523	2,891	8,404	2,715	516	7,451	3,066	728	2,815	5,411
Plan	1,627	1,837	1,719	750	1,660	2,389	3,108	3,735	5,424	6,270	5,617	8,398

- While the position has improved, there have been a number of prepayments made at the end of quarter 3.

- Better Payment Practice Code performance has remained static with 7% of invoices paid and 60% of invoice value. Clearly this remains a challenge to the Trust.

- The Trust's Use of Resources Risk Rating is outlined below

Use of resources score	Previous month YTD				Year to date				Forecast outturn			
	Plan Number	Actual Number	Variance Number	%	Plan Number	Actual Number	Variance Number	%	Plan Number	Forecast Number	Variance Number	%
Capital service cover rating	4	4			4	3			2	2		
Liquidity rating	1	1			1	1			1	1		
I&E margin rating	3	4			3	3			1	1		
I&E margin: distance from financial plan		2				1				1		
Agency rating		1				1				1		
Risk ratings after overrides		3				2				1		

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INFECTION PREVENTION AND CONTROL REPORT FOR TRUST BOARD **22nd January 2019**

Month	*C. difficile*		MSSA BSI		MRSA BSI		*E.* coli BSI		Klebsiella BSI		*Pseudomonas aeruginosa* BSI	
	HAI	CAI*	HAI	CAI	HAI	CAI	HAI	CAI	HAI	CAI	HAI	CAI
April	1	0	1	6	0	0	1	12	0	2	0	0
May	1	3	0	2	0	0	1	14	0	1	0	0
June	1	0	1	2	0	0	1	12	1	1	0	2
July	4	0	0	3	0	0	1	9	0	0	1	0
August	2	2	0	2	0	1	1	15	1	4	0	1
September	3	0	0	0	0	1	1	10	2	2	0	1
October	0	2	0	5	0	0	1	9	1	6	0	1
November	0	3	0	1	0	0	1	4	0	1	0	0
December	0	1	1	1	0	0	1	7	0	1	1	0
January	1	1	0	1	0	0	1	2	0	1	0	0
February												
March												
Running total	13	12	3	23	0	2	10	94	5	19	2	5

*Includes cases diagnosed in the community

Respiratory Viruses

The season kicked off properly in late December, although so far, the overall numbers are down on this time last year. All the influenza so far has been influenza A, either A H3, or the H1N1 2009 strain, which has also caused an outbreak on Jervaulx. RSV has been responsible for many admissions of elderly people with respiratory problems.

Table 2, respiratory viruses as of 22/01/19

Location when spec taken	Influenza			RSV			Parainfluenza		
	CAI	HAI	Indeterminate	CAI	HAI	Indeterminate	CAI	HAI	Indeterminate
AMU/MSS	7			1	1				
Byland	1	1	1						
CATT/MAU	27	1		17		1			
CAT clinic							1		
ED	4								
Farndale	1				1				
Granby	2		1			1			
Harlow				1					
ITU	2			2			1		
Jervaulx		15*			3				
Oakdale	1			1	1	1			
Pannal		1							
SROMC				6		1			
Woodlands	2			3			1		
Rowan	3								
OPD	2								

*Includes eleven patients and four members of staff.

At the time of writing, two patients with 'flu are being treated on ITU. One has been started on IV zanamivir which had ordered in for her. She has no obvious risk factors other than type 2 diabetes.

Jervaulx Ward Outbreak, January 2019

At the time of writing (22nd January 2019) since 10th January, eleven patients and four staff members have been identified as having influenza A H1N1 (2009) on Jervaulx Ward.
Six people (including two members of staff) have had RSV; two of these have had co-infection with 'flu (one patient, one staff member).

The first patient was confirmed at 6.00 pm on 10th January 2019; she had been symptomatic since 9th January 2019.

- Five have been in bay 4 (the sixth had RSV. She had been vaccinated).
- Two in bay 3
- One in bay 2
- Three in bay 1
- Five (including one patient with 'flu) have also had RSV

There has been one death so far in an elderly patient with multiple co-morbidities.

Until a second wave of staff going off sick around 15th/16th January, all affected people seemed to have become unwell within the same three day window.

Affected patients were treated with oseltamivir (Tamiflu) and ward patient contacts and three members of staff who fall into one of the risk categories for complicated 'flu were also offered prophylactic oseltamivir. They were redeployed to other areas of the hospital until the outbreak was over.

Eighteen staff members are still /have been off sick with flu-like symptoms, four have since been confirmed as having the same strain of 'flu. Thirteen were previously vaccinated, including all four with confirmed 'flu.

I have discussed this outbreak with the PHE Virus Reference Laboratory at Colindale, London on Monday 21st January. All the indications so far are that the H1N1 2009 strain ***is*** covered in the current quadrivalent vaccine given to staff, and that it is a good match. There has been no indication so far of any changes to the virus. We are collecting together some staff and patient samples with a vaccine history to send to them. Half of the confirmed patient cases had been vaccinated; however, it is known that the vaccine is less effective in the elderly.

Containment

Symptomatic patients were isolated if there were rooms available, otherwise they were cohorted in the bays where they were.

The ward was closed on the morning of Saturday 11th January, and was re-opened a week later.

The hit-rate on Jervaulx has however been unusually high, with 5/6 patients in bay 4 being affected within a 48h period. The number of admissions with 'flu in the rest of the hospital is as expected for this time of year.

Staff on Jervaulx

By 16th January, there were more staff complaining of 'flu-like symptoms on Jervaulx than patients.

At a second outbreak meeting on the 16th, we agreed that staff who are symptomatic with what clinically sounds like 'flu should:

- Not be at work, and stay away until they are better.
- Be tested for 'flu with a throat swab either before they go home from work, or on their return after a period of sick-leave. The test remains positive for several weeks after the infection.

The ICE request should state STAFF MEMBER in the clinical details and give a mobile phone number so that they can be contacted directly by the duty microbiologist or infection control team with the result. They are also asked some questions about nature, severity and onset of symptoms, risk factors, and vaccination history.

Their result will be hidden on ICE, and in the next few days, ICE will be modified so that Occupational Health exists in its own right, and only those from Occupational Health, Infection control or the Microbiology team will be able to access OH results.

Any staff member who is in one of the high risk categories for complicated flu (ie pregnancy, age >65, disease or drug-related immunosuppression, chronic disease, diabetes or morbid obesity) was redeployed to work elsewhere in the hospital for the duration of the outbreak. This particular strain seems to have a high rate of transmissibility and attack rate, and those staff with the above risk factors will be especially vulnerable. This is a compromise; as otherwise, we are trying to keep staff movements between wards to an absolute minimum.

Staff members who are not in one of the at- risk groups above, but who have not been vaccinated by choice should continue to work on the ward using appropriate PPE.
This includes phlebotomists, many of whom have not been vaccinated.

All staff should be wearing PPE in isolation areas. Masks should be worn for assessing or nursing patients with known 'flu or 'flu-like symptoms. This includes MAU and ED.

We have asked medical students and volunteers, many of whom are elderly, to stay away from the ward until the outbreak is over.

Communications

A Press statement was released on Monday 14th January, and was reported by the BBC (Look North), The Harrogate Advertiser and Stray FM.

Dr Child gave a live interview to Radio York on Monday evening (14th) and also on the 22nd January.

PHE and the CCG have been informed.

The outbreak will be included in PHE's daily report to NHSE and NHSI.

Comment

Wards have also been closed at York Hospital and Hull Royal Infirmary with a seasonal 'flu virus (A3); the epidemiology in both is much more typical, with fewer patients acquiring 'flu over a longer period. The Jervaulx outbreak is unusual for a hospital outbreak because so many people (staff and patients) became unwell all around the same time.
This particular strain of the H1N1 2009 strain seems to be very transmissible and has had an unexpectedly high hit rate.

This morning (22nd January) however, some potentially important new information has emerged concerning work being carried out on the ventilation/air conditioning system on the ward a few days prior to the first people becoming ill. Enquiries are on-going.

The overall vaccination rate on Jervaulx by Monday 14th January is being re-checked. I hope to have an up to date number by the time of the SMT meeting.

The fact that we are able to get results back, and in particular, negative results within a few hours has made a huge difference to the management of this outbreak, and for optimising the use of side-rooms elsewhere.

Dr Jenny Child, DIPC
22nd January 2019

Harrogate and District NHS Foundation Trust

6.2

Date of Meeting:	30 January 2019	**Agenda item:**	6.2
Report to:	Board of Directors		
Title:	Patient and Public Participation Strategy 2018/21		
Sponsoring Director:	Jill Foster, Chief Nurse		
Author(s):	Jill Foster, Chief Nurse		
Report Purpose:	**Decision** ✓ **Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓		
Executive Summary:	• The Patient and Public Participation Strategy is one of a suite of strategies being developed to support the Strategic Narrative which collectively will enable the Trust to fulfil its Vision and Mission statements • It has been designed to support people using our services to be at the centre of decision making at an individual level and when planning to change or develop services at scale		
	•		

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:	BAF# 10 Breach of the terms of Monitor Licence to Operate
Legal / regulatory:	In accordance with our legal duty under Section 242(1B) of the NHS Act, *we make arrangements* to involve users, whether directly or through representatives (via consultation, provision of information or other ways): • In planning the provision of services • In the development and consideration of proposals for change in the way services are provided • In any decisions to be made affecting the operation of services
Resource:	None identified
Impact Assessment:	Not applicable
Conflicts of Interest:	None identified
Reference documents:	The NHS Long Term Plan HDFT Operating Framework

Action Required by the Board of Directors:

The Trust Board is asked to

- **Approve** the Patient and Public Participation Strategy 2018/21

You matter most

Harrogate and District NHS Foundation Trust

Harrogate and District NHS Foundation Trust
Patient and Public Participation Strategy
2018/21

Working with our patients and people who use our services, wherever they are, to achieve continuous improvement

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Contents

Introduction

Harrogate and District NHS Foundation Trust (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 one to five years.

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

Harrogate and District NHS Foundation Trust's 'You Matter Most' is our first principle to deliver care which is safe, effective, caring, responsible and personal. Our mission is to be an exceptional provider of health care for the benefit of our communities, our staff and our partners.

With this Patient and Public Participation Strategy our ambition is to put the people who use our services, wherever they are, at the heart of decision making. This may be at a personal level involving individuals and their families in decisions about their treatment and care or it may mean involving people who have used a service to develop a new treatment pathway or it could be engaging service users in planning large scale service changes for the benefit of local communities.

Whatever the level of participation, listening to and acting on what people using our services want will help achieve our vision of delivering 'Excellence Every Time'.

Definition

Our ambition is to deliver excellence every time for the people who use our services. At HDFT we believe patient and public participation is about continuous improvement of our services and define participation as 'the active participation of people, patients, service users, carers and our members in the development of health services'.

We define 'patients and public' as: patients, service users, carers, families, volunteers, FT members and staff. FT members are staff and members of the public who have committed to becoming a member of the Trust and who may wish to have an active say in the planning and development of services.

The quality of care we provide is defined in terms of safety, effectiveness or outcomes and people's experience. At HDFT we believe the active participation of people in their care and the development of services will help to achieve better experiences of care and improve safety and outcomes and will lead to excellence every time. Our overall objectives for participation is to meet our pledges to the people who use our services

Our Pledges

- We will increase the involvement of the communities we are part of, including those who are 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

Scope

The Patient and Public Participation Strategy applies throughout HDFT to all hospital and community teams and across all business functions including Harrogate Integrated Facilities. It sets out our ambition of strengthening participation and how we intend to achieve it. This strategy is a significant enabler of HDFT's Strategic Narrative and overall objectives.

Participation at HDFT

We believe participation is dynamic and adaptive. Participation covers a spectrum of activities, which might also be called engagement or involvement, with the intention to capture continuous and 'live' feedback as well as structured engagement activities. At HDFT participation means making it a priority for active inclusion of all those who use our services in the shaping of our services and describes the many small steps which collectively create the conditions for innovation, learning and improvement. Our approach to patient and public involvement will be constantly evolving. We aim to continuously learn from many forms of participation as illustrated in diagram below. The Ladder of Engagement is an evidence based tool developed by NHS England designed to be used flexibly to ensure appropriate and proportional participation.

Ladder of Engagement and Participation

The ladder of engagement outlines a variety of forms of engagement and participation. It is to be used as a best practice tool by NHS England staff in a flexible way to ensure appropriate and proportional participation

Empowering	Placing decision – making in the hands of the community and individuals. For example personal health budgets r a community development approach
Collaborating	Working in partnership with communities and patients in each aspect of the decision, including the development of alternative and identification of the preferred solution.
Involving	Working directly with communities and patients to ensure that concerns and aspirations are consistently understood and considered. For Example partnership boards, reference groups and service user participation in policy groups
Consulting	Obtaining community and individual feedback on analysis, alternatives and or decisions For Example surveys, Door knocking, Citizen panels and focus groups
Informing	Providing communities and individuals with balanced and objective information to assist them in understanding problems, alternatives, opportunities, solutions. For example websites, newsletters and press releases.

Patient and Public Participation defines the way in which patients, carers and the public have a voice in decisions about themselves and how healthcare services and are planned, designed, delivered and evaluated. Patient and Public Participation at HDFT will operate on three levels:

- Involving individual patients and their carers in decisions about treatment and care and empowering them to make informed decisions about their health.
- Enabling patients, public and members to be involved and consulted on planning, monitoring, evaluating and developing services, proposals to change services and decisions about the way services operate.
- Involving and engaging patients, carers and the public in planning, development, delivery and evaluation of large scale service changes.

How are we doing now?

Harrogate and District NHS Foundation Trust cares for the population in Harrogate and the local area as well across North Yorkshire and Leeds. We provide Children's Services in the north east in County Durham, Darlington, Middlesbrough, Stockton-on-Tees, Gateshead and Sunderland.

The acute hospital provides services from three principal sites covering Harrogate, Ripon and surrounding geographical areas. The sites are: Harrogate District Hospital in Harrogate; Ripon Community Hospital in Ripon and Lascelles Rehabilitation Unit in Harrogate.

The Trust also provides outpatient services at Harrogate District, at Ripon Community Hospital and in a range of community-based facilities.

The Trust employs about 4500 members of staff to care for a wide range of people providing essential hospital treatment as well as community health services across 181 sites.

Patient Feedback

The Trust has a Patient Experience Team which handles both formal and informal complaints and compliments. Patient Experience staff will to provide resolution to concerns as they arise, on the spot advice and support patients and their relatives to navigate NHS services or signpost them to appropriate voluntary or public sector services. Early identification of concerns enables the Trust to respond to those enquiries in a timely and efficient manner which in turn reduces patients and relatives anxieties.

The Trust actively invites patient feedback from wherever patients are accessing our services. The Trust supports the national Friends and Family Test (FFT) initiative. The FFT question asks patients how likely they are to recommend our service to friends and family if they needed similar care or treatment. The Trust uses different methods of capturing this in different services. Summary data is shared in an open and transparent way with members of the public.

There are a number of websites and social media pages that allow individuals to leave and read submitted comments that relate to their experiences of the Trust. The Trust's Communications and Marketing Team monitors these comments, replies to them and shares them with relevant colleagues. Monthly feedback reports (created by teams/directorates) will continue to be publicised in all wards and departments.

As well as the national Friends and Family test question, patients are also given the opportunity to answer some additional questions and are encouraged to leave general feedback about their experiences if they wish to do so.

All feedback is disseminated to the appropriate wards and departments for them to consider, and where necessary, act on to make improvements. The Trust will continue to work hard to ensure we learn from what our patients are telling us.

Looking Ahead

Our plans to improve Patient and Public Participation at HDFT in 2018/21 and beyond are set in the context of the following strategic drivers:

- HDFT Strategic Narrative
- Delivery of the HDFT Operating Framework
- Delivering the NHS Long Term Plan

We believe we can build on how we currently involve people in their care and service provision by focussing in the following areas during 2018/21:

- To encourage individuals to participate in decisions about their care and treatment
- To create the conditions where meaningful Patient and Public Participation and engagement is embedded in service planning and development.
- To support staff to develop their awareness and understanding so they can contribute to Patient and Public Participation.
- To ensure effective monitoring and evaluation of Patient and Public Participation.
- To promote active participation between HDFT and other statutory agencies and voluntary organisations.

Roles and Responsibilities

We all have a role to play in strengthening patient and public participation in our work, both individually and collectively. All staff are responsible for considering the need for patient and public participation in their work and undertaking this as appropriate.

The following paragraphs set out specific responsibilities within HDFT.

The Trust Board of HDFT has a legal duty to make arrangements to involve the public in its service. The Chief Executive is accountable to the Trust Board and all the Executive Directors are responsible for patient and public participation within the work of their own portfolios.

The Chairman, other Non-Executive Directors and public governors are themselves largely lay members and have responsibility for ensuring that the views of patients and other members of the public are appropriately considered by the Trust Board.

The Executive Chief Nurse has responsibility for sponsoring the development and implementation of this strategy and also oversees the patient experience team and others which supports the organisation in its duties and ambitions to strengthen patient and public participation.

The Directors are responsible for ensuring appropriate patient and public participation within the work of their own areas. Specialist advice and support (internal or external) may be required. This includes working with local partners, such as Clinical Commissioning Groups, Local Authorities and voluntary sector organisations.

All Managers have responsibility for ensuring that the need for patient and public participation is considered and appropriate action is taken, for the work for which they are accountable. Those responsible for service development should be aware of the organisation's statutory duty to involve the public in this area of work, and take action as appropriate.

The Patient Experience Team and Communication Team and others have responsibility for ensuring that the need for patient and public participation is appropriate and meaningful. These staff members are key players in feeding back patient and public comments and "closing the loop".

All Managers have responsibility contributing to the implementation of this strategy and promoting an organisational culture in which patient and public participation is 'everyone's businesses. This includes supporting formal and peer to peer learning, and celebrating success.

All Managers have responsibility contributing to the monitoring, evaluation and reporting of implementation of this strategy and the effectiveness of action to strengthen patient and public participation

How We Will Deliver the Patient and Public Participation Strategy

In order to deliver our vision for excellent Patient and Public Participation we have set out the following four key elements to deliver our strategy

- Our Patient and Public Participation Cycle (Appendix 1)
- Our Patient and Public Participation organisational structure
- Our Patient and Public Participation staff's roles and responsibilities
- Our Patient and Public Participation Programmes of work for 2018/21

Identifying patient needs and seeking their views. This includes approaches that staff and services use to gain insight into the needs, views and experiences of the people we provide a service to. This helps us to understand where we need to focus our improvement efforts and identify what works well to give positive feedback to our teams.

Utilising Patient stories - To inspire and motivate change, Focus groups to explore an issue in detail and one-to-one interviews to gain insight from a broader cross-section of the population.

Participation and co-design, including approaches that can help us involve patients and the public in designing service improvements and making strategic decisions: In your shoes: setting priorities with patients and building staff ownership for delivering them

Experience-based design, staff and patients working together to design service improvements Informal consultation meetings: getting public feedback to proposals, and listening to alternative approaches.

Partnership in running services, including approaches that give our communities and service users a say in how our services are run and help us to stay patient-focused in our day-to-day management and decision-making: User and community groups: regular meetings of people who are interested in specific services to provide insight into experiences and feedback on developments.

Patient Voice Group involving patients as observers at regular management meetings to ensure decision-making is patient-centred. Carer groups: support networks for carers to understand their needs and experiences, and gain feedback on proposals.

Our expectation of Patient and Public Participation at HDFT

Working with each other	Working well together
1. Our relationships will be conducted with equality and respect.	1. We will understand what's worked in the past, and consider how to apply it to the present and the future.
2. We will listen and truly hear what is being said, proactively seeking participation from communities who experience the greatest health inequalities and poorest health outcomes.	2. We will have a shared goal and take responsibility for our work.
3. We will use all the strengths and talents that people bring to the table.	3. We will start involving people as early as possible.
4. We will respect and encourage different beliefs and opinions.	4. We will reflect the Trust values when working with others.
5. We will recognise record and reward people's contributions.	5. We will give feedback on the results of involvement.
6. We will use plain language and will openly share information.	6. We will provide support, training and the right kind of leadership so that we can work, learn and improve together.

Patient and Public Participation Organisation Structure

Activities will be led by appropriate staff members according to patient and service development need.

We will build on existing resources and good practice to:

Ensure that patients and the public have a voice throughout the organisation by developing our governance arrangements to embed participation (including decision making and business planning processes). We will offer meaningful roles on relevant working groups to those who are experts by experience or lay members.

Put in place clear and rigorous safeguards to identify and manage actual or potential conflicts of interest in respect of the Patient and Public Voice activity. This will ensure that information about the outside interests of patients and the public who work with us (for example, connections with industry) will be transparently declared.

Reach out to - and work with - a wide range of people, reflecting the diversity of our communities, to have conversations about health, wellbeing, and services. We will aim to go to people rather than expecting them to come to us. We will strengthen our partnerships (and maximise shared engagement opportunities where appropriate) with organisations which can bring different perspectives. These include (but are not limited to) Healthwatch, Health and Wellbeing Boards, Clinical Commissioning Groups, Local Authorities, Health and Care Voluntary Sector Strategic Partner organisations, and the wider voluntary and community sector, in addition to our direct engagement with patient and community groups, and advocacy organisations.

Use available information (such as complaints, patient surveys and the outcomes of any previous engagement exercise) prior to considering new engagement. Identify and try different ways of having conversations and working with patients and the public, for example using social media.

Develop a more open, transparent and responsive culture and more inclusive and participative ways of working by providing appropriate support, tools and resources (including training).

Close the loop' whenever we seek the views of patients and the public. We will do this by feeding back the results of any consultation or engagement exercise to participants and explaining how views have been considered and impacted on our work, and the rationale for decisions taken.

Celebrate success and learn from experience (positive and negative) by measuring the effectiveness of our patient and public participation activity (including outcome indicators).

We will develop new and improved measures to help us assess progress and make improvements. Part of the way we will do this is by asking for the views of different people (particularly those who are 'seldom heard', for example, people with learning disabilities) about their experiences of being involved and supported to work in partnership with us.

Monitoring

Implementation of this strategy and the associated action plan will be closely monitored. Approaches to check how we are doing in delivering our promises to ensure patients feel cared for, feel safe and feel confident in their treatment, and in delivering improvement plans eg:

- Surveys: can help determine priorities and track if services are improving over time.
- Observations during care and treatment: are helpful in providing immediate feedback to clinicians on the care they are providing and supporting behaviour change
- Recording and action planning after each Patient and Public Participation activity

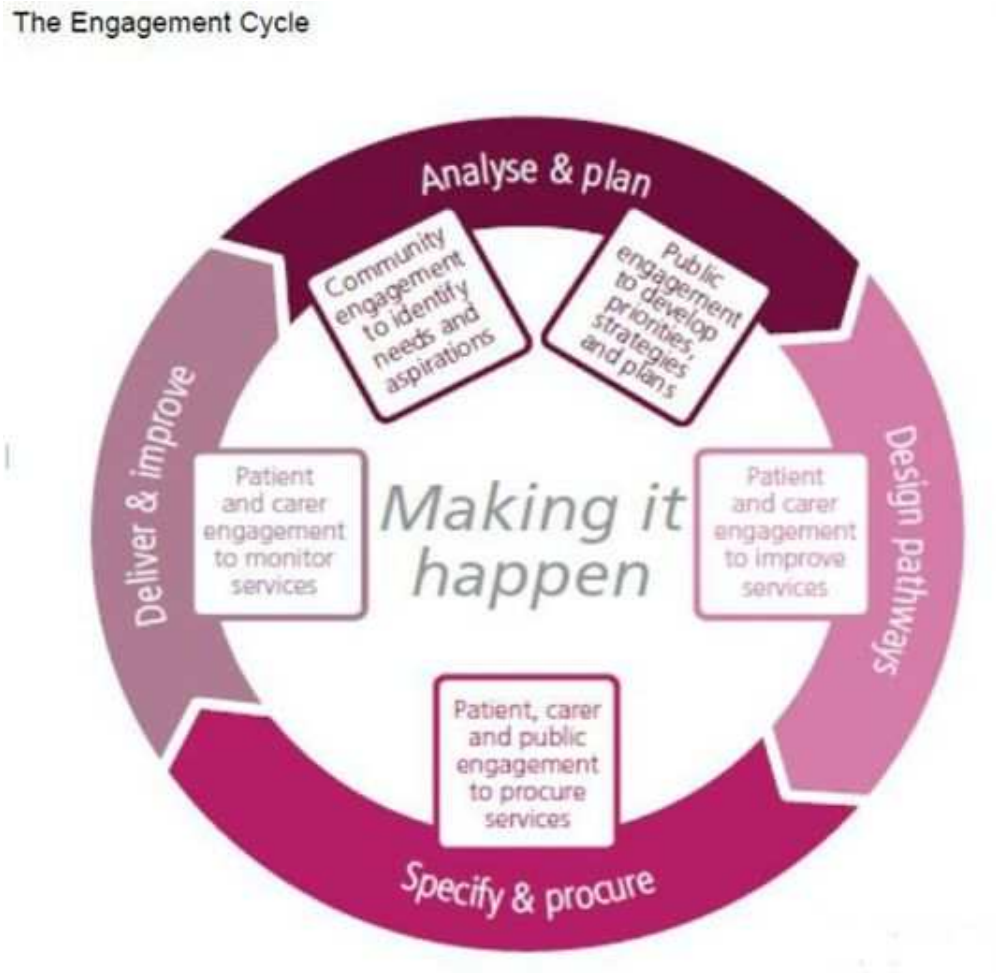
With local stakeholders, HDFT will analyse their performance against this strategy on an annual basis using formal external engagement events

Equality and Health Inequalities

This strategy forms part of HDFT commitment to create a positive culture of dignity and respect for all individuals including staff, patients, their families and carers as well as community partners. The intention is to identify, remove or minimise discriminatory practice with regard to the characteristics given protection by the Equality Act 2010 as well as to promote positive practice and value the diversity of all individuals and communities.

The Annual external engagement events will focus on specific issues, taking account of each relevant protected group. HDFT will share the evidence with their local stakeholders in accessible formats, so that local stakeholders can play their part in the analysis of performance and setting of equality objectives.

Appendix 1 – The Engagement Cycle



Harrogate and District NHS Foundation Trust

6.3

Date of Meeting:	30 January 2019	**Agenda item:**	6.3
Report to:	Board of Directors		
Title:	Seventh quarterly report on safe working hours for doctors and dentists in training		
Sponsoring Director:	Dr D Scullion, Medical Director		
Author(s):	Dr C Gray, Guardian of Safe Working Hours		
Report Purpose:	**Decision** [ ] **Discussion/ Consultation** [ ] **Assurance** [✓] **Information** [ ]		
Executive Summary:	The Board of Directors is asked to note: • The Guardian has no on-going concerns. • The number of Exception Reports is below the national average • There is a continuing national recruitment crisis in doctors in training but vacancies in this Trust are at 9.1% which is comparatively low.		

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

Key implications	
Risk Assessment:	Risks associated with the content of the report are reflected in the Board Assurance Framework
Legal / regulatory:	None identified.
Resource:	None identified.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.
Reference documents:	None.
Assurance:	

Action Required by the Board of Directors:

The Board of Directors is asked to **receive and note** the content of the report.
The Board of Directors is requested to **consider the points** at the end of the report.

Harrogate and District NHS Foundation Trust

Quarters 2 & 3 2018/19: Combined quarterly report on Safe Working Hours: Doctors and Dentists in Training

Executive summary

This is the seventh quarterly report of the Guardian of Safe Working Hours. Its purpose is to report to the Board of Directors the state of safe working of doctors in training ('junior doctors') in relation to their working hours, gaps in rotas and their educational experience. This report covers the period 1 July to 31 December 2018.

This report is a catch-up report. The orderly stream of reports was interrupted by the Board's instruction to change the periodicity of written reports. Future reports have been requested at four-monthly intervals. This is out of synchronization with the regional reporting pattern. The reports will still convey quarterly data as appropriate.

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

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

Exception reports have been received from trainees in Q2 (36) and Q3 (41) and dealt with. This is an increasing trend. These have mainly concerned over-runs of working hours ('hours and rest') owing to the busy state of the wards and to individual patient matters. There were only two reduced educational opportunity exception reports. Exception reporting, although increasing, remains comparatively low in this Trust although highly variable across the region.

There having been no breach of the European Working Time Directive, no fine has yet been levied. National trends in medical post-graduate training and indeed medical workforce numbers overall continue to be adverse.

There have been two regional meetings and one national meeting for guardians in these two quarters. Two trainee doctors' fora have been held jointly with the Director of Medical Education. These will continue bi-monthly.

The Guardian met the CQC inspectors in December 2018.

National developments include a review of the 2016 Contract by NHS Employers and BMA to be completed by August 2019 and a piece of work on improving exception reporting.

This is the key quality assurance statement for the Board:

'The Board is advised that overall working hours across the organisation are satisfactory and that there are presently no unaddressed specific concerns in departments or directorates.'

1 Introduction

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

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

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

The Board of Directors has changed its reporting requirement so that one quarterly report has been missed and the next would now be due. The Board in future requires three reports per year to cover four months each time. This becomes out of synchronization with the regional reporting custom of quarterly reports.

This is a catch-up report on the data for the period starting 1st July 2018 and ending 31st December 2018: this comprises two quarters reported separately. Future reports will be four-monthly and will report four months' data for the Trust and quarterly data to the regional office of Health Education England.

2 High level data

In January 2019:

The position is not significantly changed since July 2018:

Number of doctors / dentists in training (total established Deanery posts)	121 [last quarter: 121]
Number of doctors / dentists posts on 2016 TCS (total)	121 [last quarter: 121]
Number of doctors / dentists in training actually in post	106 [last quarter: 110]
Number of doctors/dentists in Trust posts (additional to Deanery posts)	12 [last quarter: 14]
Number of doctors/dentists in Trust posts actually in post	10 [last quarter 13]
'Gaps' in deanery posts	12.4%
Amount of time available in job plan for Guardian to do the role	1.5 PAs per week
Admin support provided to the Guardian (if any)	none [assistance from HR Department]
Amount of job-planned time for educational supervisors	0.5 PAs per trainee

The bi-annual change over takes place in early February each year, so these data may shortly change if any trainees do not arrive to take up their scheduled training posts.

3 Exception reports

Exception reports are individual notifications by trainee doctors who have had a problem occasion causing them to vary their working hours from the contracted rota by more than ½ hour. Exception reports have a time-limited process for response by the Trust. At any one time there may be a few reports awaiting attention by individual clinical supervisors.

This report presents two quarters covering the periods: Q2 (1 July – 30 September 2018) and Q3: 1 October – 31 December 2018).

Q2: 1.7.2018-30.9.2018 Exception reports by department: hours/rest & educational				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
General Surgery	0	28	28	0
General Medicine	0	8	8	0
Total	0	36	36	0

Q3: 1.10.2018-31.12.2018 Exception reports by department: hours/rest & educational				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
General Surgery	0	29	29	0
General Medicine	0	10	10	0
Paediatrics	0	1	1	0
Obs & Gynae	0	1	1	0
Total	0	41	41	0

These include just one education exception in each quarter. These last two quarters show an increasing trend in exception reporting. This may reflect a true increase in exceptional over-working. More likely it represents a greater willingness to report exceptions in the current cohort of trainees. The last two trainees' forums have shown increased interest in exception reporting - How to do it? When is it appropriate? – with strong encouragement by the Guardian and the Director for trainees to make exception reports when necessary. Nearly all reports are of over-working at the end of the day when clinical workload, acutely ill patients and too few colleagues demand working beyond normal hours.

