

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

**On: Wednesday 22 July 2015**

**Start: 0900 Finish: 1230**

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

<b>AGENDA</b>			
<b>Item No</b>	<b>Item</b>	<b>Lead</b>	<b>Paper Number</b>
<b>0845 Rapid Process Improvement Workshops Update – Mr David Plews, Deputy Director of Innovation and Partnerships</b>			
<b>0900 –</b>			
<b>0930 General Business</b>			
<b>1.0</b>	<b>Welcome and Apologies for absence:</b> <i>To receive any apologies for absence;</i>	Chairman – Mrs Sandra Dodson	
<b>2.0</b>	<b>Declarations of Interest and Board of Directors Register of Interests</b> <i>To declare any interests relevant to the agenda for the meeting and to receive any changes to the register of interests pursuant to section 6 of the Board Standing Orders</i>	Chairman – Mrs Sandra Dodson	2.0
<b>3.0</b>	<b>Minutes of Board of Directors meeting held on 24 June 2015</b> <i>To review and approve the Minutes</i>	Chairman – Mrs Sandra Dodson	3.0
<b>4.0</b>	<b>Review of Actions schedule and Matters Arising</b> <i>To review the actions schedule and provide updates on progress of actions to the Board of Directors.</i>	Chairman – Mrs Sandra Dodson	4.0
<b>0930 -</b>			
<b>1030 Implementing the Strategic Plan</b>			
<b>5.0</b>	<b>Report by the Chief Executive</b> <i>To be noted</i>	Chief Executive – Dr Ros Tolcher	5.0
<b>6.0</b>	<b>Integrated Board Report</b> <i>To be noted</i>	Chief Executive – Dr Ros Tolcher	6.0
<b>1030 –</b>			
<b>1045 Break</b>			
<b>1045 –</b>			
<b>1115 Putting Patients First</b>			
<b>7.0</b>	<b>Report by the Medical Director</b> <i>To be noted</i>	Medical Director – Dr David Scullion	7.0
<b>8.0</b>	<b>Report by the Chief Nurse</b> <i>To be noted</i> <i>To include Action Plan from Morecambe Bay Inquiry</i>	Chief Nurse – Mrs Jill Foster	8.0
<b>9.0</b>	<b>Report by the Chief Operating Officer</b> <i>To be noted</i>	Chief Operating Officer – Mr Robert Harrison	9.0

<b>1115 –</b>			
<b>1125 Managing Resources Efficiently</b>			
<b>10.0</b>	<b>Report by the Director of Finance</b> <i>To be noted</i> <b>Quarterly report on Cost Improvement Programme</b>	Director of Finance – Mr Jonathan Coulter	10.0
<b>1125 –</b>			
<b>1135 Valuing and Rewarding Staff</b>			
<b>11.0</b>	<b>Report by the Director of Workforce and Organisational Development</b> <i>To be noted</i>	Director of Workforce and Organisational Development – Mr Phillip Marshall	11.0
<b>1135 –</b>			
<b>1220 Governance</b>			
<b>12.0</b>	<b>Reports from Directorates</b> <i>i. Acute and Cancer Care</i> <i>ii Elective Care</i> <i>iii Integrated Care</i>	Clinical Director - Mr Andy Alldred Clinical Director - Dr Kat Johnson Clinical Director - Dr Peter Hammond	
<b>13.0</b>	<b>Report on Assurance Issues by the Chief Executive</b>	Chief Executive – Dr Ros Tolcher	
<b>14.0</b>	<b>Reports:</b> <i>To receive the Minutes of, and oral report from, Board Committees:</i> <i>i. Finance Committee – 21 April 2015</i> <i>ii. Quality Committee –</i> <i>to approve the Terms of Reference</i>	Committee Chairman - Mrs Maureen Taylor (Non-Executive Director) Committee Chairman - Mrs Lesley Webster (Non-Executive Director)	14.1 14.2
<b>15.0</b>	<b>Serious Complaints / Incidents/matters relating to compliance with the Trust's Licence or other exceptional items to report or that have been reported to Monitor and/or the Care Quality Commission</b> <i>To receive an update on any matters reported to regulators.</i>	Chairman – Mrs Sandra Dodson	
<b>1220 –</b>			
<b>1230</b>			
<b>16.0</b>	<b>Any Other Relevant Business</b> <i>By permission of the Chairman</i>	Chairman – Mrs Sandra Dodson	
<b>17.0</b>	<b>Board Evaluation</b>	Chairman – Mrs Sandra Dodson	
<b>18.0</b>	<b>Confidential Motion</b> <b>The Chairman to move:</b> <i>'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'.</i>		

### **BOARD OF DIRECTORS – REGISTERED DECLARED INTERESTS**

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

The register is maintained by the Foundation Trust Office.

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

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

**July 2015**

**Report Status: Open**

## **BOARD OF DIRECTORS**

Minutes of the Board of Directors meeting held on Wednesday 24 June 2015 at 9.00am in the Board Room, Harrogate District Hospital.

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

**In attendance:** Mr A Alldred, Clinical Director, Acute and Cancer Care Directorate  
Dr Claire Hall, Joint Deputy Medical Director  
Dr P Hammond, Clinical Director, Integrated Care  
Dr K Johnson, Clinical Director, Elective Care  
  
Mr A Forsyth, Interim Head of Corporate Affairs (Minutes)  
  
Three Governors of the Trust, two members of the public

Mrs Dodson welcomed the Governors and public to the meeting and reminded them that although this was a public meeting they could attend only as observers, with no right to speak or ask questions.

### **1. Apologies for Absence**

There were no apologies for absence. Mrs Dodson welcomed Dr Hall to the meeting.

### **2. Declarations of Interest**

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

### **3. Minutes of the meeting of the Board of Directors on 27 May 2015**

3.1 The draft Minutes of the meeting were accepted as a true record.

#### 4. Review of Actions Schedule and Matters Arising

Action 2 – Mr Forsyth gave a verbal report. The position had improved and all the required reports were in hand and expected to be submitted by the required deadline. A new study was underway into the care of patients admitted to acute secondary care hospitals who have significant mental health conditions. Mrs Dodson welcomed the improvement and asked whether in future these NCEPOD reports should be considered by the Quality Committee. Dr Scullion said that they would be received by the Strategic Safety Group and reported to the Quality Committee. Professor Proctor was reassured that the Board would continue to receive updates on a six-monthly basis, with the next report due in September. **Action: Dr Scullion**

Action 3 – this would be covered under Agenda paper 4.1 at the meeting – Action complete.

Action 4 – Dr Scullion reported that the timetable for medical education lectures was being drawn up and contact had been made with Professor Marks. When details were finalised Dr Scullion would circulate the dates to the Board. Action complete.

Action 5 – Mrs Foster had included an update in her report at Item 8 of the Agenda. Action complete.

Action 6 – Mrs Webster said that the Quality Committee would discuss this at its first meeting in the following week. Dr Tolcher said that it was important to stay close to the subject and give it close scrutiny. Mr Alldred said that an update would be given to the Quality Committee in June and a full report in July. Actions were in place to take the issue forward. He intended to bring a report to the Board, through the Quality Committee, in September. **Action: Mr Alldred**

Action 7 – Mrs Dodson had revised the Terms of Reference of the Senior Independent Director and Mr Ward acknowledged that he had received a copy. Action complete.

Action 8 – Mrs Foster had made the required adjustment in her report at Item 8. Action complete.

Action 10 – the meeting had taken place. Action complete.

Action 11 – Mrs Dodson said that this had been discussed in the context of the Lampard report. The report had stated that Trusts should restrict open Internet access in the hospital setting but it was considered that this was inappropriate. Mrs Foster said that, on the contrary, there was a move towards greater provision for patients. In order to allay fears of potential for grooming, the Trust policy should be about the expectations for parents and reminders about safe access. It was agreed that the risk in hospital was no greater than anywhere else with Internet access. Dr Tolcher wished to improve access to the internet for people in hospital as part of improving patient experience. The message from the Department of Health was to increase access, with the right safeguards and said that the Trust was exploring a system of providing free WiFi access for staff and patients.

Professor Proctor asked whether the policy on Internet use by staff in work time was clear. Dr Scullion said that staff should be trusted; they understood the rules and were aware of the penalties for any transgressor. Mr Ward said that the Trust should just move forward to provide the service - it was wrong not to provide it. Mr Harrison gave more details about the work which was underway with a local company to

provide free WiFi, with little capital investment required by the Trust. This would be public WiFi – the existing, secure Trust system would remain in place. Dr Scullion commented that the Trust would need to take a view on the advertising which was likely to be associated with a free system and Mr Harrison confirmed that Harrogate Borough Council had reached a satisfactory agreement and was using the system satisfactorily. Action complete.

Action 12 – The response to Monitor had been cleared by the Chairman and Chief Executive, as delegated, and submitted. Action complete.

Action 13 – Mr Harrison and Mr Ward had discussed the issue. Action complete.

Action 14 – Mrs Dodson had forwarded the necessary details. Action complete.

Action 15 – Mrs Dodson had reported that the Remuneration Committee had met. There had been no guidance issued by the Department of Health. Action complete.

There were no other Matters Arising.

#### **4.1. Board of Directors – Terms of Reference**

4.1.1 The draft revised Terms of Reference of the Board had been circulated in advance of the meeting and were taken as read.

4.1.2 Professor Proctor welcomed the revised draft. She noted the section on Leadership and Culture and wondered whether the Board took sufficient time to be assured about the embedding of the Duty of Candour across the Trust. Dr Tolcher said that she had been impressed at the way in which the organisation had embraced the Duty of Candour and staff were dealing with issues 'up front'. The Executive team would be discussing this, in the context of vision and values, at its awayday on 2 July. She said that there was not yet a consistent narrative across the Trust and the challenge was how to describe the overall direction of travel and she intended to do this visually, disseminating this widely across the staff, and she would bring this to the Board at a later date.

**Action: Dr Tolcher**

4.1.3 Dr Scullion said that the Consultant Forum had embraced the Duty of Candour and the message had been that it was a professional duty which had now been enshrined in law. He said where clinicians and staff were in doubt they were encouraged to ask for advice. The right discussions were being had with patients and relatives. He was confident that staff understood what was required of them – indeed, he felt that there was an increasing number of cases where the Duty of Candour did not apply (eg recognise complications which had been explained and consented) but that staff had proceeded as if it had, which he considered to be evidence of good practice.

4.1.4 Mrs Dodson said that it was important to think about clinicians in the community and how well the Duty of Candour could be embedded in the practice of this diverse and dispersed group. Dr Scullion said that the real-time DATIX system was one way in which to keep an eye on this. Mr Alldred said that his Directorate had developed a simple slide pack and the subject had been discussed at departmental and Directorate level – there was also a measure of cross-Directorate conversation about it. Dr Johnson highlighted that it was not always clear whether an incident had been preventable and staff were erring on the side of caution. Dr Hammond said that staff were discussing incidents more and seeking advice. Mrs Dodson said that it was a matter of how to have the conversation.

4.1.5 Dr Tolcher was confident that the systems and processes were in place and it was now a question of ensuring that the behaviour behind them matched the requirement. This would provide the right level of assurance. She said that she wrote personally to every patient or relative (as appropriate) in every case of a Category 3 or 4 pressure ulcer and a fall with harm. This was a different and significant step forward over previous arrangements. Mrs Foster confirmed that District Nurses were having the required conversations in cases in the community.

4.1.6 The draft revised Terms of Reference were **approved** by the Board, subject to correction of minor formatting issues.

## **Putting Patients First**

### **5. Report from the Chief Executive**

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

5.2 Dr Tolcher said that her report was longer than usual because of the large number of communications which had been received from the Department of Health and NHS England. She drew attention to paragraph 8, which covered the requirement for the Board to approve the statement on the CQC rating which had been included on the Trust website. The Board **approved** the statement as presented.

5.3 Moving on to the Patient Safety Visit which she and Mrs Taylor had undertaken, Dr Tolcher said that the Ophthalmology department had a large number of staff and small rooms. There were workforce pressures which would also be covered when the report was completed.

5.4 The contract discussions with HaRD Clinical Commissioning Group (CCG) were continuing. Dr Tolcher reminded Board members that the acute contract had been a two-year agreement and had therefore rolled on from last year. The contract for community services remained unsigned for 2015-16 and discussions were reaching a watershed. She had held positive one-to-one talks with the Chief Officer of the CCG but the subsequent offer, although enhanced, still fell significantly short of the Trust's requirement for the provision of the level of activity forecast, both inside and outside the hospital. The CCG offer was based on QIPP schemes which were yet to start and for which the Trust had not had sight of robust delivery plans to date. Meanwhile activity levels were up on last year. A further meeting with the CCG was being held on 25 June

5.5 Dr Tolcher said that there had been an additional communication from NHS England which confirmed that the CEO of NHS England had directed NICE to stop work on the Safe Staffing model.

5.6 Mrs Dodson said that she had received a personal letter from the Secretary of State in which Mr Hunt had asked for the views of Trust Chairmen on Very Senior staff salaries and her response was being compiled. Mr Marshall commented that the promised template had not yet been received but Mrs Dodson was confident that she would be able to meet the deadline of 30 June. She would share her response with the Board when it had been despatched.

**Action: Mrs Dodson**



5.7 Dr Tolcher noted that the Harrogate Health Transformation Board had held its monthly meeting and reminded Board colleagues that it covered both New Models of Care and the Ripon Partnership. A Principles document had been prepared, listing the priorities for that Board, but it had been decided at the last meeting that additional work was required. Dr Tolcher said that she would circulate the final version when it was agreed.

**Action: Dr Tolcher**

5.8 Turning to the financial position Dr Tolcher said that the Trust was not quite on plan against the stretch plan, which was designed to generate headroom, primarily for service improvements. In 2014-15 at the same stage there had been a widening gap between income and expenditure whereas this year whilst expenditure was over plan, income was also ahead of plan. A firm grip was being maintained on operational budgets and Cost Improvement Plans.

5.9 Dr Tolcher's said that at the Senior Management Team meeting on 17 June there had been particular emphasis placed on senior clinicians and consultants taking ownership of avoidable harms.

5.10 The interim report from Lord Carter had identified ways in which Trusts might achieve financial savings and the Trust would be examining the potential for making 'quick win' savings on procurement by co-operating with other Trusts through the West Yorkshire Association of Acute Trusts group.

5.11 Dr Tolcher confirmed that many of the measures outlined in the communications from the centre did not apply directly to the Trust, because of the levels of performance achieved, but they were advisory (ie strongly recommended).

5.12 In answer to a question from Mr Thompson, Mr Coulter confirmed that there had been no further detail about the payment of legal costs for negligence claims. He noted that the increase in the CNST premium had been lower than the average due to the performance of the Trust. Dr Scullion said that subscribing to the Sign Up to Safety campaign had also proved beneficial.

5.13 Mr Thompson moved on to ask whether there would be any reduction in the highest scoring strategic risk, the lack of an integrated IT structure, in the foreseeable future. Mr Harrison responded by saying that this was part of the New Models of Care value proposition and that a Task and Finish group was examining this in the context of how to share patient records. There would be significant costs and whilst there was a willingness to find a solution, it was not yet in place. Mr Nicholas (Deputy Director of Performance and Informatics) was representing the Trust on the group.

5.14 Mrs Webster asked about the potential for a reduction in the Trust's Continuity of Service Regulatory Rating which could result from the proposed revision of the Monitor Risk Assessment rating, especially in the context of a deficit against plan. Mr Coulter said that the Trust will respond to the consultation and it was focused on performance against plan. Mr Coulter stated that if the new approach had been in place during 2014/15 then the Trust would have had a rating of 2 (rather than 3) for the first two quarters of 2014-15 and overall a rating of 3 for the year.

5.15 Mr Coulter said that 2015-16 felt 'tight' – the plan will deliver a rating of 4 at year-end but, due to the phasing of the plan, it would only deliver a rating of 2 for months 1 and 2. He would expect the Board to sign off a rating of 3 for the first quarter. The proposed changes would certainly make it harder to achieve high ratings; it would be akin to raising the four-hour target for Emergency Department attendances in December and January to 98%. In common with many Finance

Director colleagues, Mr Coulter stated that he was nervous about the level of financial risk to be managed.

5.16 He noted that the new Risk Assessment Framework would introduce changes to the Accounting officer's Memorandum and introducing a governance risk rating for efficiency, which would include measures to examine delivery of performance through the use of agency staff. Mrs Dodson said that she and Mr Coulter would be attending a briefing session in Leeds on 29 June.

5.17 Mrs Dodson said that it was important to be realistic in the context of a new Parliament. Dr Tolcher said she thought the flurry of communications was evidence of angst at the highest levels of health. The Government had committed itself to providing the additional £8bn which had been requested but the CEO of the NHS had emphasised that the pressure was now on to close the additional £22bn gap. She said that which could be measured would be managed but that doesn't change the underlying position. It was important that Board concentrated on delivering safe, effective care. Mrs Dodson agreed, saying that it was time to deliver whilst maintaining the right balance between quality and financial performance.

5.18 Mr Ward asked about IT disaster recovery arrangements – he thought that the idea of both sites being onsite was unusual. Mr Harrison said that the Trust had two central server rooms, one of which was at higher risk because it was a small room which did not have a back-up power supply. It had been decided to relocate this to a room in the new build area of Strayside wing which would mean that the back-up sites would have independent power supplies. It was considered that the two sites were reasonably separated. Some organisations had back-up sites which were hundreds of miles apart but this brought practical management problems and potential risk. He believed that the proposed solution was robust. Mr Ward said that any issues would be picked up through audit. Mr Thompson wondered whether reciprocal arrangements could be made with another Trust.

5.19 Turning to the contract discussions, Mr McLean said he thought that the CCG was being unrealistic and that the longer there was no agreement the greater the aggregated risk was becoming. He felt that it had gone on too long and asked at what point the Trust would seek to shut down the risk. Dr Tolcher replied that whilst she agreed that the situation had gone on a long time, this was not unusual. The latest written response from the CCG did however raise the scenario that the risk would indeed have to be shut down.

5.20 Mrs Dodson said that in relation to the Carter review she hoped that there will be an internal review and a report to the Board on the outcome and savings to be made. Dr Tolcher said that whilst the report was only an interim version, with the final report due in September, the procurement group would be looking at the longer-term potential to make savings. Mr Coulter said that Lord Carter would include the results from examination of a further 10 Trusts when he reported in September and the Trust would be pragmatic since the outcomes would not be regulatory, providing advice to Boards. Mr Alldred said that pharmacy and medicines optimisation formed a major part of the Carter review and he was part of a national steering group; the Carter recommendations included some new opportunities but were generally in line with current work.

5.21 Dr Scullion said that the work with Comensura on medical staffing costs had provided a positive example of what Lord Carter was recommending. He also cited the letter from Professor Briggs on the costs of some prosthetics as an example of moving to establish most cost effective procurement. On the latter Mr Coulter said

that a session with the orthopaedic department was planned to discuss the Trust approach.

5.22 Mrs Taylor emphasised the importance of the management of absence in reducing costs. She wondered what mechanisms and initiatives were in place. Dr Hammond said that this was discussed at every Board meeting in his Directorate, with a recent emphasis on junior doctor sickness. Under a new policy Clinical Supervisors had to undertake Return to Work interviews on the occasion of every absence and the Therapy lead for the Directorate had an effective and robust protocol which was being shared. The area continued to need focus. Dr Johnson said that there were similar discussions in her Directorate, particularly around theatre staff absences and vacancies.

5.23 Mr Marshall noted that the National Support Team was focussing on the Comensura arrangement as an effective way of managing absence costs. It would look first at nursing costs and then those for medical staff. In terms of costs of staff he believed that there were too many 'exceptional' cases. The West Yorkshire Human Resources Directors would be discussing setting maximum rates for temporary medical staff. On the matter of absence, Mr Marshall was supportive of the work in the Directorates – the rate of sickness absence was better, at 3.9%, but he sought to reduce this to 3%. He also noted that there were still gaps from the regional rotation schemes, which were not helping with keeping staffing costs down. Mrs Dodson wondered whether the high levels of sickness absence for junior doctors made the Trust an outlier – Mr Marshall said that data had not been captured but he felt that the Trust was coming to grips with the issue.

5.24 Dr Tolcher reminded Board members that the Trust was one of six partners in the New Models of Care programme each with the same shared vision; in the case of the Trust this reflected the way in which we already wished to develop. The NHS England team running the programme had visited the partners on 27 and 28 May. The immediate debrief had been positive and Helen Bevan, who was part of the visiting team, had described the systems leadership as the best she had seen to date. The letter which followed expanded on a number of issues including variable levels of commitment in primary care, how to play in the Voluntary and Community sector and give it parity of influence, the need to move quickly from aspiration to realisation, a need for the workforce to be more joined up and a perceived domination by the acute Trust. There were other comments about the availability of skills and expertise, a need to involve non-doctor groups from within primary care and a lack of detail in the logic modelling.

5.25 The next step is to develop the value proposition for submission by 30 June – Dr Tolcher said this would detail the vision, the outcomes and how they would be delivered, as well as the support required. There would be a meeting of partners on 25 June to put the value proposition together. NHS England would meet in early July to make the first apportionment of funding and Dr Tolcher thought that the partnership would be in the middle category of three being ready to start work. She said that the contractual conversations were linked to the value proposition because baseline services need to be funded so that the New Models of Care monies could be disbursed on double-running linked to the change of care pathways.

5.26 On the question of double-running costs Mr Thompson asked whether the Trust would incur the costs and then be reimbursed for them? Dr Tolcher said that this would be the case and there was some risk associated with it. There would be £150,000 for project management but the partners would have to agree a mechanism for recognising and sharing the risk. The Trust was already carrying

system risk from the cessation of funding for the Fast Response Team by North Yorkshire County Council (NYCC). Mr Ward asked whether there had been a reduction of enthusiasm for the programme which Mr Coulter denied saying that it was a question of understanding how the money would need to work. More money in one place would mean less in another. There were calls for more funding in primary care and there also needed to be recognition of the implications of the changing demographics. All this would be discussed at the Harrogate Health Transformation Board with a view to all partners contributing and making the arrangements work in reality.

5.27 Professor Proctor asked how the Voluntary and Community sector, and the public, would be engaged. Dr Tolcher said that two different groups were addressing communications (HDFT and the CCG) and engagement (NYCC and Tees, Esk and Wear Valley NHS Mental Health Trust). It was important to make the arrangements feel local and replicate public involvement at a local level, possibly including Patient Voice Groups. Professor Proctor hoped that best use would be made of social media and Dr Tolcher said the strategies would be multi-faceted.

5.28 Mrs Dodson said that this work was central to the development of the Trust, even without the Vanguard programme and she looked forward to the Board hearing of progress on a monthly basis.

## **6. Integrated Board Report**

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

6.2 Mrs Dodson said that a considerable effort had been invested in developing the report and she was sure that the Board would endorse her thanks to Rachel McDonald for her work. This was a first step on a journey towards fully integrated reporting.

6.3 Dr Tolcher said that the report was comprehensive and up to date and the aim was to develop a single, integrated report to allow the Board to focus on exceptions. She thought that the identification of trends would be particularly helpful. The approach was aligned to that used by Salford Royal NHS Foundation Trust. The longer-term aim would be for this to be the only report brought to the Board, supported by a short narrative from each Executive to focus discussion.

6.4 On a point of detail Dr Scullion said that the phrase 'above national average' in the context of HSMR and SHMI was meaningless.

6.5 Mr Harrison said that he welcomed comments on either the structure or the content of the report. He expected the structure to change and views would be collated and considered with a view to an amended version being produced. Mr Mclean said that the principle should be that this was developmental and it should not be amended every week or every month. It was important to be thoughtful not reactive. He also urged the executive team to think about what the reader needed to see rather than what the author wanted to say. Dr Hammond thought that it should be shared more widely, perhaps with the Directorate Bards and with consultants. Dr Tolcher said that it was a public document and should be shared – Mrs Dodson asked that a glossary be attached to the report, to make it more comprehensible to a wide audience.

6.6 Turning to the content, Mr Ward said he was pleased to see the trends and context for incidents but nothing similar for Significant Incidents Requiring Investigation (SIRIs) and this was inconsistent. He felt that the trends should speak for themselves. Mr Coulter said that the integrated report may be considered differently when the detailed reports were not included in Board papers, which would happen in July.

6.7 Mrs Dodson said that in the context of the new governance structure for the Trust, which provided assurance at a number of levels, it could be a struggle to make the necessary 'leap of faith' to ensure that the new report provided assurance to the Directors. Dr Tolcher said that, with the exception of the Chairman herself, all the Non-Executive Directors were chairman or members of Committees which was part of overall assurance.

6.8 Mr Harrison said looking at trends highlighted starkly the apparent increase in readmissions and this needed to be understood in depth. Dr Hammond said that including percentages would give context to the figures. Some of this was due to how admissions following CAT attendance are coded.

6.9 Dr Tolcher said that it might help to walk through the RAG ratings although there were, as yet, no confidence limits. Mrs Dodson said that more narrative was needed for incidents, SIRIs and Never Events. Dr Johnson said that there had been three SIRIs in Obstetrics with common themes in recent months, these were under investigation but some may have been avoidable. The department had introduced a new screening process for growth restriction which aimed to reduce stillbirth rates. The system in place (which has been introduced nationally by the Perinatal Institute) had not been followed exactly in each case. If it had the stillbirths may have been prevented. Dr Johnson also noted that it is likely that these stillbirths would not have been prevented under the old system. The department had undertaken root cause analysis in each case to identify the (different) learning points. All growth charts were now being reviewed and she expected the outcome of this large task to be brought back to the Board in September.

**Action: Dr Johnson**

6.10 Dr Scullion said that the other cluster of SIRIs had been around drug errors in anaesthesia. There had been speedy action to tie together the learning to avoid any repetition. He had been impressed with the speed of work undertaken around both clusters. There had already been a change of practice in anaesthetic practice to reflect the learning from the SIRIs. He expected to bring the reports to the Board in September.

**Action: Dr Scullion**

6.11 Mr Thompson said that he had been a member of the investigating team for two of the Obstetrics incidents and he commented on the use of the new growth chart. He understood that it was too focused and that other providers had experienced similar issues. Dr Scullion said that it was therefore important that the Perinatal Institute receives feedback and Dr Johnson said that its use was part of a project across the north of England.

6.12 Mrs Dodson said that the report should drive improvement, which should be reflected in the accompanying narrative as well as being identifiable from the trends data. Dr Tolcher said that it would be a 'smoke detector' and Board members would be able to use it to tell them what they needed to know about the organisation.

6.13 Looking at sickness absence rates Mr Marshall said that the end of April figure was 3.91%. The Trust was using a range of techniques to reduce this,

including Return to Work interviews, a health and well-being programme (the SHU programme) and personal stress resilience training. He was optimistic that this would make a difference. Whilst the Trust was well below the regional average rate of sickness absence but he wished to do even better. Mrs Taylor asked about the systems in place to accelerate normal processes for those absent for stress-related reasons. In her experience early intervention was very helpful and the longer such staff were away the worse the condition can be.

6.14 Mr Marshall said he was trying to ensure parity of mental health issues – line managers keep in regular and frequent contact with absent staff and undertake lots of work in support. Where there are acute mental health issues the staff receive rapid support and can self-refer to the Occupational Health team.

6.15 Dr Tolcher asked about the balance between the percentage of staff on short-term sickness absence and those on long-term absence. Mr Marshall said that this always had the same profile and he was content with the position.

6.16 Moving to readmissions, Mrs Dodson invited Mr Harrison to comment on the position shown in the report. Mr Harrison said that the contract with HaRD CCG included a payback sum for readmissions within 30 days of discharge. The Trust was not paid for such readmissions. This was also the case for Leeds CCGs but work is underway to examine the reasons for readmission and agree which activity should be paid for.

6.17 Dr Scullion wondered whether a case note review would have any value. Mr Harrison said that the position was not always clear cut. There were approximately 350 readmissions a month (including CAT, planned, children and oncology which were not included in the figures used to withhold payment). Dr Hammond said that the figure did include readmissions planned by CAT and it might be helpful to have an admission sheet which would record where readmission was avoidable and provide accurate data. Mr Harrison said that a Non-Elective readmission following an attendance at CAT was not counted in the Leeds model. The Trust was trying to learn from the Leeds work, which would allow a focus on those groups with avoidable reasons for readmission.

6.18 Dr Tolcher emphasised that it might be clinically appropriate for a patient to attend at CAT and then return as a Non-Elective patient, but under the HaRD approach this would count as a readmission even though it was clinically appropriate. Mr Harrison said the current framework does not support the CAT approach, whereas Leeds CCG excludes all CAT attendances. In answer to Mrs Webster question Mr Harrison confirmed that the Trust was not paid for the second admission if it was within 30 days of discharge.

6.19 Mr Coulter was concerned that this approach drove a 'do not discharge' mentality, whilst Dr Hammond observed that some readmissions took place within 24 hours of discharge because their care package had failed and this played well into the New Models of Care work. Dr Tolcher said that whatever the reason a readmission is regarded as a failed discharge to the patient. The Trust needed to understand the risk of a 'safe to avoid - safe to discharge' approach.

6.20 Mrs Dodson said that the Trust could not continue to deliver the CAT service without funding. It was a good example of how New Models of Care would change the approach. She then asked about theatre utilisation. Mr Harrison said that the national standard for a green rating was >85% utilisation and for planned care the Trust exceeded this. However, overall the rate had been around 83% for many years.

Mr Ward said there was a need to look at the last 12 months to demonstrate the trend. Mr Harrison said that 85% of the four-hour sessions were used recurrently. It was variable on a daily basis and he said it was not possible to reach 100% utilisation. The times were measured from entering the anaesthetic area to leaving the theatre, not on a seven-day basis. There was a subset of data which measured the available time and resourcing, which he would consider adding. In responding to Mrs Dodson, he said that he would check whether this covered elective work or both elective and non-elective work.

**Action: Mr Harrison**

The classification of cases was dependent on the NCEPOD category. Mr Harrison said that theatre use after midnight was minimised for safety reasons. Dr Johnson said that waiting time for non-elective admissions could affect the data on utilisation.

6.21 Moving to outpatient follow-ups, following a comment by Mrs Dodson, Mr Harrison said that there was a need to agree on the RAG rating for outpatient follow-ups. There was a national view based on clinical condition. Dr Johnson said that junior doctors tended to ask for more follow-ups. Mr Harrison said that there was a need to agree a conditions register with primary care to identify patients for follow-up in secondary care.

6.22 Mrs Dodson emphasised that she did not wish Board members to go into the details of the individual reports and that Executive Directors should only highlight crucial issues.

6.23 Mr Coulter said that he expected the financial position to be improved at the end of June, in terms of the actual position, due to the level of activity forecast and planned for. There were some contractual risks around reablement staff and resilience funding. There were particular spending pressures in relation to pay, especially one-to-one care (which stood at double that of three years ago), which needed further executive discussion. Mr Ward asked for the integrated dashboard report to show income and expenditure separately to show the mix; Mr Coulter said this would be in the narrative. Dr Tolcher said that it was understandable if expenditure over plan was due to higher activity levels, but Mr McLean said that he needed to understand the reasons for this and there was insufficient linkage between expenditure and activity in the current report. Mr Coulter said that of the c£500,000 over expenditure, c£380,000 was not directly activity-related but referred to nurse/medical staff costs.

6.24 Mr Coulter commented that the CIP stretch target had not yet been reached. Turning to the cash position, the HaRD CCG had reversed the agreement to pay one eleventh of the annual contract per month. This had been discussed with the Area Team who were comfortable with an approach that assisted the financial resilience of the Trust at no cost to the CCG. Further negotiations in respect of this issue would continue. The first payment from the loan against the Carbon Energy Fund/Imtech contract had been received in June. Mrs Webster asked whether there would be a delay on capital spending, to which Mr Coulter replied that the payment to CEF would have to be made but that at the end of Q1 there would be a discussion and assessment of what, if any, cash could be released for capital and revenue priorities. There was a need to deliver the anticipated level of activity for June and on 22 June it appeared that the position was slightly ahead of plan. There was momentum behind the achievement of Cost Improvement Programmes and budgets around medical and nurse staffing were a major focus.

6.25 Dr Tolcher asked if there could be a metric showing staff in post vs. planned staff needed. Mrs Webster wondered whether Clinical Directors could include comment on the overall performance of their Directorates. Dr Tolcher said that even

if the RAG rating at Directorate level was Red the overall rating could be Green and Mr Mclean said that in that case he felt that there was an obligation for the Board to be told. Dr Tolcher said that this would be more visible at the committee-level and it would be down to the executive competence and expertise to escalate appropriate issues.

6.26 Whilst noting the 'flat file' approach, Mr Thompson wondered what scope there would be to drill down from the report to the underlying information and make it more interactive. Mrs Dodson said that there was a need to focus on the role of the Board and its Committees – what level of information did the Board need to see to be assured? Professor Proctor said that there needed to be a way of triangulating information from the Committees and they should have a place on the Board agenda. Mr Ward proposed that this should be formalised, with the Minutes of the Committees being presented to the Board and the Chairman of each invited to make an additional, verbal, report. This was **agreed**. **Action: Mr Forsyth**

6.27 Mr Harrison said that it might be possible to generate the capability to embed links to appropriate levels of supporting data (whilst observing patient confidentiality), or to create some electronic reports which could be made available. However, the Board would want to avoid recreating the current set of reports.

6.28 Mrs Dodson said that the structure of the report would be an item for discussion at the Board Development Day on 16 July. All the comments already submitted, any made subsequent to this meeting and those made on 16 July will be collated and considered for inclusion in an improved version of the report, which would be developed for the September Board meeting. **Action: Mr Forsyth**

6.29 Mrs Dodson asked Mr Harrison to comment on the amber rating for operational performance. He replied that this was due to the 14-day cancer standard being rated amber. There had been a significant increase in 14-day referrals for lower gastrointestinal and breast referrals following national campaigns. Along with many other Trusts HDFT had struggled to deliver – the performance in May was above the threshold but the figure for the quarter would be at 93%. Mr Harrison was optimistic about the June performance and expected to deliver a green rating at the end of the quarter. There had been no reduction in the performance against the 62-day standard.

6.30 Mr Alldred said that there had been significant pressure on radiology following this national campaign, but no real increase in follow-ups. Mr Harrison praised the efforts of staff in radiology and endoscopy, who had kept the services running for six and a half or seven days to manage the referrals. Dr Johnson voiced her concerns about the resilience of these staff and Mr Harrison said that nurse endoscopists had been involved in gastroenterology follow-ups.

6.31 Mrs Dodson asked about increased cancer screening and Mr Harrison said that the HaRD CCG had imposed rigorous controls on the criteria for access, in order to reduce costs. Very low numbers exceeded the 31-day threshold and in May one patient had chosen to delay access to the service; if this was the only one in the quarter then it would be excluded.

6.32 Moving to the Sentinel Stroke National Audit Programme, Mr Harrison said that there had been an improvement but that the scoring on thrombolysis had reduced. The Directorate was looking to redesign the process – it was currently a safe pathway but not necessarily the most effective pathway. Mrs Dodson wondered whether there was any correlation between these data and the first item of Dr



Scullion's report. The latter said that it was difficult to comment on the basis of the information available currently and Dr Tolcher said that it was very difficult to obtain source data for such a cross-reference to be made. In absolute terms the figures equated to 67 premature deaths per 160,000. As far as cancer deaths are concerned the Trust rated at 39<sup>th</sup> out of 324 Trusts nationally.

6.33 Dr Hammond commented that the stroke deaths had been flagged up and said that there had been a greater proportion of haemorrhagic stroke historically; Dr Tolcher said that it was a question of turning the data into intelligence which could inform service improvement.

6.34 In closing this discussion Mrs Dodson said that the Integrated Board Report pulled together all aspects of performance and highlighted key issues to which the Board needed to be alerted.

## **7. Report by the Medical Director**

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

7.2 Dr Scullion said that he had used a Cumulative Sum (CUSUM) mathematical model to flag excessive deviation from the normal for mortality. This showed a rate for HDFT of 4.7 for abdominal pain (where 5.0 is the alert threshold). There had been 10 cases and a blind case review had been undertaken. Only one case had so far been identified and that was nothing to do with abdominal pain.

7.3 On a personal note Dr Scullion congratulated Dr Hammond on his appointment as Postgraduate Dean of Medical Education for Yorkshire and Humber, which he would take up at the beginning of August, and thanked him for his support as Clinical Director. Mrs Dodson and the Board echoed these congratulations and thanks to Dr Hammond and she reflected that it was a great accolade both for him personally and for the Trust.

7.4 Mrs Dodson asked whether the Mortality Review Group had looked for any data on deaths at weekends. Dr Scullion said that the percentage of deaths at weekends, at 28%, was broadly in line with weekdays. He would look to investigate the number of deaths which took place within 24 or 48 hours of admission when the admission had taken place on a Thursday or Friday. **Action: Dr Scullion**

## **8. Report by the Chief Nurse**

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

8.2 Mrs Foster noted the improvement in meeting deadlines for responding to complaints from 34% to 52% but conceded that there was still a long way to go to reach a satisfactory standard. The number of reopened complaints was steady at around 12% and she considered this also to be too high – the Trust should be answering complaints satisfactorily first time every time. Mrs Foster said that the Trust should aspire to have no appeals to the Parliamentary and Health Service Ombudsman upheld. Patients and/or relative should be satisfied with the Trust's first response and it was a matter of refining the response templates and language and quality assuring the responses to a higher standard.

8.3 Turning to nurse and midwife revalidation, Mrs Foster emphasised that whilst this would be a personal responsibility, the Trust as the employer should enable staff to satisfy the criteria for revalidation. The aim would be to treat it as business as usual.

8.4 Mrs Taylor wondered why, when the timely response rate was 52% and 12% of complaints required reopening, the Integrated Board Report showed a green rating? Dr Scullion said that he understood the point she was making but away from the detail he believed that the whole process needed root and branch reform. The timeliness and formulaic approach clearly did not answer too many of the complaints received. The Trust was not providing closure and needed to start from scratch.

8.5 Mr Ward endorsed this approach and said that when dealt with properly the process can be supportive. Mrs Webster said that the use of the Duty of Candour made staff recognise where something had gone wrong and acknowledge it before the stage of complaint was reached. Dr Scullion agreed – staff should be tuned in to patient and family concerns and pre-empt the type of circumstances which lead to complaints. This has to be about getting care right so that the overall rate of complaints and concerns is reduced. Mrs Dodson said that Dr Scullion should report back to the Board in July on how the change was being prioritised.

**Action: Dr Scullion**

8.6 Mr Alldred said that answering complaints took up a huge volume of time and that considerable effort was expended to offer an appropriate response. His Directorate had not had any reopened complaints but it took time – he agreed, however, that the Trust needed to improve its performance in this area.

8.7 Dr Hammond concurred. He felt that it was not always the right people who investigated the complaint – greater clinician engagement was needed. The formulaic approach may or may not address issues raised and it was important to understand what the complainant was seeking.

8.8 Dr Johnson noted that if the investigator contacted the complainant this could open up an additional set of issues, which could extend the time taken to complete the investigation.

8.9 Dr Tolcher said that once a patient or relative became aggrieved then they quickly became dissatisfied with any response from the Trust. Staff on the wards should be aware of patients and/or relatives who are unhappy and take action to investigate that at an early stage.

8.10 Mrs Dodson said that she considered this subject should be brought back direct to the Board, although under the new governance arrangements she thought that the Quality Committee would ordinarily monitor progress on complaints management. Dr Tolcher noted that it would be the business of the Patient Experience Group, which would report to the Senior Management Team.

8.11 Finally Mrs Dodson asked Mrs Foster to comment on her visit to Salford Royal NHS Foundation Trust. Mrs Foster said the visiting team had been energised and excited, envious of the real estate and of the staffing levels they had seen. The nurse accreditation scheme for beacon wards of excellence had been of particular interest; ownership at ward level appears to drive improved quality of care. The next step was to see whether a similar scheme could be developed at Harrogate and she would bring her proposals back to the Board in due course. **Action: Mrs Foster**

## **9. Report by the Chief Operating Officer**

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

9.2 Mr Harrison asked Board members to note the results of the national Inpatient Survey in which the Trust had ranked fifth nationally (when specialist Trusts are excluded) and tenth out of 140 acute Trusts overall. He commented that the CQC Intelligent Monitoring rating had reverted to 6 (the lowest band) after being at 5 for the last assessment.

9.3 Mr Thompson asked for more reference to community services in the Integrated Board Report, including the number of child/adult visits. Mr Harrison said that he had anticipated the New Models of Care and that the activity was not included in the Integrated Board Report. He would look at including details in the performance report using proxy measures where direct data was not available. Dr Hammond said that this had been discussed at his Directorate Board and one of the issues was that visits were made in a 12 – 15 month window rather than strictly against a 12 month standard. Mrs Dodson hoped that there would be improved information on markers.

## **Managing Resources Efficiently**

### **10. Report by the Director of Finance**

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

10.2 Mr McLean asked what was driving the increased expenditure and Mr Coulter confirmed that it was a combination of increased activity and higher staff costs. £180,000 was attributed to non-activity expenditure. Mr Marshall said that increased activity had also driven up medical staffing costs.

10.3 Mr Coulter said that there had been discussions about what services might be halted if necessary (for example where the community contract did not cover the cost of delivering the existing service) but that some services attracting higher costs but delivering higher activity (for example Sunday endoscopy clinics) would continue.

## **Valuing and Rewarding Staff**

### **11. Report by the Director of Workforce and Organisational Development**

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

11.2 Mr Marshall said that he was delighted to report that the Trust had won an award from the Healthcare People Management Association for the incremental pay progression policy. As a result he had been asked to speak at the national HR Directors' meeting. He wished to thank the Trades Unions who, through the Partnership Forum, had been very supportive of the policy.

## DRAFT

11.3 On the subject of Disclosure and Barring Service checks, he commented that he was examining how the new arrangements would be resourced.

11.4 Mr Marshall said that he was investigating the potential for accessing matching European funding for education and training through the Leeds Local Enterprise Partnership.

11.5 With mixed feelings Mr Marshall informed Board members that Polly McMeekin, his deputy, would be leaving the Trust at the end of August to take up a similar role at York Hospitals NHS Foundation Trust. Applications for the vacated post would close on 13 July. Members of the Board joined Mr Marshall in congratulating Ms McMeekin on her appointment and wished her well.

11.6 Mr Marshall drew attention to his report on the Yorkshire and Humber Social Partnership Forum and asked that the Board endorse and support the statement attached to his report. The Board **agreed** to endorse and support the statement.

11.7 Mrs Dodson said that she would write to congratulate Michelle Ireland on her national award as 'Most Inspiring Student' for the Specialist Community Public Health Nursing Diploma.

**Action: Mrs Dodson**

11.8 Mr McLean commented that he had experience of generating 'matched funding' in European terms and could offer his advice to Mr Marshall.

11.9 Professor Proctor was concerned about the conditions placed on the Trust following the visit of the Local Education and Training Board team. Dr Hammond said that a locum gastroenterologist had been employed and there was increased support for junior doctors. The improvements were being built into substantive Job Plans.

11.10 Mr Thompson wondered about improving the rate of appraisals in the Integrated Care Directorate and Dr Hammond said that he was focused on problematic areas.

### **Assurance**

#### **12. Report of Harrogate Health Transformation Board**

12.1 Dr Tolcher had no assurance issues to report.

#### **13. Reports**

13.1 Mrs Dodson confirmed that there were no written or oral reports.

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

14.1 Mrs Dodson confirmed that the response to the Lampard Report had been despatched to Monitor on 15 June.

#### **15. Any Other Business**

15.1 Mrs Dodson said that the Terms of Reference stated that the Board would meet for a minimum of 10 times a year. In the absence of any compelling business

she indicated that there would not be a Board meeting in August, and a final decision would be made before the July meeting of the Board on Wednesday 22 July.

## **16. Board Evaluation**

16.1 Mrs Dodson said that the meeting had a different feel to it, featuring the piloting of the Integrated Board Report. Dr Scullion thought it had worked well, being more flexible and he felt that the discussion had been more buoyant.

16.2 In agreeing, Professor Proctor was concerned that hotspots might be masked by a green rating on the Integrated Board Report. Mrs Dodson said that it would be important to look at the data on some green ratings at every meeting. Mrs Taylor said that the narrative should reflect any hotspots. She liked having all the information in one place in the Integrated Board Report, which she thought was a good start.

16.3 Mr McLean agreed that it was important not simply to scan for the Red and Amber ratings but to read the detail of the Green ratings and flag issues. Mrs Webster said her questions on the individual reports had been answered in the Integrated Board Report. Mr Ward said that the new report represented good progress and he looked forward to the Minutes of the Board Committees coming to Board, as these would give supporting detail.

16.4 Mrs Dodson said that she would be working to reshape the Board Agenda to take into account comments from Board members, to ensure that what was in the Integrated Board Report was not duplicated elsewhere. She thought that the report had stimulated good conversations.

16.5 Dr Tolcher wondered whether the Clinical Directors should have a dedicated item on the Agenda, to strengthen clinical leadership and enable Directorates to give updates.

16.6 In closing the meeting Mrs Dodson thanked the Governors and member of the public for attending and then moved the Confidential Motion.

## **17. 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 12.32pm.

## HDFT Board of Directors Actions Schedule – July 2015

### Completed Actions

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

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

Item Description	Director/ Manager Responsible	Date due to go to Board or when a confirmation of completion/progress update is required	Confirm action Complete or detail progress and when item to return to Board if required
Include average mortality <i>indices</i> in monthly Board report	Dr Scullion, Medical Director	April 2015	Complete
Write to Dr Law to acknowledge term as DPGME	Mrs Dodson, Chairman	April 2015	Complete
Arrange publicity around RCoA accreditation of Anaesthetic Department	Mr Forsyth, Interim Head of Corporate Affairs	April 2015	Complete
Discuss Hospedia system with Mr Thompson	Mr Coulter, Deputy Chief Executive and Director of Finance	April 2015	Complete
Commentary and Action Plan on report of Deanery visit	Mr Marshall, Director of Workforce and Organisational Development	April 2015	Complete
Revise Board Terms of Reference iaw comments and new template	Mr Forsyth, Interim Head of Corporate Affairs	June 2015	Complete
Circulate to NEDs dates of medico-legal lectures by Professor Marks	Dr Scullion, Medical Director	June 2015	Complete
Report on communications campaign around nurse and midwife revalidation	Mrs Foster, Chief Nurse	June 2015	Complete
Include role as Board focus for 'whistleblowing' in TsofR for post	Mrs Sandra Dodson - Chairman	June 2015	Complete
Show trajectory of progress with pressure ulcers and falls with fractures	Mrs Foster, Chief Nurse	June 2015 <i>etc seq</i>	Complete
Meet with Professor Proctor to consider response to Lampard Review	Mrs Foster, Chief Nurse	June 2015	Complete
Discuss Wi-Fi provision in the hospital with NHS Providers and other partnerships	Mrs Foster, Chief Nurse	June 2015	Complete
Complete response to Lampard Report and submit after approval from Mrs Dodson and Dr Tolcher	Mrs Foster, Chief Nurse	June 2015	Complete

Discuss impact of changes to admission arrangements with Mr Ward	Mr Harrison (Mr Nicholas), Chief Operating Officer	June 2015	Complete
Forward details of other providers' plans to Mr Ward	Mrs Dodson, Chairman	June 2015	Complete
Report results of Remuneration Committee	Mrs Dodson, Chairman	June 2015	Complete

## **HDFT Board of Directors Actions Schedule – Outstanding Actions**

### **July 2015**

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

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

<b>Ref</b>	<b>Meeting Date</b>	<b>Item Description</b>	<b>Director/Manager Responsible</b>	<b>Date due to go to Board or when a confirmation of completion/ progress update is required</b>	<b>Detail progress and when item to return to Board if required</b>
1	July 24 2013	Report any future complaints about the LCP to the Board via the Chief Nurse report	Mrs Foster, Chief Nurse	Ongoing	Ongoing
2	April 2015	Board Paper on Admissions (including readmissions) (10.5)	Dr Hammond, Clinical Director, Integrated Care Directorate	<b>July 2015</b>	
3	February 2015	Brief Board on emerging models at next BDD (6.14)	Dr Tolcher, Chief Executive	<b>July 2015</b>	
4	March 2015	Report on Action Plan following Morecambe Bay Inquiry	Mrs Foster, Chief Nurse	<b>July 2015</b>	
5	June 2015	Circulate response to SofS letter to Board members (5.6)	Mrs Dodson, Chairman	<b>July 2015</b>	
6	June 2015	Circulate to Board members agreed HHTB Principles document (5.7)	Dr Tolcher, Chief Executive	<b>July 2015</b>	
7	June 2015	Clarify whether theatre utilisation data including both elective and non-elective procedures (6.20)	Mr Harrison, Chief Operating Officer	<b>July 2015</b>	
8	June 2015	Board Agenda to include monthly reports from, and Minutes of, Committees of the Board (6.26)	Mr Forsyth, Interim Head of Corporate Affairs	<b>July 2015</b>	
9	June 2015	Invite comments on draft Integrated Board Report for final version at September Board	Mr Forsyth, Interim Head of Corporate Affairs	<b>July 2015</b>	



		meeting (6.28)			
10	June 2015	Investigate the incidence of deaths which took place within 24 or 48 hours of admission on Thursdays or Fridays (7.4)	Dr Scullion, Medical Director	<b>July 2015</b>	
11	June 2015	Report to Board on how changes resulting from implementation of Duty of Candour are being prioritised (8.5)	Dr Scullion, Medical Director	<b>July 2015</b>	
12	June 2015	Investigate potential for HDFT to instigate Beacon Wards scheme (8.11)	Mrs Foster, Chief Nurse	<b>tbc</b>	
13	June 2015	Develop and circulate a consistent narrative and direction of travel for the Trust (4.1.2)	Dr Tolcher, Chief Executive	<b>tbc</b>	
14	June 2015	Report on review of growth charts (6.9)	Dr Johnson, Clinical Director, Elective Care	September 2015	
15	June 2015	Mr Lavalette, NCEPOD Ambassador, to report biannually (Mar/Sep) on progress of NCEPOD work (4)	Dr Scullion, Medical Director	September 2015	
16	June 2015	Report progress on GPOOH service (4)	Mr Alldred, Clinical Director, Acute and Cancer Care	September 2015	
17	March 2015	Update on immunisation screening of staff (11.9)	Mr Marshall, Director of Workforce and Organisational Development	September 2015	
18	March 2015	Possible changes to the Remuneration Committee to be discussed by NEDs (14.6)	Mrs Dodson, Chairman	<i>Date to be confirmed</i>	

<b>Report to the Trust Board of Directors:</b> <b>22 July 2015</b>	<b>Paper number: 5.0</b>
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<b>Title</b>	<b>Report from the Chief Executive</b>
<b>Sponsoring Director</b>	Chief Executive – Dr Ros Tolcher
<b>Author(s)</b>	Chief Executive
<b>Report Purpose</b>	To receive and note the contents of the report.
<b>Previously considered by</b>	N/A

**Key Issues for Board focus:**

This report gives brief information on the work of the SMT (Senior Management Team) with more detailed information on performance being contained in the performance dashboard and Executive Director reports.