If a doctor has overworked their contracted hours on an occasion, then they are entitled under the TCS to over-time pay or time off in lieu. If the over-work is caused by rota gaps, then time off is not appropriate if it will compound the shortage situation. The doctor is entitled to overtime pay even if their overtime commitment followed from their own inefficiency or misjudgment. Clinical supervisors are expected to guide their trainees in efficient working, prioritizing clinical activities and making timely hand-overs to over-night teams. The Trust will incur a small cost each month in some hours' over-time pay; but this is offset somewhat by vacant posts owing to rota gaps. But overall, the Trust is heavily over-spent on medical locum costs for consultants and trainees.

The job of filling posts, balancing rotas and workloads properly belongs to clinical directorates with professional support from the HR function. Individual trainees' employment experiences are managed by their individual clinical supervisor - a clinical consultant usually in the same or a related specialty. Clinical supervisors are intended to respond to each exception report. Despite repeated advice some never do and the report has to be managed by the Guardian. The Guardian has no actual managerial power over individuals in directorates.

Of course, ideal conditions of employment for trainee doctors are one obligation amongst many in the Trust, particularly in periods of winter pressures.

4 Work schedule reviews and interventions

4a Work schedule review

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

4b Interventions

One enquiry was raised in Q3. A trainee identified a weekend rota gap into which led to him being over-worked. This was taken up with HR and the clinical directorate. This was a timetabling error which was corrected. The directorate explained the matter to the trainee.

5 Vacancies

The vacancies are similar to previous quarters.

In January 2019, there are 15 gaps in [12.4% of 121] deanery established posts overall]. Of these posts: one is a maternity leave; five are not wanted to be filled by the department concerned; five have been filled with the doctor not yet in post and four are unfilled and out to advertisement. In February and August each year there are planned cohort changes; at other times of year there are always a few doctors coming and going for personal reasons. At any one time, there are gaps owing to failure of recruitment and vacant posts are at different stages of re-advertisement and recruitment. Departments may decide not to fill posts for various reasons: for example, the part-year Chemical Pathology post is currently unfilled by choice of the department.

Medical Workforce and Recruitment are just now finalizing the new intake for 1st February 2019. The successful filling of rota gaps is of course a measure of the diligence and ingenuity of the Medical Workforce and Recruitment team but challenged by the availability and willingness of suitable doctors to apply.

Of course, any rota gaps will add to the strain on the trainees in post and add to the Trust's workforce costs by necessitating locum and other temporary employees and working down of senior grades of staff.

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

The Guardian has access to the HR database of trainee doctors which is up-dated monthly.

There are also 12 Trust posts for doctors not in training schemes who participate in the same rotas as trainees. Two of these are currently vacant.

6 Fines

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

No fine has been necessary to date. There have been no identified breaches of the Working Time Directive. Fines have been levied in other trusts in the thousands of pounds.

Working time rules may of course change after BREXIT.

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

7 Meetings

The Guardian attended regional meetings on 2nd July 2018 and 12the November 2018, and the national meeting - which was conveniently held in Leeds – on 17th November 2018. A first joint meeting for Guardians of Safe Working Hours and of Freedom to Speak Up was also held on 12th November 2018 in Leeds, immediately after the regional meeting.

Current issues include consultation on proposed changes to the current trainees' contract and the changing nature of the guardian role away from managing exception reports towards pastoral care and preventative strategies to prevent over-working in trainees.

This Trust continues comparatively light on exception reporting rate compared to others.

Guardians of safe working and of freedom to speak up have common themes and common causes.

8 Trainees' Forum

Recent fora have been well attended. In informal discussion with the young doctors, it is striking how few of our current trainees intend to follow a linear training programme in the 'normal' way. There appears to be a worsening trend in trainees avoiding deanery training programmes. Only about 50 per cent of trainees proceed directly from FY School to higher training in primary care or hospital specialties. Many good trainees are choosing the non-deanery route and intend to spend a few years in short-term trust posts variously termed 'FY3' and 'Trust Doctor' or going abroad.

The importance of exception reporting has been canvassed and this may have contributed to increased rates of exception reporting in the last two quarters.

9 Disclosure

These quarterly Guardian reports are submitted to Health Education England at their request and by standing consent of the Trust Board of Directors. A regional summary is assembled and discussed at the regional meeting each time. Guardians assume that their quarterly reports to their boards of directors are open to the public domain. The change in periodicity of reporting to the Board has disrupted the flow of reports to Health Education England.

Health Education England will receive periodical download of the entire database of exception reports for the purpose of research by the mining of big data. The Board has agreed to this.

10 Confidentiality

Given that Guardians' reports may be in the public domain, the identities of specialties, doctors and supervisors are concealed in the Guardian's quarterly report. Full data are available to the Board of Directors in private session on request.

11 CQC

The Guardian met the CQC inspectors alone for the 'Well Led' inspection on 5th December 2018. The Guardian had submitted in advance a written account of his duties and responsibilities and two recent Board reports. The inspectors were pleasant and did not request any additional data. The discussion was largely philosophical. They were largely concerned with the ability of guardians robustly to challenge hospital management; this was not a problem in this Trust but has been in others in their experience. They were realistic about issues of rota gaps, medical workforce and training.

No safe working issue was mentioned in the initial feedback. Of course, the full CQC report is awaited.

12 'The State of Medical Education and Practice in the UK: 2018'

This GMC report was published on 5 December 2018 and is essential reading for NHS managers and directors.

The report is highly evidence-based and strong on research. The state of the medical profession in the UK in 2018 is reportedly in crisis. Although recruitment to medical schools is healthy, young doctors are not progressing to specialist or GP training and senior doctors in their 50s/60s are in large proportion intending to retire early or go part-time. These career choices by young and senior doctors are placing severe pressure on the middle-aged working doctors who are left to deliver the service work of the profession.

The underlying reasons include mainly pressure of work - the working pressures upon trainee doctors, the unattractive elements of GP principal and consultant posts - and of course the Government's pension tax changes which are driving older doctors into early retirement.

The report is highly constructive giving suggestions for policy changes which might alleviate some of these issues. None of these will find immediate results.

Overall, this report provides stark and reliable evidence that workforce strategy as currently in place in the NHS is not able to meet the shortage of medical practitioners which will intensify severely over the coming decade. [This report concerns only the medical profession but, of course, similar issues exist in all the health care professions.]

The Trust has at least made a start on diversification of the medical workforce with developing programmes for physician associates and re-skilling of biomedical scientists.

This report is strongly recommended for the Board's attention.

13 Issues arising

a. The Trust continues in comparatively good standing. We have had a below-average rate of exception reporting but there is an increasing trend.
b. There is an on-going problem of sporadic over-work and reduced educational opportunity for trainee doctors owing to colleagues off sick and rota gaps.
c. Reluctance in trainees to report exceptions exists regionally and nationally.
d. Exception reports are being received and processed.
e. There are gaps in rotas owing to failed recruitment. This a worsening issue throughout medical specialties especially in the North of England, but this Trust is doing relatively well with vacancies in process of being filled.
f. The Guardian has met the CQC inspectors in December 2018.
g. Regional and national meetings were attended in 2018.

h. NHS Employers and BMA are reviewing the 2016 contract in fulfilment of the original promise to do so. This review and any contractual changes are expected to be completed for August 2019.
i. NHS Employers and NHSI are working on improving exception reporting in 2019.

14 Actions taken to resolve issues

a. No fine has been necessary this quarter.
b. One intervention has been necessary this quarter to correct a time-tabling error.
c. At the date of reporting, the Board of Directors is assured from the evidence available that:
   i. The exception reporting system is operational for all trainees; they are now all on the 2016 TCS.
   ii. No systematic problem of unsafe working hours is known to exist currently.
   iii. The Guardian can only intervene on notified problems.
   iv. The Guardian will continue to attend regional and national meetings.

15 Questions for consideration by the Board of Directors

a. The Board is asked to receive the combined quarterly report and to consider the assurances provided by the Guardian. The Board has changed its requirement for written reports: future reports will be four monthly.
b. There are presently no issues outlined in the report which are not being (or cannot be) tackled.
c. The Guardian makes no request for escalation, internally, externally or both, which might be recommended in order to ensure that safe working hours would not be compromised in the future.
d. Issues of medical [and indeed all healthcare professional] workforce planning are an urgent strategic challenge to the Trust and to the entire NHS. The Trust always has vacancies gaps in trainee doctor posts; these currently run at 12.4 per cent.
e. Safe working hours, trainees' exception reports and rota gaps were received by the CQC in their inspection process.
f. The recent GMC report *'The State of Medical Education and Practice in the UK: 2018'* anticipates severe workforce problems in the medical profession in the coming decade: young doctors are not progressing to specialist GP training and old doctors are retiring early. Severe shortages of medical practitioners are already evident and will worsen.

Dr Carl Gray

Guardian of Safe Working Hours
24th January 2019

NHS
Harrogate and District
NHS Foundation Trust

Date of Meeting:	30 January 2019	**Agenda item:**	6.4
Report to:	Board of Directors		
Title:	Learning from deaths report Q2 and Q3 2018/19		
Sponsoring Director:	Dr David Scullion, Medical Director		
Author(s):	Dr Sylvia Wood, Deputy Director of Governance		

Report Purpose:	**Decision**		**Discussion/ Consultation**	✓	**Assurance**	✓	**Information**	✓

Executive Summary:	In general the structured judgement reviews contained numerous detailed descriptions of good practice. In a smaller proportion of cases, examples of where practice could be improved were documented. There was one case where a problem in care was associated with harm. This death is subject to a Serious Incident investigation. Regarding the review of deaths included in the orthopaedic HSMR for the period Feb-17 to Jan-18, the main theme is of good or excellent care with 96% (24/25) scoring 4 or 5 for overall care. General problems and themes are reported to the Improving Patient Safety Steering Group (IPSSG) to discuss and agree any appropriate actions. Themes and learning will be shared across the organisation using the ChatterMatters newsletter. Specific actions to be progressed are: • Review of the local education of Junior Doctors in relation to coronial processes and accurate completion of death certificates. • Clinicians completing a case review to be asked to report any specific problem regarding care as an event on Datix in order that this is followed up appropriately.

Related Trust Objectives

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

Key implications	
Risk Assessment:	The learning from deaths process aims to identify areas where improvements can be made to patient care which will reduce clinical risk.
Legal / regulatory:	A requirement to collect and publish specified information on deaths including learning points with a report to public Board meetings every quarter from Q3 2017/18 onwards.
Resource:	There is a time resource required to undertake the case note reviews, data collection and analysis.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.
Reference documents	HDFT Learning from Deaths Policy
Assurance:	Learning from quarterly reports is reviewed at the IPSSG.

Action Required by the Board of Directors:

It is recommended that the Board

- **Notes** items included within the report;

6.4

Learning from deaths report: Q2 and Q3 2018/19

For those patient deaths meeting the criteria for a detailed review of case notes, the Medical Director appoints a clinician with appropriate expertise to undertake a structured judgement review (SJR). The Trust has a number of clinicians trained to undertake the structured judgement review. Whenever possible, the clinician will not have been involved in the care of the patient who died.

A case note review is to determine not only examples of good practice, but also whether there were any problems in the care provided to the patient who died in order to learn from what happened.

The Trust has adopted the RCP National Mortality Review Tool which is hosted on Datix. This enables easy access to the information gathered but is not yet proving useful to prepare data for this report. We are communicating with Datix about this. We are also close to testing an in-house platform that will enable us to implement a screening process for all in hospital deaths, to prioritise early review of deaths that would or might benefit from a SJR.

The date of death is the date that we aim to use for the data analysis rather than the date that the SJR was undertaken. However this is currently difficult in that there is not a date of death field on Datix – only the quarter in which the death occurred – without the relevant year. This introduces the potential for error when some historic cases are being reviewed at the same time as current cases.

Some of the SJRs undertaken during Q2 and Q3 relate to deaths that occurred during 2017/18 for various reasons including:

- Trauma & Orthopaedics was flagged as a negative outlier for HSMR for the first time in relation to the period Feb-17 to Jan-18. The patients who died during this period have been identified and the work to review and undertake a SJR has been completed with 25 cases reviewed.

All case note reviews undertaken during 2018/19 Q2 and Q3 have been included in this report.

All hospital cardiac arrests are reported to the National Cardiac Arrest Audit (NCAA) to monitor and report on the incidence of, and outcome from, in-hospital cardiac arrest in order to foster improvements in the prevention, care delivery and outcomes from cardiac arrest. It is a joint initiative between the Resuscitation Council (UK) and ICNARC (Intensive Care National Audit & Research Centre) and is included in the Department of Health Quality Accounts. Further learning is sought by case notes reviews of all in-hospital cardiac arrests which are reviewed by the Resuscitation Committee to identify any areas of learning to share and determine whether the resuscitation is deemed appropriate or inappropriate; this information is also included in this report.

Results of structured case reviews Q2 and Q3 2018/19

Summary of inpatient deaths and structured case note reviews

	2014/15	2015/16	2016/17	2017/18				2017/18	2018/19				2018/19 YTD	Total
				Q1	Q2	Q3	Q4		Q1	Q2	Q3	Q4		
No of inpatient deaths				145	140	167	205	657	142	140	177		459	
SJRs previously reported	4	27	40	8	12	23	13	56	8	N/a	N/a	N/a	8	135
SJRs undertaken during Q2 2018/19				1	0	0	3	4	2	5	N/a	N/a	7	11
SJRs undertaken during Q3 2018/19				0	0	0	1	1	0	7	3	N/a	10	11
Total number of SJRs undertaken relating to deaths in the period	4	27	40					61	10	12	3	0	25	157

This table shows the number of inpatient deaths and the number of structured judgement reviews (SJRs) undertaken during Q2 (no = 11) and Q3 (no = 11), which year / quarter the death occurred and the total number of SJRs completed since the process started.

Assessment of care

2018/19 Q2 and Q3

	Good or excellent care (score 4-5)	Average care (score 3)	Poor care (score 1-2)	N/a	Total
Admission and initial management	18	3	1	0	22
On-going care	21	0	1	0	22
Care during procedure	10	2	0	10	22
Peri-operative care	8	2	0	12	22
End of life care	20	1	1	0	22
Overall assessment of care received	19	2	1	0	22
Overall assessment of patient record	21	0	1	0	22

This table shows the assessment of care for the identified stages of care provision for each of the 22 case reviews completed during Q2 and Q3. 86% (19/22) patients reviewed had good or excellent overall care. One patient accounts for the poor care noted at admission and initial management, on-going care, end of life care, overall care and overall assessment

of patient record. This case has been investigated as a serious incident (SI) and will be reported to the Board separately.

Problems with care

The SJR proforma has a section that enables the identification of problems in care. No problems in care were identified in 13 cases, with some problems in care noted in relation to 9 cases, with no harm recorded for 6 of these.

2018/19 Q2 and Q3

	Degree of harm if problems identified			Total
	No harm	Uncertain harm	Harm	
No problems with care identified				13
Problems in care identified	6	2	1	9
Total				22

Of the two cases where it was uncertain whether harm had resulted:

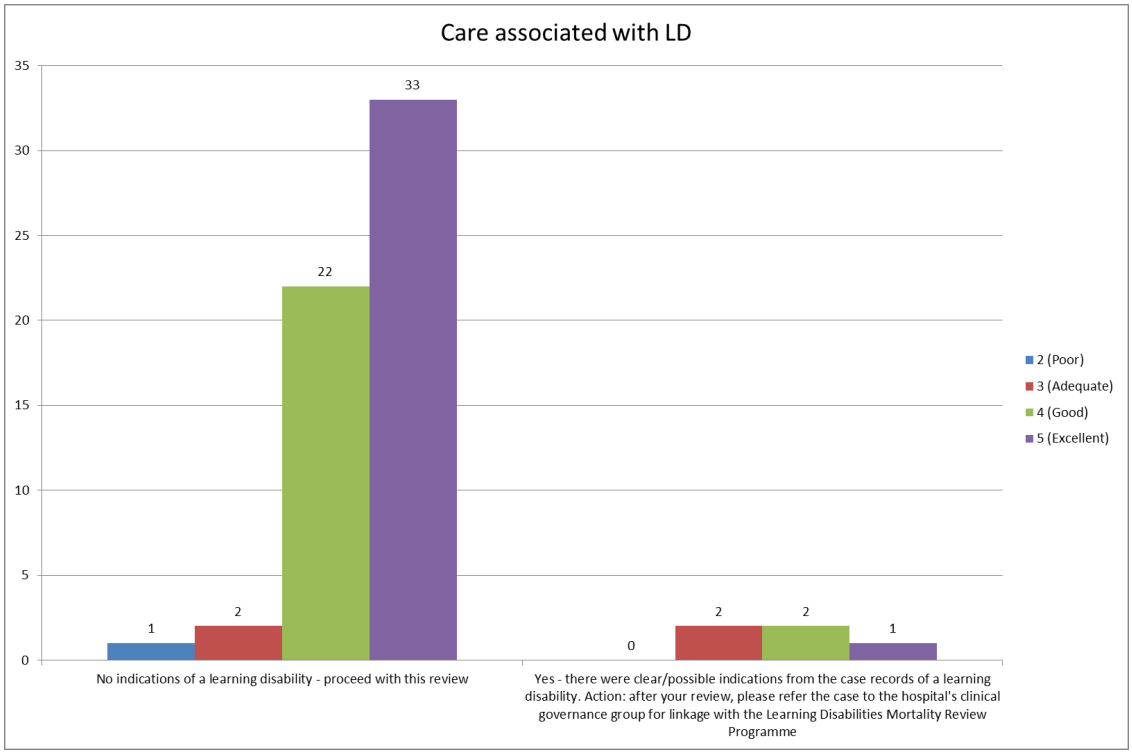
1. It was noted that there was a problem associated with end of life care:
    - Death certification – the patient clearly died of sepsis triggered by a community acquired pneumonia. It is now good practice to use the word "sepsis" on the death certificate in cases like this.
2. The case related to a patient with learning disabilities (LD). The comments about uncertain harm related to various aspects of care.
    - Did severe LD have any impact on lack of recognition of acuity in ED and delay in antibiotics??
    - Probably should have had a PM.
    - However there was much to commend in care and not convinced the outcome would have differed.

The one case associated with problems in care that resulted in harm has been investigated as a serious incident (SI) and will be reported to the Board separately.

Deaths of patients with learning disabilities

There was 1 death of a patient with learning disabilities that underwent a SJR during Q2. Care was generally good but there were some problems with care identified with uncertain harm which have been noted above.

The graph below shows the overall assessment of care for patients with / without learning disabilities (no=5) and without learning disabilities (no=58) from all HDFT SJRs recorded on Datix (n=63).



Orthopaedic HSMR outlier review

Regarding the deaths included in the orthopaedic HSMR for the period Feb-17 to Jan-18, 19 case reviews were completed and included in the Q1 report, and a further six have been included in this report.

Orthopaedic HSMR outlier summary

	Good or excellent care (score 4-5)	Average care (score 3)	Poor care (score 1-2)	N/a	Total
Admission and initial management	21	2	2	0	25
On-going care	23	1	0	1	25
Care during procedure	23	0	0	2	25
Peri-operative care	21	1	0	3	25
End of life care	22	3	0	0	25
Overall assessment of care received	24	1	0	0	25
Overall assessment of patient record	24	1	0	0	25

The main theme is of good or excellent care. Six cases identified some problem with some aspect of care but there was no associated harm. Examples include:

- Not clerked on return from Leeds
- Recognising frailty and anticipatory planning as a result. Would not have changed outcome
- Required on table conversion from spinal to GA due to severe agitation and delirium. Case has already been reviewed by Anaesthetic Team.
- Delay in assessment by Medics due to work load on Medicine.
- Initial treatment of septic patient- more aggressive antibiotic regime indicated on presentation.

This focused review is now complete.

Specific learning points identified by Q2 and Q3 case reviews

- Initial treatment of septic patient- more aggressive antibiotic regime indicated on presentation. Concerns about allergies and renal function
- Death certification – the patient clearly died of sepsis triggered by a community acquired pneumonia. It is now good practice to use the word "sepsis" on the death certificate in cases like this.
- Did severe LD have any impact on lack of recognition of acuity in ED and delay in antibiotics? Consider if any LD training is needed in ED.
- Patient probably should have had a post mortem.
- In retrospect patient did not benefit from transfer back to acute site from Trinity in last day of life.
- Incorrect procedure regarding certification of death and Coronial referral. Hip fracture should have been documented in Part II of the death certificate and the case should have been discussed with the Coroner's Officer.
- The dying phase could have been identified earlier, which may have improved symptom control in the last 24 hours. The patient was identified as deteriorating but junior staff lacked confidence to follow the plan for palliation despite acknowledging this. This delayed the ceasing of futile treatments; however anticipatory meds were prescribed and used in a timely fashion.
- Not clear from records if death certificate referred to hip fracture and no evidence of discussion of case with Coroner.
- Original plan was to discharge patient from ED following fall at home. But YAS identified that patient's poor mobility and accessing first floor property would need 3-person crew not available at the weekend. Clerking then revealed significant heart failure not responding to treatment in the community, along with concerns including struggling at home, sleeping in chair, unable to safely mobilise without assistance of 1-2 people. Admission was appropriate and discharge from ED would not have been appropriate.

Results of case notes reviews of in-hospital cardiac arrests

The case note reviews for Q3 will be included in the next report.

	2017/18						2018/2019					TOTAL
	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	2017/18 Total		Q1	Q2	Q3	Q4	2018/19 YTD	
No of inpatient cardiac arrests	8	11	16	9	44		12	7			19	63
No of case note reviews	8	11	16	9	44		12	7			19	63
No of appropriate cardiac arrests	4	3	13	4	24		10	3			13	37
No of inappropriate cardiac arrests	4	8	3	5	20		2	4			6	26

The cardiac arrest case note reviews show that the care provided prior to and during resuscitation calls is of a high standard, following national guidelines and hospital policy.

There is one case where adrenaline was not administered due to inability to get intravenous access; although this resulted in guidelines not being fully adhered to it was not thought to have adversely affected the outcome as resuscitation was soon discontinued as it was thought to be inappropriate.

The case note review of a patient who was appropriately resuscitated identified that the patient had a critical aortic stenosis which had been known of for a significant period of time; this highlighted a delay in treatment which is now under investigation to improve the referral and transfer of similar patients in the future as it is possible that earlier treatment may have prevented the cardiac arrest.

The Resuscitation Committee deemed 57% of Quarter 2 resuscitation attempts as inappropriate. The reasons for deeming resuscitation inappropriate are detailed below:

Patient had a DNACPR decision in place but not known of or not found	Resuscitation stopped quickly due to futility therefore DNACPR should have been considered pre arrest	Patient had life limiting illness so a DNACPR should have been considered	DNACPR put in place post arrest therefore should have been considered prior to arrest
1	1	3	0

The total number of reasons is greater than four due to one case note review having two possible reasons for being inappropriate as the patient had life limiting illnesses and possibly a DNACPR generated in the community which was not present when they were admitted to hospital. This had been documented and was due to be followed up; unfortunately the patient had a cardiorespiratory arrest prior to this occurring.

The consistent theme for reasons to deem resuscitation inappropriate remains “patient had life limiting illness so a DNACPR should have been considered”. This is the focus of the Appropriate Resuscitation and Escalation Operational (AERO) Group to help clinicians to identify which patients they should be having these discussions with and to provide an easy to use platform to document this on.

For one patient these discussions had taken place and the patient wanted resuscitation so it was agreed that they would remain for resuscitation but if they deteriorated they would not be escalated to HDU/ITU. This highlights some good practice where these discussions are occurring however if a patient is resuscitated they are likely to need HDU/ITU care following this so we need to continue to educate and support clinicians to have these conversations and plan appropriate care for patients who may be approaching the end of their life.

Reflection and learning identified

In general the SJRs were of good quality with numerous detailed descriptions of good practice. In a smaller proportion of cases, examples of where practice could be improved were documented. There was one case where a problem in care was associated with harm. This death is subject to a serious incident investigation.

Regarding the review of deaths included in the orthopaedic HSMR for the period Feb-17 to Jan-18, the main theme is of good or excellent care with 96% (24/25) scoring 4 or 5 for overall care.

Specific learning identified:

1. Although there was no harm associated with the care of the one patient with LD reviewed during the period, there has been some consideration given to whether severe LD had any impact on a lack of recognition of acuity in ED and delay in antibiotics, and whether any LD training is needed in ED. Looking at all of our data, there is a smaller proportion of excellent care overall for patients with LD, although numbers of patients are small.

2. Concerns about completion of death certificates and referral to HM Coroner have again been raised, and further work to improve the knowledge and skills of medical staff regarding these processes may be indicated.

3. Earlier identification of the dying phase could have improved the care of at least 2 patients, preventing an unnecessary transfer from Trinity ward and ceasing of futile treatments. Work is still needed to help clinicians have conversations about appropriate care and resuscitation.

It is important to maintain a memory of specific learning points raised in previous reports and actions taken, so any ongoing themes can be quickly identified and appropriately addressed. These are therefore listed in appendix 1 for reference.

Sharing of learning

1. Local dissemination is through feedback to teams and across the organisation where appropriate. It is not clear that this is done robustly following specific case reviews. Further consideration of identifying and acting on learning will be led through the Improving Patient Safety Steering Group.
2. ChatterMatters, the patient safety newsletter is now being used to share general learning from this process across the organisation.
3. At national level the new web based methodology for documentation of SJR using Datix, will enable identification of themes and wider learning.

Actions

This report was discussed at Improving Patient Safety Steering Group on 10 January 2019. It was agreed:

- Steps would be taken to review the education of junior doctors in relation to coronial processes and accurate completion of death certificates.
- Clinicians completing a case review would be asked to report any specific problem regarding care as an event on Datix in order that this is followed up appropriately. General problems and themes to continue to be reported to Improving Patient Safety Steering Group to discuss and agree any appropriate actions.

Appendix 1: Previous specific learning points identified

2018/19

1. Patients assessed in ED as having stroke should not be given oral intake prior to swallow assessment.
2. Patients with stroke should be admitted to the stroke unit, not other medical wards.
3. Patient transferred back from other hospitals should have a timely medical assessment.
4. Orthogeriatric input should be considered at pre-assessment clinic to manage frailty and start advanced care planning.
5. Death certificate needs to be complete and include recent hip fracture and surgery.
6. Ensure correct Coronial procedures are followed.
7. Difficulty in seeking advice using online Neurosurgical referral system when holistic and contextual decision is indicated. A patient had 3 CT brain scans on 3 consecutive days when alternative reasons for deterioration were evident: high sodium/ AKI/ Parkinson's medication changes/ delirium. Prognostic conversations took place after 3rd scan.
8. Need to minimise delays related to PEG insertion for patients who are otherwise nil by mouth. There was a period of 9 days when one patient had no nutrition. Otherwise care was excellent and the patient's family was involved and kept updated.

2017/18

9. Delay in obtaining result of CT scan from Medica. This has been extensively investigated by direct contact with the outsourcing company and feedback given to the parents of the deceased.
10. Concern related to the death certification process in a patient whose death was unexpected and the exact cause was not established. A post mortem should have been performed.
11. Patient should not have received aspirin as high risk of bleeding.
12. Incorrect falls risk assigned.
13. Patient did not need MRI brain scan.
14. Patient was given oral medication prior to formal swallow assessment.
15. No CXR on admission (but no indication beyond delirium).
16. CXR performed on a Friday afternoon and not reviewed by requesting team or planned weekend review. CXR revealed air under the diaphragm which was not a clinical suspicion.
17. The likelihood and type of final illness could have been anticipated with advanced care planning in the community and the patient could have died within a more homely environment.
18. A patient admitted with a non-haemorrhagic stroke was assessed for thrombolysis. The patient was on warfarin and had INR 1.9 so thrombolysis was contraindicated. However the patient was given aspirin which increased the risk of a haemorrhagic infarct.
- It is important that discussions and realistic treatment plans are in place for these patients including whether cardio pulmonary resuscitation would be clinically appropriate. It is recommended that these patients should have had discussions about resuscitation or their future care discussed as part of advanced care planning either prior to or on admission to hospital.

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Date of Meeting:	30 January 2019	**Agenda item:**	6.5
Report to:	Board of Directors		
Title:	Hopes for Healthcare & Standards		
Sponsoring Director:	Dr Natalie Lyth, Clinical Director, Children's and Countywide Community Care Directorate		
Author(s):	Richard Chillery, Operational Director		
Report Purpose:	**Decision** ✓ **Discussion/ Consultation** **Assurance** ✓ **Information**		
Executive Summary:	With the growth of HDFT children's services and emergence of the CCCC directorate it was advisable to develop an organisational strategy to ensure HDFT can establish and evidence child and young person centred services. At the outset it was agreed that the most child & young person centred approach would be to co-produce this "strategy" with the then burgeoning HDFT Youth Forum. The Youth Forum has subsequently gone from strength to strength. Meaningful co-production takes time, to ensure ownership but the Youth Forum has worked diligently on this piece of work, including a 3 month wider consultation with a range of children and young people from across the HDFT footprint. The Youth Forums ambition and these "products" have been positively noted nationally and they are keen to ensure what has been produced has been "jargon busted" and remains true to the work they have done. What has been developed is: - Seven Hopes for Healthcare (wording and graphics) - The standards which articulate how the Hopes may be evidenced - Explanation and posters for the hopes - Youth Forum webpage for access externally and internally Once the H4HC (and standards) has organisational sign off, they will then be formerly launched supported by Paul Widdowfield. It is likely that the standards will go through a number of		

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	iterations (PDSA cycle) which the Youth Forum will oversee, although it is likely the 7 Hopes will remain static for some time. The 3 clinical directorates will need to ensure that they can evidence delivery against the H4HC/standards and each directorate will need to produce a plan within 4 months of the formal launch - with the recognition that this may ultimately be a 1-2 year "roll out". The plans will be overseen, and the Directorates will be accountable for the delivery of the H4HC to the Youth Forum, Corporate teams and ultimately the Board. There is a Board to Board session on the 19 March between the Youth Forum and HDFT Board members to discuss the Youth Forum's aspirations and organisational support.

Related Trust Objectives

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

Key implications	
Risk Assessment:	The H4HC and standards are clear. The implementation of the standards still requires further work on how this will be managed within the Directorates and then overseen by the Youth Forum and those who support the Youth Forum. The Youth Forum would like to consider how they can support the assessment of services (i.e. spot checks) and develop training videos and materials to support services.
Legal / regulatory:	None identified
Resource:	Corporate support to the running and facilitation of the Youth Forum Each Directorate and its services will need to dedicate time to the implementation of the standards.
Impact Assessment:	Not applicable
Conflicts of Interest:	None identified
Reference documents:	See attached.
Assurance	This has been within the quality Priorities for 2071/8; and then a sub section to the Quality Priority 208/9 (development of a patient engagement strategy). Quarterly updates to the quality committee Sent to Board for consultation period of 2 weeks Approved at SMT on the 23rd January 2019

Action Required by the Board of Directors:

It is recommended that the Board of Directors:

- ***Notes*** *items included within the report;*
- ***Approves*** *these Hopes for Healthcare and accompanying standards*

You matter most

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6.5

You matter most

How we can make 'Our Hopes for Healthcare' a reality

= Communicating clearly the steps and choices available for a young person in their care.