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

<b>Risk and Assurance</b>	
<b>Legal implications/Regulatory Requirements</b>	No additional risks

**Action Required by the Board of Directors**

The Board of Directors is asked to:

- **Note** the contents of the report
- **Note** the recommendation that future Board Time Out sessions include some dedicated time to scrutinise one or more individual BAF entries to enable more detailed challenge of controls and assurances.

## **1.0 MATTERS RELATING TO QUALITY AND PATIENT EXPERIENCE**

### **1.1 Patient Safety Visits**

There have been no Patient Safety Visits since the last meeting of the Board. The next Patient Safety Visit (to the Emergency Department) is scheduled for 13 August.

## **2.0 STRATEGIC UPDATE**

### **2.1 2015/16 Contract**

Negotiations continue with HaRD in relation to both the acute and community contracts for 2015/16. Key issues remain the level of financial resource within the community service to maintain current levels of service and agreement of an acute contract activity plan that takes into account current pressures and the need to reduce demand in a credible way.

We are reaching a key point in relation to agreeing a contractual framework going forward and I will be able to update the Board verbally at the meeting.

## **3.0 WORKING IN PARTNERSHIP**

### **3.1 New Models of Care (Vanguard Programme)**

Since the last Board meeting the Harrogate Health Transformation Board met to consider our partnership response to the NMC team centrally in relation to our case for support to deliver the model we are developing.

Whilst a lot of work has been undertaken to formulate a value proposition, work is still continuing in respect of the clinical model and the financial impact and clinical outcomes. We therefore wrote to the NMC team to update them of our progress and agree that we will submit further information in relation to a support package by the middle of August. This support package will include

- Request for expertise (for example in relation to patient flow modelling and contractual mechanisms)
- Request for one-off underpinning work in relation to OD, training and IT
- Request for double-running costs for the implementation of the new model

A key discussion has been the 'value' that this new model is aiming to deliver and the shape of services and financial flows once the new model is in place and double-running support ceases.

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

As I reported last month we met as a group of Trusts in June and agreed a number of workstreams and workstream leads to help progress the aim of supporting providers to deliver clinically and financially sustainable services into the future.

As part of this work, a Vanguard proposal is being developed in relation to the Acute Provider Collaboration programme. The process of applying is similar to the

Vanguard process we have already undertaken successfully in Harrogate, with the proposal to be submitted by 31 July 2015. The proposal is being pulled together by Airedale Foundation Trust with support and input from the other members of WYAAT.

### **3.3 Harrogate Health Transformation Board**

The HHTB met in June to consider the response to the NMC national team as referred to earlier. We have also developed a Vision and Principles document, which I attach at Annex for information.

A further meeting is scheduled for 23 July with a view to challenging and then finalising the clinical model for further development and implementation.

## **4.0 FINANCIAL POSITION**

The financial position at the end of Q1 is a deficit of £134k (Month 2 cumulative deficit £372k). This is compared to a Monitor plan of a surplus of £70k and an internal stretch target (to generate some headroom for service investment) of a surplus of £420k. Whilst we earned more income than we spent in June and therefore generated a surplus, this remained below what we had planned for.

The focus needs to be on cost control and cost reduction, in particular relating to CIP delivery and nursing and medical staff costs.

The position at the end of Q1 means that at present no funding can be committed to any priority service investments.

## **5.0 SENIOR MANAGEMENT TEAM (SMT) MEETING**

The SMT met on 15 July. I will provide an oral update.

## **6.0 HEALTH SERVICE JOURNAL BEST PLACES TO WORK 2015**

On 7 July 2015 the Health Service Journal and the Nursing Times, in partnership with NHS Employers, announced their top 120 Best Places to Work in the NHS for 2015. Harrogate and District NHS Foundation Trust is one of only two acute providers across the Yorkshire and Humber region to feature on the 2015 list, out of a total of forty nationally. Using data compiled from the 2014 annual staff survey, independent research firm Best Companies Group identified 120 top performing NHS organisations. Data was categorised into seven core areas: leadership and planning, corporate culture and communication, role satisfaction, work environment, relationship with supervisor, training, development and resources, employee engagement and satisfaction.

## **7.0 COMMUNICATIONS RECEIVED AND ACTED UPON**

Following the flurry of national communications last month, there have been fewer communications received recently. The key areas to highlight are set out below.

### **7.1 Monitor Risk Assessment Framework (RAF)**

The consultation on the Monitor RAF has closed. We submitted comments through NHS Providers and we are awaiting feedback. We had a session at our Executive timeout recently on the new RAF, the measures of financial risk and the impact on the Trust. I suggest that this session is repeated for the whole Board once the RAF has been confirmed.

## **7.2 Very Senior Managers Pay**

Following receipt of the letter dated 2 June 2015 from the Secretary of State Rt Hon Jeremy Hunt MP the Trust submitted the mandatory 'Pay Collection Form' to the Department of Health on 29 June 2015. The Secretary of State's letter set out a number of measures in connection with Very Senior Manager (VSM) pay. Specifically the form requested details of any VSM in receipt of basic pay in excess of £142,500 per annum, which is the annual salary of the Prime Minister. The Trust's response confirmed one individual - the Chief Executive whose remuneration is in excess of this figure. The response specifically excludes medical staff remuneration.

## **7.3 RTT standards**

We received joint communication from Monitor, TDA and NHS England with respect to the monitoring of the 18 week standard. This confirmed the initial indication that the measurement of this standard would be simplified.

The letter states clearly that patients' legal right to start non-emergency consultant-led treatment within 18 weeks of referral is unchanged. The monitoring mechanism will be amended however.

The admitted and non-admitted operational standards are being abolished, and the incomplete standard will become our sole measure of patients' constitutional right to start treatment within 18 weeks. This means that from the date of the letter (24 June 2015), no provider or commissioner will receive any form of sanction, whether in the form of regulator investigation/intervention or the levying of financial sanctions, for failing the admitted or non-admitted standards. Over the course of the year the Department of Health, NHS England, Monitor and the NHS Trust Development Authority will formalise these changes through alterations to the Standing Rules Regulations, the NHS Standard Contract, the CCG Assurance Framework, the Risk Assessment Framework and the Accountability Framework respectively.

We will be amending our reporting of this metric to the Board in line with this change, but in operational terms the change will make little difference to the way in which we manage our waiting list and provide elective care.

## **8.0 BOARD ASSURANCE AND CORPORATE RISK**

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

### **8.1 Board Assurance Framework (BAF)**

There have been no changes in BAF scores since last month. There are 12 Risks recorded on the BAF and all were reviewed and updated, where appropriate, on 9 July by the Executive Directors. All BAF entries have action plan progress scores of 1 or 2, which provides assurance that actions to mitigate the existing gaps in controls are being progressed. There are no risks where the actions are either not defined or are delayed.

No new risks have been added to the BAF since last month and no risks have been removed. There has been progress with a number of the Action Plans for a number of the Risks but this has not changed any of the Risk or progress scores.

It is suggested that future Board Time Out sessions include some dedicated time to scrutinise one or more individual BAF entries to enable more detailed challenge of controls and assurances.

The strategic risks are as follows:

Ref	Description	Risk score	Movement since last month and progress score
BAF#1	Lack of Medical, Nursing and Clinical staff	Amber 9	unchanged at 2
BAF#2	High level of frailty in local population	Red 12	unchanged at 2
BAF#3	Failure to learn from feedback and Incidents	Amber 9	unchanged at 2
BAF#4	Lack of integrated IT structure	Red 16	unchanged at 2
BAF#5	Service Sustainability	Red 12	unchanged at 2
BAF#6	Understanding the market	Red 12	unchanged at 2
BAF#7	Lack of robust approach to new business	Amber 8	unchanged at 2
BAF#8	Visibility and reputation	Red 12	unchanged at 2
BAF#9	Failure to deliver the Operational Plan	Red 12	unchanged at 2
BAF#10	Loss of Monitor Licence to operate	Amber 5	unchanged at 2
BAF#11	Risk to current business	Green 4	unchanged at 1
BAF#12	External funding constraints	Red 12	unchanged at 2

Progress Score on Actions:

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

## 8.2 **Corporate Risk Register (CRR)**

The CRR was reviewed at the monthly meeting of the Corporate Risk Review Group on 10 July. There were two new risks to add to the Register and none to be removed.

The highest scoring risk with current risk score of 15 or above remains:

CR 49c: Risk to business objectives due to non-delivery of locality-wide IT system – 16.

The new risks which have been added to the Register are:

CR 3 (EST 1.7): Non HDFT owned premises - risk of harm to patients and staff due to gaps in assurance on building safety i.e. Legionella, Asbestos, electrical installation, gas safety etc. (C4 x L3 = 12)

CR 4 (PH 105): Risk of delays to patient care, financial risk and increased pressure on staff due to inability to prepare parenteral chemotherapy for patients due to failure of only remaining chemo isolator and increased workload due to repatriation of patients to Harrogate. (C4 x L3 = 12)

There has been progress on the Action Plans of most of the Risks, although not to the extent that any Risk score has improved. There are two Risks where the Action Plans are behind plan:

COR 63: Risk of patient harm due to failure to identify and manage mental health and mental capacity needs. Progress is being made but closing the gap in control related to the skills and knowledge of staff will take longer than the previous target date of June 2015. The target date has been extended to December 2015 and the progress score remains as 3 – Actions defined – work started but behind plan.

COR 74: Risk of harm to Ward attenders – progress score 3 – Actions defined – work started but behind plan.

Last month it was reported that CR2: Risk to the quality of service delivery due to the national reduction in trainee numbers had a progress score of 5 – Actions not yet fully defined. This has now been reduced to 2 - Actions defined, work started - because, following a meeting of the Health Education England Local Education and Training Board, an update had been provided for the risk relating to junior medical staff. The gaps in controls have been more clearly defined together with additional mitigating actions to be undertaken. The organisation is out to advert on all vacancies and implementing a number of mitigating steps. The Deanery action plan is being progressed, with exception reporting to ensure satisfactory completion of actions

There were no Risks from the Corporate Risk Register to be added to the Board Assurance Framework.

## **9.0 QUARTERLY RETURN TO MONITOR**

We will be submitting our quarterly monitoring return to Monitor for Quarter 1 at the end of July. This will show a CoSRR of 3 and Green for Governance. Further detail is contained within the Integrated Board Report.

Dr Ros Tolcher  
Chief Executive  
July 2015

Annex::

HHTB – Vision and Principles



## *Local and Personal*

### **HARROGATE HEALTH TRANSFORMATION BOARD**

### **OUR PRIORITIES FOR WORKING TOGETHER FOR BETTER HEALTH IN HARROGATE AND THE RURAL AREA**

#### **Introduction**

The NHS and local government has established a Health Transformation Board to lead our shared vision of better health and social care services in Harrogate, Knaresborough, Ripon, Boroughbridge, Pateley Bridge and the surrounding rural areas.

The Health Transformation Board will operate within the governance arrangements of each participating organisation and the wider partnership system (North Yorkshire Health & well-being Board and Delivery Board, Harrogate Public Services Leadership Board) (Appendix 1)

This document sets out our shared priorities for the next few years. In turn, we will produce an annual work programme which sets out key objectives and milestones for each year. Whilst this document is focused primarily on the adult population, many of the principles and plans apply to children and young people too. Full details of the priorities for children and young people are set out in *Young and Yorkshire* (<http://cyps.northyorks.gov.uk/index.aspx?articleid=13435>), which is a joint strategy produced by North Yorkshire County Council and the NHS.

#### **Our Health**

Of the 32 indicators included in the Public Health England (PHE) Health Profile for Harrogate in 2014 there were 18 that were significantly better than the England



average and 2 that were significantly worse (road injuries and deaths and incidence of malignant melanoma). As elsewhere, nationally and in North Yorkshire, obesity, mental health, smoking and alcohol misuse are significant factors causing poor health.

The area has a diverse and, generally, buoyant, economy. However, housing affordability is a particular issue for Harrogate. The district also has a substantial number of disabled people requiring aids or adaptations to support them in their homes.

Harrogate and its surrounding area have a population density of 121 people per km<sup>2</sup>, above the North Yorkshire average of 75 but well below the national average of 401. Rural deprivation is an issue as well as pockets of deprivation in the towns. The ethnic profile is predominantly white and there are high scores on all domains of the social capital index.

A large and growing number of older people live within the area: it is sometimes said that the Harrogate district is 'ten years ahead' of the national picture in terms of age profile. Many of the older people living within Harrogate district are very active members of the community and it is important to remember that even within the over 85 age group which, nationally, is often portrayed as more likely to need health and social care services, it is only a proportion of people who are significant users of these services.

## Our Vision

Our **ambition** is that people in Harrogate, Knaresborough, Ripon, Boroughbridge, Pateley Bridge and the surrounding rural areas enjoy good health, have access to good services if and when they need them and that they play an active role in making decisions about their own health and their own lives, as well as in influencing how health and social care services are delivered in the area.

We have set out a series of priorities based on our **vision**, which is about working together for better health so that:

- Prevention, self-care and independence are promoted
- When people need care, their needs take precedence over organisational boundaries, and people are cared for as close to home as possible
- The health and social care system delivers high quality, sustainable services
- The health and social care system is financially sustainable, achieves efficiencies and delivers excellent value for money, spending the local pound well
- Successful, thriving health and social care organisations contribute to the better health and the economic growth of the area
- What we do and how we do it is *local and personal* – putting people in control of their health and their lives

## Our Priorities

Our vision is based on the twin pillars of **new models of prevention and care** ('what we do') and **enabling better care** ('how we do it'), which in turn comprise a series of themes and objectives:

Pillars	Objectives
New models of prevention and care	Prevention is better than cure
	Re-designing the space between 24 hour care and community services <ul style="list-style-type: none"> <li>• Consistent 'any door' access to services</li> <li>• Co-located teams in the community</li> <li>• Embedded use of care plans</li> <li>• Prevention of unnecessary admission to hospital or residential and nursing care</li> <li>• Develop urgent care and primary care alternatives to secondary care</li> <li>• Develop mental health services</li> </ul>
	Healthier Places <ul style="list-style-type: none"> <li>• Progressing the Ripon project</li> <li>• Making Harrogate a Dementia Friendly Community</li> <li>• Developing Extra Care and supported living in the area</li> </ul>
Enabling better care	Putting people in control
	New ways of funding services
	A route-map to deliver safe information sharing
	Workforce development
	How we work together

### **Pillar One: New models of prevention and care ('what we do')**

We will work together to ensure that the NHS and local government pound in the Harrogate and rural area is invested well in:

#### **1. Prevention is better than cure**

- To develop a shared approach to universal prevention, including, for example, via the Stronger Communities programme and community development initiatives.

- To establish a shared prevention, information and advice offer, including a gateway to support in the voluntary and community sectors and social prescribing. This will allow people to resolve issues at first point of contact, help themselves and self-care where appropriate, without the need for long-term intervention from the health and social care system.
- To encourage the population to become 'Fully Engaged' (Wanless report) in taking responsibility for their own health and well-being.
- To bridge the gap in life expectancy between the least and the most deprived communities.
- To target individuals known to all partners to improve outcomes and decrease emergency admissions. *(Harrogate Public Services Leadership Board objective)*
- To develop local approaches which tackle major local health challenges such as alcohol misuse, obesity, loneliness and poor mental health and smoking.
- To ensure parity of esteem across mental and physical health.
- To support community resilience and to ensure a consistent approach across urban and rural areas.
- To reduce feelings of social isolation and loneliness due to rurality and the ageing population. *(Harrogate Public Services Leadership Board objective)*
- To support individuals and communities to aspire to have a positive sense of emotional health and well-being. *(Harrogate Public Services Leadership Board objective)*
- To develop the Healthy Child Programme, providing universal and targeted interventions to support children, young people and their families at home, at school and in the community, from 0-19

## **2. Re-designing the space between 24 hour and community services**

### **2.1 Consistent 'any door' access to services**

- To introduce consistent, 'any door' access, for people needing support to manage long term conditions and to prevent avoidable admission to hospital or 24 hour care.

### **2.2 Co-located teams in the community**

- To bring community health and social care teams, including mental health workers, closer together through co-location in community hubs, with better partnership working across primary and secondary care and wider community support (including domiciliary care and care homes)

### **2.3 Embedded use of care plans**

- To realise the benefits of case finding and anticipatory care planning

### **2.4 Prevention of unnecessary admission to hospital or residential and nursing care**

- To develop an integrated approach to intermediate care and reablement services.
- To continue to develop enhanced support to care homes.
- To stabilise and develop the nursing and residential care sector within the area, as part of North Yorkshire-wide market development initiatives.
- To further develop mental health liaison services.

### **2.5 Develop urgent care and primary care alternatives to secondary care**

- To consider options for the development of a network of urgent care and primary care centres and to prototype the best models aligned to primary and secondary care

### **2.6 Develop mental health services**

- To develop children and young people's emotional and mental well-being and specialist mental health services as part of North Yorkshire-wide service developments.
- To further develop inpatient mental health services for adults in the area.
- To develop the local approach to Improving Access to Psychological Therapies.
- To ensure social care mental health services play a distinctive role within integrated mental health services, as part of the North Yorkshire-wide review of the role of mental health in social care.
- To implement the multi-agency North Yorkshire Mental Health Strategy and agree priorities for local delivery within Harrogate.

## **3. Healthier places**

### **3.1 Progressing the Ripon project**

- To progress plans for a health hub incorporating new build(s), and new care models, and enhanced leisure facilities with defined benefits realisation.
- To progress plans for a new build and new care models with defined benefits realisation.

### **3.2 Making Harrogate a Dementia Friendly Community**

- To develop and agree a shared ambition for making the Harrogate district a dementia friendly community, and to utilise systems leadership approaches to progress plans with public, voluntary and business partners.

### **3.3 Developing Extra Care and supported living in the area**

- To develop the extra care housing and supported living model to support more people in the area to live independently.

## **Pillar Two: Enabling better care ('how we do it')**

### **4. Putting people in control**

- To develop our approach to involving the public in shaping and designing services and making shared decisions about their care and their lives.
- To develop the evidence on benefits realisation, through the person's story and experience and measurable metrics.
- To develop the local approach to personalisation, including personal health and social care budgets and direct payments.

### **5. New ways of funding services**

- To develop a system for obtaining patient / customer-linked data sets on cost, related to outcomes/value added and using this data to inform new types of resource allocation, budget alignment and contract (e.g. capitation).
- To explore opportunities to align and pool commissioning budgets and to develop shared service specifications where appropriate.
- To deliver both efficiencies and real cost reductions and savings as the overall investment funding available to the system reduces by 2020

### **6. A route-map to deliver safe information sharing**

- To develop shared access to information and shared records and key information – across agencies and for person-held data.

## **7. Workforce development**

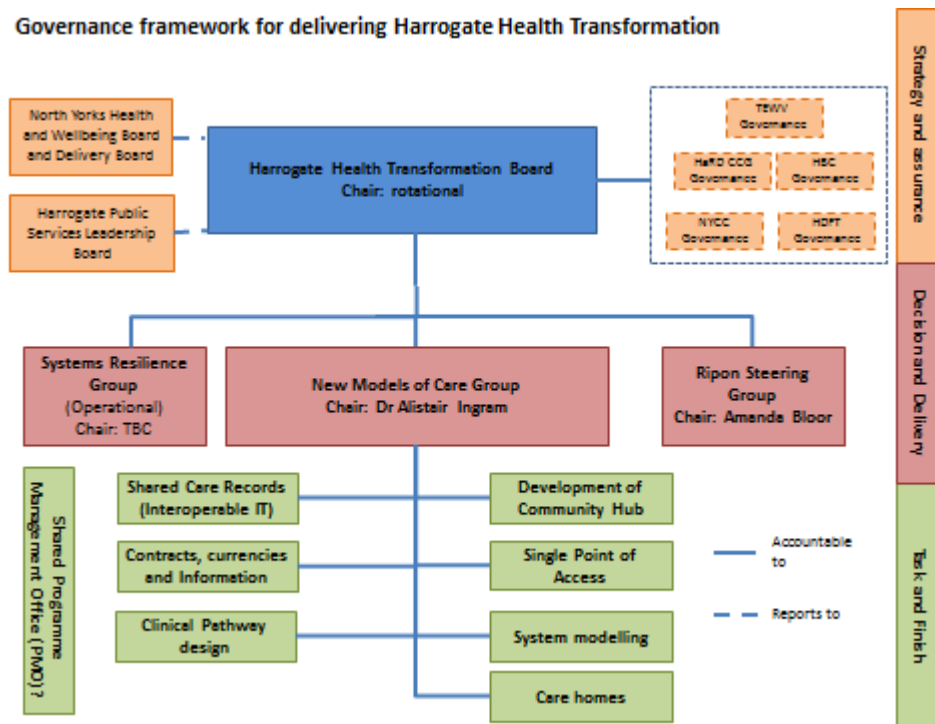
- To develop local approaches, and to inform North Yorkshire-wide initiatives, to develop the workforce and recruit and retain the right people for the right roles in health and social care across the public, independent and voluntary sectors.

## **8. How we work together**

- To promote staff involvement in how we improve the health of the population and develop our services.
- To develop the behaviours, cultures and new ways of working that will be required to deliver our vision and priorities for the future.

## APPENDIX 1

Governance framework for delivering Harrogate Health Transformation



<b>Report to the Trust Board of Directors: 22 July 2015</b>	<b>Paper No: 6.0</b>
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<b>Title</b>	<b>Integrated Board Report</b>
<b>Sponsoring Director</b>	Dr. Ros Tolcher, Chief Executive
<b>Author(s)</b>	Rachel McDonald, Head of Performance & Analysis
<b>Report Purpose</b>	For information

## Key Issues for Board Focus:

- The Trust will report to Monitor a continuity of services risk rating of 4 and a governance rating of green for Q1 2015/16.
- The two red rated indicators in this month's report are Cash balance and Agency spend in relation to pay spend.
- A glossary and detail of the traffic light criteria applied to each indicator have been added to this month's report.

## Related Trust Objectives

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

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

## Action Required by the Board of Directors

That the Board of Directors **note** the information provided in the report.



## Quality

Indicator	Description	Trend chart	Narrative
<b>Safety thermometer - harm free care</b>	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.		<p>HDFT's performance has improved over the last 2 years and the Trust has reported a harm free percentage above 95% for the last 8 months.</p> <p>The Trust reported 97.1% harm free care for June 2015, the highest harm free percentage ever reported by the Trust. The latest available national data shows that the national average is just below 94%.</p>
<b>Pressure ulcers</b>	Shows the number of grade 3 or grade 4 pressure ulcers acquired whilst the patient was in receipt of our care. The data includes hospital and community teams.		<p>The total number reported for June 15 was 8 (all grade 3), an increase on the previous month.</p> <p>The charts shows grade 3 or grade 4 pressure ulcers acquired whilst the patient was in receipt of our care. A root cause analysis is carried out for each case to determine whether the pressure ulcer was "avoidable" - for the 10 pressure ulcers reported in Q4 2014/15, 7 were identified as HDFT attributable with 4 of those identified specifically as being avoidable.</p>
<b>Falls</b>	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.		<p>As can be seen from the chart, the rate of inpatient falls per 1,000 bed days has been reducing over the last 2 years.</p>
<b>Falls causing harm</b>	The number of inpatient falls causing significant harm, expressed as a rate per 1,000 bed days. The falls data includes falls causing moderate harm, severe harm or death.		<p>There was 1 inpatient fall in June 2015 causing moderate harm.</p>

## Quality

Indicator	Description	Trend chart	Narrative
<b>Infection control</b>	<p>The chart shows the number of hospital acquired C. difficile cases. HDFT's C. difficile trajectory for 2015/16 is 12 cases. The trajectory for 2014/15 was 15 - this was achieved as the Trust reported 9 hospital acquired cases in 2014/15.</p> <p>Hospital acquired MRSA cases will be reported on an exception basis. HDFT reported no hospital acquired MRSA cases during 2014/15 and has a trajectory of 0 cases for 2015/16.</p>		<p>There were 2 cases of hospital acquired C. difficile reported in June 2015, bringing the year to date total to 4 cases at the end of June. The Trust is currently agreeing the process with the CCG for determining which C. difficile cases are due to lapses in care. It is these cases that count towards the Monitor risk assessment framework trajectory.</p> <p>No cases of hospital acquired MRSA have been reported in 2015/16 to date.</p>
<b>Mortality - HSMR</b>	<p>The Hospital Standardised Mortality Ratio (HSMR) is one of two commonly used standardised mortality ratios for in-hospital deaths. It 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.</p>		<p>There is no further update of this data this month.</p> <p>HDFT's HSMR reduced in March to 103.62. It is above the national average but within expected levels. At specialty level, there were two specialties (Respiratory Medicine and Gastroenterology) with a standardised mortality rate above expected levels. The Medical Director and Clinical Lead for General Surgery have carried a clinical case note review of 10 deaths where the initial presenting condition was recorded as abdominal pain.</p>
<b>Mortality - SHMI</b>	<p>The Summary Hospital Mortality Index (SHMI) is one of two commonly used standardised mortality ratios for in-hospital deaths. It 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.</p>		<p>There is no further update of this data this month.</p> <p>HDFT's SHMI reduced in February to 99.28. This is just below the national average and within expected levels. At specialty level, there were two specialties (Geriatric Medicine and Respiratory Medicine) with a standardised mortality rate above expected levels. The Medical Director and Clinical Lead for General Surgery have carried a clinical case note review of 10 deaths where the initial presenting condition was recorded as abdominal pain.</p>
<b>Complaints</b>	<p>The number of complaints received by the Trust, shown by month of receipt of complaint. The criteria define the severity/grading of the complaint with green and yellow signifying less serious issues, amber signifying potentially significant issues and red for complaints related to serious adverse incidents.</p> <p>The data includes complaints relating to both hospital and community services.</p>		<p>Of the 30 complaints received in June, 22 related to medical issues, 2 to nursing issues and the remaining 4 were a combination of issues.</p> <p>There was 1 amber complaint in June.</p>

## Quality

Indicator	Description	Trend chart	Narrative
<b>Incidents - all</b>	The chart shows the number of incidents reported within the Trust each month. It includes all categories of incidents, including those that were categorised as "no harm". The data includes hospital and community services.		The number of incidents reported each month remains fairly static and is generally between 400 and 500. There has been a reduction this month with 396 incidents reported in June 2015.
<b>Incidents - SIRIs and never events</b>	The chart shows the number of Serious Incidents Requiring Investigation (SIRIs) and Never Events reported within the Trust each month. The data includes hospital and community services.		There were no never events or SIRIs reported in June 2015.
<b>Friends &amp; Family Test (FFT) - Staff</b>	The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organisation they work in. Trusts were only required to carry out the survey during Q1, Q2 and Q4 2014/15 so data for Q3 2014/15 is not available. HDFT surveyed all staff for each survey during 2014/15. During 2015/16, a proportion of staff will be surveyed each quarter, which is in line with national guidance.		In the Q1 2015/16 HDFT survey, which involved staff from Acute & Cancer Care Directorate and some staff from the Corporate Directorate, 85.5% of HDFT staff surveyed would recommend the Trust as a place to receive care and 69.5% of HDFT staff would recommend the Trust as a place to work. HDFT's scores are above the most recently published national average for both the % of staff who would recommend the Trust as a place to receive care and as a place to work.
<b>Friends &amp; Family Test (FFT) - Patients</b>	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 includes hospital and community services.		The chart shows the overall score (% patients who would recommend the service) for all HDFT services currently participating in the survey. This includes inpatients and day cases, outpatients, maternity services, the emergency department, some therapy services and some community services (including district nursing, podiatry and OOH). Just under 95% of the 6,100 patients surveyed in June would recommend the service to friends and family.

## Quality

Indicator	Description	Trend chart	Narrative																														
Safer staffing levels	Trusts are required to publish information about staffing levels for registered nurses/midwives (RN) and care support workers (CSW) for each inpatient ward. The chart shows the overall fill rate at HDFT for RN and CSW for day and night shifts. The fill rate is calculated by comparing planned staffing with actual levels achieved. A ward level breakdown of this data is published on the Trust website.		Registered nurse/midwife (RN) staff levels remain around 100%. Care support workers (CSW) staffing levels have increased, particularly at night. This is reflective of the increased need for 1-1 care for some inpatients.																														
Staff appraisal rates	The chart shows the staff appraisal rate over the most recent rolling 12 months. The Trusts aims to have 90% of staff appraised.		The locally reported cumulative appraisal rate for the 12 months to end June 2015 was 75.7%. Data from the 2014 national staff survey suggested that 87% of HDFT had been appraised within the last 12 months.																														
Mandatory training rates	The table shows the most recent training rates for all mandatory elements for substantive staff.	<table><thead><tr><th>Competence Name</th><th>Total Employees</th><th>% Completed</th></tr></thead><tbody><tr><td>Equality and Diversity - General Awareness</td><td>3538</td><td>95</td></tr><tr><td>Fire Safety Awareness</td><td>3538</td><td>83</td></tr><tr><td>Health &amp; Safety</td><td>1329</td><td>98</td></tr><tr><td>Infection Prevention &amp; Control 1</td><td>670</td><td>100</td></tr><tr><td>Infection Prevention &amp; Control 2</td><td>2810</td><td>84</td></tr><tr><td>Information Governance: Introduction</td><td>3267</td><td>82</td></tr><tr><td>Information Governance: The Beginners Guide</td><td>270</td><td>79</td></tr><tr><td>Safeguarding Adults Awareness</td><td>3543</td><td>98</td></tr><tr><td>Safeguarding Children &amp; Young People Level 1</td><td>1330</td><td>98</td></tr></tbody></table>	Competence Name	Total Employees	% Completed	Equality and Diversity - General Awareness	3538	95	Fire Safety Awareness	3538	83	Health & Safety	1329	98	Infection Prevention & Control 1	670	100	Infection Prevention & Control 2	2810	84	Information Governance: Introduction	3267	82	Information Governance: The Beginners Guide	270	79	Safeguarding Adults Awareness	3543	98	Safeguarding Children & Young People Level 1	1330	98	<p>The data shown is for end June 2015. The overall training rate for mandatory elements for substantive staff (excluding recently launched elements) is 90%.</p> <p>Discussions continue with the directorate management teams to ensure non-compliant staff are individually followed up.</p>
Competence Name	Total Employees	% Completed																															
Equality and Diversity - General Awareness	3538	95																															
Fire Safety Awareness	3538	83																															
Health & Safety	1329	98																															
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Information Governance: The Beginners Guide	270	79																															
Safeguarding Adults Awareness	3543	98																															
Safeguarding Children & Young People Level 1	1330	98																															
Sickness rates	Staff sickness rate - includes short and long term sickness. The Trust has set a threshold sickness of rate of 3.9%.		<p>HDFT's staff sickness rate was 3.99% in May 2015, above the Trust threshold level (3.9%) but below the most recently published regional average of 4.5%.</p> <p>Work is continuing to progress the Trust's health and wellbeing agenda.</p>																														

## Quality

Indicator	Description	Trend chart	Narrative
Temporary staffing expenditure - medical/nursing /other	The chart shows staff expenditure per month, split into contracted staff, overtime and additional hours and temporary staff.		The proportion of spend on temporary staff during 2015/16 to date is 6.6%, compared to 7.8% in the same period in 2014/15.
Staff turnover rate	The chart shows the staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. Data from the Times Top 100 Employers indicated a turnover rate norm of 15%, i.e. the level at which organisations should be concerned.		The staff turnover rate has generally increased over the last two years but has reduced slightly in June 2015 to 12.6% and is below the turnover norm of 15%.

## Finance and Efficiency

Indicator	Description	Trend chart	Narrative
Readmissions	% of patients readmitted to hospital as an emergency within 30 days of discharge. To ensure that we are not discharging patients inappropriately early and to assess our overall surgical success rates, we monitor the numbers of patients readmitted. A low number is good performance. This data is reported a month behind so that any recent readmissions are captured in the data.		The number of readmissions within 30 days is increasing. However when expressed as a % of all emergency admissions (black line on the chart), there has been no significant change over the last two years. To support this year's CQUIN requirements, a case note audit of readmissions is being led by the Clinical Director of Integrated Care. The Trust has also been working with the Leeds CCGs to agree an extended set of exclusion criteria for readmissions for which no tariff is currently received under the Payment by Results (PbR) guidance.
Length of stay - elective	Average length of stay in days for elective (waiting list) patients. The data excludes day case patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.		The average elective length of stay for Jun-15 was 2.6 days, a decrease on the previous month.
Length of stay - non-elective	Average length of stay in days for non-elective (emergency) patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.		The average non-elective length of stay for Jun-15 was 5.3 days, a slight increase on the previous month.
Theatre utilisation	The percentage of time utilised during elective theatre sessions only (i.e. those planned in advance for waiting list patients). A higher utilisation rate is good as it demonstrates effective use of resources. A utilisation rate of around 85% is often viewed as optimal.		Theatre utilisation decreased slightly in Jun-15 to 81.0%.

## Finance and Efficiency

Indicator	Description	Trend chart	Narrative
<b>Delayed transfers of care</b>	<p>The proportion of patients in acute hospital beds who are medically fit for discharge but are still in hospital. A low rate is preferable.</p> <p>A snapshot position is taken at midnight on the last Thursday of each month. The maximum threshold shown on the chart (3.5%) has been agreed with the CCG.</p>	<p>Legend: Delayed transfers of care (blue line with diamonds), mean (green line), LCL (red dashed line), UCL (red dashed line).</p>	<p>Delayed transfers of care were at 3.4% when the snapshot was taken in June. This is an increase on the previous month but just below the maximum threshold of 3.5% set out in the contract.</p>
<b>Outpatient DNA rate</b>	<p>Percentage of new outpatient attendances where the patient does not attend their appointment, without notifying the trust in advance.</p> <p>A low percentage is good. Patient DNAs will usually result in an unused clinic slot.</p>	<p>Legend: DNA rate (blue line with diamonds), mean (green line), LCL (red dashed line), UCL (red dashed line).</p>	<p>The outpatient DNA rate for first attendances in Jun-15 was 4.3%, an increase on the previous month.</p>
<b>Outpatient new to follow up ratio</b>	<p>The number of follow-up appointments per new appointment. A lower ratio is preferable. A high ratio could indicate that unnecessary follow ups are taking place.</p>	<p>Legend: Ratio (blue line with diamonds), mean (green line), LCL (red dashed line), UCL (red dashed line).</p>	<p>The new to follow up ratio was 2.02 in June 2015, no change on the previous month.</p> <p>The Deputy Director of Performance &amp; Informatics is leading a review with the CCG of patients who wait longer than 6 months for a follow up appointment.</p>
<b>Day case rate</b>	<p>The proportion of elective (waiting list) procedures carried out as a day case procedure, i.e. the patient did not stay overnight.</p> <p>A higher day case rate is preferable.</p>	<p>Legend: Day case rate (blue line with diamonds), mean (green line), LCL (red dashed line), UCL (red dashed line).</p>	<p>The elective day case rate in Jun-15 was 87.9%. As can be seen from the chart, the day case rate has steadily increased over the last two years.</p>



## Finance and Efficiency

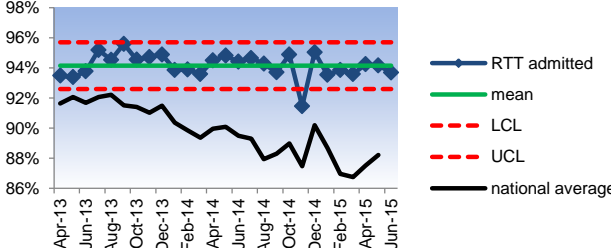
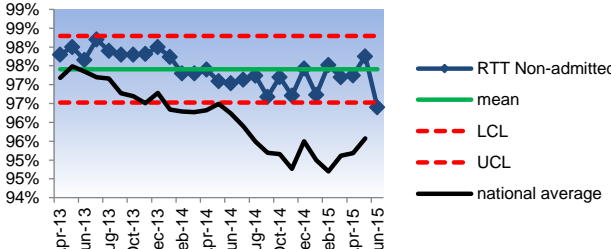
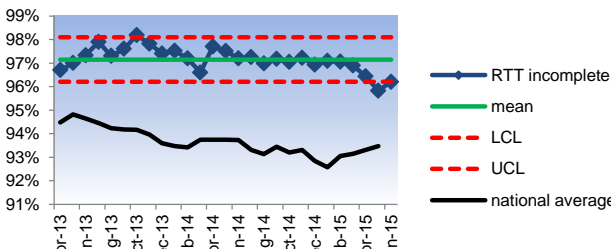
Indicator	Description	Trend chart	Narrative																									
Surplus / deficit and variance to plan	Monthly Surplus/Deficit (£'000s)		The Trust reported a surplus of £238k for June, £398k behind plan. The year to date position is therefore a deficit of £134k, £554k behind the internal plan. This position is also £193k behind the external plan submitted to Monitor which set out a I&E surplus of £59k for Quarter 1. Significant variances in relation to Medical Staffing (£335k), Ward nursing (£273k) and the cost improvement programme (£403k) are the main drivers for this deficit position. These are offset by a favourable clinical income variance of £527k, however, with contracts yet to be agreed there is an element of risk to this.																									
Cash balance	Monthly cash balance (£'000s)		The Trust cash balance is reported at £2,376k for June 2015. This is significantly behind plan. A significant amount is outstanding with HaRD CCG, with estimates between £5-6m. Not all of this is invoiced due to national reporting timescales, however, issues do include 2014/15 reconciliation, agreed cash profile changes and overperformance during Q1.																									
Monitor continuity of services risk rating	The Monitor Continuity of Services (CoS) risk rating is made up of two components, liquidity and capital service cover. An overall rating is calculated ranging from 4 (no concerns) to 1 (significant concerns).	<table><thead><tr><th></th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr></thead><tbody><tr><td>Planned rating - consolidated rating</td><td>3</td><td>4</td><td>4</td><td>4</td></tr><tr><td>Actual rating - capital service cover</td><td>3</td><td></td><td></td><td></td></tr><tr><td>Actual rating - liquidity</td><td>4</td><td></td><td></td><td></td></tr><tr><td>Actual rating - consolidated rating</td><td>4</td><td></td><td></td><td></td></tr></tbody></table>		Q1	Q2	Q3	Q4	Planned rating - consolidated rating	3	4	4	4	Actual rating - capital service cover	3				Actual rating - liquidity	4				Actual rating - consolidated rating	4				<p>The Trust will report a risk rating of 4 for Quarter 1 in line with plan. If the position had been £20k worse the Trust would have reported a 3.</p> <p>The potential new metrics as described in the RAF consultation paper would have resulted in the Trust reporting a risk rating of 3. The consultation has only recently closed and we await feedback.</p>
	Q1	Q2	Q3	Q4																								
Planned rating - consolidated rating	3	4	4	4																								
Actual rating - capital service cover	3																											
Actual rating - liquidity	4																											
Actual rating - consolidated rating	4																											
CIP achievement	Cost Improvement Programme performance outlines full year achievement on a monthly basis. The target is set at the internal efficiency requirement. (£'000s)		<p>75% of plans have been actioned by directorates. A further 14% of plans are in place at present following risk adjustment.</p> <p>Work continues with the directorates to ensure plans are actioned and the planning gap is closed.</p>																									



## Finance and Efficiency

Indicator	Description	Trend chart	Narrative
Capital spend	Cumulative Capital Expenditure by month (£'000s)	<p>£14,000 £12,000 £10,000 £8,000 £6,000 £4,000 £2,000 £-</p> <p>Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar</p> <p>Actual - cum - 2014/15 Actual - cum - 2015/16 Plan - cum - 2015/16</p>	Capital expenditure is in line with planned levels for the year to date. The Carbon Energy Fund scheme is the largest element of this and is expected to continue at planned levels.
Agency spend in relation to pay spend	Expenditure in relation to Agency staff on a monthly basis (£'s).	<p>£600,000 £500,000 £400,000 £300,000 £200,000 £100,000 £-</p> <p>Apr-13 Jul-13 Oct-13 Jan-14 Apr-14 Jul-14 Oct-14 Jan-15 Apr-15</p> <p>Agency spend mean LCL UCL</p>	<p>Despite the overall trend of agency spend reducing over the previous year, there was a significant spike in June. This has been the result of some issues in both medical and nurse staffing.</p> <p>There will be a significant focus on this area at this month's finance and activity meetings which will be fed back at this month's Board meeting.</p>

## Operational Performance

Indicator	Description	Trend chart	Narrative																																							
Monitor governance rating	Monitor use a variety of information to assess a Trust's governance risk rating, including CQC information, access and outcomes metrics, third party reports and quality governance metrics. The table to the left shows how the Trust is performing against the national performance standards in the “access and outcomes metrics” section of the Risk Assessment Framework.	<table><tr><th>Indicator</th><th>Q1 score</th><th>Q1 score</th></tr><tr><td>18 weeks - admitted</td><td>0.0</td><td>Cancer - 31 day first treatment</td><td>0.0</td></tr><tr><td>18 weeks - non-admitted</td><td>0.0</td><td>Cancer - 14 days</td><td>0.0</td></tr><tr><td>18 weeks - incomplete</td><td>0.0</td><td>Cancer - 14-days -breast symptoms</td><td>0.0</td></tr><tr><td>A&amp;E- 4 hour standard</td><td>0.0</td><td>C-Difficile</td><td>0.0</td></tr><tr><td>Cancer - 62 days to treatment</td><td>0.0</td><td>MRSA</td><td>0.0</td></tr><tr><td>Cancer - 62 days to treatment - screening</td><td>0.0</td><td>Compliance with requirements regarding access to healthcare for patients with learning disabilities</td><td>0.0</td></tr><tr><td>Cancer - 31 day subsequent treatment -Surgery</td><td>0.0</td><td>Community services data completeness - RTT information</td><td>0.0</td></tr><tr><td>Cancer - 31 day subsequent treatment - Anti-Cancer drug</td><td>0.0</td><td>Community services data completeness - Referral information</td><td>0.0</td></tr><tr><td>Cancer - 31 day subsequent treatment - Radiotherapy</td><td>N/A</td><td>Community services data completeness - Treatment activity information</td><td>0.0</td></tr></table>	Indicator	Q1 score	Q1 score	18 weeks - admitted	0.0	Cancer - 31 day first treatment	0.0	18 weeks - non-admitted	0.0	Cancer - 14 days	0.0	18 weeks - incomplete	0.0	Cancer - 14-days -breast symptoms	0.0	A&E- 4 hour standard	0.0	C-Difficile	0.0	Cancer - 62 days to treatment	0.0	MRSA	0.0	Cancer - 62 days to treatment - screening	0.0	Compliance with requirements regarding access to healthcare for patients with learning disabilities	0.0	Cancer - 31 day subsequent treatment -Surgery	0.0	Community services data completeness - RTT information	0.0	Cancer - 31 day subsequent treatment - Anti-Cancer drug	0.0	Community services data completeness - Referral information	0.0	Cancer - 31 day subsequent treatment - Radiotherapy	N/A	Community services data completeness - Treatment activity information	0.0	HDFT's governance rating for Q1 is Green.
		Indicator	Q1 score	Q1 score																																						
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		RTT Admitted pathways performance	<p>Percentage of admitted pathways completed within 18 weeks. The national standard is that 90% of admitted pathways to be completed within 18 weeks. The data shown is the adjusted performance which takes into account the effect of any clock pauses along the pathway (where the patient has chosen to delay treatment).</p> 	NHS England announced in June that it will no longer monitor 18 weeks using this measure and will only look at the proportion of incomplete pathways seen within 18 weeks. We will therefore not report this measure in future months. As can be seen from the chart, HDFT has maintained its performance position on this measure despite the national average deteriorating.																																						
RTT Non-admitted pathways performance	<p>Percentage of non-admitted pathways completed within 18 weeks. The national standard is that 95% of non-admitted pathways to be completed within 18 weeks. Clock pauses cannot be applied to non-admitted pathways.</p> 				NHS England announced in June that it will no longer monitor 18 weeks using this measure and will only look at the proportion of incomplete pathways seen within 18 weeks. We will therefore not report this measure in future months. There has been a small deterioration in performance on this measure in June. This is partly due to shifting focus to monitoring the incomplete measure.																																					
						RTT Incomplete pathways performance	<p>Percentage of incomplete pathways waiting less than 18 weeks. The national standard is that 92% of non-admitted pathways to be completed within 18 weeks.</p> 	HDFT consistently perform above national average and above the required standard of 92%. The Trust has recently identified that it had been incorrectly applying clock pauses to this data (national guidance advises that clock pauses should only be applied to completed pathways). This has now been corrected and we are reporting on the revised basis from April 2015 onwards. It is estimated that the impact of this reporting change has reduced the overall % achievement by about 0.5%.																																		

## Operational Performance

Indicator	Description	Trend chart	Narrative
<b>A&amp;E 4 hour standard</b>	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).	<p>Legend: % &lt;4 hours, mean, LCL, UCL, national average</p>	HDFT's overall trust level performance for Jun-15 was 96.4%, above the required 95%. This includes data for the Emergency Department at Harrogate and Ripon MIU. Performance of the main Emergency Department was 95.9%. From 1st May 2015, the Trust has agreed that York Teaching Hospitals NHS Foundation Trust will report the Selby MIU performance within their data.
<b>Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals</b>	Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%.	<p>Legend: % within 14 days, mean, LCL, UCL, national standard</p>	Whilst the Trust achieved the required 93% for each quarter of 2014/15, there has been a deterioration in performance during the year as illustrated in the trend chart. There has been a significant increase in the number of 2 week wait referrals received by the Trust since Q4 2014/15, partly due to the impact of several national and local cancer awareness campaigns. The Trust achieved the 93% standard in 2 out of 3 months during Q1 2015/16 and the overall position for Q1 is above the required 93%.
<b>Cancer - 14 days maximum wait from GP referral for symptomatic breast patients</b>	Percentage of GP referrals for breast symptomatic patients seen within 14 days. The operational standard is 93%.	<p>Legend: % within 14 days, mean, LCL, UCL, national standard</p>	The Trust consistently achieved the 93% standard throughout 2014/15 and 2015/16 to date with performance at 96.5% in June.
<b>Cancer - 31 days maximum wait from diagnosis to treatment for all cancers</b>	Percentage of cancer patients starting first treatment within 31 days of diagnosis. The operational standard is 96%.	<p>Legend: % within 31 days, mean, LCL, UCL, national standard</p>	The Trust achieved 100% throughout 2014/15 and 2015/16 to date.

## Operational Performance

Indicator	Description	Trend chart	Narrative
<b>Cancer - 31 day wait for second or subsequent treatment: Surgery</b>	Percentage of cancer patients starting subsequent surgical treatment within 31 days. The operational standard is 94%.		Only a small number of patients at HDFT are covered by this target which explains the variability in performance for some months. However the Trust is above the required 94% standard for Q1 2015/16.
<b>Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug</b>	Percentage of cancer patients starting subsequent drug treatment within 31 days. The operational standard is 98%.		The Trust achieved 100% throughout 2014/15 and 2015/16 to date.
<b>Cancer - 62 day wait for first treatment from urgent GP referral to treatment</b>	Percentage of cancer patients starting first treatment within 62 days of urgent GP referral. The operational standard is 85%.		The Trust achieved the operational standard of 85% throughout 2014/15 and 2015/16 to date. Performance for May 2015 was at 89.8%.
<b>Cancer - 62 day wait for first treatment from consultant screening service referral</b>	Percentage of cancer patients starting first treatment within 62 days of referral from a consultant screening service. The operational standard is 90%.		Only a small number of patients at HDFT are covered by this target which explains the variability in performance for some months. However the Trust has been above the required 90% standard for each month where the number of pathways reported has been above the de minimis level for reporting performance.