What could make this Hope a reality?	How can we prove this Hope is being achieved?	Where are we now?
• The service actively encourages young people to be involved in their care by listening and taking the time to explain what is happening. • There are processes in place to ensure that young people's views are	• Young people can tell you about their treatment and / or Care Plan. • Leaflets explaining what young people should expect. • ***Survey question -*** *were you*	

included in care planning. • Care Plans (what is happening to the young person) are developed with young people. • The Care Plan should take into account all aspects of their life and how they would like their parent or carer to be involved in their care.	*spoken to / directly involved in decision-making about your care?* • Report from Patient Experience Team based on complaints / compliments. • Audits within case files	
• Feedback about care is actively sought in a range of ways, including electronic feedback, and then reviewed and acted upon.	• A two-sided paper feedback form designed by the Youth Forum - one side with smiley face feedback for younger children and the other side with written questions for young people. It will include a QR code to link to an online survey and / or the Youth Forum page of the HDFT website. • Anonymous and independent feedback is encouraged by staff. • Notice boards which describe what services have changed as a result of feedback from young people. • Range of feedback opportunities, which are young person centred	

	(social media; electronic; via schools etc)	
• Information leaflet given to all young people aged 11-18 about what they can expect from their care upon arrival and how they can give feedback while they wait for their appointment.	• Leaflet created in consultation with the Youth Forum. • Check if leaflets are being given out and ask young people if they are helpful.	
• There are clear processes in place for when there are disagreements regarding care between young people / their healthcare professional / parents or carers – this may include access to advocacy services.	• Young people are given information about the HDFT Patient Experience Team. • Written policy, process and / or statement. • Posters in key areas advertising this. • The information leaflet about care will make it clear that it's ok to question / disagree and what the process is.	
• The service has nominated colleagues to be 'young people's champions' who will provide assistance to support communication around the care of young people to make sure others hear what they	• Champions are in place and have a clear purpose. • Clinical staff knows how to contact them. • Young people know how to contact them.	

say. • The champions will also support the participation of young people in providing insights and feedback at a strategic level.	• Champions to attend Youth Forum meetings periodically.	

= Creating a positive and friendly environment to welcome children and young people into their care.

What could make this Hope a reality?	How can we prove this activity is happening?	Where are we now?
• Make sure children and young people are greeted in a direct, kind and professional manner – with an awareness of young people's needs. • Staff to promptly introduce	• ***Survey question*** **–** *did the people looking after you say hello and tell you their name and job title or what they do?*	

themselves when meeting a young person for the first time.	• Youth Forum spot checks. • Reminders to staff.	
• All health related information for children and young people is clear and easy to understand.	• Services to look at the documents they have and think about if they can be understood by young people (jargon busting!) • Provide easy to understand leaflets for common procedures / conditions experienced by children and young people. • The Youth Forum and other young people are asked to review information leaflets. • Young people are asked if they understand everything about their care or whether they need further support.	
• Where possible, young people can use the service at times convenient to them and be given a choice about service location.	• Survey done to understand the locations / times needed for services relating to children and young people.	• Work started to look at the possibility of this.
• The reception, waiting and treatment areas are accessible, young people friendly, comfortable and welcoming.	• Spot checks by the Youth Forum. • Evidence produced by service – such a photographs	

• Young people's privacy and dignity are maintained at all times ie private areas when needed for sensitive conversations.	• PLACE assessments	
• There is a range of activities in the reception, treatment and waiting areas appropriate for young people, which are refreshed regularly.	• Ask patients and / or Youth Forum for ideas.	
• The service makes use of modern technology used by young people eg text messaging service, face timing, online prescriptions, online appointment booking systems.	• New services are launched and young people use them. • Access to services is increased.	• Work started to look at the possibility of this.
• Signs to healthcare areas used by children and young people are clear and easy to understand.	• When new signs are needed, the needs of children and young people are considered.	

= Developing methods to increase the encouragement of questions and appropriate answers between young people and staff.

What could make this Hope a reality?	How can we prove this activity is happening?	Where are we now?
All staff who come into contact with children and young people will receive training, supervision and appraisal: - On communicating in an engaging and meaningful way. This will include adaptions for children who are vulnerable.	• Staff training – to various levels - Induction; - Use of videos with young people stories / case studies / role play; developed by the Youth Forum	

- On understanding young people and the issues that they face which can impact on their health and wellbeing. - On safeguarding, confidentiality and consent, including guidance on seeing young people without a parent / carer present. - To ensure that they can manage sensitive and / or difficult consultations and support young people in making their own informed choices where children may be scared, defensive or confused.	- Training session for all staff (statutory and mandatory) ; and - Staff to choose a Hope to focus on in their appraisal. • Develop Hopes for Healthcare charter which staff can sign up to.	
• Young people are directly given the name and contact details of a staff member so they can follow up any concerns, both on the ward and in the community.	• ***Survey question –*** *Were you given the name of a member of staff who you could get in contact with if you needed more information?*	Contact details are provided if ongoing support is required. Many staff are already on board with the #mynameis campaign
• Help young people to feel safe and explain that honesty when answering questions and their opinion is valued.	• ***Survey question –*** *Did you feel able to tell healthcare staff the truth?*	

= Promoting a seamless transition for children to adult services to minimise stress on the patient and families.

What could make this Hope a reality?	How can we prove this activity is happening?	Where are we now?
• All young people who are moving ('transitioning') from children to adult health services has at least one 'transition talk' to talk about what the move will be like. • The young person's voice should be heard during these talks. • A follow up talk should take place	• Services are identifying young people who will be moving into adult services over the next few years. • 'Transition talk' is recorded in patient notes. • Produce a checklist for Health Professionals of what to talk	

after the move to check that the young person is coping with the change.	about in the transition meeting.	
• All young people have a 'transition care plan' and the young person has a copy of it. • The plan will include a named key worker who will provide continuity during the move and beyond.	• Ask young people if they have a copy of their transition plan. • ***Survey question*** *(if relevant) Do you understand what will happen when you move to adult services?* • Feedback asked for a few months after transition and information is acted on.	
• Clear transition protocols / procedures in place. • Staff are trained to help young people and their parents / carers with the transition to adult services from the age of 12 onwards and where appropriate make use of tools such as 'Ready, Steady, Go'.	• Protocols / procedures in place. • Staff have received training. • Ask young people how they are feeling about transitioning and what more they need.	
• All young people who are transitioning from children's to adult healthcare receive a booklet with a step by step guide on transitions and be easy to understand. • The booklet will also show local	• All young people who will move to adult services will be given a booklet. • Make sure health professionals consider what a step by step process will look like.	

support services available for adults.		
• Specialist children's services establish closer links with the equivalent adult service so that information about young people who are moving across is passed on. • Encourage adult services to let young people visit them in advance of the formal transition.	• Links have been made. • Visits are taking place.	

= Via the use of feedback aimed at young people in order to shape the services provided for others to come.

What could make this Hope a reality?	How can we prove this activity is happening?	Where are we now?
• Promote the work of the Youth Forum internally and externally. • Tell young people about the opportunities we offer to be involved in decision making and to have a voice.	• Promote the Youth Forum around the hospital and in community locations. • Communicate Youth Forum discussions and decisions in local newspapers, on the Trust website, social media etc.	Youth Forum posters are displayed in relevant areas.
• All Trust staff knows about the Youth Forum.	• Include Youth Forum discussions and decisions in the Trusts bulletin.	

	• Provide small scale training about the Forum by the Forum. • Include information about the Forum in new recruit induction.	
• The Youth Forum will work with external organisations who also aim to improve services for young people eg North Yorkshire Youth Executive.	• Review work done with other organisations and the outcomes every six months. • New projects should consider how to broaden participation with other groups and collaborate.	• Youth Forum members make suggestions of who to work with. • Collaboration has already begun with other groups.
• Young people are actively involved in public Trust meetings and the interview process for senior appointments.	• Youth Forum members to be invited to all public meetings. • Some meetings are planned in a way to make them accessible and engaging to young people. • One Youth Forum to Board session per year (or a take-over challenge) to create links with senior leaders in the Trust. • Two Youth Forum places reserved for recruitment activities related to senior appointments	• Youth Forum members are invited to public meetings taking place outside school time. • Youth Forum members have already taken part in the interview process for a number of appointments. • A Youth Forum to Board session is planned for March 2019.
• Young people are routinely included in patient experience surveys. • Feedback is collected using a range of methods that are accessible and	• A plan, based on research, is in place to make surveys and feedback accessible and relevant to young people.	•

relevant to young people. • Young people are actively encouraged to provide feedback by explaining that feedback can result in service improvement.	• A range of effective methods to gather young people's feedback is in place via technology eg text surveys, social media and the website.	
• Services include young people's feedback and views in supervision and revalidation processes for staff. Feedback is also shared with teams.	• Reports and internal audits. • Services tell young people about changes as a result of children and young people's feedback.	

= To prepare and raise awareness of how children and young people use NHS services provided.

What could make this Hope a reality?	How can we prove this activity is happening?	Where are we now?
• Young people receive a 'quick guide' to healthcare when they start secondary school with information about the Healthy Child Team. To include what services they offer and how to get in touch, plus basic information about other healthcare services on offer eg pharmacy, 111	• An engaging and informative booklet is created based on the needs of young people. • The booklet is distributed to all young people who receive services from the Trust either electronically or in paper format (the Youth Forum said that they	• We have started to ask young people if they would know where to go if they are worried about their health via the Youth Forum and the Patient Voice Group. The results so far show that young

and when to use the Emergency Department. • Other methods of promoting this information can be used eg posters, social media, peer to peer information, schools and community organisations. Click below to see an example: https://www.cambridgeshireandpeterboroughccg.nhs.uk/your-health-and-services/self-care/guide-to-local-nhs-services/	wanted a paper copy.) • Posters in schools with ways to communicate with the Healthy Child Team. • Ask young people before and after receiving the booklet what they would do in a number of healthcare related scenarios.	people are uncertain who to approach about healthcare matters, particularly at an early stage, to stop the issue escalating.

= Incorporating and promoting the outline of rights to children and young people within all areas of healthcare.

What is happening to make this Hope a reality?	How can we prove this activity is happening?	Where are we now?
• Young people's healthcare rights are promoted in a way they understand: - Confidentiality (keeping information private); - What a young person can and cannot consent (agree) to; and - How to complain or provide feedback.	• Posters created by the national NHS Youth Forum are displayed. • This information is included in leaflets being developed for transition to adult services and a 'quick guide' to the NHS.	• Posters created by the national NHS Youth Forum will be displayed in early 2019.

• All staff are able to inform young people, if they ask, of their rights around confidentiality, consent and the right to complain.	• Staff have received information / training.	
• Easy to understand confidentiality and consent policies are available online, plus paper copies in waiting areas used by young people.	• Policy available on the Trust's website and the link promoted to young people and carers. • Hard copies available in young people's service areas.	
• Young people are made aware of where information about them / their health is stored, how it might be shared and how they can access their health record.	• Easy to understand privacy notice on the Trust's website. • This information is included in leaflets being developed for transition to adult services and a 'quick guide' to the NHS.	• An Easy Read privacy notice has been co-developed by Youth Forum and Trust staff and is available on the Trust's website.

Our Hopes for Healthcare at HDFT

co-produced by

the HDFT Youth Forum and

the Children's and County Wide Community Care Directorate

in consultation with

young people who receive healthcare services from HDFT

The HDFT Youth Forum

We are listening.

We are a group of young people aged 13-19 who are passionate about giving young people a voice in decision making about the future of healthcare in this area.

We welcome new members and ideas from children and young people living or studying in the HDFT area.

We are passionate about making health care accessible to children and young people. Our Hopes for Healthcare aim to make this happen. For youth. From the youth.

Dr Ros Tolcher, Chief Executive

Our Trust vision is to provide Excellence Every Time when we care for children and young people. To gain an understanding of the needs and expectations of young people, in terms of their health and healthcare provision, in 2016 HDFT created a Youth Forum. Over the past year, the HDFT Youth Forum, in consultation with other children and young people from a range of backgrounds and experiences , have worked hard to develop seven standards or 'hopes' by which we can assess our services in providing child and young person centred care.

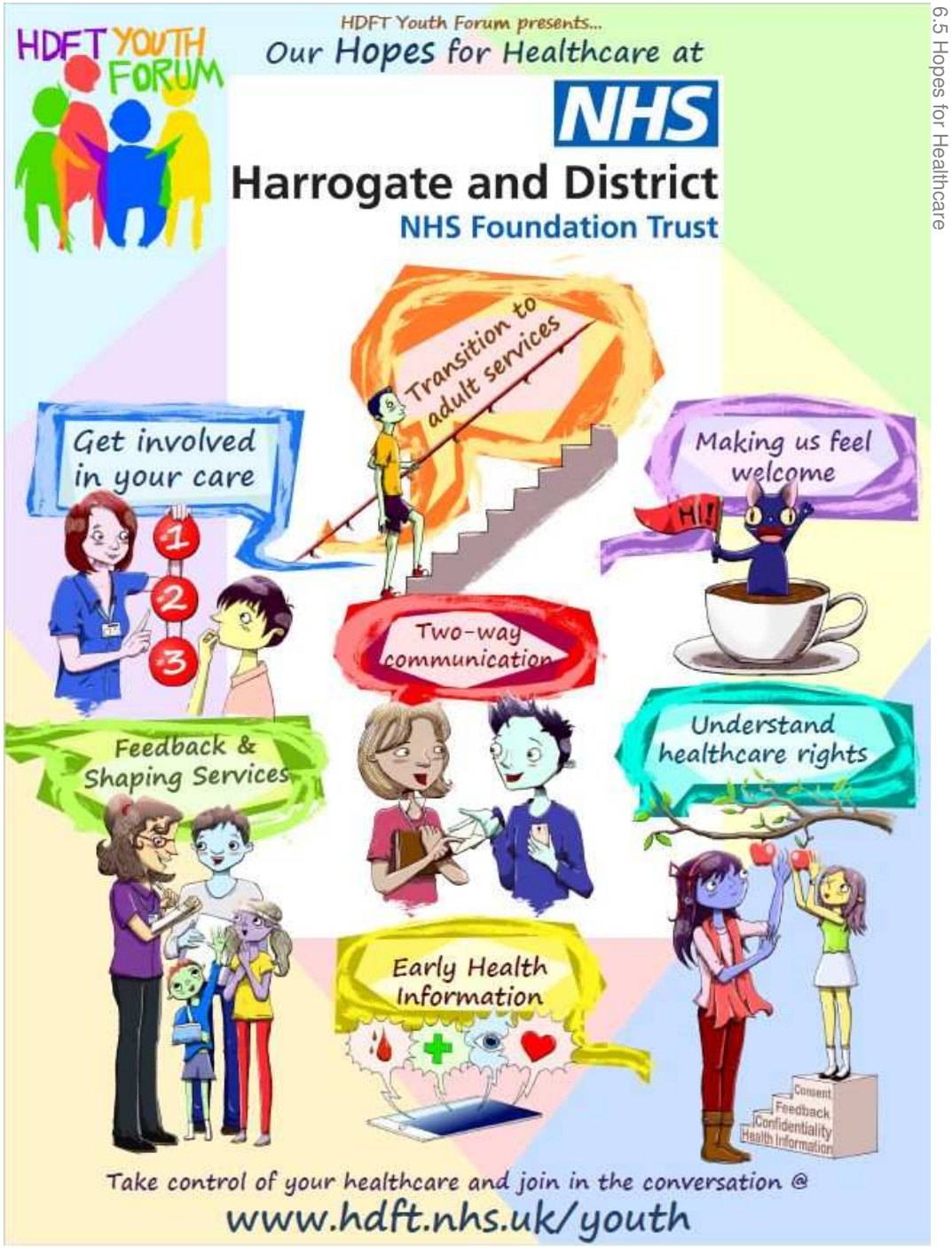
Each year we will tell you how we measure up to these standards and what we are doing to continually improve our service for Children and Young People who use our services.

Richard Chillery, Operational Director, Children's and County Wide Community Care

I am keen to ensure that as an organisation we are able to articulate how we are child and young person centred. It has been both exciting and a privilege to work closely with the HDFT Youth Forum on this co-produced piece of work, which provides a road map for services of how children and young people would like their services to look like. We have consulted widely with children and young people across all of the areas HDFT delivers services into to ensure we are inclusive and all young people can see themselves in this charter. It is important we are accountable to the children and young people who use our services and we provide opportunities to shape those services.

You matter most

The Youth Forum and HDFT would like to thank Nicholas Burgoyne from Sterile Services for donating his time, vision and creativity to design this document.



Making Children And Young People Feel Welcome

- Provide a variety of easy to understand healthcare information.
- Explain how to book convenient appointment times with text reminders.
- Have clear signs and directions using non-jargon words within buildings.
- Provide a warm welcome and the opportunity to speak in confidence.
- Create spaces which are bright and have things for children and young people to distract themselves with.

Understanding Healthcare Rights

- Treat all children and young people as individuals and respect their opinions.
- Help young people to better understand their rights to:
  - Confidentiality.
  - Consent to treatment.
  - Accessing healthcare without parents or guardians.
- Help to support the rights of young carers.

Confident Two Way Communication

- Health professionals to listen and notice verbal and non-verbal communication.
- Build confidence in children and young people by encouraging questions, providing information and giving clear explanations.
- Avoid children and young people having to repeat their story.
- Health professionals to ask rather than assume how a young person is feeling.

Having A Voice And Improving Healthcare Services

- Provide a range of opportunities to give anonymous feedback, independent of parents and carers.
- Feedback to be used to make a difference in services for children and young people.
- Involve young people in decision making at a high level through the Trust's Youth Forum and other groups.

Moving To Adult Healthcare Services

- Start early with conversations about moving to adult healthcare services and outline a step by step process.
- Explain the different options to young people and provide information on what to expect.
- Where possible, continue connections with young people for a short while following the move to adult services.

Involving Children And Young People In Their Care

- Listen carefully to what children and young people are saying.
- Take time to clearly explain what is happening at each stage.
- Speak directly to the child or young person.
- Actively involve children and young people in decision making, even when it involves tough decisions.

Starting Early With Health Information

- Health Professionals should try to stop a small problem turning into a bigger one.
- Make it clear which Health Professional to speak to for different issues.
- Promote the Healthy Child teams, both in and out of school, and make it easy to contact them.
- Provide information at the right time e.g. emotional health support during stressful periods.
- Advise children and young people how to access and use the NHS and its services.

NHS
Harrogate and District
NHS Foundation Trust

The HDFT Youth Forum and the Children's and County Wide Community Care Directorate

have co-produced

Our Hopes for Healthcare at HDFT

You matter most

6.5

Involving Children And Young People In Their Care

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Harrogate and District NHS Foundation Trust

Date of Meeting:	30 January 2019	**Agenda item:**	6.6
Report to:	Board of Directors		
Title:	Equality Delivery System (EDS2) Assessment January 2019		
Sponsoring Director:	Jill Foster, Chief Nurse		
Author(s):	Dr Sylvia Wood, Deputy Director of Governance		
Report Purpose:	**Decision**		**Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓
Executive Summary:	Each year the Trust defines its equality objectives and the Equality and Diversity Group establishes a plan to progress work to deliver the objectives. At the end of each year there is a review of progress and analysis of relevant data to consider the evidence available for self-assessment against the Equality Delivery System goals and outcomes. We are required to agree our objectives and self-assessment with stakeholders and therefore we hold a stakeholder event each January. Following this, the HDFT annual summary report is completed and presented to Senior Management Team and the Board of Directors for approval prior to publication at: Equality and diversity - Harrogate and District NHS Foundation Trust		
Related Trust Objectives			
To deliver high quality care ✓	**To work with partners to deliver integrated care:** ✓	**To ensure clinical and financial sustainability:** ✓	
Key implications			
Risk Assessment:	The use of the EDS2 helps NHS organisations review and improve their performance for people with characteristics protected by the Equality Act 2010 and therefore reduces the risk of breaching the Equality Act.		
Legal / regulatory:	The Equality Act 2010		
Resource:	Resource may be required for specific work plans.		
Impact Assessment:	Not applicable.		
Conflicts of Interest:	None identified.		
Reference documents	NHS England » Equality Delivery System		
Assurance:	This report describes the assurance provided by stakeholder engagement and Senior Management Team.		
Action Required by the Board of Directors:			
It is recommended that the Board: • **Notes** items included within the report; • **Supports** the approach taken to meet the requirements of EDS2 • **Approves** the summary report for publication and • **Supports** the plan of work for 2019/20.			

6.6

Introduction

The main purpose of Equality Delivery System (EDS2) is to help NHS organisations, in discussion with local partners including local people, review and improve their performance for people with characteristics protected by the Equality Act 2010. Organisations are required to assess their performance in relation to the 4 goals and 18 outcomes, and to consider for each whether people whose characteristics are protected by the Equality Act, fare as well as people overall. The goals and outcomes together with our associated equality objectives are provided at the end of this report. The grading to be used in assessing performance is:

Each year the Trust defines its equality objectives. The Equality and Diversity Group then establishes a plan to progress work to deliver the objectives. At the end of each year there is a review of progress and analysis of relevant data to evidence for self-assessment against EDS2.

We are required to agree our objectives and self-assessment with stakeholders and therefore we hold a stakeholder event each January. Following this, the HDFT annual summary report is completed and presented to SMT and the Board of Directors for approval prior to publication at: Equality and diversity - Harrogate and District NHS Foundation Trust

Equality Objectives 2018 – 2020

In 2018 we defined equality objectives for a 2 year period for each of the four goals:

Better health outcomes

- To ensure that our services provide effective and safe treatment and care that is sensitive to people's personal and cultural needs as well as appropriate to their clinical condition.

Improved patient access and experience

- To seek effective feedback about the experiences of people with protected characteristics who use our services in order to improve access and experience, and improve staff awareness and communications about equality.

A representative and supported workforce

- To utilise the workforce equality group to deliver action plans focused on improving the availability of workforce equality information to assess our progress towards ensuring we have a representative and supported workforce.

Inclusive leadership

- To ensure that Trust leaders have the right information and skills to promote equality within and beyond the organisation and to support their staff to work in a fair, diverse and inclusive environment.

Self-assessment results

We have reviewed progress in relation to the specific workstreams progressed during 2018-19 which have been:

- Continuing the work of the Youth Forum;
- Continuing the work to support the care of people with learning disabilities;
- Continuing public health work to reduce inequalities in health with Gypsy, Roma and Traveller population in Co. Durham with specialist health promotion;
- Establishing a Changing Places facility within the Endoscopy Unit at HDH;
- Work to develop policy and guidance to support transgender patients and staff;
- Work to develop a Patient and Public Participation Strategy;
- Various projects to support our workforce;
- Developing systems and processes to consistently meet the requirements of the Accessible Information Standard;
- Increasing engagement with stakeholders – public and staff;
- Supporting patients with hearing impairment;
- Supporting people with visual impairment;
- Improving our impact assessment processes.

Based on the work done and analysis of data including the staff survey, staff FFT, and patient feedback including local and national patient surveys we have self-assessed as follows:

Better health outcomes		Improved patient access and experience		A represented and supported workforce		Inclusive leadership	
1.1	Achieving	2.1	Achieving	3.1	Achieving	4.1	Achieving
1.2	Achieving	2.2	Achieving	3.2	Achieving	4.2	Achieving
1.3	Achieving	2.3	Achieving	3.3	Achieving	4.3	Achieving
1.4	Achieving	2.4	Achieving	3.4	Developing		
1.5	Achieving			3.5	Achieving		
				3.6	Achieving		

The outcome which is assessed as developing is 3.4: When at work, staff are free from abuse, harassment, bullying and violence from any source. This is because of the evidence from the 2017 staff survey of an increased proportion of BAME staff who participated reporting harassment, bullying or abuse from staff. Considerable work has been undertaken as a result but evidence of improvement is not yet available.

On 15 January we held our E&D stakeholder event and presented a summary of a selection of work progressed during the last year. The stakeholders present who represented HaRD CCG, Patient Voice Group, HDFT Governors, and Equality Stakeholder Group, supported our approach, self-assessment and proposed work plan for 2019/20.

Equality work for 2019/20

Our plan of work for 2019/20 includes:

- Reviewing and strengthening governance arrangements to ensure we have our equality objectives embedded in other business and the work and progress has enough visibility throughout the organisation;
- Working with stakeholders including disabled patients and staff, and Capital Planning to improve access and support. To consider signing the Think Access pledge to show support for Harrogate Advertiser's campaign with Disability Action Yorkshire to make the Harrogate district the most accessible and disability-friendly place in the country.
- Completing and implementing a Trust policy to support transgender patients, service users and staff;
- Completing and implementing the HDFT Patient and Public Participation Strategy;
- Continuing actions to progress a 'fair and just culture' and implement WRES, gender pay gap and staff engagement plans;
- Implementing processes to deliver the Accessible Information Standard consistently and effectively;
- Focused work to enable staff to support patients with hearing and visual impairment
- Completing and embedding robust impact assessment processes.

Summary

The Board of Directors is asked to support the approach taken to meet the requirements of EDS2, to approve the summary report for publication and to support the plan of work for 2019/20.

eds2 18-19
summary report final

EDS2 Goals and Outcomes and HDFT Equality Objectives 2018 - 20	
Goal : Better health outcomes	
Objective 2018-20 To ensure that our services provide effective and safe treatment and care that is sensitive to people's personal and cultural needs as well as appropriate to their clinical condition	
1.1	Services are designed and delivered to meet the health needs of local communities
1.2	Individual people's health needs are assessed and met in appropriate and effective ways
1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed
1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse
1.5	Screening, vaccination and other health promotion services reach and benefit all local communities
Goal: Improved patient access and experiences	
Objective 2018-20: To strengthen our systems and processes to meet the requirements of the Accessible Information Standard, to continue to work with patients with learning disabilities to provide even better patient access and experience, and to introduce the Patient Participation Strategy.	
2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds
2.2	People are informed and supported to be as involved as they wish to be in decisions about their care
2.3	People report positive experiences of the NHS
2.4	People's complaints about services are handled respectfully and efficiently
Goal: A representative and supported workforce	
Objective 2018-20 To utilise the workforce equality group to deliver action plans focused on improving the availability of workforce equality information to assess our progress towards ensuring we have a representative and supported workforce	
3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations
3.3	Training and development opportunities are taken up and positively evaluated by all staff
3.4	When at work, staff are free from abuse, harrassment, bullying and violence from any source
3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives
3.6	Staff report positive experiences of their membership of the workforce
Goal: Inclusive leadership	
Objective 2018-20: To ensure that Trust leaders have the right information and skills to promote equality within and beyond the organisation and to support their staff to work in a fair, diverse and inclusive environment	
4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations
4.2	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are managed
4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

Equality Delivery System for the NHS
EDS2 Summary Report

Implementation of the Equality Delivery System – EDS2 is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS2 in accordance with the '9 Steps for EDS2 Implementation' as outlined in the 2013 EDS2 guidance document. The document can be found at: **http://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf**

This *EDS2 Summary Report* is designed to give an overview of the organisation's most recent EDS2 implementation. It is recommended that once completed, this Summary Report is published on the organisation's website.

NHS organisation name:

Harrogate and District NHS Foundation Trust

Organisation's Board lead for EDS2:

Jill Foster, Chief Nurse

Organisation's EDS2 lead (name/email):

Dr Sylvia Wood, Deputy Director of Governance (sylvia.wood@hdft.nhs.uk)

Organisation's Equality Objectives (including duration period):

These are our objectives for 2018-2020:

Level of stakeholder involvement in EDS2 grading and subsequent actions:

Stakeholders invited to annual event to share progress with equality objectives and to discuss and agree EDS2 grading included this year:

Headline good practice examples of EDS2 outcomes (for patients/community/workforce):

We have this year progressed work in relation to:

Publication Gateway Reference Number: 03247

Date of EDS2 grading January 2019 **Date of next EDS2 grading** January 2020

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Better health outcomes	1.1	**Services are commissioned, procured, designed and delivered to meet the health needs of local communities** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ☐ Disability; ☐ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ☐ Sexual orientation Evidence drawn upon for rating: Evidence from previous years and:	✓
	1.2	**Individual people's health needs are assessed and met in appropriate and effective ways** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ☐ Disability; ☐ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ☐ Sexual orientation Evidence drawn upon for rating: Evidence from previous years and:	✓
	1.3	**Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ☐ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ☐ Sexual orientation Evidence drawn upon for rating: Evidence from previous years and:	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Better health outcomes, continued	1.4	**When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: Evidence from previous years and:	✓
	1.5	**Screening, vaccination and other health promotion services reach and benefit all local communities** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: Evidence from previous years and:	✓
Improved patient access and experience	2.1	**People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: Evidence from previous years and:	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Improved patient access and experience	2.2	**People are informed and supported to be as involved as they wish to be in decisions about their care** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: Evidence from previous years and:	✓
	2.3	**People report positive experiences of the NHS** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: Evidence from previous years and:	✓
	2.4	**People's complaints about services are handled respectfully and efficiently** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: Evidence from previous years and:	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
A representative and supported workforce	3.1	**Fair NHS recruitment and selection processes lead to a more representative workforce at all levels** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ☐ Disability; ✓ Gender reassignment; ☐ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ☐ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: See evidence from previous years.	✓
	3.2	**The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ☐ Disability; ✓ Gender reassignment; ☐ Marriage and civil partnership; ✓ Pregnancy and maternity; ☐ Race; ✓ Religion or belief; ✓ Sex; ☐ Sexual orientation Evidence drawn upon for rating: See evidence from previous years.	✓
	3.3	**Training and development opportunities are taken up and positively evaluated by all staff** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: See evidence from previous years.	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
A representative and supported workforce	3.4	**When at work, staff are free from abuse, harassment, bullying and violence from any source** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ☐ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: Evidence from previous years.	✓
	3.5	**Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: See evidence from previous years.	✓
	3.6	**Staff report positive experiences of their membership of the workforce** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: See evidence from previous years.	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Inclusive leadership	4.1	**Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: Evidence from previous years and:	✓
	4.2	**Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: Evidence from previous years and:	✓
	4.3	**Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation Evidence drawn upon for rating: Evidence from previous years and:	✓

Harrogate and District NHS Foundation Trust

Date of Meeting:	30 January 2019	**Agenda item:**	6.7
Report to:	Board of Directors		
Title:	NHS Improvement (NHSi) Nurse Staffing Review Improvement Plan		
Sponsoring Director:	Mrs Jill Foster, Chief Nurse		
Author(s):	Mrs Jill Foster, Chief Nurse		
Report Purpose:	**Decision** ☐ **Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓		
Executive Summary:	• This paper is to provide the Trust Board with the improvement plan developed in response to the recommendations of the NHSi Nurse Staffing Review conducted in September 2018. • The report 'Review of Nursing and Midwifery Establishments at Harrogate and District NHS Foundation Trust. Final draft: For Trust scoping and ratification can be found in the reading room • The Board is asked to note the content of the report, be assured about nurse and midwifery staffing establishments for in-patient areas at HDFT and approve the improvement plan,		

Related Trust Objectives

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

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

Action Required by the Board of Directors:

- **Note** the content of review
- **Approve** the improvement plan developed in response to the recommendations
- Be **assured** that nursing and midwifery establishment levels are safe and appropriate for in-patient areas at HDFT
- Be **assured** appropriate measures are being undertaken to strengthen planning, operational, quality and financial oversight of nursing and midwifery establishments

6.7

Introduction

In May 2018 NHSi were invited to undertake an independent peer review of the nursing and midwifery establishment levels at the Trust. This was to allow an independent professional view as to whether the staffing levels are appropriate and ultimately safe and to suggest any areas of improvement to further strengthen and to quality assure the quality measures and financial controls which currently support nursing and midwifery establishment levels within the organisation.