## Operational Performance

Indicator	Description	Trend chart	Narrative
<b>Cancer - 62 day wait for first treatment from consultant upgrade</b>	Percentage of cancer patients starting first treatment within 62 days of consultant upgrade. The operational standard is 85%.		Only a small number of patients at HDFT are covered by this target which explains the variability in performance for some months. However the Trust has been above the required 85% standard for each month where the number of pathways reported has been above the de minimis level for reporting performance.
<b>CQUIN - dementia screening</b>	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.		The Trust has consistently achieved 100% for Step 2 and Step 3 of the dementia screening process. The chart shows the trend in Step 1 of the dementia screening process. As can be seen, HDFT has scored above the required 90% for Step 1 for every month during the period. Performance in May 2015 was at 94.7%. June 2015 data will be available at the end of July.
<b>CQUIN - Acute Kidney Injury</b>	Percentage of patients with Acute Kidney Injury whose discharge summary includes four defined key items.		This data will be reported quarterly from the end of Quarter 1, 2015/16.
<b>CQUIN - sepsis screening</b>	Percentage of patients presenting to ED/other wards/units who met the criteria of the local protocol and were screened for sepsis.		This data will be reported quarterly from the end of Quarter 1, 2015/16.

## Operational Performance

Indicator	Description	Trend chart	Narrative
<b>CQUIN - severe sepsis treatment</b>	Percentage of patients presenting to ED/other wards/units with severe sepsis, Red Flag Sepsis or Septic Shock and who received IV antibiotics within 1 hour of presenting		This data will be reported quarterly from the end of Quarter 1, 2015/16.

# Acronyms/ terminology

<i>A&amp;E/ ED</i>	Accident and emergency department
<i>Acute Kidney Injury</i>	Acute kidney injury (AKI) is sudden damage to the kidneys that causes them to stop working properly. It can range from minor loss of kidney function to complete kidney failure. AKI is common and normally happens as a complication of another serious illness. This type of kidney damage is usually seen in older people who are unwell enough to be admitted to hospital. It's essential that AKI is detected early and treated promptly.
<i>Acute ward</i>	A ward in which patients with an illness that is of short duration and rapidly progressive are given urgent care.
<i>Admission</i>	The act of admitting a patient for a day case or inpatient procedure.
<i>Admission - inpatient</i>	An admission to the hospital for diagnosis and/or treatment which requires at least one overnight stay.
<i>Admission - day case</i>	A planned admission to the hospital for diagnosis and/or treatment where the patient is discharged on the same day without an overnight stay.
<i>Admission - elective</i>	A procedure that is chosen (elected) by the patient or consultant and arranged in advance.
<i>Admission - non-elective</i>	An admission to hospital which is unplanned and at short notice because of clinical need. For example, this will include patients being seen in CAT having emergency surgery and admitted to a hospital bed via A&E.
<i>Admitted pathway</i>	A pathway that ends in a clock-stop for admission (day case or inpatient).
<i>Adult Community Teams</i>	This service includes the four integrated district nursing teams, the fast response teams, and the community matrons and case managers.
<i>CCG</i>	Clinical Commissioning Group. CCGs are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area. The local CCG is Harrogate and Rural District (HARD) CCG.
<i>Choose and Book</i>	A national electronic referral service that gives patients a choice of place, date and time for their first consultant outpatient appointment in a hospital or clinic.
<i>CIP</i>	Cost Improvement Programme
<i>Clinical Assessment Team (CAT)</i>	A consultant led rapid assessment of medical and surgical patients. Conditions assessed include cardiac chest pain, strokes, and deep vein thrombosis (DVT's).
<i>Consultant-led</i>	A consultant retains overall clinical responsibility for the service, team or treatment. The consultant will not necessarily be physically present for each patient's appointment, but he/she takes overall clinical responsibility for patient care.
<i>CQUIN</i>	Commissioning for Quality and Innovation - a national scheme of contract levers used to incentivise Trusts to deliver quality improvements.
<i>Decision to admit</i>	Where a clinical decision is taken to admit the patient for either a day case or inpatient treatment.
<i>Decision to treat</i>	Where a clinical decision is taken to treat the patient. This could be treatment as an inpatient or day case, but also includes treatments performed in other settings e.g. as an outpatient.
<i>Delayed transfer of care</i>	When the patient is ready to be discharged from hospital however they remain in a bed.
<i>DNA – Did Not Attend</i>	DNA (sometimes known as an FTA – Failed to attend). This is defined as where a patient fails to attend an appointment/ admission without prior notice.
<i>First definitive treatment</i>	An intervention intended to manage a patient's disease, condition or injury and avoid further intervention.
<i>Follow-up appointment</i>	Any subsequent attendances in an outpatient clinic following a first attendance.
<i>Friends &amp; Family Test</i>	A nationally driven patient and staff survey.
<i>FTE/WTE</i>	Full time equivalent or whole time equivalent - used to specify the size of the workforce.
<i>General ward</i>	A ward in which patients with many different types of ailments are given care.
<i>HDFT</i>	Harrogate and District NHS Foundation Trust
<i>HSMR</i>	The Hospital Standardised Mortality Ratio (HSMR) is one of two commonly used standardised mortality ratios for in-hospital deaths.
<i>Length of stay (LOS)</i>	The number of nights spent in hospital as an inpatient.
<i>MRSA</i>	Methicillin Resistant Staphylococcus aureus
<i>MSSA</i>	Methicillin Sensitive Staphylococcus aureus
<i>New appointment</i>	A patient's first attendance in a specific outpatient clinic
<i>Never event</i>	Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
<i>Non-admitted pathway</i>	A pathway that results in a clock stop for treatment that does not require an admission or for 'non-treatment'.
<i>OOH</i>	Out of hours
<i>Outpatient</i>	A patient who comes to the hospital, clinic, or dispensary for diagnosis and/or treatment who does not require an overnight stay.
<i>PbR</i>	Payment by Results
<i>Referral to treatment period</i>	The part of a patient's care following initial referral, which initiates a clock start, leading up to the start of first definitive treatment or other clock stop that is covered by the 18 week target.
<i>RTT</i>	Referral to treatment
<i>Safety thermometer</i>	Audits carried out on one day each month where patients are surveyed for four types of harm (pressure ulcers, falls, urine infection in patients with a catheter and VTEs). Trusts are required to carry out the survey each month on all inpatient wards and adult community services and to submit the results nationally.
<i>SHMI</i>	The Summary Hospital Mortality Index (SHMI) is one of two commonly used standardised mortality ratios for in-hospital deaths.
<i>SIRI</i>	Serious incident requiring investigation
<i>TIA</i>	Transient ischaemic attack

Indicator traffic light criteria

Section	Indicator	Further detail	Proposed traffic light criteria
Quality	Safety thermometer - harm free care	% harm free	Green if latest month >=95%, red if latest month <95%
Quality	Pressure ulcers	No. grade 3 and grade 4 avoidable pressure ulcers (hosp and community)	Green if latest month < UCL, Red if latest month > UCL.
Quality	Falls	IP falls per 1,000 bed days	Green if latest month < UCL, Red if latest month > UCL.
Quality	Falls causing harm	IP falls causing moderate harm, sever harm or death, per 1,000 bed days	Green if latest month < UCL, Red if latest month > UCL.
Quality	Infection control	No. hospital acquired C.diff and MRSA cases	Green if below trajectory YTD, Amber if above trajectory YTD, Red if above trajectory at end year.
Quality	Mortality - HSMR		Green = better than expected or as expected, Red = worse than expected.
Quality	Mortality - SHMI		Green = better than expected or as expected, Red = worse than expected.
Quality	Complaints	No. complaints, split by criteria	Green if no red graded complaints in most recent month.
Quality	Incidents - all	Incidents split by grade (hosp and community)	Green if latest month < UCL, Red if latest month > UCL.
Quality	Incidents - SIRIs and never events	SIRI and never events (hosp and community)	Green if latest month =0, red if latest month >0.
Quality	Friends & Family Test (FFT) - Staff	% recommend work and % recommend care	Green if latest data on or above national average, red if below national average.
Quality	Friends & Family Test (FFT) - Patients	% recommend, % not recommend - combined score for all services currently doing patient FFT	Green if latest month < UCL, Red if latest month > UCL.
Quality	Safer staffing levels	RN and CSW - day and night overall fill rates at trust level	Green if latest month overall staffing >=100%, amber if between 95% and 100%, red if below 95%.
Quality	Staff appraisal rate	Latest position on no. staff who had an appraisal within the last 12 months	Annual rolling total - 90% green. Amber between 70% and 90%, red<70%.
Quality	Mandatory training rate	Latest position on the % staff trained for each mandatory training requirement	Green if latest month >=90% overall, amber if between 80% and 90%, red if below 80%.
Quality	Staff sickness rate	Staff sickness rate	Green if <3.9%, amber if between 3.9% and regional average, Red if > regional average
Quality	Temporary staffing - medical/nursing/other	Expenditure per month on staff types.	Green if spend on temporary staff < last YTD, red if > last YTD.
Quality	Staff turnover		Green if remaining static or decreasing, amber if increasing but below 15%, red if above 15%.
Finance and efficiency	Readmissions	No. emergency readmissions (following elective or non-elective admission) within 30 days.	Green if latest month < UCL, Red if latest month > UCL.
Finance and efficiency	Length of stay - elective	Average LOS for elective patients	Green if latest month < UCL, Red if latest month > UCL.
Finance and efficiency	Length of stay - non-elective	Average LOS for non-elective patients	Green if latest month < UCL, Red if latest month > UCL.
Finance and efficiency	Theatre utilisation	% of theatre time utilised for elective operating sessions	Green = >=85%, Amber = between 75% and 85%, Red = <75%
Finance and efficiency	Delayed transfers of care	% acute beds occupied by patients whose transfer is delayed - snapshot on last Thursday of the month.	Red if latest month >3.5%, Green <=3.5%



Section	Indicator	Further detail	Proposed traffic light criteria
Finance and efficiency	Outpatient DNA rate	% first OP appointments DNA'd	Green if latest month < UCL, Red if latest month > UCL.
Finance and efficiency	Outpatient new to follow up ratio	No. follow up appointments per new appointment.	Green if latest month < UCL, Red if latest month > UCL.
Finance and efficiency	Day case rate	% elective admissions that are day case	Green if latest month >LCL, Red if latest month < LCL.
Finance and efficiency	Surplus / deficit and variance to plan		Green if on plan, amber <1% behind plan, red >1% behind plan
Finance and efficiency	Cash balance		Green if on plan, amber <10% behind plan, red >10% behind plan
Finance and efficiency	Monitor continuity of services risk rating		Green if rating =4, amber if rating = 3, red if rating = 2 or 1
Finance and efficiency	CIP achievement		Green if achieving stretch CIP target, amber if achieving standard CIP target, red if not achieving standard CIP target.
Finance and efficiency	Capital spend	Cumulative capital expenditure	Green if on plan or <10% below, amber if between 10% and 25% below plan, red if >25% below plan
Finance and efficiency	Agency spend in relation to pay spend		Green if <1% of pay bill, amber if between 1% and 3% of pay bill, red if >3% of pay bill.
Operational Performance	Monitor governance rating		As per defined governance rating
Operational Performance	RTT Admitted pathways performance		Green if latest month >LCL, Red if latest month < LCL.
Operational Performance	RTT Non-admitted pathways performance		Green if latest month >LCL, Red if latest month < LCL.
Operational Performance	RTT Incomplete pathways performance		Green if latest month >LCL, Red if latest month < LCL.
Operational Performance	A&E 4 hour standard		Green if latest month >LCL, Red if latest month < LCL.
Operational Performance	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals		Green if latest month >LCL, Red if latest month < LCL.
Operational Performance	Cancer - 14 days maximum wait from GP referral for symptomatic breast patients		Green if latest month >LCL, Red if latest month < LCL.
Operational Performance	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers		Green if latest month >LCL, Red if latest month < LCL.
Operational Performance	Cancer - 31 day wait for second or subsequent treatment: Surgery		Green if latest month >LCL, Red if latest month < LCL.
Operational Performance	Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug		Green if latest month >LCL, Red if latest month < LCL.
Operational Performance	Cancer - 31 day wait for second or subsequent treatment: Radiotherapy		Green if latest month >LCL, Red if latest month < LCL.
Operational Performance	Cancer - 62 day wait for first treatment from urgent GP referral to treatment		Green if latest month >LCL, Red if latest month < LCL.
Operational Performance	Cancer - 62 day wait for first treatment from consultant screening service referral		Green if latest month >LCL, Red if latest month < LCL.
Operational Performance	Cancer - 62 day wait for first treatment from consultant upgrade		Green if latest month >LCL, Red if latest month < LCL.
Operational Performance	CQUIN - dementia screening		Green if latest month >LCL, Red if latest month < LCL.
Operational Performance	CQUIN - Acute Kidney Injury		tbc
Operational Performance	CQUIN - sepsis screening		tbc
Operational Performance	CQUIN - severe sepsis treatment		tbc

<b>Report to the Trust Board of Directors: 22 July 2015</b>	<b>Paper No: 7.0</b>
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<b>Title</b>	<b>Report by the Medical Director</b>
<b>Sponsoring Director</b>	Dr David Scullion, Medical Director
<b>Author(s)</b>	Dr David Scullion, Medical Director
<b>Report Purpose</b>	To update the Board on clinical matters for the month of July 2015

<b>Key Issues for Board Focus:</b> <ul style="list-style-type: none"> <li>• Review of mortality of patients with abdominal pain</li> <li>• Single provider for mental health services in North Yorkshire</li> <li>• NCEPOD report on gastro-intestinal haemorrhage</li> <li>• Gynaecological Surgical Oncology support for MDT</li> </ul>
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<b>Related Trust Objectives</b>	
1. Driving up quality	YES
2. Working with partners	YES
3. Integrating care	YES
4. Growing our business	YES

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

<b>Action Required by the Board of Directors</b> The Board of Directors is requested to note the content of this Report.
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### **1. Mortality reviews:**

There are no published mortality indices since the last BoD report. A CUSUM flag was reported related to abdominal pain. This consisted of 10 patients. Since the last BoD both myself and Mr Chris Mahon have each reviewed all 10 sets of case notes. There were no lapses of care identified. Three patients were medical with non-specific abdominal symptoms not related to cause of death. One patient probably died as a result of aortic dissection or bowel ischaemia or indeed both. The remaining six patients all confirmed or strongly clinically suspicious of mesenteric ischaemia (acute loss of blood supply to the bowel). I am happy to expand on this subject further, though have no concerns around the level of care and support provided in all 1-0 patients. Mr Mahon is in agreement with this.

### **2. Revalidation:**

The General Medical Council has commissioned two project reviews of the revalidation process. They have been coordinated to avoid duplication and minimise the effect on participants in the review. They will consist of online surveys of Responsible Officers to collect information around structure, systems and processes and more detailed information on the appraisal process. This seems to be a “stock taking” exercise in order to take the temperature of the revalidation process as it currently stands. Any significant future changes that will impact upon the process within the Trust will be reported to BoD as they become known.

### **3. National Emergency Laparotomy Audit:**

This report was recently published and was covered in the media. It was commissioned to compare the outcomes of patients undergoing emergency abdominal surgery in England and Wales with a view to improving quality and safety. Key themes are:

- Early input by senior clinicians
- Prompt administration of antibiotics when suspected peritonitis
- Robust risk assessment and critical care planning
- Timely access to support services such as radiology and anaesthetists
- Timely access to theatres
- Medical geriatric support

Trust specific metrics are available in the report. Flag areas for HDFT are Consultant review within 12hrs and access to medical geriatric support. I shall be working with Directorates to address gaps in service going forward. The link to the full report can be found on:

<http://nela.org.uk/article.php?newsid=1461>

### **4. Mental Health services:**

Tees, Esk and Wear Valley Trust (TEWV) has recently been announced as the provider of mental health and learning disability services for the Vale of York. This is a five year renewable contract. Whilst this does not have a direct impact on the service provided to HDFT, I believe there is an advantage to a single provider covering the North Yorkshire patch. Any potential benefits to service users overall can be explored at our regular meetings with TEWV.

The first mental capacity training session is scheduled for 24 July.

## **5. Research and Development:**

Currently we are the third highest network recruiter nationally. HDFT has achieved 167% of its local target and 158% of its aspirational target, one of only three Trusts in the network to overachieve on both. The R and D strategy is in an advanced state of preparation and will be discussed at SMT when finalised. Amongst a number of other issues, the R and D group are exploring community and commercial potential to boost recruitment.

## **6. NCEPOD report on acute gastro-intestinal haemorrhage:**

This report has only recently been received by me. A number of key findings have been highlighted, based on an analysis of 4780 cases over a 4 month study period. Findings relate broadly to organisation of care, patient demographics, admission, diagnostic pathways, control of bleeding, outcomes and overall quality of care. A tool kit for Trusts is available to check progress against adopting the key recommendations made by the report authors. I shall be sharing the report with senior clinicians in both general surgery and gastro-enterology to discuss current gaps in service provision and how these might be best addressed. A link to the report can be found at:

<http://www.ncepod.org.uk/2015qih.htm>

## **7. Gynaecological Surgical Oncology support for MDT:**

Due to an early retirement and increasing service pressure, surgical support from Leeds to our Gynaecology MDT has been temporarily withdrawn. Airedale has been similarly affected. Interviews in Leeds are planned for September 2015. Two posts are planned, one replacement and one additional. Normal service is expected to resume when the first of these appointments is in post. In the meantime some local changes to service provision have been put in place to minimise the impact on service delivery. Leeds are aware of my own concern on this matter, and I am mindful of the strong MDT link between both organisations that will not be affected.

## **8. Middle Grade recruitment::**

In conjunction with the HR team, initial communication has taken place with the MD of Airedale to discuss particular staffing pressure areas. ED and Anaesthetics were the main topic of mutual interest. In addition to current work with Certificate of Eligibility for Specialist Registration (CESR) recruitment locally, further discussion will address the possibility of cross site posts in order to attract high quality applicants. I will feed back to the Board on progress.

<b>Report to the Trust Board of Directors: 22 July 2015</b>	<b>Paper No: 8.0</b>
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<b>Title</b>	Chief Nurse Report
<b>Sponsoring Director</b>	Chief Nurse
<b>Author(s)</b>	Jill Foster, Chief Nurse
<b>Report Purpose</b>	To provide the Board of Directors with an update on care quality improvement and patient experience within the Trust

**Key Issues for Board Focus:**

- the position for defined aspects of care quality and patient experience within the Trust with a particular focus on nurse staffing levels
- the ongoing work to review and benchmark the Trust against the recommendations from the Morecombe Bay Investigation
- the verbal feedback from the Antenatal and New-born Screening Quality Assurance visit
- an update on the Dementia Commissioning for Quality and Innovation (CQUIN)

**Related Trust Objectives**

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

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

**Action Required by the Board of Directors**

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

## Patient Safety and Effectiveness of Care

### Nurse Staffing Levels – June 2015

Actual versus planned nurse staffing - inpatient areas

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

June 2015	Day		Night	
Ward name	Average fill rate - registered nurses/midwives	Average fill rate - care staff	Average fill rate - registered nurses/midwives	Average fill rate - care staff
AMU-Bolton	99%	129%	153%	158%
AMU-Fountains	96%	99%	101%	109%
Byland	95%	111%	101%	142%
Farndale	102%	114%	100%	123%
Granby	101%	104%	100%	115%
Harlow	108%	78%	100%	-
ITU/HDU	95%	-	90%	-
Jervaulx	91%	110%	96%	136%
Lascelles	91%	111%	100%	100%
Littondale	104%	124%	100%	130%
Maternity Wards	91%	155%	103%	150%
Nidderdale	101%	117%	116%	89%
Oakdale	100%	101%	100%	118%
Special Care Baby Unit	98%	76%	97%	-
Trinity	104%	106%	102%	103%
Wensleydale	94%	119%	103%	118%
Woodlands	101%	83%	105%	100%
<b>Trust total</b>	<b>97%</b>	<b>113%</b>	<b>102%</b>	<b>122%</b>

### **Further information on this month's data**

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

On Harlow Suite the daytime care staff hours in June was less than planned due to staff sickness.

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

On Jervaulx ward the actual RN day and night staff hours were less than planned in June because the ward occupancy levels varied which enabled staff to assist in other areas

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

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

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

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

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

The actual care staff hours were less than planned on Woodlands ward due to staff sickness however the ward occupancy levels vary considerably which means that particularly in this area the number of planned and actual nurses is kept under constant review.

**The Nursing Dashboard can be found in Appendix One.**

## Recommendations from Morecombe Bay Investigation

This document reviews the recommendations for both University Hospitals of Morecambe Bay NHS Foundation Trust (HUBNFT) and other NHS organisations which are relevant to our service and trust. There are specific recommendations for UHBNFT which it is important we benchmark ourselves against - the principle being would we meet the standard expected in the recommendations.

The Morecombe Bay Investigation recommendations reach further than the maternity service. There are recommendations which needed to be considered at a trust level and they are also listed here.

Consider at a departmental level
<b>Recommendation 3</b>
<b>The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up plans to deliver the training and development of staff identified as a result of the review of maternity, neonatal and other staff, and should identify opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice. These should be in place in time for June 2015.</b>
<b>Comment</b>
Maternity training needs analysis updated June 2014 – review date June 2016
<b>Action</b>
Complete

<b>Recommendation 2</b>
<b>The University Hospitals of Morecambe Bay NHS Foundation Trust should review the skills, knowledge, competencies and professional duties of care of all obstetric, paediatric, midwifery and neonatal nursing staff, and other staff caring for critically ill patients in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies. This review should be completed by June 2015, and identify requirements for additional training, development and, where necessary, a period of experience elsewhere.</b>
<b>Comment</b>
HDU policy details responsibilities of key staff members but is out of date and currently under review
<b>Action</b>
Review of HDU policy to take account of actions for UHMNT



**Recommendation 5**

The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and develop measures that will promote effective multidisciplinary team-working, in particular between paediatricians, obstetricians, midwives and neonatal staff. These measures should include, but not be limited to, joint training sessions, clinical, policy and management meetings and staff development activities. Attendance at designated events must be compulsory within terms of employment. These measures should be identified by April 2015 and begun by June 2015.

**Comment**

Joint training sessions currently undertaken for emergencies training  
Neonatal obstetric meeting occurs monthly  
Multidisciplinary quality improvement meeting occurs monthly  
Maternity risk management strategy details multidisciplinary meetings – QUIS, LWF, MRMG etc.

**Action**

Review membership of departmental meetings to ensure wide cross section of staff and responsibilities of consultant body

Review team development at consultant level

**Recommendation 6**

The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up a protocol for risk assessment in maternity services, setting out clearly: who should be offered the option of delivery at Furness General Hospital and who should not; who will carry out this assessment against which criteria; and how this will be discussed with pregnant women and families. The protocol should involve all relevant staff groups, including midwives, paediatricians, obstetricians and those in the receiving units within the region. The Trust should ensure that individual decisions on delivery are clearly recorded as part of the plan of care, including what risk factors may trigger escalation of care, and that all Trust staff are aware that they should not vary decisions without a documented risk assessment. This should be completed by June 2015.

**Comment**

Antenatal and intrapartum guidelines include section on risk assessment.  
Process for neonatal alerts in progress  
Good links with Leeds foetal medicine service  
In-utero transfer guideline out of date

**Action**

Review in-utero transfer guideline

**Recommendation 11**

The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and implement a programme to raise awareness of incident reporting, including requirements, benefits and processes. The Trust should also review its policy of openness and honesty in line with the duty of candour of professional staff, and incorporate into the programme compliance with the refreshed policy. This should be begun with maternity staff by April 2015 and rolled out to other staff by April 2016.