The key drivers to requesting the independent review were to

- Determine if the nursing and midwifery staffing establishments in the in-patient areas are safe and appropriate
- Identify the drivers of the overspend of the in-patient nursing budget and to understand any additional restorative measures that could deployed to address this variance

The review took place on 6th September 2018 and e received the final draft for Trust scoping and ratification on 25th November 2018.

The Director Team agreed the senior nursing team would review the report recommendations and develop an improvement plan for agreement at Director Team, SMT and Trust Board.

Results

The senior nursing team reviewed the report and developed an improvement plan. The improvement plan was agreed by Director Team and SMT. The table below summarises the recommendations and improvement plan.

	NHSi Recommendation	HDFT Response	Action by and when
1	Consider how nursing and midwifery spend information is presented to ensure greater transparency and differentiation between substantive and all methods of variable pay. Financial reporting on escalation beds should remain discrete from the core establishment budget.	Agreed - Ward budgets and spend known at ward level and reviewed at monthly performance meetings by directorate management team. - Bank and agency spend clearly defined on monthly ward and department budget statements - Financial position is standing item on Directorate Board Agendas - Monthly ward spend reported in detail ay Workforce Efficiency Group (WEG) with oversight from SMT	Completed
2	Review and determine a single process for the authorisation of agency spend and premium/over-cap spend to ensure that these are sufficiently robust and owned by relevant staff	Agreed Single process exists	Completed
3	Present nursing establishment, fill rate and CHPPD data alongside nursing quality and outcome metrics. Alongside this, identify any evident relationships between staffing levels	Agreed - Planned versus actual in-patient nurse staffing levels reported monthly at Trust Board alongside the Integrated Board (IBR)	Completed

	and the quality of patient care and the professional judgement of the Heads of Nursing or other senior nurses	detailing key nursing quality and outcomes measures. The professional judgement of the Chief Nurse is included in the narrative sections of the IBR. - The Quality Committee (QC), a committee of the Trust board receives a detailed dashboard of quality metrics regarding each ward and department every month. There is a monthly discussion and concerns, by exception, are escalated to the Trust Board.	
4	Review the Trust's compliance with national safer staffing recommendations from the National Quality Board, NHS Improvement and NICE. Review the reporting of this to the Trust Board to ensure that it is equipped fully to exercise its accountability in this regard	Agreed Current Trust compliance with recommendations from the National Quality Board, NHSi and NICE reviewed by the Director Team and SMT. Nurse Safer Staffing Paper to Trust Board in March 2019 (Annual Paper) Review of Nurse Safer Staffing Paper to Trust Board in September 2019	Nurse Safer Staffing paper for Trust Board in March 2019 – JF Nurse Safer Staffing Paper to be scheduled for Trust Board in March 2019 - AF
5	Promote awareness of the national safer staffing requirements to all senior nurses and senior midwives so that they are cognisant of the requirements and are able to articulate them.	Agreed Senior Nurse Masterclass held 23rd November 2018	Completed
6	Establish more robust processes for involving sisters and charge nurses in setting and agreeing their budgets. This is to complement the actions in 4 and 5 above	Agreed Annual budget meetings held with ward managers and matrons, the directorate management teams and finance	Consider other line of accountability meetings and escalation to executive team – JC, RH, JF
7	The Chief Nurse to consider establishing regular meetings with Heads of Nursing to hold them to account for budget management. The trust should also consider how a move to a more prospective focus on financial spend could be incorporated into the accountability process.	Agreed Monthly meetings already held by directorate management teams, including Heads of Nursing/Midwifery. Workforce Efficiency Group meeting	Complete
8	Review the composition of the 23% establishment uplift (mark-up) and promote awareness of this amongst	Agreed All ward managers aware of 20.68% uplift in establishment	Completed

	senior nurses/midwives and budget holders. In line with this, develop a methodology to measure how well this is used and how well it is complied with	budgets – masterclass 23rd November 2018	
9	Review the paediatric nurse staffing paper to ensure that the Trust is assured of its findings and recommendations, and appropriate acuity tools are used for measuring risk and determining budgets	Agreed Trust is aware of Paediatric Nurse Staffing paper	Review as part of Nurse Safer Staffing paper for Trust Board in March 2019 – JF
10	Undertake a skill-mix review to look at RN to non-registered staff ratios to determine if these are appropriate. Also, the Trust may wish to consider the use of new roles such as patient discharge assistants, AHPs etc	Agreed Current skill-mix is appropriate. Trust has developed roles of discharge coordinators, discharge team, nutritional assistants, stores person, assistant practitioners and trainees nurse associates	Review as part of Nurse Safer Staffing paper for Trust Board in March 2019 – JF
11	Senior nurses and midwives to be more cognisant of bed occupancy levels.	Agreed Senior nurses and midwives are aware daily of bed occupancy levels and manage the risk accordingly	Completed
12	Review rota practices to ensure that the costliest staff are not distributed inappropriately across the more expensive shifts (evenings and weekends)	Agreed Head of Nursing/Midewifery to undertake one - off review	Completed
13	Review and streamline, in priority order, the process for securing additional staff for wards and departments	Agreed Process being streamlined	Completed
14	Consider using quality metrics at bed meetings alongside bed numbers and flow issues to help understand the patient acuity and other specific determinants of workload in a given area to aid better decision making	Agreed Matrons have assurance checklists which they complete, at least, daily. They attend the bed meetings and report any pressure within the system. Risk is managed accordingly	Completed
15	Consider whether a replacement for Roster Pro is feasible	Agreed Rosterpro is the current electronic rostering system. There is an established process for how rosters are produced, verified and rechecked	Business case is being explored to potentially replace rosterpro
16	Review the roster policy, agree roster KPI metrics and / review policy and the associated governance	Agreed Roster policy being reviewed KPI Metrics agreed	DB Feb 2019
17	Complete the clinical nurse specialist	Not in scope of NHSi Nurse	Completed

	review (NHS Improvement will support by providing identifying other Trusts that have undertaken a similar piece of work)	Staffing Review	
18	The Trust should test whether Quality Impact Assessments are robustly used when reducing budgets	Agreed No service has had their staffing establishment budget reduced. There is a QIA Policy in place if required	Completed
19	The Trust should consider the development of a safe nursing and midwifery staffing escalation policy in place, which would be helpful to manage the available staffing resource	Agreed Process being streamlined	Completed
20	Review the functioning of the bed meeting in considering patient harms with the allocation of patients and staff	Agreed Purpose of bed/flow meetings, which includes managing of risk of harm to patients, well established	Completed
21	Develop an action plan and governance mechanism to oversee delivery of the recommendations within this report	Agreed Improvement Plan developed and agreed at Director Team, SMT and Trust Board Internal Audit of Improvement Plan in six months	Jill Foster January 2019 To be developed by IA team and JF – July 2019

Discussion

Whilst the report highlighted some useful recommendations it was disappointing it that one of the key drivers for requesting the review remained unanswered. The report is silent on the key question 'are the nursing and midwifery staffing establishments in the in-patient areas safe and appropriate? In subsequent meetings with NHSi I it has been agreed in the absence of comment or recommendation the nurse and midwifery staffing levels in HDFT's in-patient areas are safe and appropriate.

The report made some useful recommendations around daily operational practice, planning and strengthening governance arrangements. Some of these recommendations had already been commenced prior to the review and the subsequent report and have contributed to the significant reduction of the monthly ward overspend. The other recommendations will be completed as indicated in the improvement plan.

The improvement plan will be audited by Internal Audit in six months.

Following approval of the improvement plan this report will be submitted to NHSi.

Jill Foster
Chief Nurse
January 2019

(FINAL DRAFT: FOR TRUST SCOPING AND RATIFICATION)

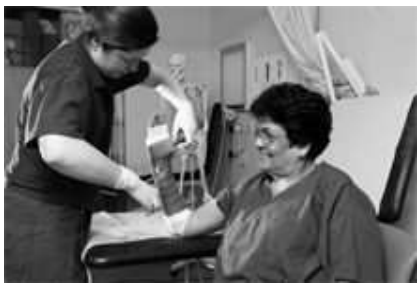
NHS Improvement

6.7

Review of Nursing and Midwifery Establishments at Harrogate and District NHS Foundation Trust

(FINAL DRAFT: FOR TRUST SCOPING AND RATIFICATION)

Date of review: 6th September 2018



About NHS Improvement

NHS Improvement is responsible for overseeing foundation Trusts, NHS Trusts and independent providers. We offer the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening, we help the NHS to meet its short-term challenges and secure its future.

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

Contents

1. Background

The Chief Nurse of Harrogate and District NHS Foundation Trust, Mrs Jill Foster, supported by NHS Improvement, requested an independent peer review of the nursing and midwifery staffing establishment levels at the Trust. This was to allow an independent professional view as to whether the staffing levels were appropriate, and to suggest any areas of improvement to further strengthen, and to quality assure the quality measures and financial controls which currently support nursing and midwifery staffing establishment levels within the organisation.

The Chief Nurse, on behalf of her executive team, was keen to seek an independent peer review to help to identify the drivers for the overspend of the inpatient nursing budget and to understand any additional restorative measures that could be deployed by the Trust to address this variance.

An expert peer review team comprising senior nurses and managers from both NHS Improvement and several NHS acute Trusts, was convened to undertake the peer review. This was led by NHS Improvement and supported by the Chief Nurse of Hull and East Yorkshire Hospitals NHS Trust (Appendix 1 details the peer review team members). The peer review took place at Harrogate District Hospital on Thursday 6th September 2018; following receipt and consideration of a pack of qualitative and quantitative information submitted by the Trust before the visit.

This peer review was not an inspection and presents only a snapshot of findings in as much as could reasonably be covered in one day. This was a peer review designed to help the Trust to 'hold a mirror up to itself' and reflect the position that was seen by the peer review team. Limitations to the report are that findings are based on:

- A review of printed information and reports pertaining to nursing and staffing
- A presentation from the chief nurse alongside a discussion with senior rnurses and midwives
- Focus group meetings that only had small numbers of staff.
- A small number of planned visits to clinical and non-clinical areas and discussion with the ward managers and matrons.

Staff were very welcoming and demonstrated warmth and a friendly approach throughout. However, they did appear to be under-prepared for the conversation and, whilst they described use of dashboards and tools, no copies were brought to the meetings. The use of visual aids and prompts may have helped staff explain Trust staffing processes and assurance more clearly.

As a result, the peer review team cannot make a judgement as to whether process and evidence seen on the day are embedded and sustained and can only share the findings of that particular day back and offer some suggestions on opportunities that the Trust may wish to consider to help it manage its nursing and midwifery workforce and associated costs more effectively.

2. Terms of reference

The terms of reference were agreed, as follows:

a. Review nursing and midwifery staffing across the Trust for the past year (excluding community services), including funded establishment, vacancies and fill rates compared to the recommendations from the National Quality Board.
b. Undertake ward and department visits, including discussions with the lead nurses to observe staffing levels, management of rotas, escalation processes for staff shortages and use of temporary staff
c. Benchmark Harrogate and District NHS FT with similar hospitals on the staffing data publicly available. The will include Care Hours Per Patient Day (CHPPD), shift fill rate, and skill mix
d. Perform a baseline assessment using the NICE Guidance assessment tool
e. Review actions the Trust has taken to manage its use of temporary staffing
f. Review the Trust's governance, reporting and management of the nursing and midwifery agenda
g. Consider further actions or mitigation the Trust should consider in its response to the challenges of the nursing and midwifery workforce agenda
h. Complete a report on findings from the assurance review for submission to the Trust's Chief Nurse and Board of Directors.

3. Methodology

The methodology was agreed, as follows:

a. Introduction to Harrogate and District NHS Foundation Trust and work undertaken to date

b. Review of evidence submitted by Harrogate NHSFT

c. Ward visits

d. Focus Group interviews with nursing and midwifery staffing leaders

A comprehensive pack of information was supplied to, and reviewed by, each member of the peer review team in advance of the assessment. This comprised:

- Acuity and Dependency Data
- Daily Flow Template
- Divisional information
- NHSP Agency Cascade
- Nursing Strategy
- Safer Staffing papers to Board of Directors
- Workforce Efficiency Group papers
- Draft New Quality Dashboard
- Matron Daily Quality Checks template
- Patient experience reports for Q3 and Q4
- Quality audit documents and templates
- Quality Dashboards
- High Level Nursing and Midwifery Financial Data (provided on the day of the visit)

The peer review team undertook a full day of reviews comprising a presentation from the Chief Nurse, with senior nurse's present; and interviews and focus groups with Heads of Nursing, Matrons and Sisters/Charge Nurses and representatives from workforce, finance and management along with ward visits.

Firstly, it is important to acknowledge the positive reception given to each member of the review team by officers of the Trust. The team was made very welcome and the preparation for the assessment visit and supporting information were very comprehensive. Collectively, staff were all extremely welcoming, open, honest, professional and transparent and were very generous with their time. A wide range of honest views and interpretations were gathered, and the peer review team concluded that these were fair, balanced and appropriate.

4. Peer Review Team Findings

The peer review team took some time to consolidate its views and were in unanimous agreement of the review findings, which are, as follows:

1. There was an evident passion and commitment from the Chief Nurse and the executive team to get this right and to learn from others. The team was honest and open regarding its challenges. Much positive work has been commenced and additional work is underway to manage the nursing and midwifery resource effectively. The Chief Nurse advised the peer review team that the Trust had experienced an overspend against the nursing budget in 2017/18 of circa £800k and that these trends had continued into the first few months of 2018/19, although these appeared to be abating in the more recent months, particularly since May 2018.

2. On average, the Trust has a high aggregated Care Hours per Patient Day (CHPPD) when compared nationally and against peers. Since April 2017, these have been at or above national or peer average, which suggests higher than average costs.

3. At the time of the review, the Trust was recording the second highest Weighted Activity Unit cost (WAU) for substantive nursing and midwifery staff on Model Hospital. Recognising that Trusts with a high proportion of community

services are generally in the upper quartile, this remains an outlier position as the Trust is also the second highest in a peer group with a similar proportion of community reference costs.

4. The Trust ended the 2017/18 Financial Year with the following spend variances on nursing and midwifery:

Inpatient	£ 1,131,818 (Overspend)
Community	£ 188,865 (Underspend)
Other	£ 682,728 (Underspend)
Total	**£ 260,226 (Overspend)**

Within these amounts:

- Inpatients underspent on permanent staff (but with bank and agency driving the overspend in this area.)
- Community underspent on permanent staff. They were over budget for bank and agency but underspent overall.
- The 'other' category (which was not clearly defined by the Trust or review team) underspent on permanent staff, overspent on bank and agency but underspent overall.
- The Trust uses agency non-registered staff at premium cost although the Trust panel members discussed an intention to eventually move away from this. The use of non-registered agency staff was unusual to most peer review team members, as substantive non-registered staff are not usually difficult to recruit, however the Trust did describe some demographic challenges of the working age populating in Harrogate, e.g. a significant

elderly population and that many of the younger workforce are in full time education. Whilst recognising the Trust may find this workforce harder to recruit to than other areas, it is recommended that this is still a priority for further exploration as the cost benefit may be significant.

- Escalation beds had been opened on several wards to manage winter pressures. The Chief Nurse confirmed these were funded in 17/18. However, the extra costs that these beds generated in terms of staffing were not clear in terms of how they contributed to the Trust's overall financial position. This is an area of financial reporting that should remain discrete from the core establishment budget for 18/19 and beyond.

- It was not clear how much of the spend was 'premium' and 'over-cap' agency and how much Trust overtime incentive premium was a factor in these spends, contributing to the cumulative position. To address this the Trust would benefit from establishing single processes for the booking and authorization of agency staff. The peer review team saw different processes in different divisions for the booking and authorisation of agency staff.

5. The registered nurse fill rates for May 2018 were at 96.2% (Day) and 97.8% night and although an enviable capacity position there is potential to look at the actual requirement to staff to this level, triangulated to quality metrics. At one level, this is very positive. However, most Trusts are not able to meet such high fill rate levels and rely on alternative models of care delivery to address the variance such as nutritional assistants, safety guardians, pharmacy technicians. The positive fill rate position will inevitably be one of the drivers for the higher than average CHPPD and WAU costs when compared to others. It has not been possible to split cost per WAU between hospital and community. However, the Trust may wish to review whether such high levels of RN staffing is affordable, always justifiable and always necessary, especially in the current financial climate and where achievement of this is reliant on high cost agency and premium rate overtime. Nonetheless, this is not just about pure costs and the Chief Nurse was clear that on behalf of the Board they try actively to mitigate potential or avoidable harms, which could be attributed to the nursing and midwifery establishment levels. Irrespective of the high fill rates, this cannot be achieved currently without reliance on temporary staffing, namely bank

and agency and the Trusts internal incentive scheme. This may be acceptable to the Trust, in which case it needs to accept that it may overspend on nursing and midwifery budgets.

The peer review team agreed with the approach that nursing and midwifery establishments costs must always be considered alongside nursing quality metrics and audit measures/findings. A litmus test for the Trust is that such high staffing levels should be evidencing, delivering and assuring the highest quality and reliability of nursing and midwifery care. It was regrettable that the peer review team on the day did not have this evidence presented to it, or through the focus groups and discussions with staff. To be clear, the peer review team is not saying that this triangulation is not there, it is just affirming that this wasn't presented in a manner that triangulated care delivery with the establishment for the peer review team to assess. Additionally, from the pack of information provided to the peer review team; the peer review team were was not assured the appropriate information was available, reviewed and triangulated in a timely manner to support decision making (such as falls, pressure ulcers, missed medication doses, enhanced care delivery). The professional judgement of the peer review team was that the evidence presented needed to be strengthened in terms of:

- day to day oversight of nursing and midwifery nursing establishments
- the information going to Trust Board; to specifically allow assurance and oversight as to how these decisions are made, and that nursing and midwifery staffing levels had been determined and deployed using an appropriate evidence-based methodology.

6. It was difficult to determine whether nursing and midwifery establishments were set appropriately at Harrogate and District NHSFT, in accordance with the requirements of the 'National Quality Board (NQB, 2016)' and good professional practice, particularly, 'NICE Safe staffing for nursing in adult inpatient wards in acute hospitals (July 2014)'. Whilst the information in the pack presented prior to the peer review was helpful and included nursing and midwifery establishment level information that is presented to the Trust Board; unfortunately, the peer review team was unable (on the day) to find explicit and transparent triangulation of the nursing and midwifery staffing information available, with consideration of quality metrics and

nursing red flags in use, as determined by NICE (2014). There appeared to be a lack of knowledge of the red flag escalation process and concerns were raised as to how staff recorded escalation of gaps in staffing and the decision making process in terms of how areas are supported, and staff are moved to support shortfalls elsewhere. The daily matron checklist appeared to be the only monitoring of this. It was reassuring that Chief Nurse could describe to the peer review team how these are used and triangulated across the Trust. This included a description that patient dependency assessments were undertaken two to three times a year to assist in the determination of nursing establishments and that these were then set in line with the results and the required national guidance. The process then involved ward managers/senior sisters setting their budgets each year alongside the results of the patient dependency audits and supported by finance managers. The review team apologises for not being able to quantify this through discussions with senior nurses, ward staff, and the documentation reviewed; however they were pleased to find evidence of the Birth Rate Plus tool currently being undertaken in Maternity Services and an audit report referencing the Royal College Nursing paediatric standards 'Defining staffing levels for children's and young people's services (2013)'. It may be that this was a presentation issue and staff struggled to articulate the triangulation of harms alongside the nursing and midwifery establishment levels set. There was clear evidence that some discussion about staffing took place because the peer review team was informed that two wards had recently been closed to accommodate safe staffing levels. The consequence of that was that on the review date, any triangulation was not necessarily abundantly clear to the peer review team. This was compounded by the fact that members of the Trust panel at times appeared to be unclear with the language and terminology associated with the NICE (2014) and NQB (2016) guidance. It was apparent in the group discussions that the senior nursing leadership team appeared to have opportunities to further understand and apply the Trust Board's obligations of fulfilling the requirements set out in the NICE Safe staffing for nursing in adult inpatient wards in acute hospitals (July 2014), the supplementary Care Contact Time report and the National Quality Board: Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time (2016). To conclude, the professional view of the review team was that the ward managers appeared to have a different understanding of the governance

processes versus the senior nursing and midwifery team, in terms of budget setting and accountability.

This was some of the feedback from staff to peer review team during the day;

- Some managers were not able to articulate ward occupancy levels and how these informed the funded bed base and staffing levels and/or skill mix. Responses were vague and, when probed, staff explained they did not have access to up to date occupancy data.
- They did not recognise the NQB (2016) and NICE (2014) staffing guidance and requirements.
- They did not recognise that they had been involved in agreeing their establishment budgets each year. Some ward managers and matrons described no involvement in budget setting and so were not able to describe adequately how budget setting impacted on their current workforce and/or future staffing plans.
- There was confusion as to the frequency that budgets were set, as one ward manager described they had not been involved in setting establishment and budgets for at least three years . Another ward manager described their budget as being set before the acuity and dependency study had been completed.
- The community staff interviewed could not describe the metrics they use to manage and/or vary their community caseloads according to patient demand.
- Some senior nurses were unable to articulate their ward occupancy levels
- In the case of paediatrics, it was unclear what number of beds the budget was for.
- It was reported that some Band 7 staff rostered themselves at weekends and evenings to benefit from enhanced payments. (The peer review team could not substantiate nor disprove this. However, if accurate, this would be a driver of the excess costs).
- Some ward managers described a feeling that they had lost a lot of their autonomy, e.g. involved in setting their establishments, vacancy and recruitment management, etc.

- One manager described having £100K removed from her budget this year but she could not recall a Quality Impact Assessment being undertaken or explain the impact of budgetary reduction on the workforce model and roster, or how she assessed the impact of changes on the quality of care of her ward.
- Managers did not seem to understand how 'headroom' was broken down and calculated. The paediatric matron described encouraging more annual leave in the summer than winter which varied from trust policy. Staff knew there was a Shelford Paediatric Tool but had not yet seen it. An acuity tool or safe staffing tool (such as the RCN age-based tool) was not used daily.
- Management of critically ill children awaiting Embrace transfer and the impact of this in terms of safe staffing of the remaining inpatient children was unclear. Flex between NICU and the paediatric ward was discussed but the service may want to consider a clearer escalation policy to manage this situation.
- Senior nurse leaders were unable to articulate clearly how nurse staffing workforce templates and underpinning budgets are set, with blurred understanding of accountability.
- Traditional workforce models were utilised and there were missed opportunities to introduce innovative roles to build a sustainable workforce based on patient need and required outcomes.
- Lack of regular 6 monthly nurse staffing reviews or delivery plan agreed by board.
- It was not apparent that there was a safe nurse staffing escalation policy in place, which would be helpful to manage the available staffing resource.

Due to these findings the Trust may wish to strengthen the involvement of ward managers in setting and agreeing their budgets to generate greater ownership. Additionally, there did not appear to be regular budget meetings between the Chief Nurse and Heads of Nursing to hold them to account for budget spend and management;the strengthening of which may prove dividends.

7. The peer review team was pleased that ward managers did positively acknowledge that they met regularly with their management accountants and

matrons to discuss budget performance. Also, they agreed that their budget statements were easy to understand. This is an area of good practice and is positive.

Recognising that the budget holder information was clear and easy to understand there were some omissions in that they did not appear to be informing ward managers on where and why they were overspending, for example understanding the cost of premium rates, roster compliance or management of establishment 'mark up'. Addressing these matters will be a suggested recommendation for improvement as will including prospective planning of budget setting and review meetings, into a corporate diary.

To further support the Trust, the peer review team would like to reflect that many budgetary controls seen were retrospective. In parallel with other organisations now moving to a forward look on financial spend and focusing on influencing, the peer review team suggest this would be beneficial to the organisation to introduce more rigour and accountability to the process. This has helped to bring costs under greater control in other organisations.

8. The peer review team was provided with a paper that benchmarked paediatric nurse staffing against the Royal College of Nursing's guidance Defining staffing levels for children and young people's services (2013). A recommendation will be that The Trust may wish to review the level of assurance provided by this paper, as there may be evidence of deviation from guidance without associated mitigating evidence being described. However, as this was out with the term of reference of the review it was not explored further.

9. The peer review team also found that there was a lack of understanding and clarity on the Trust's roster policy could not find through the qualitative or quantitative evidence any indication of the routine monitoring of the implementation of or adherence to this policy. A recommendation will be made to address this.

10. Recognising that the Board of Directors, as a unitary board are accountable for setting safe nursing and midwifery establishments, a recommendation is being made by the peer review team that to assist them with their duty to review nursing and midwifery establishments, that they receive a paper every six months setting out the current establishments against the evidence based guidance, particularly NQB

(2016) and NICE (2014) , and a triangulation of harms and clinical risk, which sits alongside a professional judgement review. It was regrettable that, other than the Chief Nurse, no other board directors were able to be interviewed on the day to test this. It was not abundantly clear to the peer review team how this responsibility and accountability is being exercised by the unitary Board, particularly its duty to review nursing and midwifery establishments every six months. This should test the peer review team's professional judgement that senior nurse leaders were not always able to articulate the governance structure and a true understanding of the nurse staffing capacity and demand matters based on acuity and dependency of patients triangulated against patient outcome and experience metrics. The peer review team suggest as a recommendation that the Trust Board undertakes a further internal review of the current nursing and establishments that have already been set to be assured that the establishments are supported by evidenced based tools. If the Trust Board is assured, it may want to explore how staff can be supported further to describe and articulate the methodologies used.

11. There were many areas of strength and opportunity seen by the peer review team. One area of opportunity identified by the peer review team was that the Trust may not have exhausted all alternative skill mix opportunities and/or the use of new/support roles of different professionals within the ward establishments to address the registered nurse workforce gap and/or achieve a more affordable skill mix on the wards and departments (with the exception of the theatres department which were currently exploring this). The senior team described the introduction of alternative roles such as the pharmacy technicians; this is perhaps an area to revisit in order to consider other workforce models and what other trusts are doing in this regard.

An area ripe for adoption of this approach would be as RN vacancies arise: these may present an opportunity for the Trust for further exploration (particularly around support roles such as nutritional assistants, physio assistants, pharmacy technicians.)

12. The Trust should be commended as it has stopped paying 'above cap' agency mostly, which is positive. Also, the Trust had participated in the NHS Improvement Enhanced Care Collaborative, which was helping to manage nursing allocation and

spend more effectively, and by improving outcomes for patients by ensuring they are cohorted and cared for appropriately.

13. It was noted that the Trust funded the backfill of its trainee nursing associates, which is very positive and good practice.

14. The Trust had implemented mechanisms whereby new starters were enrolled automatically on the nurse bank (as opposed to opt in). This again is also very positive and good practice.

15. The peer review team heard different accounts of how staffing shortfalls are addressed. Ward managers reported the use of a Band 3 officer that 'held the nursing staffing levels for each day' and advised ward sisters and matrons about these accordingly and where shortfalls and/or support might exist. This person seemed pivotal in ensuring staffing levels across the wards were balanced. However, different staff described different methods used to cover staffing shortfalls but in no order or priority. From this, the peer review team determined that there was not an agreed corporate priority pathway for the various stages of the approach to try and cover staffing shortfalls. This may be something that the Trust may wish to look at to reduce multiple efforts and to streamline the process and to give back control to Ward Managers and Heads of Service.

One member of the peer review team observed a bed meeting. From this, it was apparent that this was a functional bed numbers and patient flow meeting. This did not consider the acuity of patients or other quality/dependency indicators that might advise on the workload of a given ward. This may be something that the Trust may wish to review.

16. There was a general lack of understanding across the board of the 'mark-up' (uplift) applied to nursing budgets to cover annual leave, sickness and study leave. No-one was able to articulate fully what this percentage was and what this comprised, and no-one was able to advise how the Trust was performing overall against this element of the budget. This percentage budget had to be confirmed with a finance manager. Matrons were aware of the Trust's sickness/absence target percentage though, which is part of this. Understanding mark-up/uplift is important as budget holders need to understand that which is already accounted for before

incurring variable pay costs (e.g. a percentage allowance for sickness cover). Also, if budget holders don't understand this, it is not clear how the Trust can hold them to account for delivery of behaviours within budget. This is something the Trust may wish to look at along with greater education and transparency of what each budget comprises. A meeting with ward managers suggested budget values were adjusted depending on the types of shifts worked (i.e. mix of long and short shifts) however it was unclear that there was an understanding of how this then linked to overall delivery of the budget.

A handover document was observed on a ward. This was very positive and included patient acuity, harms and risks and is good practice. Staffing data on the wards was presented alongside quality indicators and this was also positive.

17. The Trust uses Roster Pro as its e-roster system plus a Management Information tool overlaying this. However, this is now quite dated and, despite the best efforts to make this system work to its full benefits, it does not appear to be meeting the full needs of its users. As examples, the review team was told:

- It takes a ward manager two days to compile a rota.
- Only one user can be on the system at one time when updating data.
- HR data is not uploaded automatically to other Trust systems, so double entry is required, which consumed valuable ward manager/matron time.
- Management reports are limited and/or not used by many senior nursing staff.
- No assurance could be given to the team that the system was appropriately managing staff hours worked.
- It did not appear to 'release time to care' (Releasing time to care: The productive ward.)

This system is not well liked by users. They find it cumbersome and outdated. The Trust may wish to consider the option of upgrading this system to achieve a better and more real time understanding of its workforce and greater deployment efficiency. Clear issues were evident regarding not having live roster systems, with variations in practice, lack of transparency, live Safer Nursing Care Tool data (or equivalent) inability to monitor roster KPI and the governance needed to ensure compliance

against a roster policy. The use of three systems to roster seems to be outdated and appears to be hindering organisational efficiency and operational view.

18. The Trust had commenced a review of Clinical Nurse Specialist roles. However, whilst this had started over a year ago, it had not yet concluded. It is recommended that the Trust completes this work.

5. Recommendations

The peer review team has made the following recommendations for consideration by the Trust:

1.	Consider how nursing and midwifery spend information is presented to ensure greater transparency and differentiation between substantive and all methods of variable pay. Financial reporting on escalation beds should remain discrete from the core establishment budget.
2.	Review and determine a single process for the authorisation of agency spend and premium/over-cap spend to ensure that these are sufficiently robust and owned by relevant staff
3.	Present nursing establishment, fill rate and CHPPD data alongside nursing quality and outcome metrics. Alongside this, identify any evident relationships between staffing levels and the quality of patient care and the professional judgement of the Heads of Nursing or other senior nurses
4.	Review the Trust's compliance with national safer staffing recommendations from the National Quality Board, NHS Improvement and NICE. Review the reporting of this to the Trust Board to ensure that it is equipped fully to exercise its accountability in this regard
5.	Promote awareness of the national safer staffing requirements to all senior nurses and senior midwives so that they are cognisant of the requirements and are able to articulate them.

6.	Establish more robust processes for involving sisters and charge nurses in setting and agreeing their budgets. This is to complement the actions in 4 and 5 above
7.	The Chief Nurse to consider establishing regular meetings with Heads of Nursing to hold them to account for budget management. The trust should also consider how a move to a more prospective focus on financial spend could be incorporated into the accountability process.
8.	Review the composition of the 23% establishment uplift (mark-up) and promote awareness of this amongst senior nurses/midwives and budget holders. In line with this, develop a methodology to measure how well this is used and how well it is complied with
9.	Review the paediatric nurse staffing paper to ensure that the Trust is assured of its findings and recommendations, and appropriate acuity tools are used for measuring risk and determining budgets
10.	Undertake a skill-mix review to look at RN to non-registered staff ratios to determine if these are appropriate. Also, the Trust may wish to consider the use of new roles such as patient discharge assistants, AHPs etc
11.	Senior nurses and midwives to be more cognisant of bed occupancy levels.
12.	Review rota practices to ensure that the costliest staff are not distributed inappropriately across the more expensive shifts (evenings and weekends)
13.	Review and streamline, in priority order, the process for securing additional staff for wards and departments
14.	Consider using quality metrics at bed meetings alongside bed numbers and flow issues to help understand the patient acuity and other specific determinants of workload in a given area to aid better decision making
15.	Consider whether a replacement for Roster Pro is feasible

16.	Review the roster policy, agree roster KPI metrics and / review policy and the associated governance
17.	Complete the clinical nurse specialist review (NHS Improvement will support by providing identifying other Trusts that have undertaken a similar piece of work)
18.	The Trust should test whether Quality Impact Assessments are robustly used when reducing budgets
19.	The Trust should consider the development of a safe nursing and midwifery staffing escalation policy in place, which would be helpful to manage the available staffing resource
20.	Review the functioning of the bed meeting in considering patient harms with the allocation of patients and staff
21.	Develop an action plan and governance mechanism to oversee delivery of the recommendations within this report

For and on Behalf of the Review Team:

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Signature:	
Date: 01/11/18	

Appendix One

Review Contributors

Name	Title	Organisation
Mike Wright	Executive Chief Nurse	Hull and East Yorkshire Hospitals NHS Trust
Deborah Turner	Senior Clinical Lead	NHS Improvement (Yorkshire and Humber)
Fiona Hibbits	Senior Delivery and Improvement Lead	NHS Improvement (Yorkshire and Humber)
Gemma Charlton	Senior Clinical Team Manager	NHS Improvement (Yorkshire and Humber)
Donna Cassidy	Senior Finance Lead	NHS Improvement (Yorkshire and Humber)
Dawn Parkes	Deputy Chief Nurse	Mid Yorkshire Hospitals NHS Trust
Anne-Marie Henshaw	Assistant Director of Quality and Safety	Calderdale and Huddersfield NHS Foundation Trust
Denise Todd	Head of Nursing	Airedale NHS Foundation Trust

Appendix Two Reference List

How to ensure the right people, with the right skills, are in the right place at the right time: A guide to nursing, midwifery and care staffing capacity and capability (National Quality Board, 2013)

Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe sustainable and productive staffing (National Quality Board, 2016)

Safe staffing for nursing in adult inpatient wards in acute hospitals (NICE, July 2014)

Defining staffing levels for children's and young people's services (Royal College of Nursing, 2013)

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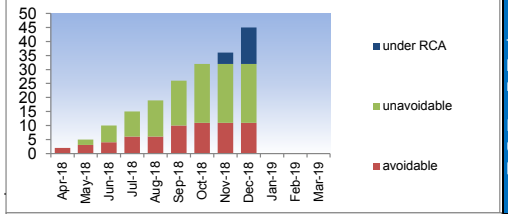
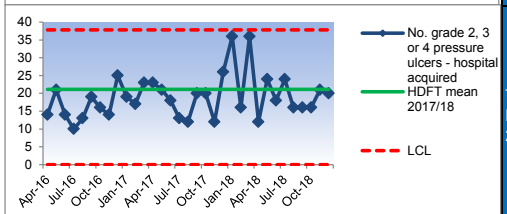
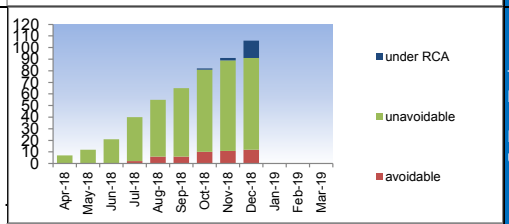
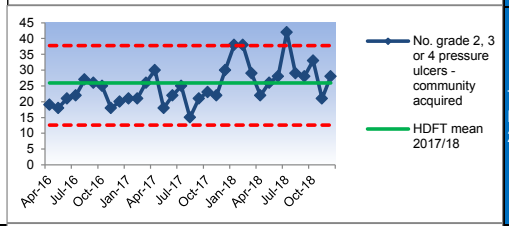
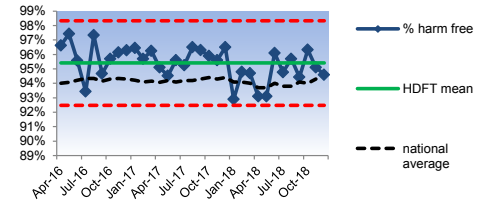
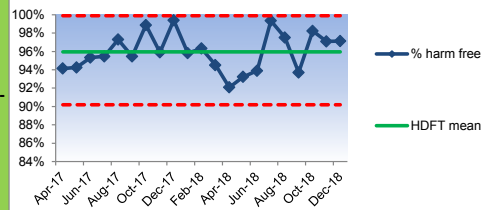
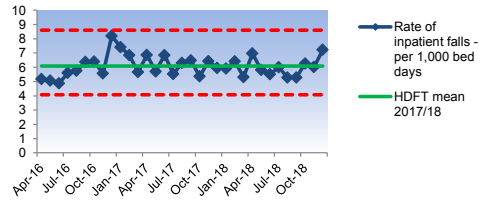
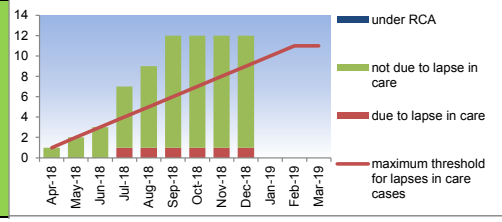
NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

Harrogate and District NHS Foundation Trust

Section 1 - Safe - December 2018

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.1a	DQ Pressure ulcers - hospital acquired		There were 9 hospital acquired unstageable or category 3 pressure ulcers reported in December, bringing the year to date total to 45. This is in line with last year with an average of 5 per month reported in 2017/18. For the 45 cases reported in 2018/19 to date, 11 have been assessed as avoidable, 21 as unavoidable and 13 are still under root cause analysis (RCA). No category 4 hospital acquired pressure ulcers have been reported in 2018/19 to date.
1.1b	DQ		The number of hospital acquired category 2-4 (or unstageable) pressure ulcers reported in December was 20, a decrease on last month and just below the average per month reported in 2017/18.
1.2a	DQ Pressure ulcers - community acquired		There were 15 community acquired unstageable or category 3 pressure ulcers reported in December, compared to 9 last month. The average per month reported in 2017/18 was 12. For the 106 cases reported in 2018/19 to date, 12 have been assessed as avoidable, 79 as unavoidable and 15 are still under root cause analysis (RCA).
1.2b	DQ		The number of community acquired category 2-4 (or unstageable) pressure ulcers reported in December was 28, an increase on last month and above the average per month reported in 2017/18.

Section 1 - Safe - December 2018

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.3	Safety Thermometer - harm free care DQ		The harm free percentage for December was 94.6%, a reduction on last month and below 95%. 5 new urinary tract infections for patients with catheters were reported in this month's survey – this is the highest number reported in any single month this year.
1.4	Safety thermometer - harm free care - Community Care Teams DQ		The harm free percentage for December was 97.2%, no change on last month and remaining well above 95%.
1.5	Falls DQ		The rate of inpatient falls was 7.23 per 1,000 bed days in December, an increase on last month and above the average HDFT rate for 2017/18. However, there were no falls resulting in a fracture this month.
1.6	Infection control DQ		There were no cases of hospital apportioned C. difficile reported in December, with the year to date total remaining at 12 cases. All 12 cases have had root cause analysis completed and shared with HARD CCG. The outcome for 11 out of 12 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. No hospital apportioned MRSA cases have been reported in 2018/19 to date.

Harrogate and District NHS Foundation Trust

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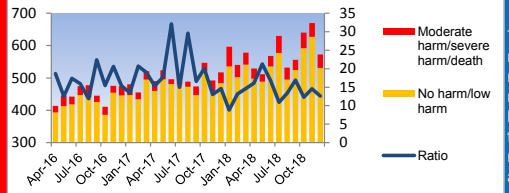
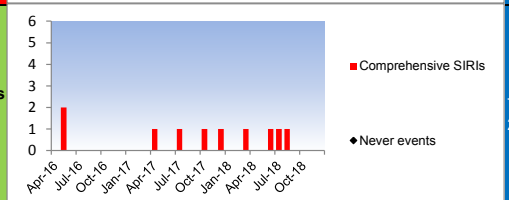
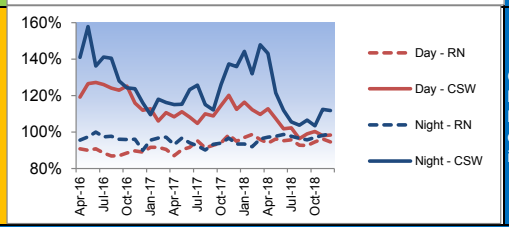
Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.7	Incidents - all DQ		The latest published national data (for the period Oct 17 - Mar 18) shows that Acute Trusts reported an average ratio of 47 no harm/low harm incidents for each incident classified as moderate harm, severe harm or death (a high ratio is better). HDFT's published ratio was 17, a reduction on the last publication and remaining in the bottom 25% of Trusts nationally. HDFT's latest local data gives a ratio of 13, a further 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.
1.8	Incidents - SIRIs and never events DQ		There were no comprehensive SIRIs reported in December. No Never Events were reported in 2017/18 or in 2018/19 to date.
1.9	Safer staffing levels DQ		Overall staffing compared to planned was at 98.5% in December. 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.

Narrative

Joint Targeted Area Inspection (JTAI)

Between 9 and 13 July 2018, Ofsted, the Care Quality Commission, Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) and HMI Probation undertook a Joint Targeted Area Inspection (JTAI) of the multi-agency response to domestic abuse in Durham. This inspection included a 'deep dive' focus on the response to children of all ages living with domestic abuse. A report of the findings of the multi-agency JTAI inspection was published on 24 August 2018 and contained 42 recommendations. No overall grade was given, however inspectors did identify a number of key strengths and areas they wished partners to improve upon in relation to their practice and support for children and families who experience Domestic Abuse.

The Corporate Director of Children's Services for Durham County Council is the lead officer and was required to work with Chief Officers of the Local Safeguarding Children's Board (LSCB) to provide a response to the letter by 3 December 2018 with a written statement of proposed actions to the findings. The Chief Officer Group met on 19th November and approved the JTAI Improvement Action Plan for final submission to the Joint Inspectorate. Staff in the Children's and County Wide Directorate are fully engaged in this work and the small number of recommendations for which the Trust has direct responsibility are all progressing as planned. The Accountable Officers group acknowledged the need to build in some independent scrutiny as part of a dedicated multi-agency assurance framework and this will be developed in the coming weeks.

The Board is asked to note the outcome of the inspection and actions agreed as set out in the action plan.

Section 1 - Safe - December 2018

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation

Stroke services

The Trust is continuting discussions with Leeds and York about the move of Hyper Acute Stroke from the 3rd April. We have reached broad agreement around clinical pathways but there are still a couple of areas that are not yet decided that need further conversation. The most significant of these is around access to TIA services on weekends to ensure patients can be seen within 24 hours of presentation. We would not be able to provide this service from April and currently York and Leeds feel that they do not have the capacity to pick this up.

Oncology Services

There is concern regarding severe pressures currently being experienced by other local Trusts' oncology services and the potential impact this may have on HDFT. Hull Trust may have to withdraw their support to Scarborough Hospital which would have implications for both HDFT and York as this support may need to be provided by York. This would impact on the case we have had approved to enhance specialist oncology nursing to deliver acute oncology which relies on good access to visiting oncologists. A follow up call has been arranged to discuss possible solutions with Leeds, York and Hull.

Safer staffing

A summary of the December safer staffing results is presented below. 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 December was 7.82 care hours per patient per day.

	Dec-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	97.6%	92.2%	100.0%	106.5%	4.41	2.63	7.04
Byland	88.7%	97.6%	92.9%	114.5%	2.67	3.38	6.05
CATT	88.9%	109.7%	105.2%	104.0%	4.76	3.02	7.78
Farndale	97.1%	83.3%	100.0%	119.6%	3.10	2.84	5.94
Granby	111.5%	130.6%	100.0%	101.6%	3.15	3.00	6.15
Harlow	102.4%	100.0%	100.0%	-	7.53	3.26	10.79
ITU/HDU	98.9%	-	103.9%	-	24.16	0.94	25.10
Jervaulx	94.8%	96.8%	95.5%	124.7%	2.81	3.47	6.28
Lascelles	103.3%	94.2%	100.0%	103.2%	4.48	3.88	8.36
Littondale	92.9%	98.9%	98.9%	132.3%	4.21	2.74	6.95
Maternity Wards	99.6%	91.9%	95.0%	82.3%	20.59	5.69	26.28
Nidderdale	100.1%	94.1%	103.2%	96.8%	3.77	2.10	5.88
Oakdale	88.0%	95.2%	96.8%	116.1%	4.07	2.55	6.62
Special Care Baby Unit	92.2%	34.5%	90.3%	-	13.75	1.32	15.07
Trinity	98.6%	105.8%	100.0%	100.0%	3.23	3.79	7.02
Wensleydale	87.5%	112.9%	103.2%	111.3%	3.73	2.80	6.53
Woodlands	79.4%	96.8%	95.7%	96.8%	8.52	2.77	11.29
Trust total	**94.6%**	**98.4%**	**99.0%**	**111.7%**	**4.84**	**2.98**	**7.82**

Harrogate and District NHS Foundation Trust

Section 1 - Safe - December 2018

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation

Further information to support the December safer staffing data

On the wards CATT, Oakdale, Byland and Jervaulx, 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.

On Granby and Trinity wards, the increase in day duty RN hours (Granby) and day duty CSW hours (Trinity) above plan was to support the opening of additional escalation beds in December, as required.

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 December, however a professional assessment was made on a shift by shift basis to ensure that nurse staffing numbers matched the activity.

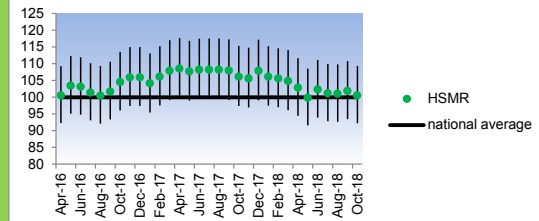
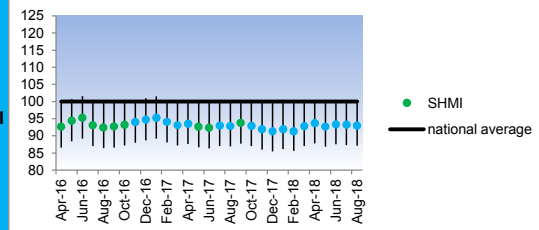
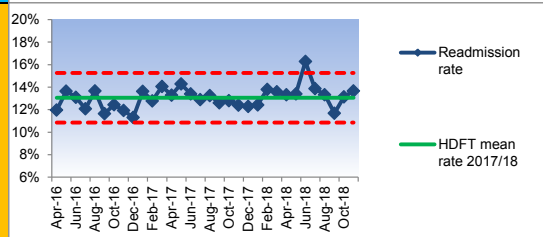
In some wards, the actual care staff hours show additional hours used for enhanced care for those patients who require intensive support. In December, this is reflected on the wards Byland, Farndale, Jervaulx, Oakdale, Lascelles and Littondale.

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

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 and care staff hours are less than planned in December, however the ward occupancy levels vary considerably which means that particularly in this area that the number of planned and actual nurses is kept under constant review.

Harrogate and District NHS Foundation Trust

Section 2 - Effective - December 2018

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
2.1	Mortality - HSMR DQ		HDFT's HSMR for the rolling 12 months ending October 2018 was 100.51, a decrease on last month and remaining within expected levels. At specialty level, 4 specialties have a higher than expected standardised mortality rate - General Medicine, Geriatric Medicine, Trauma & Orthopaedics and Endocrinology.
2.2	Mortality - SHMI DQ		SHMI data is now available on HED up to end August 2018. HDFT's SHMI for the most recent rolling 12 months (September 2017 to August 2018) was 92.98. This remains below expected levels. At specialty level, 3 specialties (Geriatric Medicine, Respiratory Medicine and General Medicine) have a standardised mortality rate above expected levels.
2.3	Readmissions DQ		The number of emergency readmissions in November (after PbR exclusions are applied) was 270. This equates to 13.7% when expressed as a percentage of all emergency admissions. This is an increase on last month and just HDFT average for 2017/18.

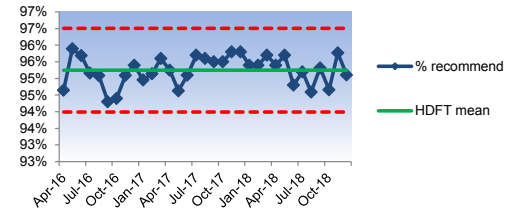
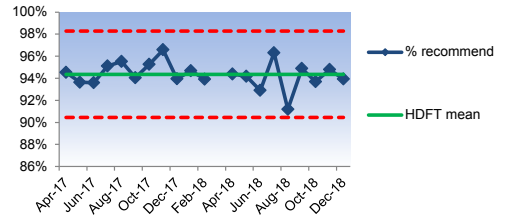
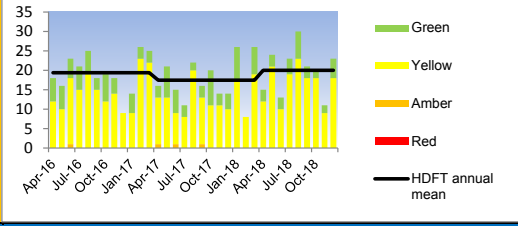
Narrative

UNICEF Baby Friendly Initiative

In December 2018, the Maternity Unit undertook the reassessment process to remain accredited at gold standard for being baby friendly. The Maternity Unit has maintained gold standard practice. It is notable, in addition to Harrogate having the highest breast feeding rate at initiation in Yorkshire and Humber, that the team have also achieved an improvement in the number of babies still being breastfed at 10-14 days from 54.4% in 2014 to 70.5% in 2018.

Harrogate and District NHS Foundation Trust

Section 3 - Caring - December 2018

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
3.1	Friends & Family Test (FFT) - Patients DQ		95.1% of patients surveyed in December would recommend our services, a reduction on last month but remaining above the latest published national average (93.6%). Around 3,500 patients responded to the survey this month. This is lower than recent months and may be partly due to reduced activity during the Christmas period.
3.2	Friends & Family Test (FFT) - Adult community services DQ		93.9% of patients surveyed in December would recommend our services, a decrease on last month and remaining below the national average performance for community services (95.9%). 350 patients from adult community services responded to the survey this month. This indicator is based on the FFT for Rehabilitation & Therapy Services, Children & Family Services and GPOOH. The only service of these three which is below the national average is GPOOH at 73.3%. When reviewing the narrative, it appears that the main reasons for users not recommending the service are due to the waiting times to be seen and the information shared around waits. This is being picked up with the service to agree how we might improve the information given to patients around expected waits in GPOOH and how we might use other services (such as Extended Access) to support capacity issues in the service.
3.3	Complaints DQ		23 complaints were received in December, an increase on last month and above the average for 2018/19. 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 about delay or failure in treatment or procedure.

Narrative

Complaints

From April - December 2018, the Trust has received 178 formal complaints. This compares to 150 formal complaints in the same period last year, representing an increase of 16%. The Patient Experience Team are preparing further analysis.

Harrogate and District NHS Foundation Trust

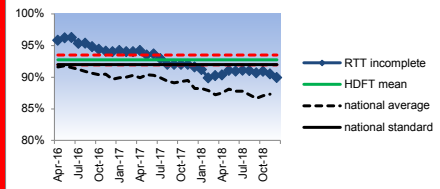
Section 4 - Responsive - December 2018

NHS Improvement Single Oversight Framework

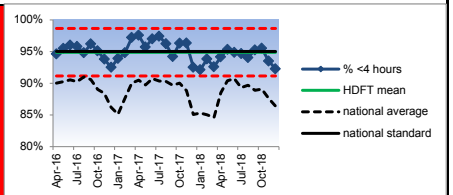
4.1 **NHS Improvement Single Oversight Framework** — DQ

Standard	Q1	Q2	Q3	Q4	YTD
RTT incomplete pathways	90.8%	90.9%	90.4%		90.7%
A&E 4-hour standard	94.8%	94.6%	93.8%		94.4%
Cancer - 62 days	87.3%	85.3%	85.5%		86.0%
Diagnostic waits	98.4%	99.0%	99.5%		98.96%
Dementia screening - Step 1	95.6%	93.0%	93.0%		93.8%
Dementia screening - Step 2	95.7%	100.0%	98.1%		97.8%
Dementia screening - Step 3	97.4%	100.0%	96.8%		97.8%

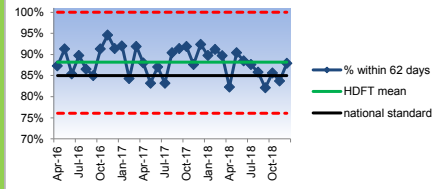
4.2 **RTT Incomplete pathways performance** — DQ



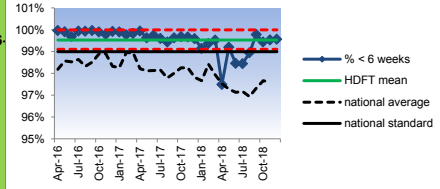
4.3 **A&E 4 hour standard** — DQ



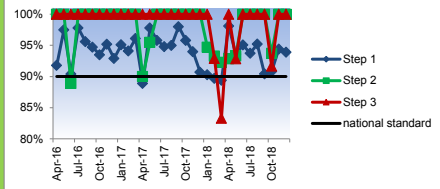
4.4 **Cancer - 62 day wait for first treatment from urgent GP referral to treatment** — DQ



4.5 **Diagnostic waiting times - 6-week standard** — DQ



4.6 **Dementia screening** — DQ



Narrative

In Quarter 3, HDFT's performance is below the required level for 2 of the operational performance metrics - the18 weeks standard and the A&E 4-hour standard. RTT performance was at 89.9% in December, a further deterioration on the previous month. The total RTT waiting list size increased in December to 14,800 and remains above the position reported at the end of 2017/18 (14,005).

For the A&E 4-hour standard, HDFT's Trust level performance for December was 92.3%, a further deterioration on recent months. This includes data for the Emergency Department at Harrogate and Ripon MIU. A new Task and Finish group has been established to focus on improving performance to back above 95% between now and year end. It is anticipated this will ensure the delivery of the performance required to meet the PSF requirements for Quarter 4.

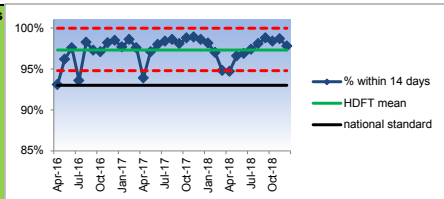
Performance against the 62 day cancer standard has improved and is now above the 85% standard for December and for Quarter 3 overall.

NHS
Harrogate and District
NHS Foundation Trust

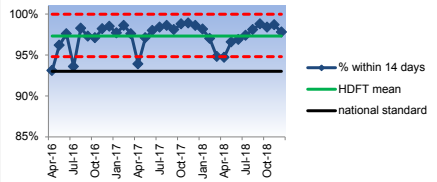
Section 4 - Responsive - December 2018

Cancer waiting times standards

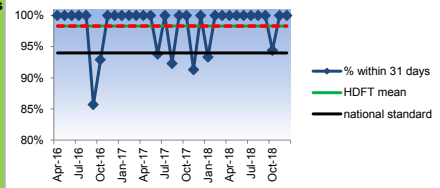
4.7 Cancer - 14 days max wait from urgent GP referral for suspected cancer (DQ)



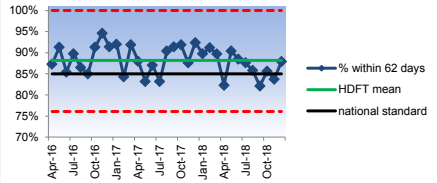
4.8 Cancer - 14 days maximum wait from GP referral for symptomatic breast patients (DQ)



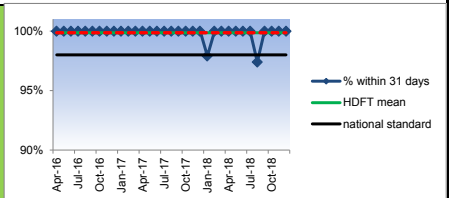
4.9 Cancer - 31 days maximum wait from diagnosis to treatment for all cancers (DQ)



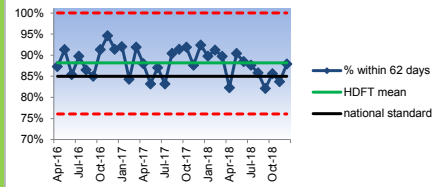
4.10 Cancer - 31 day wait for second or subsequent treatment: Surgery (DQ)



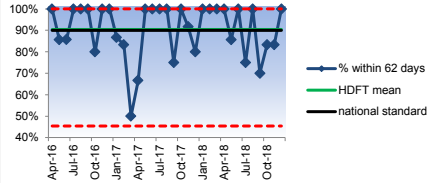
4.11 Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug (DQ)



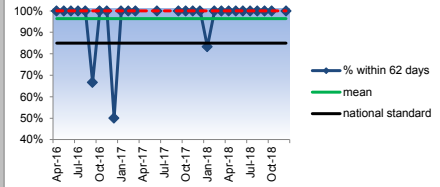
4.12 Cancer - 62 day wait for first treatment from urgent GP referral to treatment (DQ)



4.13 Cancer - 62 day wait for first treatment from screening service (DQ)



4.14 Cancer - 62 day wait for first treatment from consultant upgrade (DQ)



Narrative

Provisional data indicates that all cancer waiting times standards were achieved for December. All standards were also achieved for Quarter 3 overall with the exception of the 62 day screening standard where performance was at 88.9% for the quarter against the 90% minimum standard. With 13.5 accountable pathways in the quarter, this is above the de minimis level for reporting performance.

Looking forward into Quarter 4, the 62 day standard for January will be challenging to deliver due to capacity constraints over the Christmas period and patient choice of appointments during that period. This has also affected the 14 day breast standard for January.

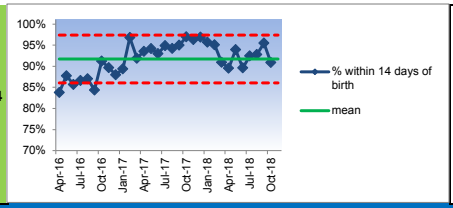
For the main 62 day standard, of the 11 tumour sites, 4 had performance below 85% in December - haematological (1.0 breach), other (0.5), upper gastrointestinal (2.0) and urological (2.5). 3 patients waited over 104 days in December. The reasons for the delays were availabilty of elective capacity at other local providers and patient choice.

Section 4 - Responsive - December 2018

Children's Services metrics

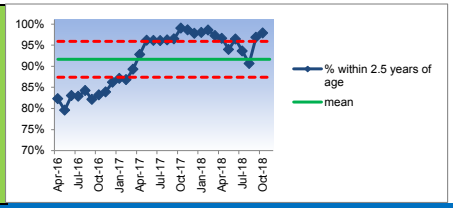
4.15 **Children's Services - 10-14 day new birth visit**

DQ



4.16 **Children's Services - 2.5 year review**

DQ



Narrative

The charts present a combined performance position for all Children's Services contracts. The data is reported a month in arrears so that the validated position can be shared. Data for Gateshead and Sunderland is now included from July 2018 onwards.

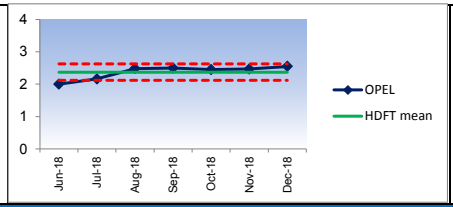
In November, the validated performance position for new birth visits is that 93% of babies were recorded on Systmone as having had a new birth visit within 14 days of birth. Performance in November in the different localities varies from 88% in Darlington to 95% in Durham and Middlesborugh. The validated performance position for 2.5 year reviews is that 97% of children were recorded on Systmone as having had a 2.5 year review. Performance in November in the different localities varies from 79% in Gateshead to 100% in Stockton and Sunderland.

Work is ongoing to develop additional metrics for Children's Services for inclusion in this report going forward.

Adult Community Services metrics

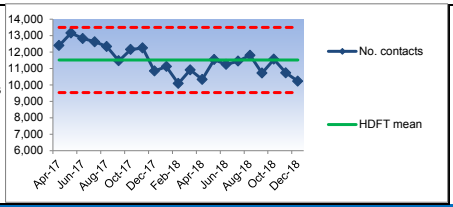
4.17 **OPEL level - Community Care Teams**

DQ



4.18 **Community Care Teams - patient contacts**

DQ



Narrative

During December, the average community OPEL level reported was 2.54, a minor increase on last month. OPEL 3 was reported on 19 out of 31 days during the month.

Following the work to review the caseload in Adult Community Services and the introduction of the clinical triage process for new referrals, patient contacts have stabilised within the funded establishment. The development and transition to single integrated Health and Social Care locality teams continues to progress and it is anticipated that the final plans will be ready by January 2019 to bring to Board to enable Phase 1 to progress from April 2019.