**Comments and actions**

See recommendation 24

<b>Recommendation 12</b>
<b>The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in investigating incidents, carrying out root cause analyses, reporting results and disseminating learning from incidents, identifying any residual conflicts of interest and requirements for additional training. The Trust should ensure that robust documentation is used, based on a recognised system, and that Board reports include details of how services have been improved in response. The review should include the provision of appropriate arrangements for staff debriefing and support following a serious incident. This should be begun with maternity units by April 2015 and rolled out across the Trust by April 2016.</b>
<p><b>Comments</b></p> <p>The Trust has an incident reporting policy and an investigative, learning and supporting policy which sets out the above. This requires review in light of changes to process and duty of candour requirements.</p> <p>See recommendation 23 also</p>
<p><b>Action</b></p> <p>Review incident reporting policy and the investigative, learning and supporting policy</p>

<b>Recommendation 13</b>
<b>The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in responding to complaints, and introduce measures to promote the use of complaints as a source of improvement and reduce defensive 'closed' responses to complainants. The Trust should increase public and patient involvement in resolving complaints, in the case of maternity services through the Maternity Services Liaison Committee. This should be completed, and the improvements demonstrated at an open Board meeting, by December 2015.</b>
<p><b>Comments</b></p> <p>The Trust has a complaints policy and an investigative, learning and supporting policy which sets out the above.</p> <p>This requires review to improve response times and reduce the number of re-opened case and to reflect duty of candour requirement</p>
<p><b>Action</b></p> <p>The Trust is reviewing the complaint handling process and associated policies</p>

<b>Recommendation 14</b>
<b>The University Hospitals of Morecambe Bay NHS Foundation Trust should review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support. The Trust has implemented change at executive level, but this needs to be carried through to the levels below. All staff with defined responsibilities for clinical leadership should show evidence of attendance at appropriate training and development events. This review should be commenced by April 2015.</b>
<p><b>Comments</b></p> <p>Clinical lead post in obstetrics and gynaecology currently unfilled Job description updated and sent out to consultants in department</p>
<p><b>Actions</b></p> <p>Ensure clinical lead in post and that appropriate training and development opportunities are provided</p> <p>At a directorate level HR training planned for clinical leads</p>

<b>Recommendation 16</b>
<b>As part of the governance systems work, we consider that the University Hospitals of Morecambe Bay NHS Foundation Trust should ensure that middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality, and it should provide appropriate guidance and where necessary training. This should be completed by December 2015.</b>
<b>Comments</b> Quality Governance structures have recently been remodelled with a focus on simplifying complex arrangements, layering the structure, improving the effectiveness of meetings and better communicating the role of individual staff in providing quality care. This has meant: <ul style="list-style-type: none"> <li>- delivering new content on quality governance as part of staff induction</li> <li>- communicating a new simple graphic to facilitate clearer understanding of how individuals can contribute to providing quality care.</li> <li>- strongly linking individual staff's contribution (at every level in the organisation) to the quality agenda through their appraisal,</li> </ul>
<b>Actions</b> Continue to embed quality governance structures

<b>Recommendation 23</b>
<b>Clear standards should be drawn up for incident reporting and investigation in maternity services. These should include the mandatory reporting and investigation as serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. We believe that there is a strong case to include a requirement that investigation of these incidents be subject to a standardised process, which <u>includes input from and feedback to families</u>, and <u>independent, multidisciplinary peer review</u>, and should certainly be framed to exclude conflicts of interest between staff. We recommend that this build on national work already begun on how such a process would work. Action: the Care Quality Commission, NHS England, the Department of Health.</b>
<b>Comment</b> Current maternity risk management strategy identifies intrapartum stillbirths and unexpected neonatal deaths as 'potential SIRIs' but not late stillbirths.
<b>Action</b> Maternity risk management strategy to be reviewed to reflect inclusion of late stillbirths, intrapartum still-births and unexpected neonatal deaths as SIRIs. Review of SRI policy/ maternity risk management strategy to make clear what is meant by <u>'independent multidisciplinary peer review'</u>

**Recommendation 24**

**We commend the introduction of the duty of candour for all NHS professionals. This should be extended to include the involvement of patients and relatives in the investigation of serious incidents, both to provide evidence that may otherwise be lacking and to receive personal feedback on the results. Action: the Care Quality Commission, NHS England.**

**Comment**

Trust being open policy does not reflect duty of candour and has passed its review date (June 2014)

Duty of candour is not reflected in maternity risk management strategy

**Action**

Trust to review guidance on duty of candour and ensure it is reflected through SIRI policy, being open policy etc.

Maternity risk management strategy to be reviewed to reflect duty of candour

**Recommendation 28.**

**Clear national standards should be drawn up setting out the professional duties and expectations of clinical leads at all levels, including, but not limited to, clinical directors, clinical leads, heads of service, medical directors, nurse directors. Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, the General Medical Council, the Nursing and Midwifery Council, all Trusts.**

**Comment**

Clinical leads job descriptions recently reviewed in all directorates

**Action**

Trust to review professional duties and expectations of clinical leads at all levels including appropriate policies and training

**Recommendation 29**

**Clear national standards should be drawn up setting out the responsibilities for clinical quality of other managers, including executive directors, middle managers and non-executives. All Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, all Trusts.**

**Comment** All Job Descriptions used for recruitment make clear the responsibilities of roles for clinical quality. Induction and in-service training of Executive and Non-Executive Directors, and senior and middle managers, ensures regular reinforcement of responsibilities for clinical quality

**Action** Review emphasis placed on responsibility for clinical quality in recruitment and induction process.

## **Quality Assurance Visit for Antenatal and New-born Screening Programmes at HDFT by NHS National Screening Programmes (part of Public Health England)**

On Wednesday 24<sup>th</sup> June 2015 HDFT took part in the quality assurance (QA) visit of the antenatal and new-born screening programmes from the North East, Yorkshire and The Humber region screening quality assurance team.

Quality Assurance in the NHS Screening Programmes is about achieving high standards and continuous improvement across screening and referral pathways, in order to ensure that pregnant women and their babies have access to a high quality service wherever they reside.

Quality Assurance is essential in order to minimise harm and maximise benefits. Formal QA visits to a screening programme provide the forum for a review of the whole multidisciplinary screening pathway, and an assessment of the effectiveness of team working within the screening centre and associated referral sites.

The aim of the Quality Assurance visit was to:

- Examine the quality of the screening programme
- Identify areas of good practice
- Mutual exchange of ideas and experience
- Identify areas where improvements can/should be made
- Minimise harm, maximise benefits
- Support the programme to achieve excellence

All screening pathways are quality assured but due to the complexity of provision the following service areas were considered as part of this QA process:

- All maternity and children's services provided by Harrogate and District NHS Foundation Trust which deliver elements of the antenatal and newborn screening pathways (diagnostic services will not be quality assured but the efficiency and effectiveness of referral to diagnostic services and relevant failsafe processes will be covered)
- The hearing screening service which provides hearing screening for the maternity units (diagnostic audiology will not be included)
- Microbiology laboratories to which booking samples are sent for infectious diseases screening
- Haematology laboratories to which booking samples are sent for haemoglobinopathy screening
- All child health records departments which link to the maternity unit
- Leeds New-born bloodspot laboratory
- Leeds Down's syndrome screening laboratory

Overall the visit was positive with verbal feedback on the day identifying several areas of good practice. A smaller number of issues were also flagged as areas of improvement. I am waiting for the written report.

## Local Supervisory Advisory Maternity Office Annual Audit

Midwifery Supervision is a statutory responsibility which provides a mechanism for support and guidance to every practising midwife in the United Kingdom. The purpose of Midwifery Supervision is to protect women and babies by actively promoting a safe standard of midwifery practice.

Supervisors of Midwives are Registered Midwives who have undertaken a further programme of study in order to provide leadership and guidance to Midwives, support best, evidence based practice, and act as an advocate for women.

There are currently 7 appointed Supervisors at HDFT, achieving the recommended minimum ratio of 1:15 Midwives, with a robust succession plan in place to maintain this.

Midwifery Supervision was criticised heavily in the investigation into events at Morecombe Bay, resulting in all Supervisory Teams benchmarking themselves against a series of NMC recommendations. The Supervisory Team here at HDFT completed and submitted the benchmarking tool in July 2014, and met 17/19 of the NMC recommendations in full, and was partially compliant in the remaining 2 with an action plan to ensure full compliance.

The Supervisory team provide 24 hour on call support both for midwives and members of the public, they participate in supervisory activities at local, regional and national level.

The annual audit conducted by the Local Supervisory Midwifery Officer (LSAMO) for Yorkshire and the Humber, is scheduled for 17 July 2015. The purpose of the audit is to review the practice of the Supervisory team against specific domains, and is undertaken by the LSAMO, Supervisors from neighbouring Trusts and Service Users. The outcome of this audit visit will be shared across the Midwifery / Maternity Team, Elective Care directorate and the HDFT Board.

## Patient Experience

### Dementia

#### Summary of changes to the Dementia CQUIN

The national dementia CQUIN has been issued for 2015-16. There are still three parts to it:

1. Dementia and Delirium - Find, Assess, Investigate, Refer and Inform (FAIRI)
2. Staff Training
3. Supporting Carers

But there have been some key changes to the dementia CQUIN, which now includes patients with delirium:

- To add to the existing “**find, assess, investigate and refer**” process for our clinical staff in connection with patients with dementia are new requirements to “inform” all services and/or professionals involved in the case. Case-finding will now apply not just to those using hospital services but also to people accessing community services, including from within their usual place of residence. The Fast Response Rehabilitation Team are now undertaking case-finding assessments to fulfil this new CQUIN requirement. New monthly, rather than quarterly, targets have been set.

**Written care plans** for discharged patients should be shared with the patient's GP and there are new minimum requirements for what these plans should contain.

- It is recommended that a **dementia training programme** is commissioned and delivered as part of a collaborative effort across the local health and care economy. There will be monthly rather than annual reporting.
- Commissioners and providers will need to agree on the content of the **carers' survey** and local processes for surveying carers of people with dementia and delirium which should cover the whole health and social care economy. The findings of the survey should be presented to the Board biannually.

### **Training Needs Assessment and Staff Training**

In respect of dementia training, in quarter 1 of 2015/16 we have trained:

- 259 staff in Dementia Awareness
- 341 staff in Dementia Tier 1
- 10 staff in a 1 day Knowledge and Skills in Dementia Care session

Our overall percentage compliance against our Training Needs Analysis (TNA) as on the 1 July 2015 is:

- Dementia Awareness - 62%
- Dementia Tier 1 - 77%

Since this data was collected and following changes to the dementia CQUIN, our training needs analysis is being reviewed to reflect our changing training needs as we seek to strengthen our commitments to becoming a dementia-friendly organisation.

### **Carers' Survey**

Until any new arrangements are agreed, the trust has continued to interview carers of people with dementia as it did last year in order to fulfil the carers' survey aspect of the CQUIN. The trust has agreed to work with the CCG Dementia Lead, the Patient Voice Group and carer representatives to revise the content of the survey used in 2014-15. A meeting is due to take place week commencing 20<sup>th</sup> July to begin this process. The trust is also seeking the feedback of carers of those patients with delirium or dementia who have accessed the Rapid Response Rehabilitation Team.

The results of the four interviews undertaken to date this year have been shared with the Dementia Working Group, which reports directly to the Supporting Vulnerable People Steering Group and is now chaired by Dr Jane Paisley. Actions have been identified to improve staff awareness of delirium and dementia, the use of the 'All About Me' form and appropriate use of the Butterfly Scheme.

The Board will receive two further updates on dementia during 2015/16.

**Jill Foster**  
**Chief Nurse**  
**July 2015**

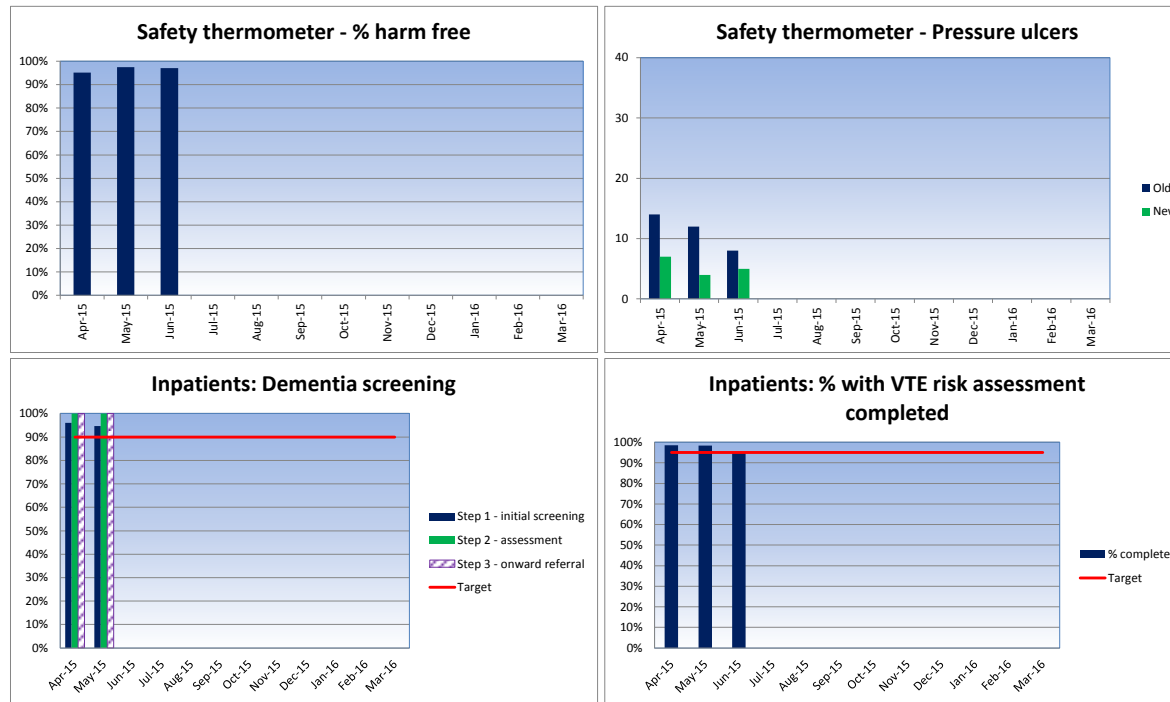
July 2015



## Appendix 1 Quality and Safety Dashboard - June 15

Select location:

### National CQUIN indicators



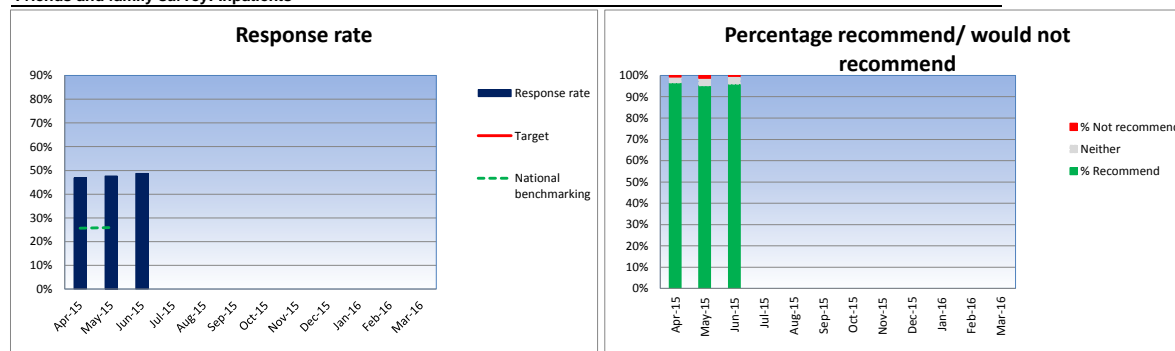
**Safety thermometer** - Harm free care measured using the NHS Safety Thermometer remained constant in June with only 3% of measured care associated with a harm, largely pressure ulcers. The Pressure Ulcer Steering Group are leading the local work to reduce pressure ulcers.

**Dementia screening** - The Trust achieved all three indicators in May and provisional data suggests that all three will be continued to be met in June.

**VTE**- Provisional data suggests that VTE risk assessment compliance was at 95.1% in June against the target of 95%.



### Friends and family survey: Inpatients

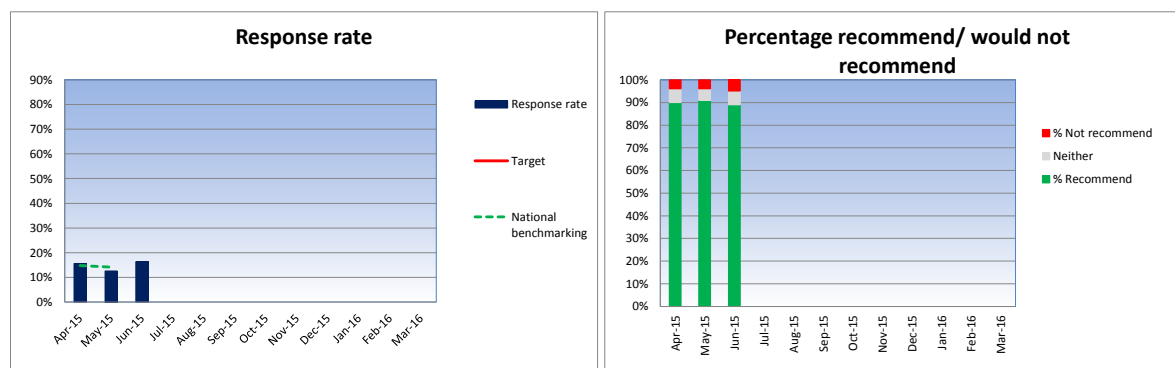


From April 2015 the FFT inpatient has been expanded to include patients seen within a daycase setting.

Response rate: The FFT inpatient response rate in June was 48.7%.

FFT score: The national benchmarking % would/would not recommend score for May 2015 has been published and shows that we performed slightly worse than average for inpatients (national average 95.4%/1.5%, HDFT 95.2%/1.3%). The FFT % would/would not recommend score for inpatients in June 15 is 96.0%/0.5%. Work continues to use feedback to improve patient experience.

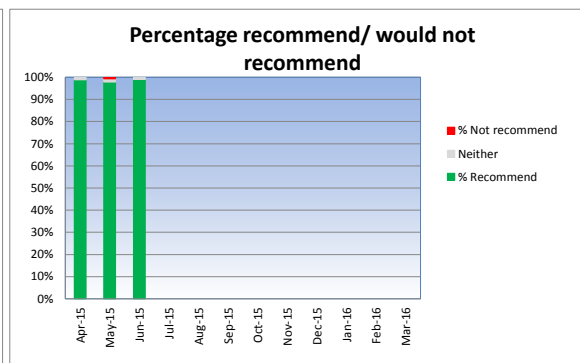
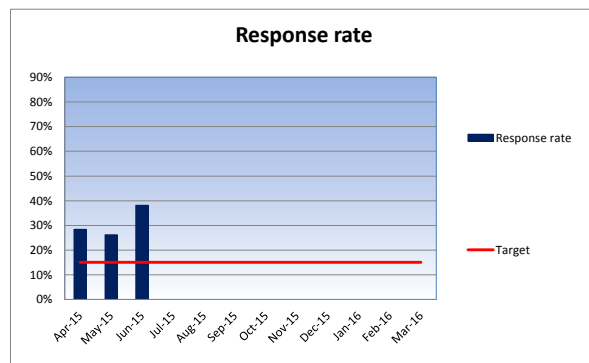
### Friends and family survey: Emergency department



Response rate: The FFT Emergency Department response rate in June was 16.3%. Automated telephone contacts are being used and the capacity of this system is being addressed to improve the number of contacts that can be made, in order to improve the response rate.

FFT score: The national benchmarking % would/would not recommend score for May 2015 shows that we performed better than average for the Emergency Department (national average 88.3%/6.0%, HDFT 91.0%/4.0%). The FFT % would/would not recommend score for Emergency Department in June is 89%/5%. Work continues to use feedback to improve patient experience.

### Friends and family survey: Maternity

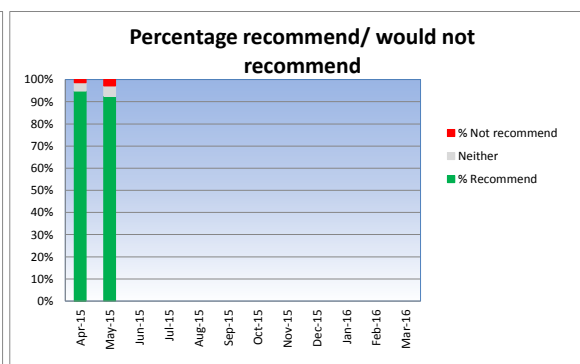
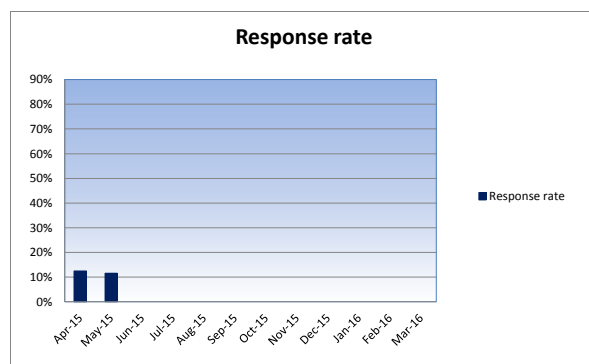


During June the combined maternity response was 38.2%. The percentage of respondents who would/would not recommend the service was 99%/0.7%. The results for each area are as follows:

- 1) Antenatal: response rate = 21.8%, % would/would not recommend = 97%/0%
- 2) Birth: response rate = 50.7%, % would/would not recommend = 99%/0%
- 3) Postnatal ward: response rate 50.0%, % would/would not recommend = 100%/2.9%
- 4) Postnatal community: response rate 25.5%, % would/would not recommend = 100%/0%

The national benchmarking % would/would not recommend score for May 2015 shows that we performed better than average in all of the 4 of the areas: Antenatal (national average 95.9%/1.5%, HDFT 98%/0%), birth (national average 97%/1%, HDFT 100%/0%), postnatal ward (93.3%/2%, HDFT 94%/2.9%) and postnatal community (97.8%/0.9%, HDFT 100%/0%).

### Friends and Family - Community

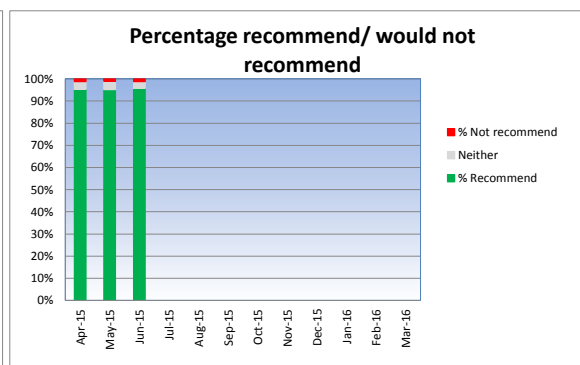
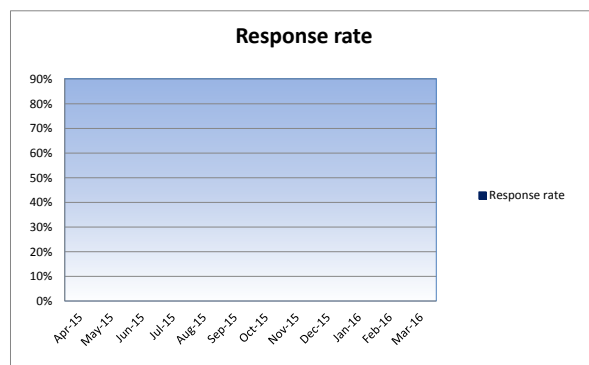


During May 2015 the combined community response was 11.5%. The percentage of respondents who would/would not recommend the service was 92.5%/2.8%. The results for each area are as follows:

- 1) Inpatient services: response rate = 30.8, % would/would not recommend = 100%/0%
- 2) Nursing services: response rate = 13.6%, % would/would not recommend = 95.5%/4.5%
- 3) Rehabilitation & therapy services: response rate 23.6%, % would/would not recommend = 92.2%/2.9%
- 4) Specialist services: response rate = 19.6%, % would/would not recommend = 100%/0%
- 5) Children & family services: response rate = 1.4%, % would/would not recommend = 91.7%/0%
- 6) Healthcare other: response rate = 2.9%, % would/would not recommend = 90.9%/1.5%

Due to reporting deadlines data for June is not yet available and will be included in next months dashboard.

### Friends and Family - Outpatients

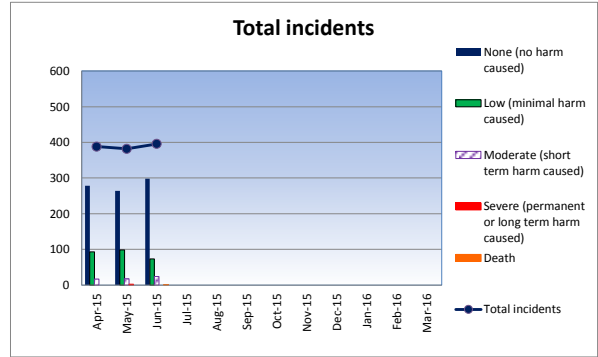


From April 2015 the FFT has been expanded to include patients seen in an outpatient setting. This data includes patients seen as ward attenders.

The response rate will be calculated using outpatient attendance data as taken from a monthly average of the NHS England Quarterly Activity Return (QAR), and will be included in next months dashboard.

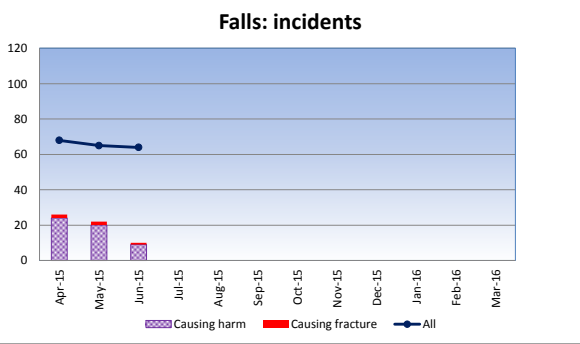
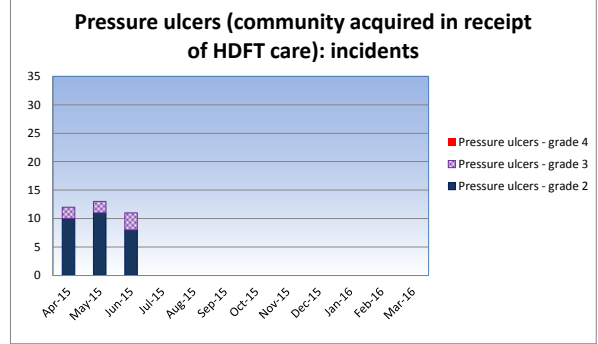
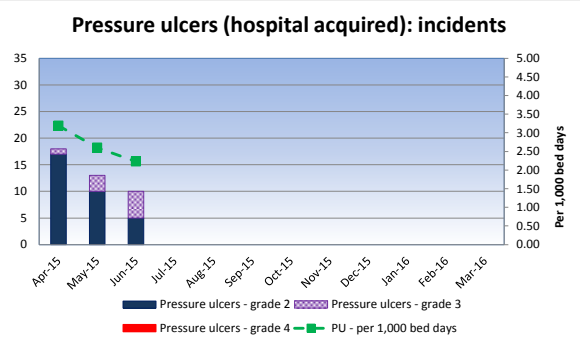
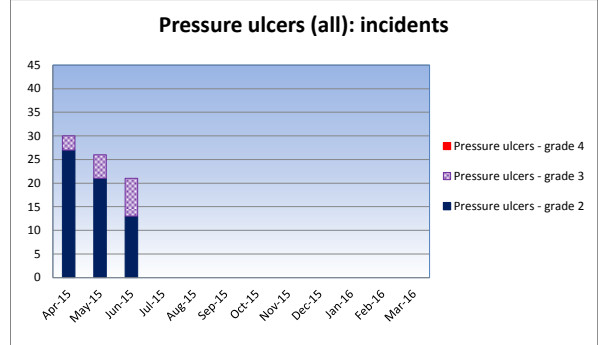
During June the percentage of respondents who would/would not recommend the service was 95.7%/1.2%.

Incident reporting



The top 5 incidents types at sub-category level, during June 15

	Incident	
1	Fall (found on floor) Day	20
2	Bangs, Bumps, Slips, Trips & Falls	11
3	Other	11
4	Fall/Trip/Slip while Mobilising Alone - Night	10
5	Fall/Trip/Slip while mobilising alone - Day	10



The total number of incidents reported this month has increased from 382 to 396 in June. The Medical Director has asked for an external review of one case in June the results of which are still awaited. The proportion of incidents graded as moderate (short term harm) has increased from 4.7 to 6.1% this month.

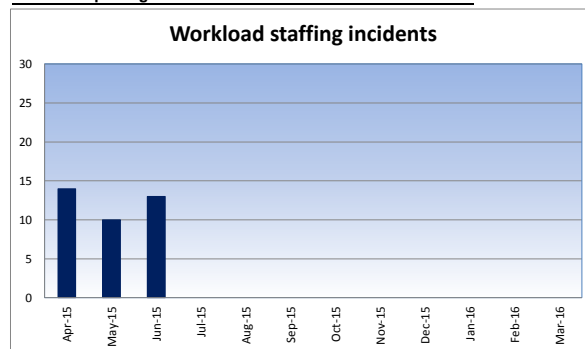
Falls and bangs, bumps, slips, trips and falls are in the top 5 sub categories this month. Category 2 pressure ulcers home acquired featured last month and has now decreased out of the top 5 this month.

The total number of all grade 2 and 3 pressure ulcers reported this month has decreased from 26 to 21 (10 were hospital acquired and 11 were community acquired). There were 13 Grade 2 pressure ulcers (5 Hospital acquired and 8 community acquired) and 8 grade 3 ulcers this month (5 hospital acquired and 3 community acquired).

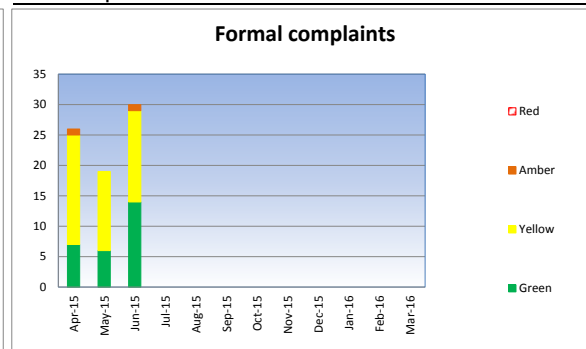
The data comes from Datix but the tissue viability nurses review all the grade 3 and 4 pressure ulcers to validate the data. Root cause analysis is undertaken by the ward sisters/team leaders for grades 3 and 4 pressure ulcers and learning and improvement actions fed back to the teams. Themes for learning identified will also be reviewed at the pressure ulcer steering group.

The proportion of falls causing harm has decreased this month from 30.8% to 14.1%. There has been 1 fracture in June, which is currently being investigated via root cause analysis.

### Incident reporting cont.



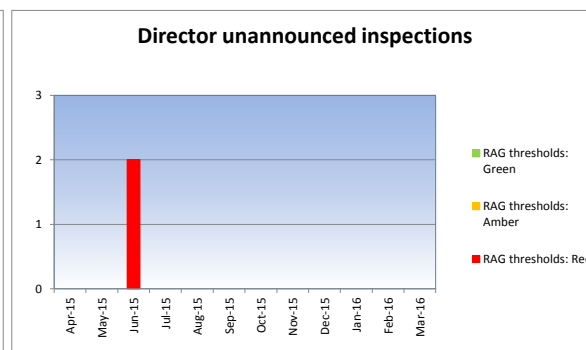
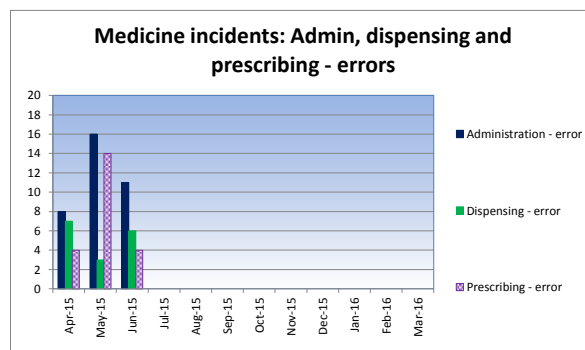
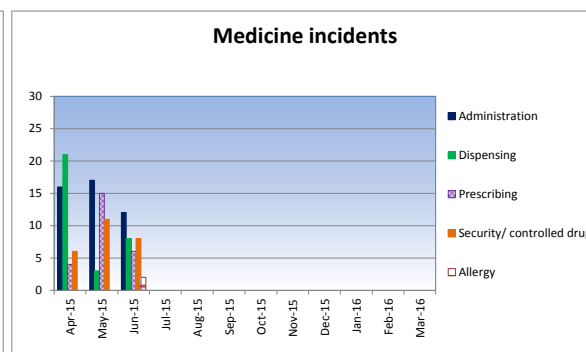
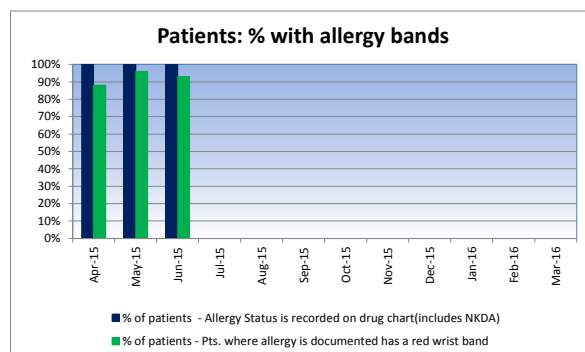
### Formal complaints



Of the 30 complaints received in June:  
Medical = 22  
Nursing = 2  
Medical/Nursing = 3  
Medical/Nursing/Other = 1  
Other = 2

1 complaint was graded Amber  
15 complaints were graded Yellow  
14 complaints were graded Green

### Pharmacy



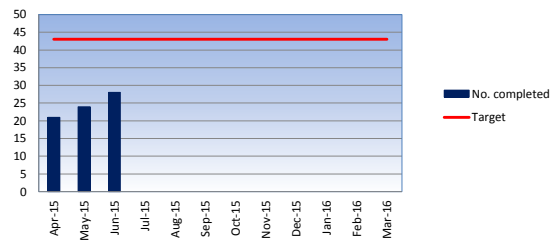
**Allergies** – This month's data showed that all patients had their allergy status recorded. However three patients were not wearing the correct red wrist bands when checked, one of these was for a clinical reason.

**Medication Incidents** - The total number of incidents and errors have reduced again this month. Security and CD incidents have decreased slightly. There are 2 reported allergy incidents. All incidents are discussed at CORM and reviewed at the Medicines Safety Review Group.

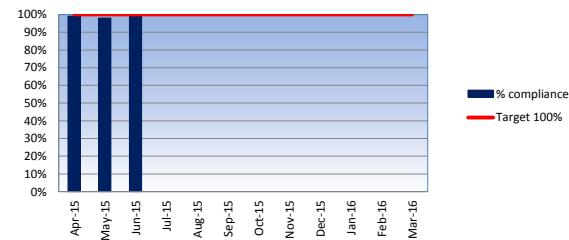
**Director unannounced inspections** - Two inspections were carried out in June – Farndale and Wensleydale both of whom were RED.

## Hygiene standards

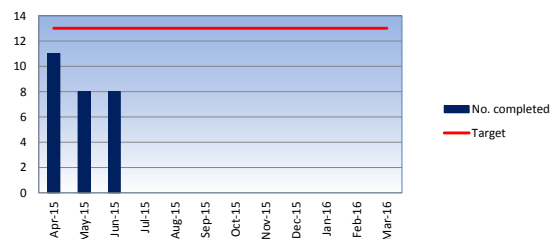
Staff: Hand hygiene audits, number completed



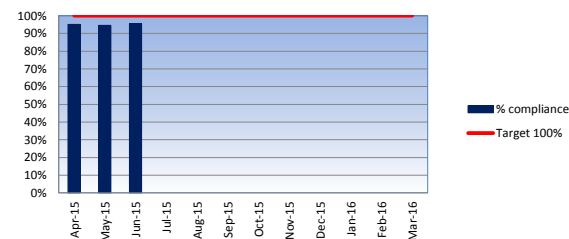
Staff: Hand hygiene, % compliance



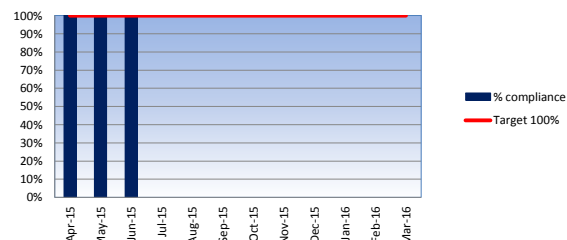
Promotion of patient hand hygiene audits, number completed



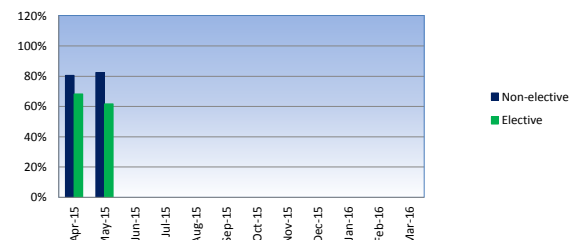
Promotion of patient hand hygiene audits, % compliance



Staff: Commode cleanliness % compliance



MRSA screening % compliance



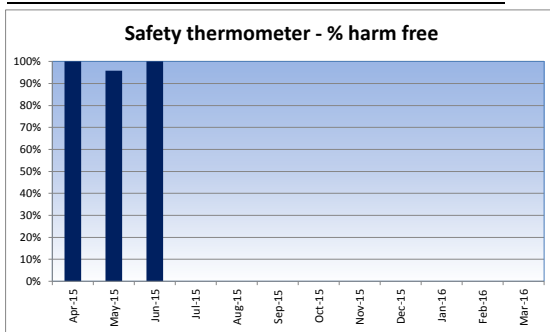
**Staff Hand Hygiene and Patient Hand Hygiene:** The IPC Operational Group and IPC Team continue to support submission of both staff and patient hand hygiene audits with variable success. In June the Chief Nurse wrote to all Clinical Directors, Operational Directors and Matrons highlighting the need to ensure completion and submission of these audits.

**MRSA-** Since January 5th the Trust no longer screens low risk surgical day case admissions. Patients with a history of MRSA within the previous 12 months continue to be screened. Patients are also still screened upon their own request, or on the request of their Consultant or a Consultant Microbiologist. The apparent sub-optimal compliance for screening of elective patients will be addressed once the MRSA surveillance system has been updated to reflect these changes.

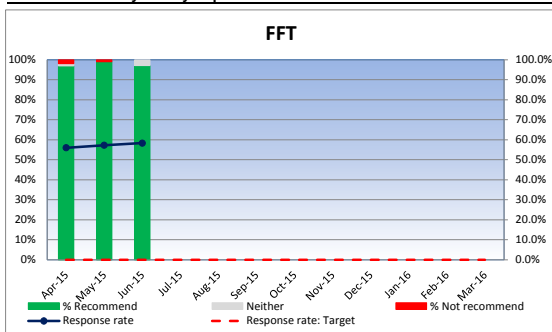
## Quality and Safety Dashboard - June 15

Ward: **AMU Fountains**

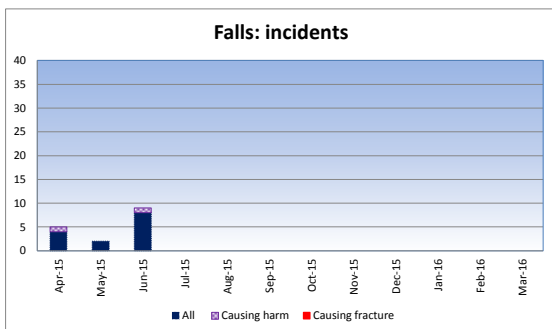
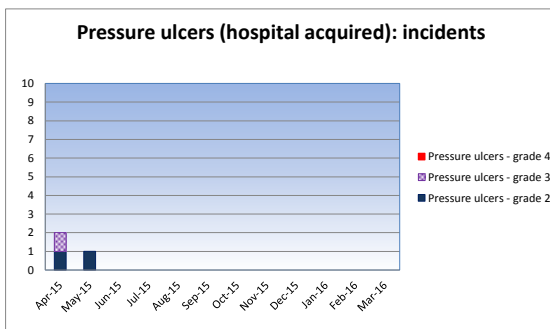
### National QUIN indicators



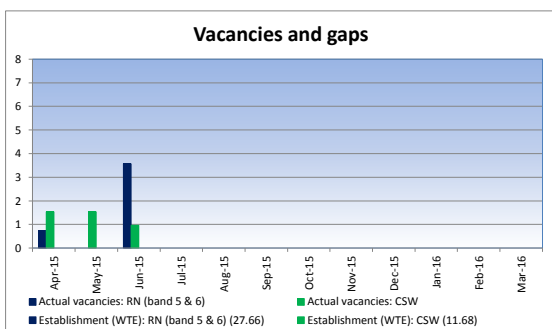
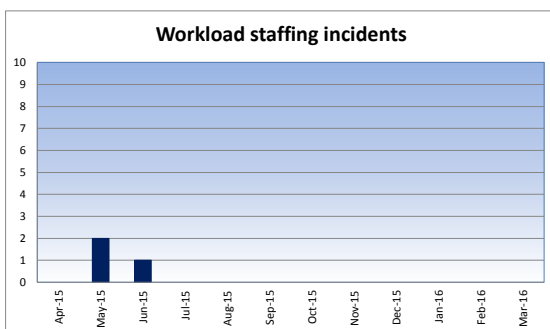
### Friends and family survey: Inpatients



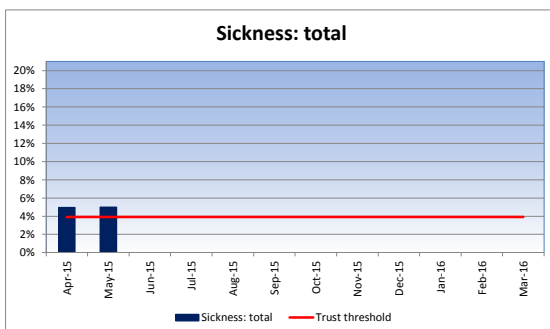
### Incident reporting



### Workforce



### Workforce cont.



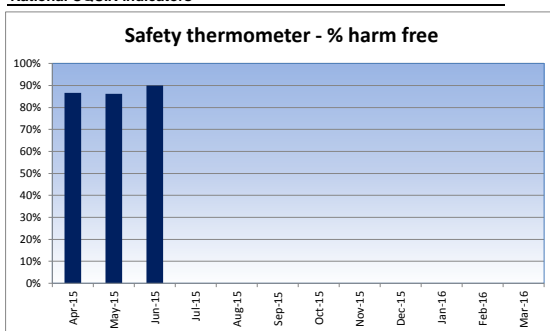
Vacancies + gaps reported in the April Chief Nurse report are recorded in the March section

Note, sickness data for the reporting month is not available at the time of publication

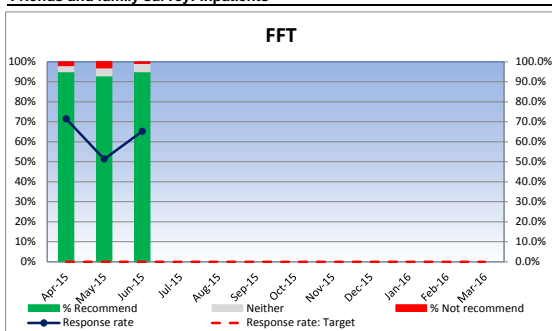
## Quality and Safety Dashboard - June 15

Ward: **AMU Bolton**

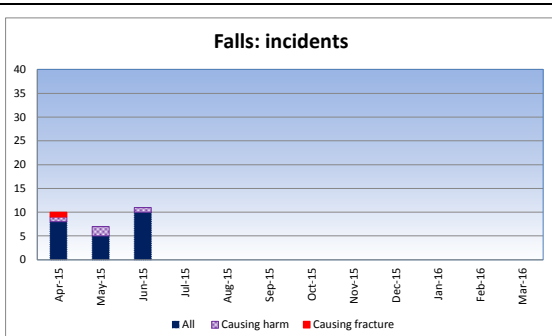
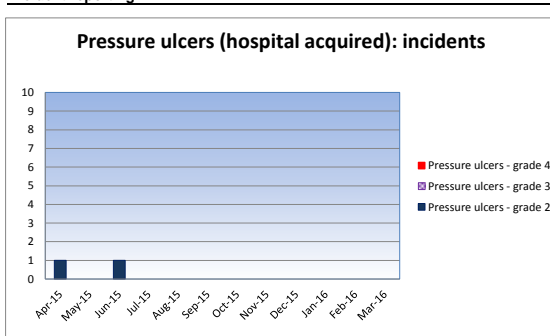
### National CQUIN indicators



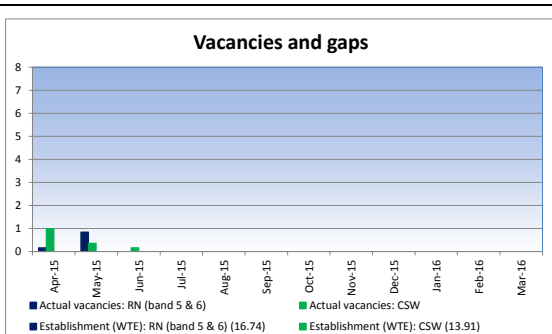
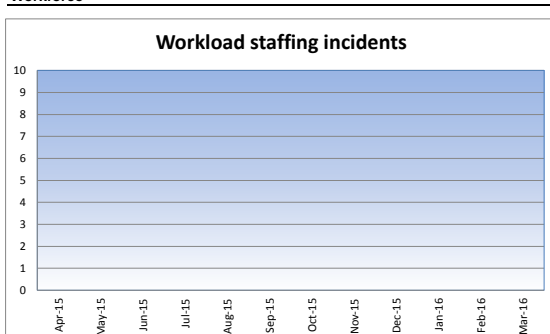
### Friends and family survey: Inpatients



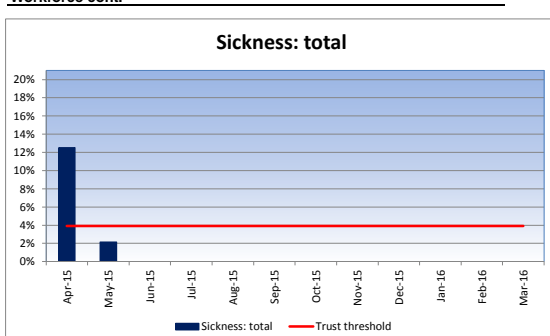
### Incident reporting



### Workforce



### Workforce cont.



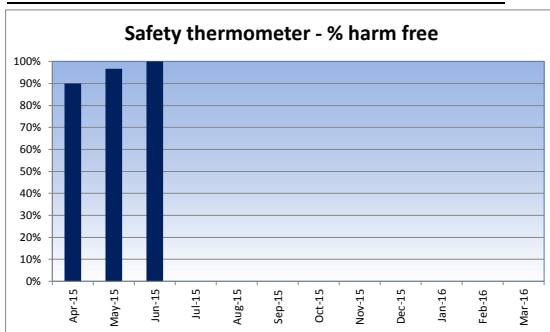
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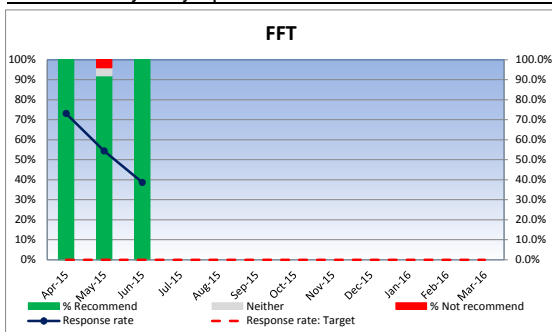
## Quality and Safety Dashboard - June 15

Ward: Byland

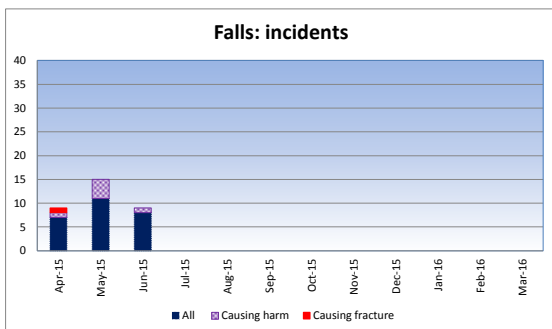
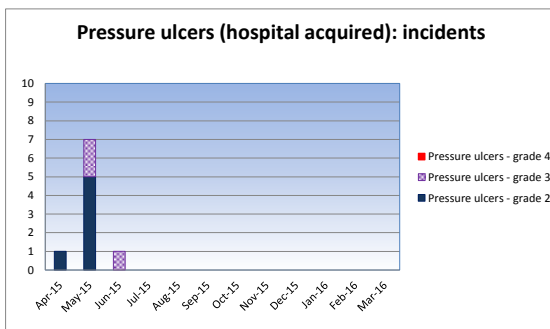
### National QUIN indicators



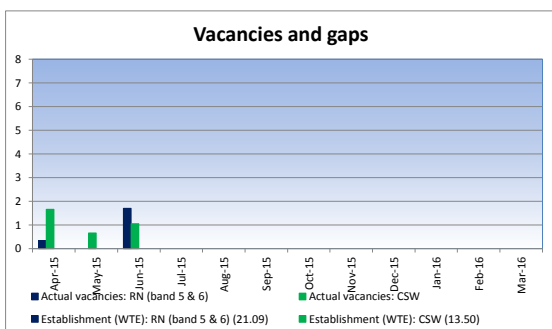
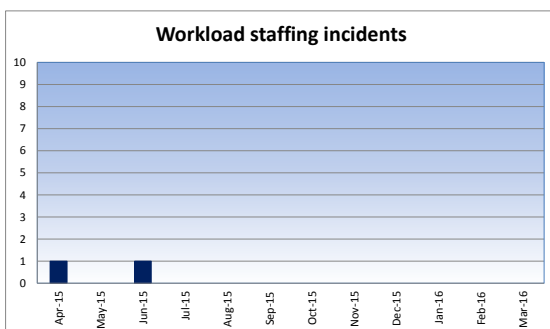
### Friends and family survey: Inpatients



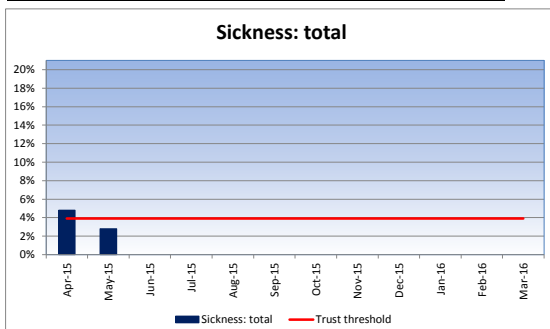
### Incident reporting



### Workforce



### Workforce cont.



Vacancies + gaps reported in the April Chief Nurse report are recorded in the March section