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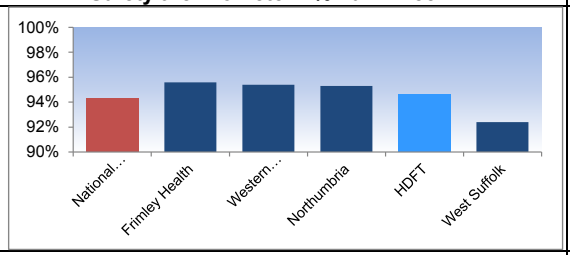
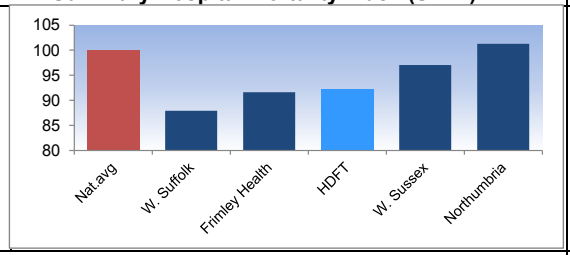
Section 8 - Benchmarking - December 2018

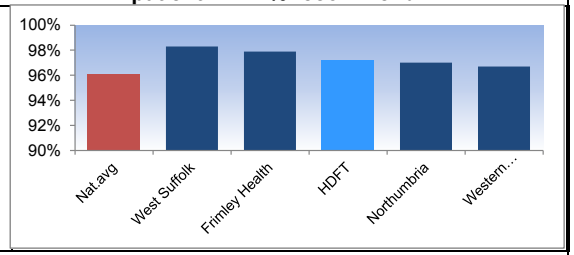
8.1 Safety thermometer - % harm free



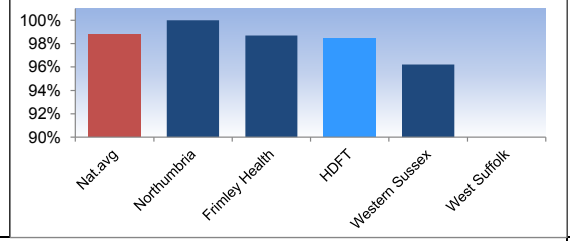
8.2 Summary Hospital Mortality Index (SHMI)



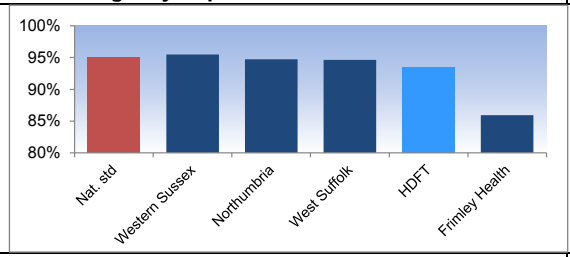
8.3 Inpatient FFT - % recommend



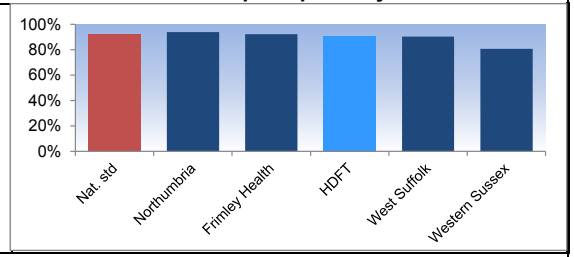
8.4 Maternity FFT - Q2 Birth - % recommend



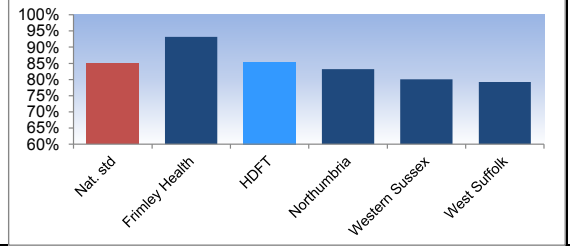
8.5 Emergency Department 4 hour standard



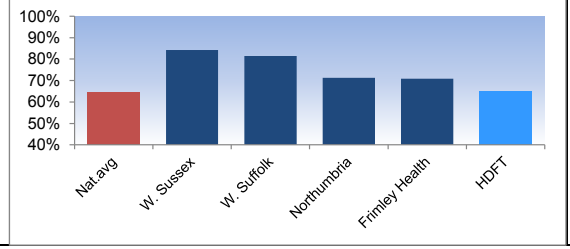
8.6 RTT incomplete pathways



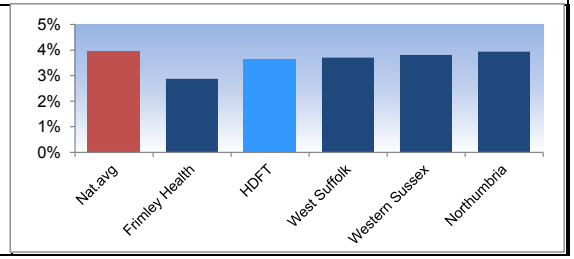
8.7 Cancer 62 days



8.8 Staff FFT - % recommend (place to work)



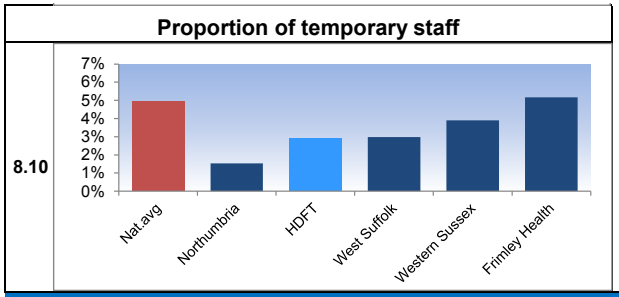
8.9 Sickness absence



Section 8 - Benchmarking - December 2018

Harrogate and District NHS Foundation Trust

8.10



Narrative

The charts above show HDFT's latest published performance benchmarked against small Trusts with an outstanding CQC rating. The metrics have been selected based on a subset of metrics presented in the main report where benchmarking data is readily available. For the majority of the metrics, the information has been sourced from the Model Hospital website.

As can be seen from the charts, HDFT performs better than average for the cancer 62-day standard, staff sickness absence and the proportion of temporary staffing. Conversely, HDFT performs worst for the staff Friends & Family Test (% staff recommending the Trust as a place to work) .

Harrogate and District NHS
NHS Foundation Trust

Board Committee report to the Board of Directors

Committee Name:	Finance Committee
Committee Chair:	Maureen Taylor
Date of last meeting:	28th January 2019
Date of Board meeting for which this report is prepared	30th January 2019

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

1. The committee received an update on the latest financial position for 2018/19. The Trust achieved a surplus position in December of £1,214k which is £833k ahead of the external plan. This reduces the year to date deficit to £687k which is £158k ahead of the external plan but £2.8m behind the internal plan. To achieve the Q4 control total and secure Provider Sustainability Funding (PSF) a surplus of £3.3m is required in the period January to March 2019.
2. The in-month ward and theatre staffing position showed an overspend of £50k but is much improved on earlier months in the financial year. The main spending pressures in-month were CIP and high costs drugs.
3. It has been assumed that Provider Sustainability Funding for Q1, Q2 and Q3 for both financial performance and A&E performance will be received. As discussed previously, there is a risk relating to the element of PSF for A&E performance in all quarters.
4. Plans are in place to deliver 98% of the CIP required for the year. After risk adjustment this reduces to 96%. Some savings are non-recurrent and will create a risk for next year. Work is ongoing to action the final £200k of CIP plans.
5. Monthly income is largely on track. Compared to plan, new outpatient's attendance is up in December with a reduction in follow-ups. Elective in-patients are down whilst elective day cases are up. Non-electives are down with A&E attendances ahead of plan by 3.2% and comparing the year to date position to the same period in 2017, A&E attendances are up by 1,783. With regard to HaRD CCG activity to date, all activity is ahead of plan except elective in-patients which are 3.1% behind plan.
6. Workforce information presented showed all workforce areas were under establishment in December. There continue to be cost pressures in theatres and day surgery. Medical staffing was balanced in-month.
7. Outturn forecasts were presented based on the best, medium and worse case positions. The current likely scenario is for the medium case position which is a deficit of £200k after PSF funding (£3m deficit without PSF funding). Non-receipt of PSF funding in Q4 will result in a larger deficit.

8. The consolidated cash position (Trust and HIF) improved significantly in December largely due to a number of pre-payments being made in Q3 to the Trust. The cash position is impacting on the Trust's ability to invest in capital.
9. Mr Coulter gave a confidential update on the 2018/19 contract discussions with HaRD CCG. Meetings are continuing to take place with HaRD CCG, NHS Improvement and the ICS to reach an agreed position.
10. The main focus of the meeting was discussion of the budget strategy papers following a recent meeting with Commissioners and Regulators. Budget planning guidance has now been received and reflected in our budget planning assumptions.
11. The Committee considered information on the planning assumptions presented by HaRD CCG and the Trust in terms of anticipated growth in activity and reasons for variances in assumptions. Discussions will continue over the next few weeks in advance of a second meeting with Regulators.
12. Discussions took place around:
    - The affordability for HaRD CCG of the anticipated activity
    - The capital and cash position
    - The level of efficiency programme that will be required in 2019/20.
13. Work is continuing on the development of the workforce strategy to support the activity required in the plan.
14. Further discussions will be required about the form of contract with HaRD CCG for 2019/20 and specifically how risk is shared and variances dealt with.
15. The Committee considered an update report on WebV project. Work has progressed well with a number of modules live or being tested and the project remains within budget. Modules have been developed with and for Clinicians who have embraced the new technology. The first paperless clinic is to be tested in Urology and if successful will be a significant efficiency gain. A number of modules will now be rolled out across other disciplines. There have been difficulties recruiting to the development team. Some issues need to be resolved in advance of signing the co-development agreement.
16. The Committee received a request from the Executive team for the CEO to be added to the membership of the Committee and this was agreed.

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

- A surplus of £3.3m in the last quarter is required if the Trust is to hit its control total and receive Q4 PSF.
- Cash remains a risk and work needs to continue to manage payments and collect sums due.

Matters for decision

The Board of Directors is asked to approve the attached, updated Terms of Reference for Resources Committee.

8

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 organization.

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 case s 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
- Chief Executive
- 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 Resources 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 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 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 will be reviewed at least annually.

DRAFT ~~September 2018~~January 2019

NHS
Harrogate and District
NHS Foundation Trust

Board Committee report to the Board of Directors

Committee Name:	Resources Committee
Committee Chair:	Maureen Taylor
Date of last meeting:	7th January 2019
Date of Board meeting for which this report is prepared	30th January 2019

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

1. The committee received an update on the latest financial position for 2018/19. The Trust achieved a surplus position in November of £583k which is £707k behind the external control total. This reduces the year to date deficit to £1.9m which is £674k behind the external plan. To achieve the Q3 control total and secure Provider Sustainability Funding (PSF) a surplus of £1.1m is required in December which is £700k more than the in-month plan.
2. The in-month ward and theatre staffing position is much improved. The main spending pressures in-month were waiting list initiative and drugs.
3. It has been assumed that Provider Sustainability Funding for Q1and Q2 for both financial performance and A&E performance will be received. As discussed previously, there is a risk relating to the element of PSF for A&E performance in Q1 & Q2. PSF for Q3 has been assumed based on recovering the financial position in December to meet the control total.
4. Plans are in place to deliver 97% of the CIP required for the year. After risk adjustment this reduces to 94%. Some savings are non-recurrent and will create a risk for next year. Some high risk schemes remain in Long Term Unscheduled Care and are to be reviewed.
5. Monthly income is largely on track; however there are some activity variances. Compared to plan, new outpatient's attendance is up in November with a reduction in follow-ups. Elective in-patients and day cases are both down against plan but non-electives are up by 6.5%. ED attendances for November were 1.3% ahead of plan and comparing the year to date position to the same period in 2017, ED attendances have increased by 2850. With regard to HaRD CCG activity, all activity is ahead of plan except elective in-patients which are 2.8% behind plan. However, within this, orthopaedics is ahead of plan.
6. Workforce information presented highlighted in particular, the continued costs pressures in theatres and medical staffing. It was noted that changes to the staffing complement in theatres has improved the in-month overspend position.

7. Outturn forecasts were presented based on the best, medium and worse case positions. The current likely scenario is for the medium case position which is a deficit of £2.72m before PSF funding.
8. The cash position continues to be a concern and is being managed on a daily basis. The cash position is impacting on the Trust's ability to invest in capital. Some long standing debtors are being tackled through threat of withdrawal of service.
9. Mr Coulter gave a confidential update on the 2018/19 contract discussions with HaRD CCG. Meetings are continuing to take place with HaRD CCG, NHS Improvement and the ICS to reach an agreed position.
10. The main focus of the meeting was discussion of the budget strategy papers. The Committee discussed:
    - Detailed guidance is still awaited so the assumptions in the strategy presented may have to change when the detail is known.
    - Key changes in the financial framework for 2019/20 including the abolition of the marginal rate emergency tariff and deduction for readmissions and the fact that 40% of PSF will be included in the tariff for urgent care.
    - Key financial pressures for 2019/20 including unavoidable inflation, non-recurrent CIP and funding winter and the Discharge Service in 2019/20.
    - The capital and cash position
    - Activity and capacity planning has taken place and Commissioners have been involved throughout the process. It is anticipated that the activity forecast for HaRD CCG will be unaffordable for the CCG.
    - Analysis of workforce vacancies and baseline expenditure.
    - Workforce strategy guidance focusses on supply and retention and reduction in agency spend. Key aims are to increase use of internal bank, reduce spend over cap or off framework and reduce agency spend rates.
11. There was a discussion about the options for the form of contract with HaRD CCG for 2019/20 and further consideration need to be given to how we move forward on this.
12. The Committee considered an update report on the Briary wing which is expected to become vacant within the next 18 to 24 months. There is a 12 month notice period on the lease which has not yet been triggered. Options for use of the site going forward need to be re-visited.

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

1) The financial deficit stands at £1.9m which is £4.4m behind our internal plan and work on the recovery plan is needed to improve this position.
2) Detailed NHS guidance is still awaited which could impact on our budget assumptions for 2019/20.
3) The cash position of the Trust is a concern and collection of sums owed is paramount, alongside an improvement in the Income & Expenditure run-rate performance.

Matters for decision

None.

Action Required by Board of Directors: None

Harrogate and District NHS Foundation Trust

Date of Meeting:	30 January 2019	**Agenda item:**	8.2
Report to:	Board of Directors		
Title:	Clinical Workforce Strategy – Interim Report Year 2		
Sponsoring Director:	Angela Wilkinson, Director of Workforce and Organisational Development		
Author(s):	Joanne Harrison, Deputy Director of Workforce and Organisational Development & Shirley Silvester, Head of Learning and Organisational Development		

Report Purpose:							
Decision		**Discussion/ Consultation**		**Assurance**	✓	**Information**	✓

Executive Summary:

This paper evidences the continued progress against the Clinical Workforce Strategy and the plans that are in place across the Trust against the three key performance indicators:

Growing our Capability

- The current Clinical Workforce Strategy schemes and new role implementation are anticipated to deliver efficiencies of £1.7million to 2022.

Staff Engagement

- Work continues to be developed on improving staff engagement through the Staff Friends & Family Test and delivery of the staff engagement action plan.
- Appraisal compliance across the Trust has significantly improved in 2018/19 when compared to the previous three years.

Productivity & Efficiency

- Temporary workforce spend has continued to increase in all clinical areas with the exception of SAS doctors. This is mainly attributable to the implementation of CESR rotations. Successful implementation of the Master Vend for Medical and Dental staff has resulted in an agency spend reduction of over £540k since implementation with an anticipated £145K savings through the Direct Engagement platform.
- Key focus for the year ahead needs to be on reducing the temporary spend for Registered and Non Registers Clinical staff and delivering the ambitions of the recruitment plan to fill all Registered Nurse vacancies by 2020.
- The cumulative sickness rate for the Trust continues to increase. Pilot programmes for 'Building Personal Resilience', and the launch of the rapid access physiotherapy service for MSK related absence have been implemented to support the Trust to deliver improvements in these areas.

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:	Not applicable
Legal / regulatory:	None identified.
Resource:	None identified.
Impact Assessment:	None identified
Conflicts of Interest:	None identified.
Reference documents	Staff Friends and Family Test Results, Workforce Information Data.
Assurance:	Workforce Efficiency Group and Workforce & Organisational Development steering Group.

Action Required by the Board of Directors:

It is recommended that the Board **notes** the items included within the report.

8.2

Harrogate and District NHS Foundation Trust

Clinical Workforce Strategy
Year 2 Interim Report – January 2019

1.0 Introduction

The Clinical Workforce Strategy was introduced in 2016 and is a parallel strategy to the Trusts overarching Workforce Strategy. Its aim is to ensure that the Trust has a specific plan to ensure the right number of appropriately skilled staff, working at the most appropriate clinical level for their role and to support the Trust in the achievement of its strategic aims. The strategy is designed to ensure that we are making the best use of finite NHS resources.

This interim report details the progress made so far in year 2 against the priorities developed with clinical Directorates for the Clinical Workforce strategy in advance of a ful review at the end of year 2..

Vision: Excellent care every time, delivered by an excellent workforce where every contact counts

Key Performance Indicators:

Growing our Capability – develop a sustainable, high quality, competent workforce

Staff Engagement – create an engaged and motivated workforce and a performance improvement culture; to be an employer and provider of choice

Productivity and Efficiency – create a sustainable, permanent workforce; improve staff retention and resilience

2.0 Growing our Capability

Diagram 2.1 Schemes to grow our capability

By the close of the strategy, the schemes on the diagram above are planned to deliver estimated efficiencies through cost avoidance and skill mix changes, of £1.7million.

The theatres staffing strategy outlined a new model of delivery in order to reduce reliance on agency staff. The Trainee Assistant Practitioners and the Trainee Theatre Assistant Practitioners are the new roles associated with this strategy.

Since the Apprenticeship levy was introduced in 2017 the Trust has spent £411,000 of funding for clinical apprenticeships which is at least circa 35% of our total contribution to the National Levy. Potential future apprenticeship developments are being explored and include: Emergency Department and Ophthalmology Nursing Associates, Theatres Operating Department Practitioner apprenticeships and level 3 Clinical Support Worker apprenticeships. The purpose of this work is to maximise the draw down on the apprenticeship levy for the Trust.

3.0 Staff Engagement

Staff friends and family test

The result of quarter 1 and quarter 2 staff friends and family test have already been reported to the Board. These form part of the KPI's within the Clinical Workforce Strategy and the tables below illustrate the results so far this year alongside progress against the staff engagement plan.

How likely are you to recommend HDFT to friends and family if they needed care or treatment?

Quarter	% who are likely to recommend		% who are unlikely to recommend	
	HDFT	National	HDFT	National
1	87.6%	81%	3.3%	6%
2	83.5%	TBA	4.5%	TBA
% Difference from Q1 to Q2	-4.1%		+1.2%	

How likely are you to recommend HDFT to friends and family as a place to work?

Quarter	% who are likely to recommend	% who are unlikely to recommend
1	70.1%	14.1%
2	65%	17.1%
% Difference from Q1 to Q2	- 5.1%	+3%

Key achievements implemented during 2018 from the staff engagement plan include: introduction of Fairness Champions; a review of the incident reporting process within the organisation; improved engagement with staff regarding bullying and harassment through the Call to Action and focus groups undertaken by Ros Tolcher and an increase in the numbers of Quality Improvement Champions as well as the launch of the Team accreditation.

Appraisal Compliance

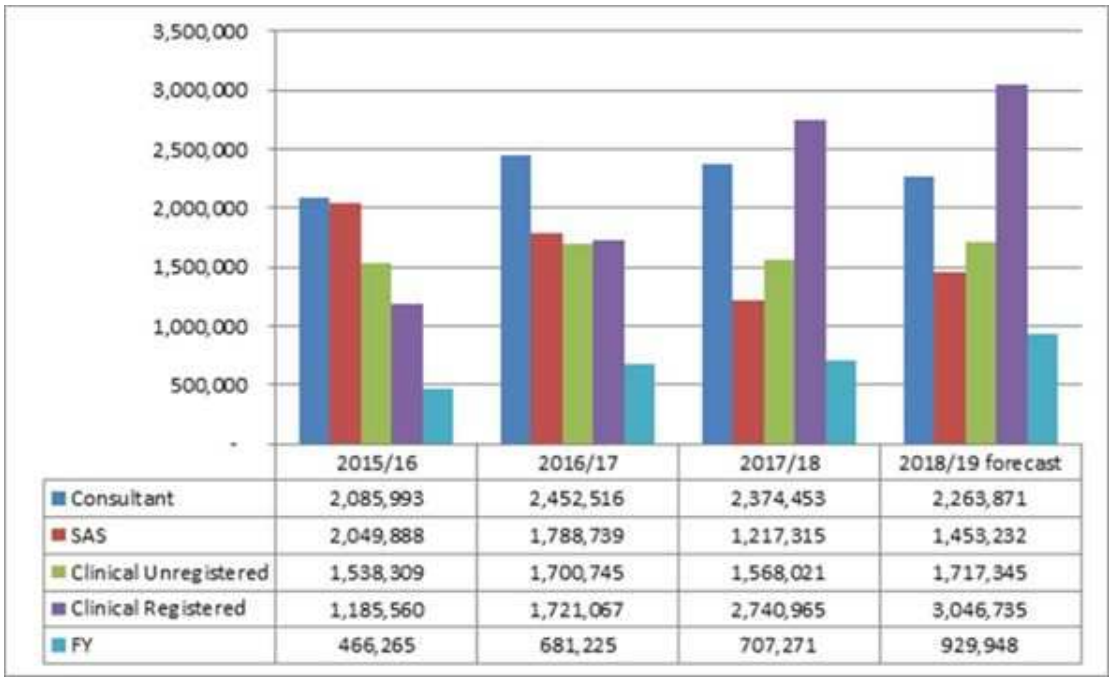
One of the KPI's of the Clinical Workforce Strategy was to improve the performance culture of the Trust through delivery of appraisal compliance. The diagram below shows appraisal compliance since April 2016 and the improvements made to date.

Diagram 3.1 – Appraisal compliance

Appraisal completion during the appraisal period was significantly improved in 2018/19. In November 2018 the Trust achieved 85% appraisal completion against a target of 90% which was a 5% increase in comparison to 2017/18.

4.0 Productivity & Efficiency

Diagram 4.1. Temporary Staffing Spend



	2015/16	2016/17	2017/18	2018/19 forecast
Consultant	2,085,993	2,452,516	2,374,453	2,263,871
SAS	2,049,888	1,788,739	1,217,315	1,453,232
Clinical Unregistered	1,538,309	1,700,745	1,568,021	1,717,345
Clinical Registered	1,185,560	1,721,067	2,740,965	3,046,735
FY	466,265	681,225	707,271	929,948

The diagram above shows that temporary staffing spend has continued to increase in all clinical groups, with the exception of SAS doctors when compared to the baseline data from 2015/16. In line with the previous report to the Board, the original £2million target identified in the Clinical workforce Strategy was amended to reflect the increasing spend position to £3.5million. There are some key changes to draw out.

4.2 The spend on temporary Consultant staff has fallen by over £250K in the last two years from the 2016/17 high. The internal escalation processes have contributed to the management of this spend through agency bookings and the risk assessment process undertaken within the Workforce Efficiency Group on a monthly basis.

4.3 The SAS doctor spend has reduced by £600K against the baseline data, saving £1.7million over the last 3 years. This is due to the continued introduction of CESR rotations and although there was an increase in 18/19 it is envisaged this spend will fall again in 2019/20 following the implementation of a CESR rotation in Paediatrics.

4.4 The clinical unregistered spend has increased by 11% between 2015/16 and 2018/19. New processes have been implemented within ward nursing in relation to enhanced care assessments and this has significantly reduced spend in our inpatient ward.

4.5 The clinical registered spend has increased by 256% when compared to the baseline data. This can be attributed to the ward nursing and theatre vacancy position. We have revisited the Theatres staffing strategy to ensure this remains fit for purpose and new controls have been put into place in relation to ward nursing spend. This year the Trust will also seek to deliver the recruitment plan which includes Trainee Nurse Associates and the Global Learners programme with the ambition to fill all vacancies by 2020. The Trust is also reviewing the opportunity to implement a new e-Rostering system to support more effective deployment of staff.

4.6 The Foundation Year spend has increased but remains the lowest contributor to the temporary workforce spend. The Trust is reviewing the implementation and deployment of the new Advanced Clinical Practitioner roles (ACP's) to identify if there is an opportunity for these staff to be incorporated into the FY rota's as envisaged. In some specialties these have been implemented as additional staffing.

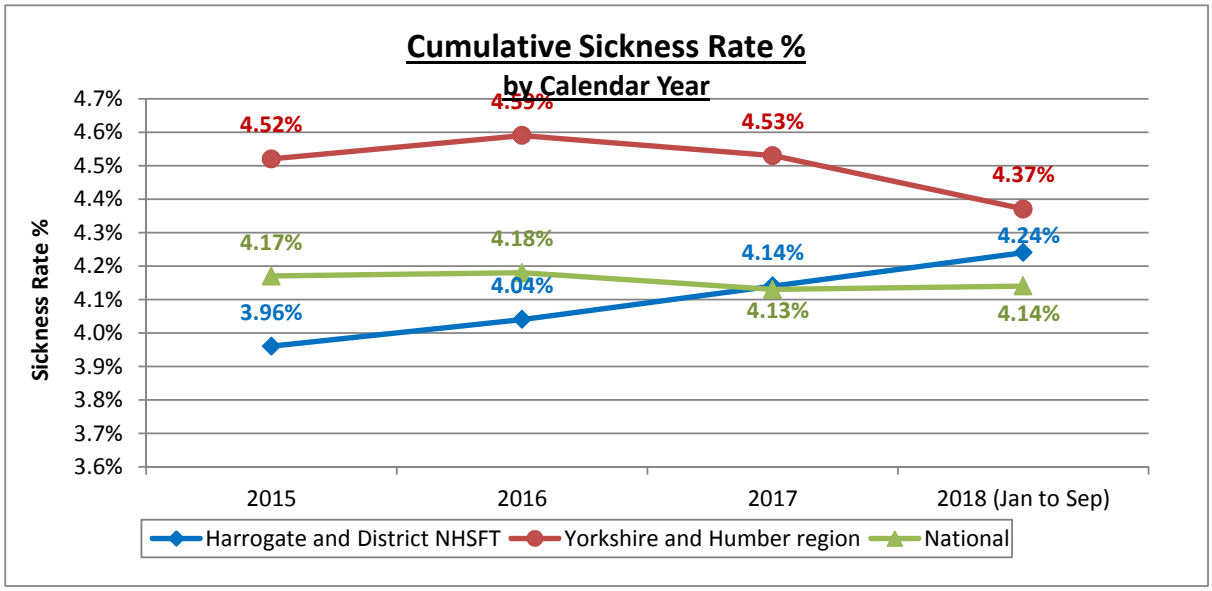
The Trust launched an Agency Master Vend for Medical and Dental staff with Medacs, and a Direct Engagement Platform with Liaison in 2017. Significant benefits have been seen since implementation and sustained:

Table 5 - Medical and Dental Master Vend and Direct Engagement Platform

	2016	**2018**
Average fill rates	39%	63%
Agency Spend	£1.2million	£659k
Direct engagement bookings	0%	88%
Direct engagement savings	£0	£130K

Challenges remain in improving our compliance with NHSi capped rates as all agencies bookings remain above these rates currently. Anticipated Direct Engagement savings to the end of 2018/19 are £145K. We have also seen a significant increase in our use of medical bank staff which will contribute to the reductions in agency commission. In 2018/19 there were 21,483 additional bank hours in comparison to 2016/17. Which supports our principle of BANK FIRST; there are plans to launch the internal medical bank platform in 2019/20 with estimated savings in agency commission of £40K full year effect

Diagram 6 - Sickness Absence for a rolling 12 months Jan-Dec



Trust sickness absence has gradually increased from 3.96% in 2015 to 4.24% for the current calendar year to date. The cumulative sickness rate for the Trust is currently above the national rate of 4.14%, however remains below other Trusts in the Yorkshire and Humber region. The two main reasons for sickness absence within the Trust remain stress, anxiety and depression (24% of overall sickness absence) and Musculoskeletal absences (18% of overall sickness absence). To support the targeted improvements in this area the Trust has launched the 'Building Personal Resilience' programme and a rapid access physiotherapy service. Management Information will be provided to the Trust to enable a full evaluation throughout the 12 month pilot for both schemes.

5.0 Conclusion

This paper evidences the continued progress against the KPI's within the Clinical Workforce Strategy, including the plans that have been developed and the areas of delivery across the Trust.

Significant strides have been made in improving the KPI's in all three areas; growing our capability, staff engagement and productivity and efficiency. Particular successes have been:

- The implementation of CESR rotations for SAS Doctors and the 30% reduction in temporary staffing spend
- Master Vend model which has delivered increased fill rates and a 45% reduction in Medical and Dental agency spend
- Direct engagement platform for Medical and Dental staff which has delivered a £130K saving since the contract commenced.
- Successful recruitment to cohorts 1 and 2 of the Nurse Associate apprentices.

Work continues to address the on-going challenge of the increasing temporary staff spend on Registered Clinical and Non-registered Clinical staff, the success of which will be critical to the delivery of the productivity and efficiency KPI.

The Trust continues to perform well in the staff survey for engagement however the delivery of the staff friends and family test KPI requires on-going focus and effort across the Trust.
The Clinical Workforce Strategy continues to adapt and respond to the changes that are occurring within the Trust and the operating environment in the NHS. We are alert to these changes and continue to work with Clinical Directorate and Corporate colleagues to rise to these challenges and ensure the delivery of our vision: *Excellent care every time, delivered by an excellent workforce where every contact counts*

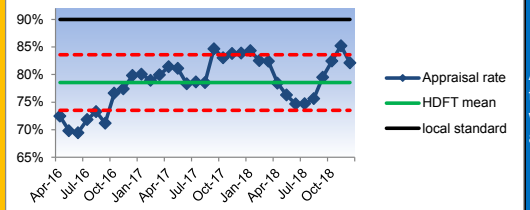
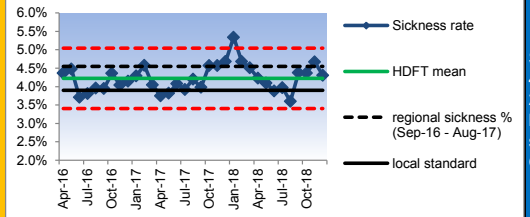
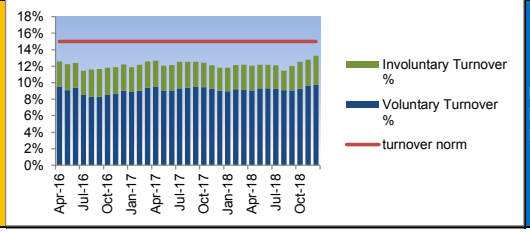
This activity continues to be monitored through the Workforce Efficiency Group and Workforce and Organisational Development Steering Group, where appropriate.

Joanne Harrison, Deputy Director of Workforce and Organisational Development

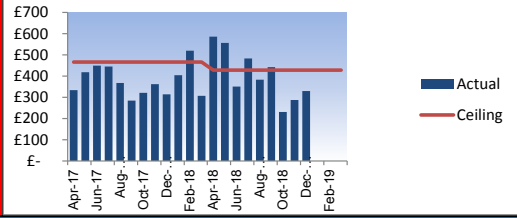
Shirley Silvester, Head of Learning and Organisational Development

Harrogate and District NHS Foundation Trust

Section 5 - Workforce - December 2018

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
5.1	Staff appraisal rates DQ		Appraisal compliance is reported at 82.1% in December 2018, this is a decline when compared to November's 85.2% position. This is to be expected as we are now outside our appraisal window which ended in September 2018. We are making arrangements to re-launch the appraisal period in March 2019.
5.2	Mandatory training rates DQ	Competence Name / Compliance %: Data Security Awareness 91% Equality, Diversity and Human Rights 92% Fire Safety 84% Infection Control 98% Safeguarding Children & Young People Level 1 92% Risk Awareness 98% Health & Safety Elearning 96% Manual Handling eLearning 92%	The data shown is for the end of December and excludes the Harrogate Healthcare Facilities Management (HHFM) staff who transferred into the new organisation on the 1st March 2018 and excludes Stockton who Tupe transferred into the Trust on 1st April 2018 and Gateshead and Sunderland who Tupe transferred into the Trust on 1st July 2018. The overall training rate for mandatory elements for substantive staff is 93% and has stayed the same since the last reporting cycle.
5.3	Sickness rates DQ		Staff sickness has seen a marginal reduction in December, reporting 4.3% in comparison to 4.7% in November 2018. The Trust remains above the 3.9% target, but is lower than December 2017 and remains in line with the higher rates usually experienced over the winter period. There has been a focus of increasing return to work compliance across the Trust with a new streamlined return to work document, which is currently being trialled in a number of areas. Occupational Health referral documentation has also been revised and is now live.
5.4	Staff turnover rate DQ		Labour turnover has shown a slight increase in December at 13.3% compared with 12.8% in November 2018. The split between voluntary and involuntary turnover has remained static in December, however the involuntary figure is slightly higher compared to the last 7 months.

Section 5 - Workforce - December 2018

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
5.5	Agency spend in relation to pay spend DQ		Agency expenditure continues to increase at a similar trend, which is slightly adverse to the agency ceiling position.

Narrative

Launch of Rapid Access MSK Service

The HDFT Occupational Health Department is pleased to announce that the Trust has launched a new Rapid Access MSK (Musculoskeletal) Service, delivered through PhysioMed for a 12 month pilot. HDFT employees may be referred to PhysioMed by their manager, via Occupational Health, if they have a musculoskeletal related concern which affects their ability to perform their job. A specialist clinician from PhysioMed will subsequently undertake a telephone assessment with the employee and appropriate treatment/advice will be offered in accordance with PAL (Patient Advice Line) pathways. Occupational Health will triage referrals to the physiotherapy service. MSK related absence represents about 20% of the Trust's overall sickness absence and is the second highest reason for absence across the Trust. This is a really positive development in the Trust's health and wellbeing offer.

Flu

We have now vaccinated 2,556 HDFT staff out of a total workforce of 4,603 since the commencement of the flu campaign on the 1 October 2018, equating to 56% of our total workforce being vaccinated. The individual directorate compliance rates are as follows:

Directorate	Headcount	Vaccinated	Percentage
Children's & County Wide	1,585	746	47%
Corporate	429	267	62%
Long Term and Unscheduled Care	1,510	906	60%
Planned and Surgical	1,079	637	59%
Total HDFT	**4,603**	**2,556**	**56%**
HHFM	319	142	45%
Total Inc. HHFM	**4,922**	**2,698**	**55%**

The breakdown of clinical staff and the numbers vaccinated are below:

Staff Group	Headcount	Vaccinated	Percentage
All Doctors	494	279	56%
Qualified Nurse	1,762	961	55%
Qualified Other	576	352	61%
Support to Clinical	936	496	53%
Total	**3,768**	**2,088**	**55%**

Harrogate and District NHS Foundation Trust

Section 5 - Workforce - December 2018

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation

In the last week we have seen a significant outbreak of flu on one of our medical wards and a number of communications have been sent to encourage those not yet vaccinated to do so. Colleagues have also been asked to complete a form for Occupational Health if there is no record of them having the vaccination yet and to confirm if they are unfit to receive the vaccination or are declining to have it and if so, on what grounds. The data from this is currently being inputted onto our system and from this we will be able to follow up with individuals where no response has yet been received. Analysis will also take place of the reasons colleagues have provided for not having the jab which will inform the communications plan for 2019/20 flu campaign.

Job Planning Compliance

The December job planning figures show an improvement in the rate of completed consultant doctor's job plans from 79.9% to 81.3% and a decrease in completed SAS doctor's job plans from 58.9% to 57.9%. Despite the demonstrated improvements, the target of reaching 100% compliance in December 2018 was unfortunately not reached.

DECEMBER 2018 JOB PLANNING CENTRAL REPORT - CONSULTANTS

Directorate	Number of Consultants	Current Job Plans (ie < 12 months)	%	Job Plans older than 12 months	%	Number of Consultant with no Job Plans recorded	%	In progress	Previous month current JPs	RAG
C & CWCC	10	9	90.00%	0	0.00%	1	10.00%	0	90.00%	
C & CWCC - Dental	2	2	100.00%	0	0.00%	0	0.00%	0	100.00%	
LT & UC	54	44	81.48%	10	18.52%	0	0.00%	0	83.33%	
P & SC	68	54	79.41%	9	13.24%	5	7.35%	0	75.00%	
Total	**134**	**109**	**81.34%**	**19**	**14.18%**	**6**	**4.48%**	0	**79.85%**	

DECEMBER 2018 JOB PLANNING CENTRAL REPORT - SAS GRADES

Directorate	Number of SAS Doctors	Current Job Plans (ie < 12 months)	%	Job Plans older than 12 months	%	Number of SAS Doctors with no Job Plans recorded	%	In progress	Previous month current JPs	RAG
C & CWCC	6	3	50.00%	0	0.00%	3	50.00%	0	60.00%	
LT & UC	11	2	18.18%	8	72.73%	1	9.09%	0	18.18%	
P & SC	40	28	70.00%	3	7.50%	9	22.50%	0	70.00%	
Total	**57**	**33**	**57.89%**	**11**	**19.30%**	**13**	**22.81%**	0	**58.93%**	

Excludes locums, maternity leave, bank; new starters u/6 months

Change from previous month (current JPs)

Improved **No change** **Deteriorated**

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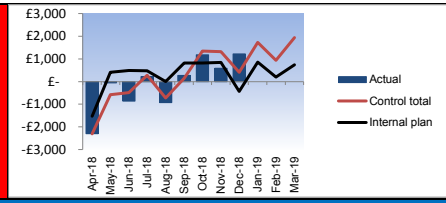
Section 6 - Efficiency and Finance - December 2018

Finance

6.1 Surplus / deficit and variance to plan — DQ



6.2 NHS Improvement Single Oversight Framework - Use of Resource Metric — DQ

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

6.3 Capital spend — DQ

Narrative

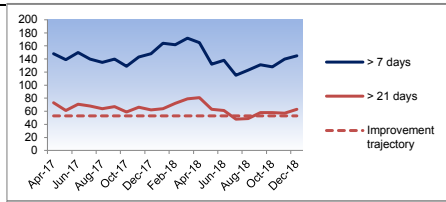
The Trust reported a surplus of £1,214k in December. This improved the year to date position to £687k, ensuring the control total for the Trust was achieved for Quarter 3. Risks still remain in the position, with the finance report outlining the best, worst and likely forecast positions.

The Trust continues to report a UoR rating of 3. While this is at the current plan, this remains a challenging position as a result of I&E performance.

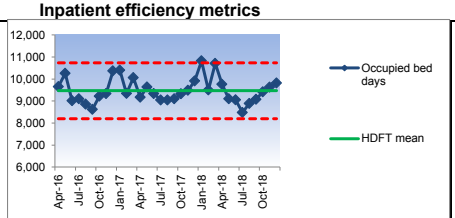
While resource for capital remains a risk, expenditure is exceeding planned levels.

Inpatient efficiency metrics

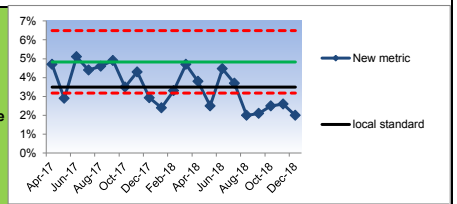
6.4 Long stay patients



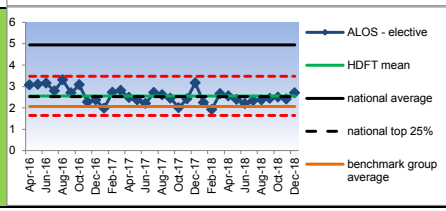
6.5 Occupied bed days



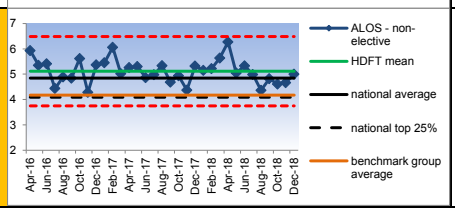
6.6 Delayed transfers of care — DQ



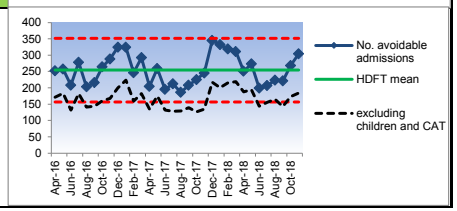
6.7 Length of stay - elective



6.8 Length of stay - non-elective



6.9 Avoidable admissions — DQ



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Section 6 - Efficiency and Finance - December 2018

Narrative

The number of long stay patients (>21 days) at HDFT increased to 63 in December. NHS Improvement has set improvement trajectories for Trusts to reduce the number of super-stranded patients by around 25% by Quarter 4 2018/19. 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.

In December, there were 9,800 occupied bed days, an increase on last month but below the level reported last December (9,900).

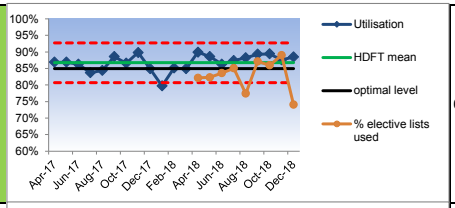
HDFT's average elective length of stay for December was 2.7 days, an increase on last month. HDFT remains in the top 25% (best) of Trusts nationally in the most recently available benchmarking data. HDFT's average non-elective length of stay for December was 5.0 days, an increase on last month but lower than December last year. The Trust remains in the middle 50% of Trusts nationally when compared to the most recently available benchmarking data.

Provisional data indicates that there were 304 avoidable admissions in November, an increase on last month and above the level reported in November last year. Adult avoidable admissions (excluding CAT attendances) also increased this month.

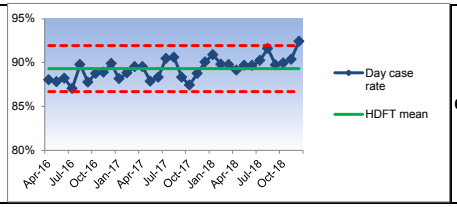
In December, 2.0% of bed days were lost due to delayed transfers of care, a decrease on last month and remaining below the local standard of 3.5%.

Productivity metrics

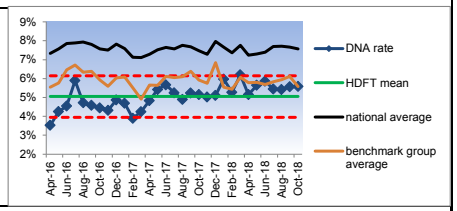
6.10 **Theatre utilisation**



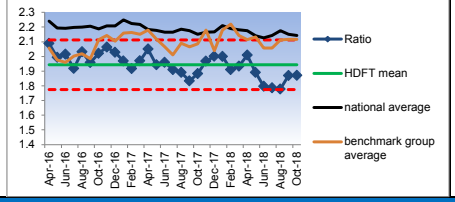
6.11 **Day case rate** DQ



6.12 **Outpatient DNA rate** DQ



6.13 **Outpatient new to follow up ratio** DQ



Narrative

Elective theatre utilisation was at 88.5% in December, an increase on last month and remaining above the 85% optimal level. This utilisation only reflects the elective lists that took place as planned. An extra line has been added to the chart to show the percentage of planned elective lists that took place each month. This is the first time that we have presented this additional metric. Further work will be done in the coming weeks to ensure that it accurately reflects list utilisation. In December, 74% of elective lists were used. This is lower than recent months but is reflective of the number of bank holidays during the month and the reduced need for elective lists over the Christmas holiday period.

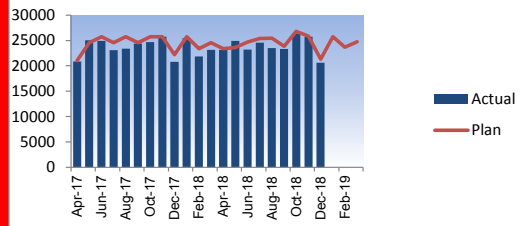
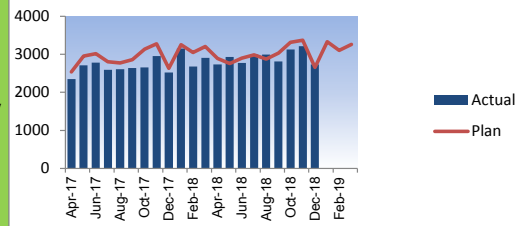
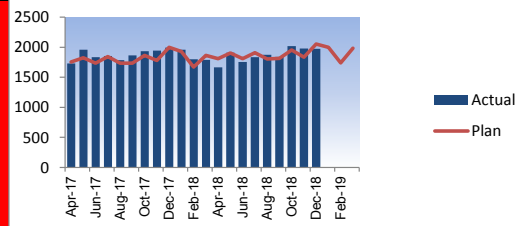
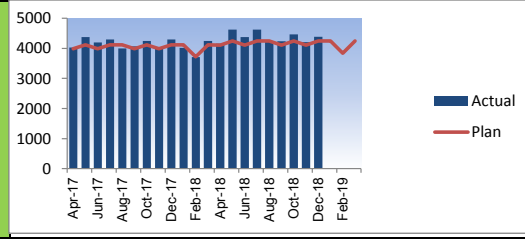
The day case rate was 92.4% in December, a significant increase on last month - this is partly reflective of a planned reduction in the number of elective inpatient admissions during December to enable maximium bed availability for non-elective admissions during the winter period.

HDFT's DNA rate was 5.6% in October, no significant change on recent months. This remains below the level reported by the benchmarked group of trusts and below the national average.

The clinical teams continue to implement opportunities to reduce follow up activity through the use of appropriate alternatives. This work is being managed through the Planned Care Board which oversees work in relation to the Aligned Incentive Contract. HDFT's new to follow up ratio was 1.87 in October, no change on last month 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.

Harrogate and District NHS Foundation Trust

Section 7 - Activity - December 2018

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
7.1	Outpatient activity against plan DQ		Outpatient activity was 3.5% below plan in December and remains 2.2% below plan year to date.
7.2	Elective activity against plan DQ		Elective activity was 2.8% above plan in December, but remains 1.7% below plan year to date.
7.3	Non-elective activity against plan DQ		Non-elective activity was 3.7% below plan in December and 0.3% below plan year to date.
7.4	A&E activity against plan DQ		A&E attendances were 3.2% above plan in December. The year to date position is 4.3% above plan. The figures presented include patients streamed to primary care.

NHS
Harrogate and District
NHS Foundation Trust

Section 7 - Activity - December 2018

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation

Narrative

The specialities continue to deliver above plan for new outpatient activity and below for follow ups. This reflects the ongoing work to modify clinical pathways to reduce follow ups. It continues to be of concern that activity for HaRD CCG remains above plan and although agreement has been reached to cover the costs this year, work continues to seek to resolve this going into next year. There also continues to be a focus on recovery of day case activity against plan for endoscopy following the opening of the new unit, however it should be noted that activity in the Wharfedale unit is now achieving plan following work to improve utilisation of lists with Leeds Teaching Hospitals.

The tables below summarise the activity position for the Trust overall and for HARD CCG.

Activity Summary - Trust total

	Nov-18			Dec-18			Dec-18 YTD			Dec-17 YTD		
Activity type	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
New outpatients	9024	8656	4.3%	7284	7175	1.5%	75560	73803	2.4%	72518	73112	-0.8%
Follow-up outpatients	16725	17195	-2.7%	13374	14169	-5.6%	139985	146592	-4.5%	140366	146633	-4.3%
Elective inpatients	312	331	-5.9%	208	257	-18.9%	2551	2692	-5.2%	2615	2916	-10.3%
Elective day cases	2903	3041	-4.5%	2524	2402	5.1%	23756	24081	-1.4%	21191	23069	-8.1%
Non-electives	1977	1835	7.7%	1972	2050	-3.8%	16845	16894	-0.3%	16906	16268	3.9%
A&E attendances	4210	4108	2.5%	4380	4245	3.2%	39282	37657	4.3%	37499	36546	2.6%

Activity Summary - HARD CCG

	Nov-18			Dec-18			Dec-18 YTD			Dec-17 YTD		
Activity type	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
New outpatients	5969	5720	4.4%	4956	4745	4.4%	50865	48776	4.3%	49478	45408	9.0%
Follow-up outpatients	11838	11241	5.3%	9478	9258	2.4%	98837	95859	3.1%	98968	88140	12.3%
Elective inpatients	192	207	-7.4%	144	161	-10.3%	1621	1672	-3.1%	1638	1621	1.0%
Elective day cases	1926	1789	7.7%	1638	1407	16.4%	15473	14268	8.4%	14663	13478	8.8%
Non-electives	1511	1363	10.9%	1498	1523	-1.6%	12851	12544	2.5%	12735	12077	5.5%
A&E attendances	3094	3033	2.0%	3207	3134	2.3%	28376	27803	2.1%	27177	26346	3.2%

Harrogate and District NHS Foundation Trust

Board Committee report to the Board of Directors

Committee **Name:**	Audit Committee
Committee Chair:	Chris Thompson
Date of last meeting:	5th December 2018
Date of Board meeting for which this report is prepared	30th January 2019

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. Dean Harker and Ross Mitchell from HHFM joined the meeting to discuss the outcomes of an evening security visit on 25th September by David Barker, Local Security Management Specialist – this in itself being a follow up to an earlier unsatisfactory visit. The Committee were extremely concerned that there appeared to be many instances of poor security in evidence, with access being freely available to offices containing patient records that were not being held in secure storage. There were also a number of instances of roll cages of high value items being left unattended on corridors. The Committee were reassured that actions were being taken to address the deficiencies and it was agreed that there would be a follow up attendance at the Audit Committee meeting in January 2019, where evidence of progress would be reviewed.

3. 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.

4. The Committee confirms that there are no matters relating to regulatory compliance to be brought to the attention of the Board

5. The Committee considered the report on the self-assessment of the Audit Committee's effectiveness. Following detailed consideration of those areas where the assessment showed movement from 12 months earlier and also those areas of apparent disagreement in the assessment, it was agreed that there were no significant changes required to the planned work programme for the Committee.

6. The Periodic Internal Audit Report considered at the meeting contained details of 12 audits that had been finalised during the period under review. There were 11 assurance reports and one advisory benchmarking report on the approach adopted by Audit Yorkshire members and clients to the way in which the Business Assurance Framework (BAF) operates. Of these audits, one received a split assurance level, 3 reports limited assurance with the remaining reports all being significant assurance. Mr Tom Watson explained that there are 2 further reports that have been issued in draft and that both of these indicated significant assurance. The 3 limited assurance reports were as follows:

- Rota Management – issues around the recording and handling of annual leave
- Statutory Reporting – HR Metrics around trade union reporting
- Theatre Utilisation – issues around reporting for cancelled sessions

It was noted that the Trusts approach to the way in which the BAF is utilised, and the major areas of strategic risk identified, were not out of line with other providers.

7. The proposed protocol for Non-Audit services to be undertaken by KPMG was agreed by the Committee.

8. The Committee was very pleased to note that significant progress appears to have been made by the Post Project Evaluation Committee in ensuring that evaluations are both worthwhile and submitted on time. In particular progress has been made in ensuring that responsibilities are properly transferred when responsible officials leave the Trust. The Committee reiterated its willingness to meet with selected project sponsors if it was felt that this would be helpful.

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

The Board are asked to note the concerns of the Committee around Evening Security across the District Hospital site. A further update will be provided to the Board after the January Audit Committee meeting.

Matters for decision

There are no matters requiring a decision of the Board.

Action Required by Board of Directors:

There are no specific actions required of the Board.

Harrogate and District NHS Foundation Trust

AUDIT COMMITTEE TERMS OF REFERENCE

Accountable: to the Board of Directors

Reporting: to the Board of Directors

Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Audit Committee (the Committee). The Committee is a ~~non-executive~~ committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

Membership

The Committee shall be appointed by the Board from amongst the Nn~~o~~n-e~~E~~xecutive d~~D~~irectors of the Trust and shall consist of not ~~less~~ fewer than three members. One member of the Committee, who will be the Chairman of the Committee, is to ~~should~~ have recent and relevant experience (e.g. audit/financial accounting/financial management) and one member of the Committee should also be a member of the Quality Committee concurrently. One of the members will be appointed Chair of the Committee by the Board. The Chairman of the Foundation Trust~~organisation~~ shall not be a member of the Committee.

9.1

Quorum

A quorum shall be two members.

Attendance

The Director of Finance ~~Director~~, members of the Senior Finance Team, the Deputy Director of Governance, the Company Secretary, and ~~appropriate~~ internal and external audit representatives as appropriate, shall normally attend meetings. The Local Counter Fraud representative shall also attend twice per year and the Local Security Management Specialist on an annual basis. At least once a year the Committee should meet privately with the external and internal auditors.

The Chief Executive should be invited to attend and should discuss at least annually with the Audit Committee the process for assurance that supports the Annual Governance Statement. The Chief Executive~~He or she~~ should normally~~also~~ attend when the Committee considers the ~~a~~Annual ~~a~~Accounts. All other e~~E~~xecutive D~~d~~irectors are~~should be~~ invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that d~~D~~irector.

Governors are also invited to attend the Audit Committee meetings as~~in an~~ observers and may speak at the discretion of the Chairman of the Committee.~~ational capacity.~~

A secretary shall be appointed to the Committee ~~shall attend~~ to take minutes of the meeting and provide appropriate administrative support to the Chairman and Committee members.

Frequency

~~Each Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.~~ The Committee will meet for at least~~A benchmark of~~ six meetings per annum at appropriate times in the reporting and audit cycle~~. is suggested.~~ The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

Authority

The Committee is authorised by the Board to investigate any activity within its ~~t~~Terms of ~~r~~Reference. It is authorised to seek any information it requires from any Trust employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of external experts~~outsiders~~ with relevant experience and expertise if it considers this necessary. Details of the estimated cost of such advice should be advised to the Director of ~~Finance~~ Director for budgetary, cash flow and control purposes.

Duties

The duties of the Committee can be categorised as follows:

Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust~~organisation~~'s activities (both clinical and non-clinical), that supports the achievement of the Trust's~~organisation's~~ objectives.

In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board
- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
- The policies and procedures for all work related to fraud and corruption as set out in the NHS Protect Counter Fraud Standards for Providers and as required by the Counter Fraud and Security Management Service
- The procedures for detecting fraud and whistle blowing (HDFT's Whistle Blowing Policy) and ensure that arrangements are in place by which staff may,

in confidence, raise concerns about possible improprieties in matters of financial reporting, financial control or any other matters.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal
- Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework
- Considering the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise audit resources
- Ensuring that the internal audit function is independent; adequately resourced and has appropriate standing within the organisation
- Annual review of the quality and effectiveness of internal audit.

External Audit

The Committee shall review the work and findings of the external auditors appointed by the Council of Governors and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the external auditors, and reporting annually to the Council of Governors by way of an evaluation of the external auditors' performance and whether they should be reappointed
- Recommendation of the audit fee to the Board (and Governors if a new appointment) and pre-approve any fees in respect of non-audit services provided by the external auditors and to ensure that the provision of non-audit services does not impair the independence or objectivity of the external auditor
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee

- Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
- Annual review of the quality and effectiveness of external audit.

The External Auditor or Head of Internal Audit may, at any time, request a meeting if they consider it necessary.

Clinical Assurance

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health and Social Care Arms Length Bodies or Regulators/Inspectors (for example, the Care Quality Commission, NHS Improvement, NHS Resolution, etc.) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies, etc.)

The Quality Committee will provide assurance from the clinical audit function. The Audit Committee will review the work of the Quality Committee by receiving minutes, and exception reports, from the Nnon-eExecutive dDirector who is a member of both committees. In addition, the Company Secretary also attends both committees.

The Audit Committee will receive minutes and regular reports from the Corporate Risk Review Group.

Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work and receive the counter fraud annual report.

Security Management Service

The Committee shall satisfy itself that the organisation has adequate arrangements in place for Security Management Services and that the Committee will receive from the Local Security Management Specialist an annual report on its activities and plan for the following year.

Management

The Committee shall request and review reports and positive assurances from dDirectors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit) as they may be appropriate to the overall arrangements.

Financial Reporting

The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Audit Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted miss-statements in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit
- Schedule of losses and special payments
- Letter of representation
- Qualitative aspects of financial reporting
- The going concern assumption
- The extent to which the financial statements are affected by any unusual transactions in the year and how they are disclosed
- Any reservations and disagreements between the external auditors and management which had not been satisfactorily resolved.

Standing Orders, Standing Financial Instructions and Standards of Business Conduct

The Committee will review, on behalf of the Board, the operation of and proposed changes to the Standing Orders, Standing Financial Instructions, and HDFT's Code of Business Conduct, including Staff Registers of Interest.

Quality Account

The Quality Committee will approve the Quality Account and present it to the Audit Committee. The Audit Committee will review the Quality Account and submit it to the Board.

Other Matters

The minutes of Audit Committee meetings shall be formally recorded by the Ssecretary to the Committee and submitted to the Board. The Chairman of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

The Committee will report to the Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and 'embeddedness' of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against external regulations including the Care Quality Commission.

The Committee shall also:

- Review third party assurances (both clinical and relating to financial management)
- Review Post Project Evaluations and Single Tender Actions
- Receive an annual report on procurement activity and savings
- Review the Treasury Management Policy, on behalf of the Board, and receive the annual report on treasury activity.

The Committee shall be supported administratively by the ~~S~~secretary to the Commitee, whose duties in this respect will include:

- Agreement of agenda with Chairman and attendees and collation of papers
- Taking the minutes
- Keeping a record of matters arising and issues to be carried forward
- Advising the Committee on pertinent areas

Where disagreements between the Audit Committee and the Board cannot be resolved, the Audit Committee shall report the issue to the Council of Governors. If the issue still cannot be resolved the Audit Committee shall report the issue as part of the report on its activities in the Annual report and Financial Statements.

As agreed with the Council of Governors, the Audit Committee Chairman shall be available to attend the Annual Members' Meeting~~GM~~ and shall answer questions on the Audit Committee's activities and responsibilities.through the Chairman of the Board of Governors ~~on the Audit Committee's activities and responsibilities.~~

Review

These Terms of Reference will be reviewed annually, in conjunction with a review of the effectiveness of the Committee.

January 201~~8~~9

Harrogate and District NHS Foundation Trust

Council of Governors' Meeting

Minutes of the public Council of Governors' meeting held on 1 August 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
Mr Ian Barlow, Public Governor
Mrs Cath Clelland, Public Governor
Mrs Angie Colvin, Corporate Affairs and Membership Manager
Mr Robert Cowans, Public Governor
Ms Clare Cressey, Stakeholder Governor
Mr Tony Doveston, Public Governor
Miss Sue Eddleston, Public Governor
Mrs Emma Edgar, Staff Governor
Dr Sheila Fisher, Public Governor
Mrs Jill Foster, Chief Nurse
Mrs Pat Jones, Public Governor
Mr Neil Lauber, Staff Governor
Cllr John Mann, Stakeholder Governor
Mrs Rosemary Marsh, Public Governor
Mr Phillip Marshall, Director of Workforce and Organisational Development
Cllr Samantha Mearns, Stakeholder Governor
Dr Christopher Mitchell, Public Governor
Mrs Katherine Roberts, Company Secretary
Mrs Laura Robson, Non-Executive Director
Mr Richard Stiff, Non-Executive Director
Mr Chris Thompson, Non-Executive Director
Dr Ros Tolcher, Chief Executive
Mr Steve Treece, Public Governor
Mr Ian Ward, Non-Executive Director
Mrs Lesley Webster, Non-Executive Director

In attendance:

6 members of the public

Mr Andrew Forsyth, Compliance and Revalidation Manager
Mr Rashpal Khangura, Director – Public Sector Audit, KPMG
Dr Sylvia Wood, Deputy Director of Governance and Freedom to Speak Up Guardian

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 12 on the agenda to be submitted during the break.

Mrs Schofield introduced the newly elected and nominated Governors and Mr Stiff, newly appointed Non-Executive Director. She also welcomed Mr Rashpal Khangura from KPMG who would be presenting the External Audit Assurance Report at item 8 on the agenda.

Apologies were received from Dr Pam Bagley, Stakeholder Governor, Mr Jonathan Coulter, Finance Director/Deputy Chief Executive, Mrs Liz Dean, Public Governor, Mr Rob Harrison, Chief Operating Officer, Ms Carolyn Heaney, Stakeholder Governor, Mrs Mikalie Lord, Staff Governor, Mr Andy Masters, Staff Governor, Mrs Zoe Metcalfe, Public Governor, Dr Daniel Scott, Staff Governor, Dr David Scullion, Medical Director and, Mrs Maureen Taylor, Non-Executive Director.

2. Minutes of the last meeting held on 2 May 2018

The minutes of the last meeting on 2 May were agreed as a true and accurate record.

3. Matters arising and review of action log

Item 1 – Dr Tolcher would be including new contract arrangements with Harrogate and Rural District Clinical Commissioning Group (HaRD CCG) in her presentation at item 11 on the agenda.

Item 2 – consideration of the Youth Forum's involvement at public Council of Governors' meetings would be included in the Trust's Constitution Review at item 7 on the agenda.

Item 3 – a letter had been sent to Mr Crawley therefore this item was now complete.

Items 4 and 5 – both these actions were now complete. Non-Executive Directors (NEDs) would now also attend bi-monthly Governor Briefings on a rota basis in addition to the twice yearly Governor/NED meetings and Board to Board meetings. This arrangement would provide a further opportunity for Governors to interact with NEDs in a variety of forums.

There were no other matters arising.

4. Declaration of interests

There were no further declarations of interest in addition to paper 4.

It was noted Mr Thompson was a Director of Harrogate Healthcare Facilities Management. No agenda items were planned which would present a conflict of interest. It was however agreed that 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 Ward who had been a NED for six years and would be leaving the Trust at the end of September. He had also undertaken the role of Senior Independent Director and worked closely with Governors.

Mr Ward commented that he was pleased to have been a NED for two terms of office and was particularly proud to be involved with such a high performing trust. He acknowledged the work of the Board, Governors, and all staff and wished the Trust every success in the future.

Mrs Schofield also thanked Mr Marshall, Director of Workforce and Organisational Development, who after 12 years on the Board would be leaving the Trust to undertake the same role on the Board at The Mid Yorkshire Hospitals NHS Foundation Trust. She highlighted that Mr Marshall had won the Healthcare People Management Association's award for Human Resources Director of the Year 2017 and wished him well for the future.

Mrs Schofield also wished the very best to Mrs Roberts, Company Secretary, who would be commencing maternity leave the following week. She introduced Mr Forsyth who would be taking over as Interim Company Secretary.

On other matters, Mrs Schofield highlighted the celebration of volunteering which took place on 3 July 2018 to coincide with the NHS celebrating its 70th birthday. Volunteers were presented with long service awards ranging from 10 years to an amazing 40 years' service. A long-service tea party also took place on 16 July 2018 to celebrate the Trust's long-serving members of staff. Staff were awarded for their outstanding service to the NHS for 25, 35 and 40 years; there was also special recognition for those who have recently retired from the Trust.

Mrs Schofield was delighted to confirm the opening of the new endoscopy suite and commented on the new pattern of Board meetings which were now being held in public on a bi-monthly basis. Governor briefings would now take place on alternate months; the next one scheduled for 30 August.

The Annual Members' Meeting was being held on Monday, 3 September at 6.00 – 8.00pm at The Pavilions of Harrogate. Registration, refreshments, networking and informative stands would be held between 5.00 – 6.00pm and everyone was welcome.

Finally, Mrs Schofield referred to the agenda for the meeting which focussed on governance related topics, the Trust's constitution, the External Audit Assurance report and an update from the Freedom to Speak Up Guardian.

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 acknowledged and thanked the Corporate team for their hard work.

Dr Fisher reiterated Mrs Jones's thanks and expressed her delight that students were now offered the opportunity to go into theatres during their work experience placements.

Mrs Schofield reinforced the work of the volunteers and thanked them for all the support they offer to staff in delivering high quality patient care.

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 emphasised that the Annual Members' Meeting was a statutory meeting for Governors and she looked forward to seeing as many of them there as possible.

Mrs Schofield confirmed that the Annual Members' Meeting agenda would continue to follow the tradition to engage with members and ask them to contribute to the Trust's ongoing focus on delivering high quality care. There would also be the opportunity for the audience to put questions to an expert panel.

There were no questions for Ms Allen.

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 work of the Trust's Equality and Diversity Group referred to in her report. The Group was responsible for leading the Trust's equality agenda and promoting the Trust's commitment towards inclusiveness and equality for all.

There were no questions for Miss Eddleston.

6.4 Update from the Deputy Chair of Governors on Non-Executive Director Appraisals

Ms Allen confirmed she had undertaken the Non-Executive Directors' appraisals with Mrs Schofield and Mrs Schofield's appraisal with Mr Ward; each process had been completed successfully. She thanked Governors for their feedback and commented that the Trust was extremely fortunate to have such a robust team of Non-Executive Directors on the Board.

Mrs Schofield thanked Ms Allen for her time and commitment in undertaking the appraisals and for Governors involvement in the process.

There were no questions for Ms Allen.

7. HDFT Constitution Review

a) Constitution

Mrs Schofield thanked Mrs Roberts who had reviewed the Constitution in line with national guidance and best practice and worked with the Constitution Working Group (the Group) to produce the documents for approval by the Council of Governors.

All proposals had been considered by the Group in fine detail and had been discussed and approved by the Trust Board on 25 July.

Mrs Roberts thanked the Governors involved in the Group and summarised the key proposed amendments to the Trust's Constitution detailed in the report.

Mrs Schofield highlighted each proposal and sought approval from the Council of Governors:

The Council of Governors approved the proposed amendments to the Constitution noting they were approved by the Board of Directors on 25 July 2018.

b) Constitution Working Group Terms of Reference

Mrs Roberts summarised the proposed amendments to the Constitution Working Group Terms of Reference including the membership of the Group.

The Council of Governors approved the amended Constitution Working Group Terms of Reference.

c) Procedure for Management of Governor Conduct Concerns

Mrs Roberts reminded Governors that it was a requirement of the Code of Governance for Foundation Trusts to have a procedure for removal of Governors. The Constitution Work Group reviewed the procedure based on recommended practice from NHS Providers and an example from another Foundation Trust.

The Council of Governors approved the procedure for management of Governor Conduct Concerns.

d) Remuneration, Nominations and Conduct Committee Terms of Reference

Mrs Roberts referred to the Terms of Reference for the new Remuneration, Nominations and Conduct Committee. In line with the proposed amendments to the Constitution, the new Committee would replace the previous Remuneration Committee and the Nominations Committee.

The Council of Governors approved the Terms of Reference for the Remuneration, Nominations and Conduct Committee

Mrs Schofield noted that members of the Committee would be confirmed in due course.

7.1 Governor Code of Conduct

Mrs Roberts referred to the updated version of the Code of Conduct based on the Trust's existing document and best governance practice recommended by NHS Providers. If approved, all Governors would be asked to sign the new Code of Conduct.

The Council of Governors approved the updated Governor Code of Conduct.

7.2 Procedure for disagreements between Council of Governors and the Board

Mrs Roberts referred to the Dispute Resolution Procedure for disputes between the Board of Directors and Council of Governors; a key document in achieving compliance with the Code of Governance for NHS Foundation Trusts. The updated version of the dispute resolution procedure was considered and approved by the Board of Directors on 25 July 2018.

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

noting the Board of Directors had considered and approved the procedure on 25 July 2018.

Mrs Schofield thanked Mrs Roberts and the Constitution Review Working Group again for such a considerable and important piece of work.

8. Annual Report and Accounts 2017/18 (including the External Audit Assurance Report to the Council of Governors)

Mrs Schofield welcomed Mr Rashpal Khangura from KPMG to present the annual external audit report to the Council of Governors.

The annual External Audit Report 2017/18 had been circulated prior to the meeting. Mr Khangura reflected on KPMG's work with the Trust over the past year and highlighted the following key messages from his report:

- Financial Statements Audit – based on the Audit Code, which sets out the rules and regulations of their work, they provide an opinion on the Trust's accounts.

  He described the benefits of their work as 'adding a layer of credibility' to the Trust's financial statements. He explained the importance of an external eye on the accounts to provide assurance to Governors and the general public; similar to the Care Quality Commission (CQC) focussing on the quality of service. He highlighted key areas of focus including valuation of land and buildings, valuation of NHS income and receivables and, accounting for and related disclosures as a result of implementing Harrogate Healthcare Facilities Management (HHFM). Following a range of audit work, Mr Khangura confirmed that a clean unqualified audit opinion had been issued to the Trust. The audit identified a couple of differences and some minor presentational changes however, these were not material to the overall opinion. He was pleased to state that the Annual Report and Annual Governance Statement were consistent with financial statements and complied with the Group Accounting Manual. He acknowledged the work of the Trust's Finance Team and thanked them for their support.

- Use of resources – External Audit were required to issue a value for money conclusion taking into account the Trust having adequate arrangements to secure economy, efficiency and effectiveness in its use of resources.

  Assessed against three criteria – informed decision making, sustainable resource deployment and working with partners and third parties; Mr Khangura confirmed the key focus area was the medium/long term financial sustainability of the Trust. The audit identified arrangements in place to manage financial risks and no significant issues at year-end. He was pleased to confirm that an unqualified use of resources opinion was issued for 2017/18.

- Quality Report – The content of the Quality Report complied with the requirements issued by NHS Improvement.

Mr Khangura referred to the three indicators audited, included the following two mandated indicators:

- the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period and,

- the percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.

The third local indicator, as selected by Governors, was emergency re-admissions within 28 days of discharge from hospital.

KPMG provided a clean limited assurance opinion on the two mandated indicators. There was one low priority recommendation raised in relation to A&E however, this did not affect the opinion. KPMG were not required to provide assurance on the third indicator, but if they were, Mr Khangura assured Governors this would have also received a clean limited assurance opinion.

Mr Khangura thanked the Trust for the opportunity to present the audit findings at the meeting.

Mrs Schofield clarified that a clean limited assurance was the best opinion the Trust could achieve and would pass on Mr Khangura's thanks to the finance team.

Mrs Schofield asked if there were any questions.

A member of the public asked how many people from KPMG were involved in the audit to which Mr Khangura confirmed there were four.

A member of the public made several comments regarding his disappointment and lack of understanding on the process and he referred to hospitals needing more money.

A member of the public also informed the Chairman that she was having difficulty in hearing what people were saying throughout the meeting.

Mrs Schofield apologised and reminded everyone to use the microphones available.

In response, Mr Khangura clarified that The National Audit Office produced guidance in line with NHS Improvements requirement for Foundation Trusts to obtain external assurance on their quality reports. KPMG had no responsibility over any political arrangements

In support, Mr Thompson, Chair of the Audit Committee, provided reassurance that the role of the external auditor was to provide an independent, true and fair view of the Trust's accounts.

Dr Tolcher confirmed the statutory responsibility of the Council of Governors to appoint the External Auditor and seek independent assurance from them

on the Trust's annual Quality Report. This was one of the ways in which members of the public could understand how trusts were using their resources effectively to provide high quality, efficient and sustainable care along with NHS Improvement's 'Use of Resources' assessments and CQC inspections. Dr Tolcher informed members of the public that the Trust was expecting an inspection by the CQC later in the year.

There were no questions from Governors who were happy to receive the report.

Mr Khangura left the meeting after this item on the agenda.

9. Audit Committee update on the External Auditor Performance

Mr Thompson referred to his report circulated prior to the meeting and taken as read.

He confirmed that the Audit Committee considered the performance of the External Auditor in May following the completion of the 2017/18 external audit work. The External Audit Effectiveness Assessment demonstrated an average rating of 4.5 for 2018 (the maximum score was 5.0) a slight deterioration on last year's score of 4.6. Mr Thompson summarised some of the scores from the questions used in the assessment and confirmed the Audit Committee evaluation overall was very good.

Dr Fisher asked if the Committee used benchmarking data. Mr Thompson responded and confirmed this was done formally through the appointment process looking at value for money against other companies. He confirmed that KPMG had significant expertise and audited more NHS Foundation Trusts than any other organisation. He was pleased to report that the Audit Committee received detailed information from KPMG on a regular basis and this was incredibly helpful. Mr Thompson also confirmed that KPMG had been appointed for a three year term of office commencing 1 December 2016 with an option to extend for a further two years subject to satisfactory service and performance and to be reviewed on an annual basis.

Mrs Clelland referred to the three year term and asked when the Trust last tested the market. Mr Thompson confirmed this was done at the appointment of KPMG in 2016 and would be reviewed formally in August 2019. As stated, based on satisfactory service and performance, Governors would have the option to extend the term by a further two years.

There were no further questions for Mr Thompson.

Mrs Schofield called for a break at this stage in the meeting.

10. Presentation – Update from the Freedom to Speak Up Guardian

Mrs Schofield introduced Dr Sylvia Wood, Deputy Director of Governance and Freedom to Speak Up Guardian

Dr Wood was delighted to be given the opportunity to present about 'Speaking Up' to Governors and members of the public. She provided some background to how the role of Freedom to Speak Up Guardian had developed, what the Trust had achieved so far and, what the aims were for the future.

Following the Public Inquiry into the Mid Staffordshire NHS Foundation Trust, which exposed unacceptably poor levels of patient care and a staff culture that deterred staff from raising concerns, the recommendations of 'Freedom to Speak Up' provided independent advice and recommendations on creating a more open and honest reporting culture in the NHS. Supported by the National Guardian for the NHS, Dr Henrietta Hughes, the NHS now has over 500 guardians and champions of this review.

Dr Wood emphasised the importance for staff to be able to speak up to be able to make a difference and feel safe to do so.

Freedom to Speak Up Guardians help:

- Protect patient safety and the quality of care.
- Improve the experience of workers.
- Promote learning and improvement.

By ensuring that:

- Workers are supported in speaking up.
- Barriers to speaking up are addressed.
- A positive culture of speaking up is fostered.
- Issues raised are used as opportunities for learning and improvement.

Moving on to describe freedom to speak up at the Trust, Dr Wood confirmed she had been in post since October 2016 and, whilst there had been significant process made, there was still work to do. She highlighted some of the achievements including raising awareness, staff engagement, policy reviews, and recruitment of Bullying and Harassment Advisors. She reiterated the importance of the role of others in supporting the Freedom to Speak Up Guardian including line managers, Staff Governors, Human Resources and Non-Executive Directors, to name a few.

The Trust was committed to a healthy, supportive and positive culture to deliver excellent care and enable staff to be happy at work. Dr Wood confirmed that when people speak up, this provides a message that the Trust can learn from. There had been a small number of cases so far however, this was just starting to creep up a little and there were now 15 cases across the organisation from staff, volunteers and patients. The theme so far from these cases was around concerns about workforce behaviours; there had been no concerns raised about patient care.

Dr Wood talked about next steps which included a self-assessment report to go back to the Board and ongoing work to drive forward the Trust's vision and ambitions for speaking up. Dr Wood also highlighted that trusts would be expected to demonstrate how they supported the guardian role as part of the CQC inspection.

October was 'Speaking Up Month'; a time to drive the ambition for speaking up to be 'business as usual' and to treat everyone with kindness and respect.

Mrs Schofield thanked Dr Wood for such an informative and interesting presentation; she expressed how important this piece of work was and was pleased that Dr Wood was leading this initiative.

Mrs Schofield asked for questions from the floor.

Mrs Edgar asked if bullying was a key theme from speaking up across other organisations. Dr Wood confirmed that her peers were seeing a similar picture.

Mrs Edgar commented that she would be keen to become a champion in order to be more aware.

Mrs Marsh stated that she found the presentation interesting and acknowledged that it could be difficult for staff to talk about something that was worrying them. She asked if there was training for line managers around complaints. Dr Wood confirmed it was not part of her role to provide such training, but the Trust did offer leadership and management training for staff in a line management position.

Mr Marshall commented on examples which demonstrated a positive culture across the organisation including the Trust's values, appraisal process, and staff survey results. He assured Governors that HR would offer support to all staff including line managers.

Dr Fisher asked if the Trust would be sharing evidence with staff to demonstrate that speaking up would make a difference. Dr Wood stated that it was really important to obtain feedback at the end of each case and she was starting to use feedback as a support mechanism for change.

Mrs Schofield referred to the role of the Senior Independent Director, as discussed earlier in the meeting, and confirmed they would be a further contact for people to raise a concern. Mr Ward acknowledged the Senior Independent Director's support with this initiative.

There were no further questions for Dr Wood.

11. Chief Executive's Strategic and Operational Update, including Integrated Board Report (IBR)

Dr Tolcher presented the following headlines:

Operational Performance

The Integrated Board Report (IBR) circulated prior to the meeting provided further detailed information to support Dr Tolcher's summary.

Taking a snapshot from the 2018 Q1 April to June IBR, Dr Tolcher acknowledged there were more areas showing red than Governors were used to seeing in previous reports. She highlighted three key performance indicators where the Trust was not achieving the national standards in the first quarter of the financial year. Firstly, the referral to treatment incomplete pathways performance had dipped below the

national standard of 92% (of which should be waiting less than 18 weeks). Secondly, the A&E 4-hour standard was marginally below the 95% target at 94.8%. Dr Tolcher confirmed that if 27 more patients had spent less than four hours in A&E, this indicator would have shown as green. She added that the department had seen 13,000 patients within the first quarter, almost a 10% increase above projected figures and four times the national trend in terms of growth. Most of the increased activity related to minor injuries and minor illnesses however, it was reassuring that patients continued to receive safe and timely care. The third red area was diagnostic waits which had dipped slightly below the national standard of 99% to 98.4%. This was due to the impact on capacity during the refurbishment work in Radiology and Cardiology, which had now recovered. Dr Tolcher expected the A&E 4-hour standard to recover but she did not expect the referral to treatment standard to recover for the next 12 months.

Moving on to the next slide in her presentation, she was delighted to confirm that community children's services continued to perform well.

In relation to Q1 finances, the year to date position showed a deficit of £3.2m compared to a planned deficit of £600k. A consequence of this position meant fewer opportunities for capital investment such as new operating theatres; a significant risk for the Trust going forward. Dr Tolcher confirmed the Trust was a little behind on the savings plan and there was overspend in some areas including workforce (registered nurses and theatre staff) however the income year to date was on plan.

Strategic Developments

Dr Tolcher went on to talk about strategic developments and provide an explanation on the new type of contract with the commissioners in light of the action following the last meeting.

Dr Tolcher summarised the up to date position of the West Yorkshire and Harrogate Integrated Care System (ICS); working closely together with West Yorkshire acute trusts covering Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield to plan health and care services across the area. The partnership was making good progress with access to national funding and both Dr Tolcher and Mrs Schofield were members ensuring senior representation from the Trust.

Dr Tolcher was delighted to welcome staff who had joined the Trust in July to provide 0-19 Children's services in Sunderland and Gateshead. The Trust was extremely proud to be the largest provider of children's services in the country.

Dr Tolcher was also pleased to confirm that the new endoscopy suite had opened in July. This now provided a much improved environment for patients and staff, with five procedure rooms, separate changing facilities and dedicated admissions and discharge rooms. The department had been designed to provide capacity to meet the anticipated future needs of the local population.

Moving on to explain the new Aligned Incentive Contract with HaRD CCG, Dr Tolcher summarised the need to work in partnership to manage both the demand for hospital care and the provision of high quality lower cost care in order to create a balanced system. The total value of the agreement with HaRD CCG this year to provide healthcare to the population of Harrogate was £94m. The Trust would receive less

money than last year for the same amount of work but the freedom to spend that money in the most cost effective way. Dr Tolcher provided a pictorial slide to demonstrate how the money was proportioned based on cost of care provided. The two highest areas of spend were planned care and unplanned care. The Trust would be working closely with GPs around extra support in primary care however the ability to be flexible with funding across the different areas was positive.

Key Risks

Dr Tolcher summarised the top scoring strategic and operational risks for the Trust. The common themes between the two being related to workforce and finances.

Finally, Dr Tolcher highlighted some of the Trust's achievements including a CHKS Top 40 Hospitals Award and a 5% improvement in the staff Friends and Family score in Q1. She echoed the Chairman's earlier comments about the NHS's 70th birthday celebrations and confirmed that a CQC inspection was expected in the autumn.

Mrs Schofield thanked Dr Tolcher for her presentation and asked for questions.

Cllr Mann asked for further clarification regarding the new type of contract. Dr Tolcher confirmed that the new contract provided the Trust with increased flexibility. There were opportunities to provide services to a much larger footprint than the Harrogate population; currently around a third of the Trust's work was provided to other areas.

There were no further questions for Dr Tolcher.

12. Question and Answer session for members of the public and Governors

Mrs Schofield moved to the tabled questions submitted prior to the meeting. She explained there had been quite a lot of questions submitted so these had had to be prioritised due to the time allocated for this item. Questions from members of the public would be taken first as Governors had many more opportunities in which to ask questions from members of the Board.

Mr Andy Griffiths, member of the public, had submitted the following question prior to the meeting however he was not in attendance today:

"Do we have a backlog in maintenance, if so, how assured are the public Governors and Non-Executive Directors these are not impacting on patient care and experiences?"

Dr Tolcher reported backlog issues totalling a value of £11.6m; a risk assessment confirmed there were none classed as high risk. The Trust has invested £500k in the current year and Harrogate Healthcare Facilities Management (HHFM) was working on backlog issues.

Mr Thompson, Non-Executive Director for the Trust and Director of HHFM, confirmed that data in the backlog maintenance plan was discussed at the HHFM Board meeting on 19 June 2018. He was confident that the risks had been identified appropriately and work was being prioritised accordingly.

Mrs Webster, Non-Executive Director, added that HHFM had provided an update to the Trust's Board, where it was confirmed that the benefits of the new company pay structure had enabled them to fill a number of long standing vacancies enabling them to focus on the backlog in maintenance.

Mrs Edgar, Staff Governor, was assured by the responses provided by the Non-Executive Directors of both the Trust and HHFM.

"How assured are our public Governors and Non-Executive Directors on all decisions made by the Board?"

Ms Allen, Public Governor, confirmed the responsibility of the Council of Governors to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors. She stated that Governors had the opportunity to seek assurance in a variety of ways including interaction with Non-Executive Directors at meetings and events, receiving reports, asking questions and appropriate challenge, and observing Non-Executive Directors at Board meetings and sub-committees. She was therefore assured.

"How is the 'Model Hospital' been used in our Trust and what does it tell us about our Trust?"

In response, Dr Tolcher summarised the 'Model Hospital'; a digital tool from NHS Improvement to enable trusts to compare their productivity and identify opportunities to improve - supporting the NHS to provide the best patient care in the most efficient way.

She confirmed the Trust's Board and clinical staff continuously referred to the 'Model Hospital' and used it as a valuable tool and resource to compare this Trust with others across the country, including for quality, financial and workforce data and thereby identify opportunities for service and efficiency improvements.

Mrs Schofield moved on to the questions which had been submitted by Governors and had been selected, with Ms Allen's input, as those with a direct public interest.

Mrs Rosemary Marsh, Public Governor, had submitted the following question:

"Could we please have an update on the HHFM enterprise in terms of whether a Business Manager has now been appointed; any progress made on obtaining outside work, general feelings of the facilities people with a cultural identity of being in the new enterprise beginning to emerge? Is there any other future independent enterprise being considered by the Board?"

Mr Thompson responded to this question and confirmed that a Business Manager had been appointed and would commence in post in September. He referred to the 14 meetings which had been held for HHFM colleagues and he was pleased that staff had been actively engaged in the decision of the new company trading name, logo and values. General feedback was that staff didn't feel much different as they were still working in the same place and providing the same services. The management team however had more accountability and would be focussing on expanding opportunities and the company's independence.

Mrs Schofield informed Governors that the Chairman of HHFM, Mr Phillip Severs, would be attending the next Governor briefing on 30 August.

Mr Doveston, Public Governor, had submitted the following question:

"I have recently had the opportunity to visit the new Endoscopy Unit. Clearly, it is a state of the art facility which the Trust should be justifiably proud. Could you please give an indication, and a degree of assurance, that not only would the new unit improve patient care, but also that the facility will be fully utilised to maximise income generation thereby helping to improve the Trust's financial wellbeing."

In addition to her earlier comments, Dr Tolcher was pleased to confirm that the new Endoscopy Suite would certainly bring income generation to the Trust. Following a recent meeting with the West Yorkshire Association of Acute Trusts (WYATT), the Trust was pleased to be able to offer services to support trusts with capacity issues.

Miss Eddleston, Public Governor, had submitted the following comments for response:

"The reception area at Ripon Community Hospital was not staffed. The blinds were down and there was a notice on the window stating sickness being the cause for no-one in reception. This was first noticed 4-5 weeks ago and again this week. Patients were looking lost and searching for someone to help them as they entered the building.

On occasions over the past 4-5 weeks X-ray department reception had also been closed at certain times. Can someone explain why these two reception areas are not staffed as normal?

Patients are remarking that the car park for the hospital seems full yet not many patients are seen in the hospital. It is worse on Thursdays which is market day. GP surgeries have notices in each waiting area asking patients to remove their cars once they have seen the doctor. Are staff/visiting clinicians finding the same problem?"

Dr Tolcher confirmed that staff sickness was creating a challenge in order to keep the reception areas open. The Trust was working through some long-term solutions including electronic check-in which was proving popular and successful. She recognised there was still work to do in relation to improving signage and security and a conversation had taken place with the Friends of Ripon Hospitals to listen to their views. Where the receptionist had previously provided services to patients such as hearing aids and orthotics, these were being covered by the audiology department and orthotic main clinic.

In relation to the car park, Dr Tolcher clarified that NHS Property Services owned the car park not the Trust. The suggestion of a barrier would not be cost effective and there was still work to do to improve signage. She acknowledged the support from GP surgeries in putting notices up and the staff who had tried to speak to people about using the car park inappropriately, but this was difficult.

Mrs Schofield thanked Governors for their questions. Mrs Fisher's and Mr Treece's questions were unable to be formally answered at the meeting today due to time restrictions. Mr Treece commented that some of his questions had been answered from Dr Tolcher's presentation. Governors also had opportunities for their questions to be answered at other meetings such as Governor Briefings, Governor meetings with Non-Executive Directors or within the Governors' newsletter.

13. Any other relevant business not included on the agenda

There were no further items of business.

14. Member Evaluation

Mrs Schofield sought views about the meeting.

Governors discussed the time restraints of the meeting with regards to the opportunity for submitted questions to be answered.

Mrs Schofield acknowledged that on this occasion, there had been a lot of questions submitted. She commented on her reluctance to run over the 8pm finish time and a judgement had been made on prioritising the questions to be answered today.

In support, Dr Tolcher reiterated that the meeting was not the only forum to seek assurance and she hoped that the public Board papers would provide Governors and members of the public with a range of detailed information.

Following further detailed discussion Mrs Schofield confirmed that a review of the meeting agenda would take place and feedback from the evaluation forms would be considered.

As this was his last meeting, Mr Marshall wished to take the opportunity to thank Governors for their contribution, challenge and commitment to the organisation.

There were no further comments.

15. Close of meeting

Mrs Schofield closed the meeting. She thanked everyone for attending and confirmed the next meeting would take place on Wednesday, 7 November at 5.45 – 8.00pm, venue to be confirmed.

Harrogate and District NHS Foundation Trust

HARROGATE AND DISTRICT NHS FOUNDATION TRUST
GLOSSARY OF ABBREVIATIONS

A

A&E	*Accident and Emergency*
AfC / A4C	*Agenda for Change*
AHPs	*Allied Health Professionals*
AIC	*Aligned Incentive Contract*
AMM	*Annual Members' Meeting*
AMU	*Acute Medical Unit*
AQP	*Any Qualified Provider*

B

BAF	*Board Assurance Framework*
BME	*Black and Minority Ethnic*
BoD	*Board of Directors*

C

CAT	*Clinical Assessment Team*
CATT	*Clinical Assessment, Triage and Treatment Ward*
C.Diff I	*Clostridium difficile Infection*
CCCC	*Children's and County Wide Community Care Directorate*
CCG	*Clinical Commissioning Group*
CCTs	*Community Care Teams*
CCU	*Coronary Care Unit*
CE / CEO	*Chief Executive Officer*
CEA	*Clinical Excellence Awards*
CEPOD	*Confidential Enquiry into Perioperative Death*
CIP	*Cost Improvement Plan*
CLAS	*Children Looked After and Safeguarding Reviews*
CNST	*Clinical Negligence Scheme for Trusts*
CoG	*Council of Governors*
COO	*Chief Operating Officer*
CORM	*Complaints and Risk Management*
CQC	*Care Quality Commission*
CQUIN	*Commissioning for Quality and Innovation*
CRR	*Corporate Risk Register*
CSA	*Child Seualx Abuse*
CSW	*Care Support Worker*
CT	*Computerised Tomography*
CT DR	*Core trainee doctor*

D

Datix	*National Software Programme for Risk Management*
DBS	*Disclosure and Barring Service*
DNA	*Did not attend*
DoH	*Department of Health*
DoLS	*Deprivation of Liberty Safeguards*
Dr Foster	*Provides health information and NHS performance data to the public*
DSU	*Day Surgery Unit*
DToC	*Delayed Transfer of Care*

E

E&D	*Equality and Diversity*
eNEWS	*National Early Warning Score*
ENT	*Ear, Nose and Throat*
EoLC	*End of Life Care*
ERCP	*Endoscopic Retrograde Cholangiopancreatography*
ESR	*Electronic Staff Record*
EU	*European Union*
EWTD	*European Working Time Directive*

F

FAQ	*Frequently Asked Questions*
FFT	*Friends and Family Test*
FC	*Finance Committee*
FNP	*Family Nurse Partnership*
FOI	*Freedom of Information*
FT	*NHS Foundation Trusts*
FTSU	*Freedom to Speak Up*
FY DR	*Foundation Year doctor*

G

GIRFT	Get it Right First Time
GPOOH	GP Out of Hours
GWG MD&C	Governor Working Group – Membership Development and Communications
GWG V&E	Governor Working Group – Volunteering and Education

H

H@N	*Hospital at Night*
HaRD CCG	*Harrogate and Rural District Clinical Commissioning Group*
HaRCVS	*Harrogate and Ripon Centres for Voluntary Service*
HBC	*Harrogate Borough Council*
HCP	*Health and Care Partnership*
HDFT	*Harrogate and District NHS Foundation Trust*
HDU	*High Dependency Unit*
HED	*Hospital Episodic Data*
HEE	*Health Education England*
HFMA	*Healthcare Financial Management Association*
HHFM	*Harrogate Healthcare Facilities Management Ltd*

HR	*Human Resources*
HSIB	*Healthcare Safety Investigation Branch*
HSE	*Health & Safety Executive*
HSMR	*Hospital Standardised Mortality Ratios*

I

ICU or ITU	*Intensive Care Unit or Intensive Therapy Unit*
ICS	*Integrated Community Services*
IG	*Information Governance*
IBR	*Integrated Board Report*
IT or IM&T	*Information Technology or Information Management & Technology*

K

KPI	*Key Performance Indicator*
KSF	*Knowledge & Skills Framework*

L

L&D	*Learning & Development*
LAS DR	*Locally acquired for service doctor*
LAT DR	*Locally acquired for training doctor*
LCFS	*Local Counter Fraud Specialist*
LEPs	*Local Education Providers*
LMC	*Local Medical Council*
LNC	*Local Negotiating Committee*
LoS	*Length of Stay*
LPEG	*Learning from Patient Experience Group*
LSCB	*Local Safeguarding Children Board*
LTUC	*Long Term and Unscheduled Care Directorate*
LWAB	*Local Workforce Action Board*

M

MAC	*Medical Advisory Committee*
MAPPA	*Multi-agency Public Protection Arrangements*
MARAC	*Multi Agency Risk Assessment Conference*
MASH	*Multi Agency Safeguarding Hub*
MDT	*Multi-Disciplinary Team*
Mortality rate	*The ratio of total deaths to total population in relation to area and time.*
MOU	*Memorandum of Understanding*
MRI	*Magnetic Resonance Imaging*
MRSA	*Methicillin Resistant Staphylococcus Aureus*
MRET	*Marginal Rate Emergency Tariff*
MTI	*Medical Training Initiative*

N

NCEPOD	*NCEPOD (National Confidential Enquiry into Perioperative Death)*
NED	*Non-Executive Director*
NHSE	*National Health Service England*
NHSI	*NHS Improvement*

NHSR	*National Health Service Resolution*
NICE	*National Institute for Health & Clinical Excellence*
NMC	*Nursing and Midwifery Council*
NPSA	*National Patient Safety Agency*
NRLS	*The National Reporting and Learning System*
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*
PSF	*Provider Sustainability Funding*
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*
RCP	*Royal College of Physicians*
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*

SDS	*Supported Discharge Service*
SHMI	*Summary Hospital Mortality Indicator*
SHU	*Sheffield Hallum University*
SI	*Serious Incident*
SID	*Senior Independent Director*
SIRI	*Serious Incidents Requiring Investigation*
SJR	*Structured Judgement Review*
SLA	*Service Level Agreement*
SMR	*Standardised Mortality rate – see Mortality Rate*
SMT	*Senior Management Team*
SPF	*Social Partnership Forum*
SpR	*Specialist Registrar – medical staff grade below consultant*
ST DR	*Specialist trainee doctors*
STEIS	*Strategic Executive Information System*
STP	*Sustainability and Transformation Plan/Partnerships*

T

TARN	*Trauma Audit Research Network*
TOR	*Terms of Reference*
TU	*Trade Union*
TUPE	*Transfer of Undertakings (Protection of Employment) Regulations 2006*

V

VC	*Vice Chairman*
VSM	*Very Senior Manager*
VTE	*Venous Thromboembolism*

W

WTE	*Whole Time Equivalent*
WY&H HCP	*West Yorkshire and Harrogate Health Care Partnership*
WYAAT	*West Yorkshire Association of Acute Trusts*

Y

YTD	*Year to Date*

Further information can be found at:
NHS Providers – Jargon Buster –
http://nhsproviders.org/programmes/governwell/information-and-guidance/jargon-buster

January 2019