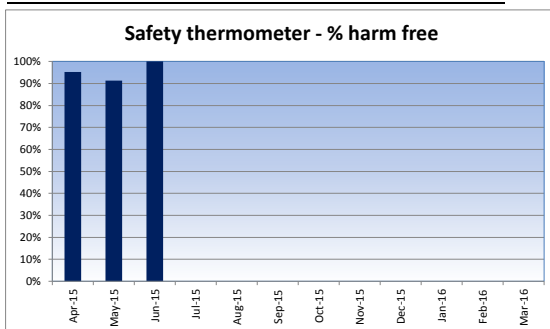
Note, sickness data for the reporting month is not available at the time of publication



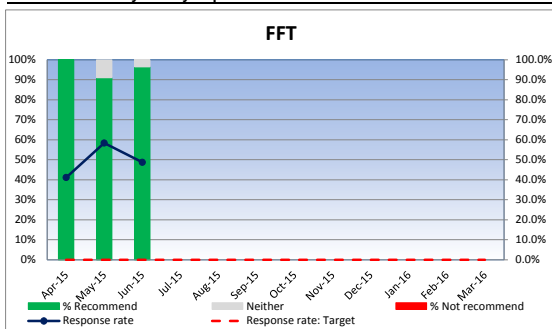
## Quality and Safety Dashboard - June 15

Ward: **Farndale**

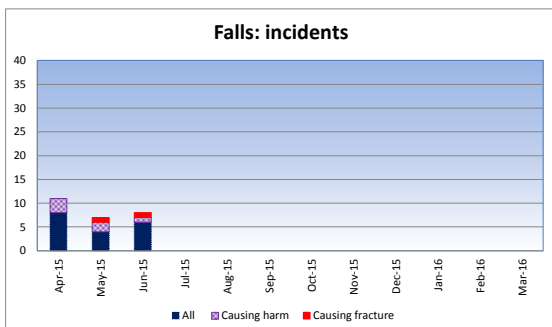
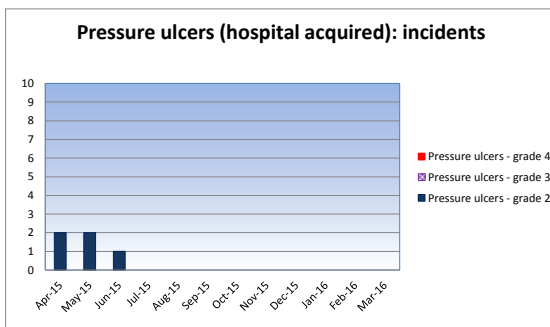
### National CQUIN indicators



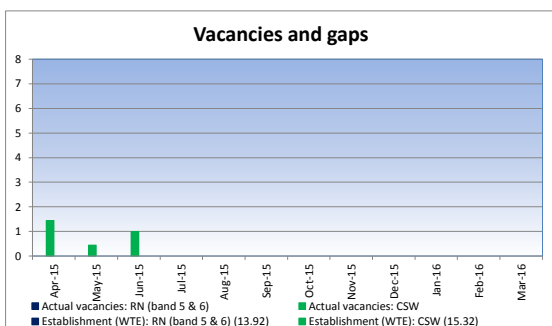
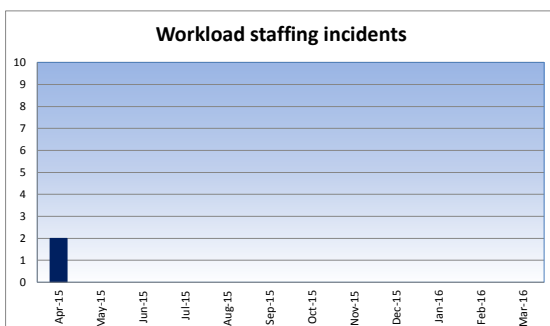
### Friends and family survey: Inpatients



### Incident reporting

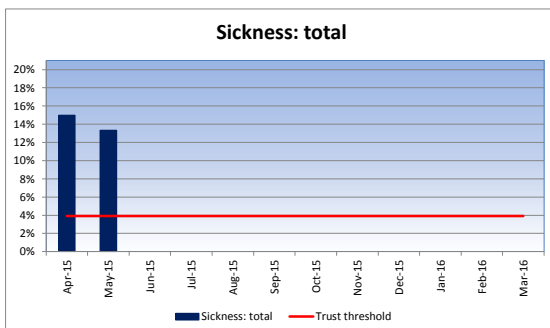


### Workforce



Vacancies + gaps reported in the April Chief Nurse report are recorded in the March section

### Workforce cont.

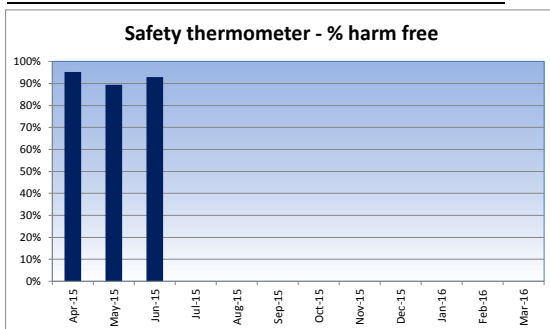


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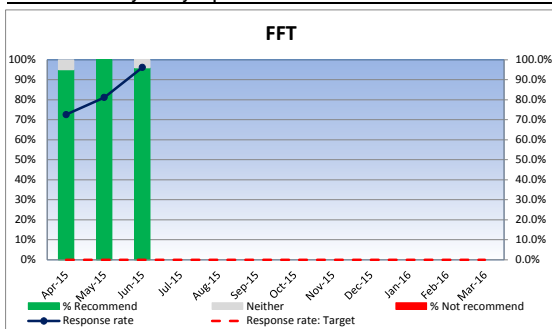
## Quality and Safety Dashboard - June 15

Ward: Granby

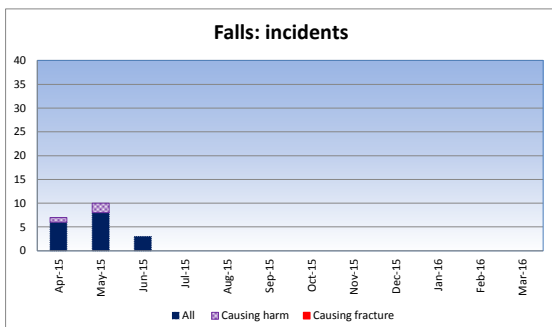
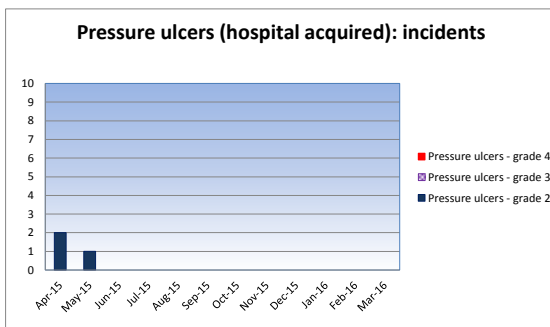
### National CQUIN indicators



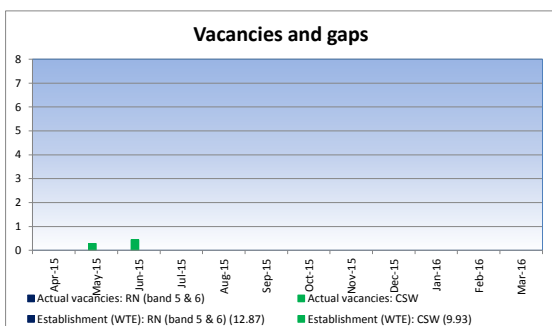
### Friends and family survey: Inpatients



### Incident reporting

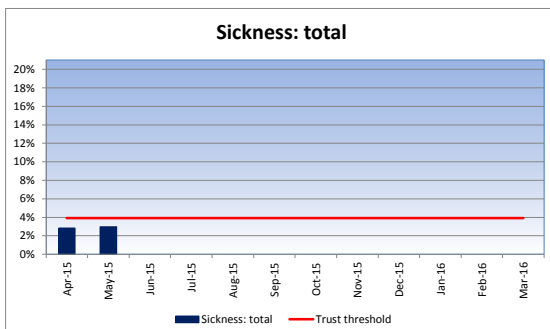


### Workforce



Vacancies + gaps reported in the April Chief Nurse report are recorded in the March section

### Workforce cont.

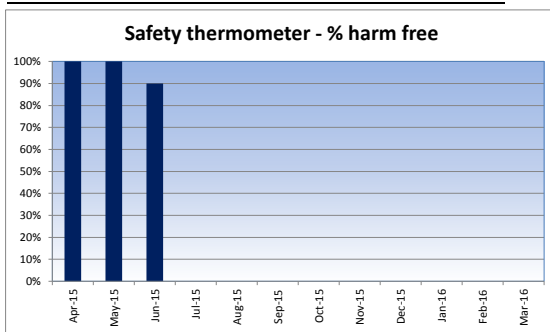


Note, sickness data for the reporting month is not available at the time of publication

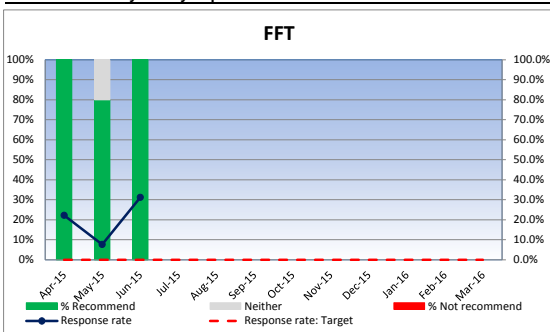
## Quality and Safety Dashboard - June 15

Ward: Harlow

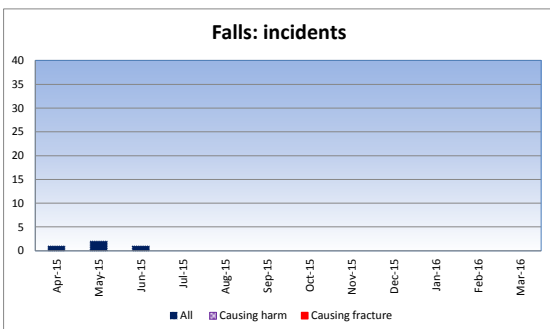
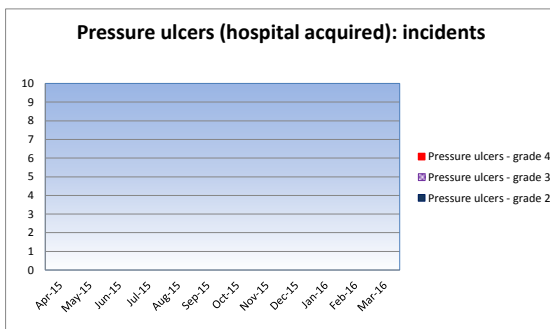
### National QUIN indicators



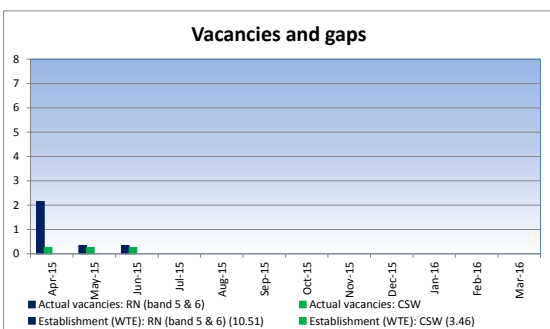
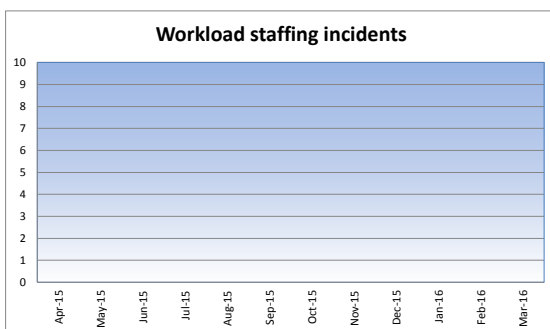
### Friends and family survey: Inpatients



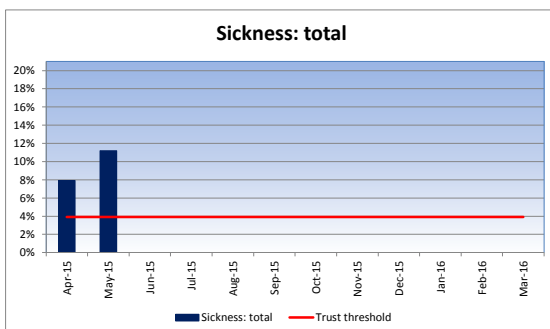
### Incident reporting



### Workforce



### Workforce cont.



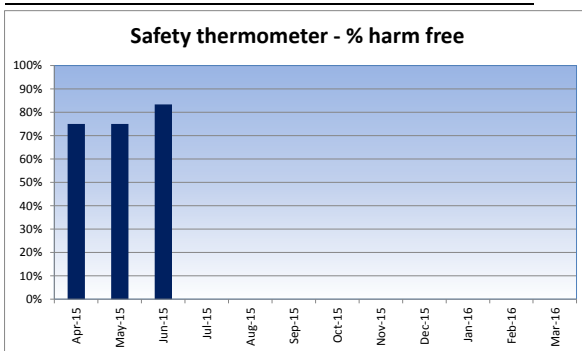
Note, sickness data for the reporting month is not available at the time of publication

Vacancies + gaps reported in the April Chief Nurse report are recorded in the March section

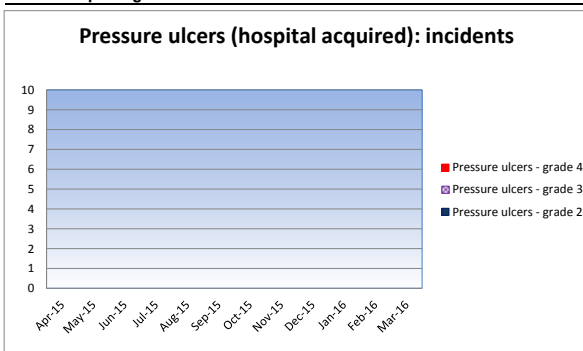
## Quality and Safety Dashboard - June 15

Ward: ITU

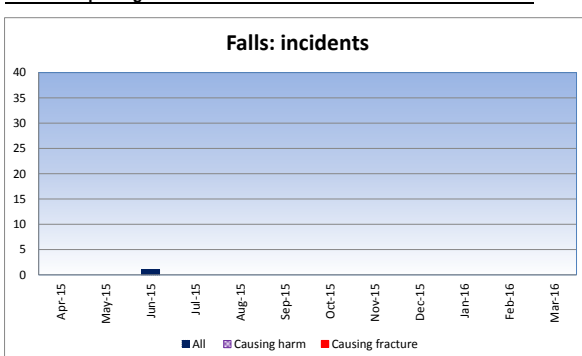
### National CQUIN indicators



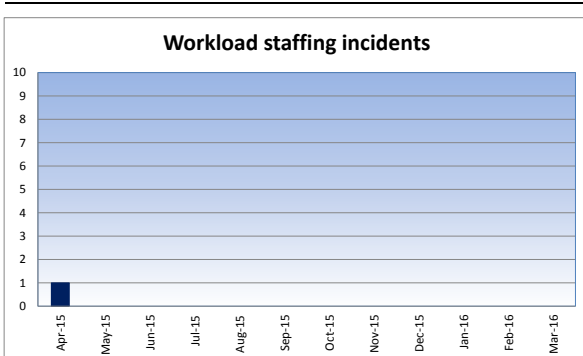
### Incident reporting



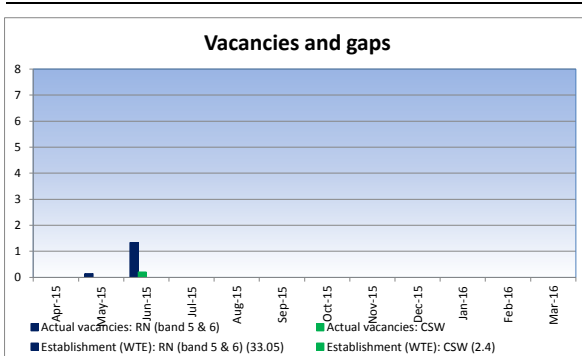
### Incident reporting cont.



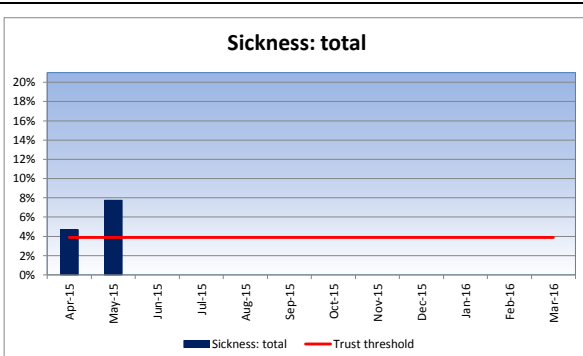
### Workforce



### Workforce cont.



Vacancies + gaps reported in the April Chief Nurse report are recorded in the March section

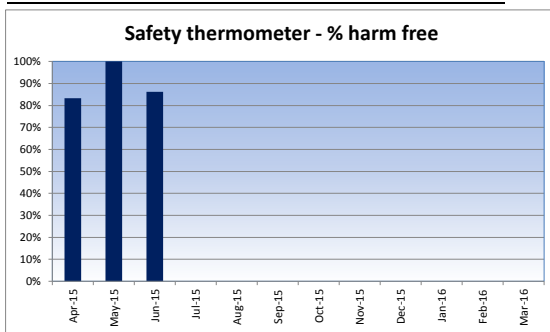


Note, sickness data for the reporting month is not available at the time of publication

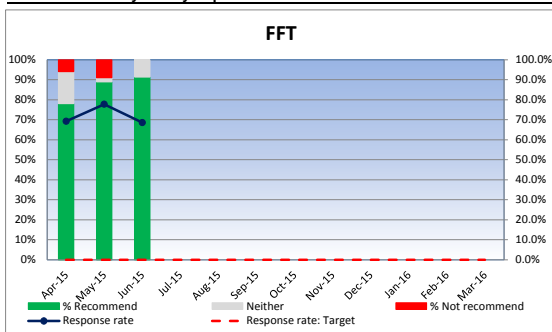
## Quality and Safety Dashboard - June 15

Ward: Jervaulx

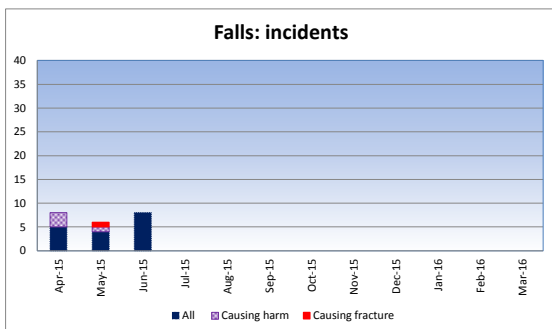
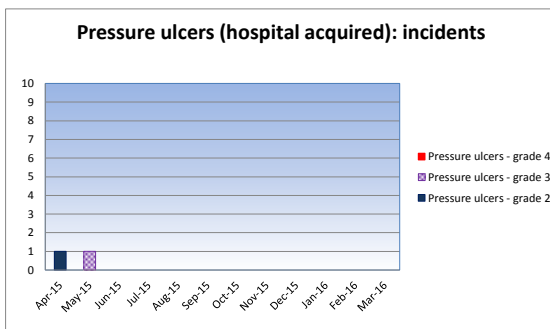
### National QUIN indicators



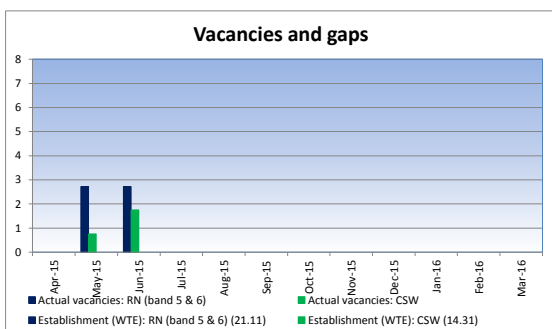
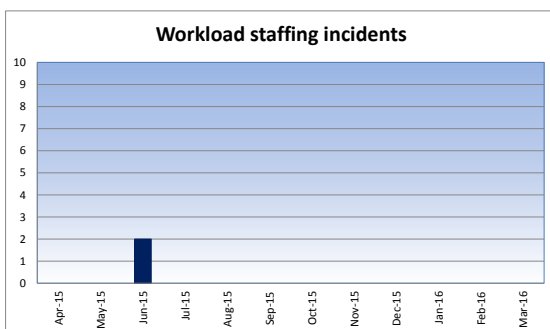
### Friends and family survey: Inpatients



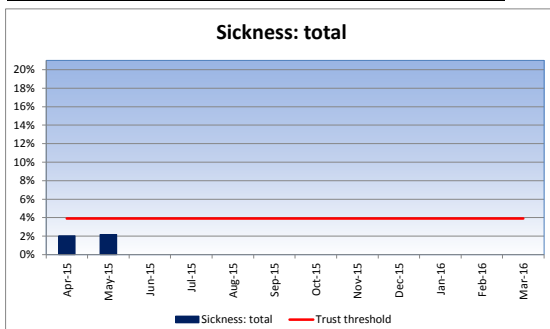
### Incident reporting



### Workforce



### Workforce cont.



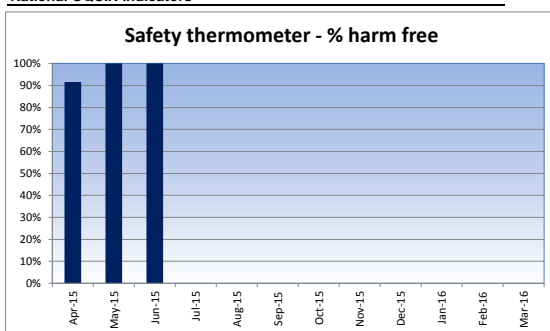
Vacancies + gaps reported in the April Chief Nurse report are recorded in the March section

Note, sickness data for the reporting month is not available at the time of publication

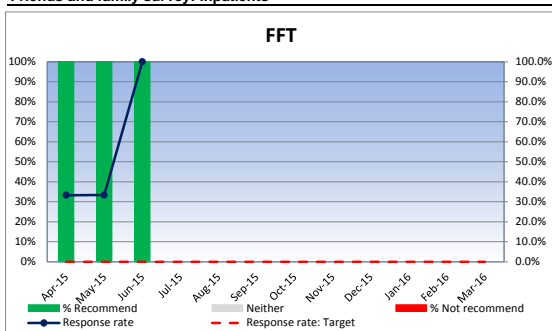
## Quality and Safety Dashboard - June 15

Ward: Lascelles

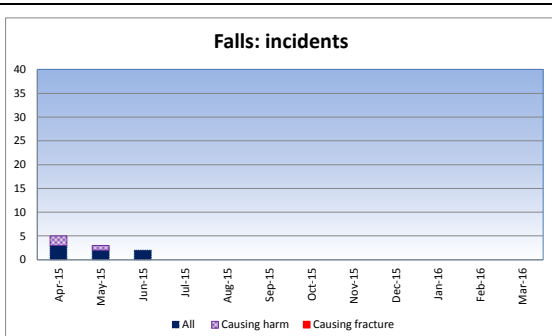
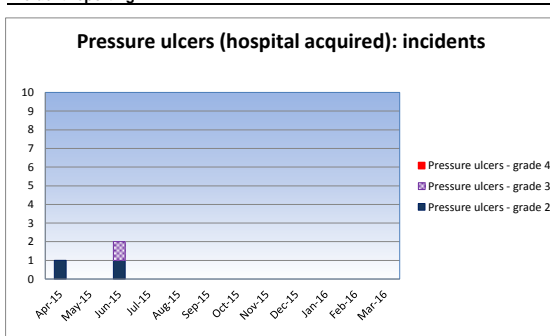
### National QUIN indicators



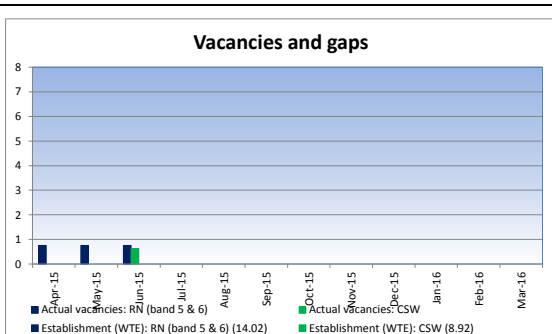
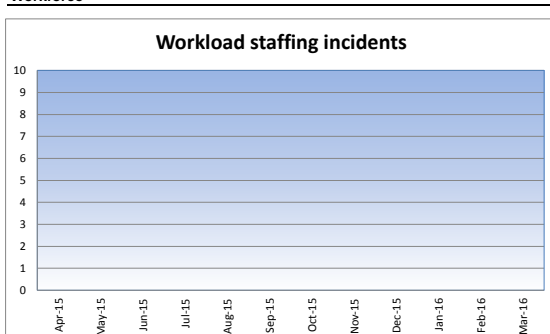
### Friends and family survey: Inpatients



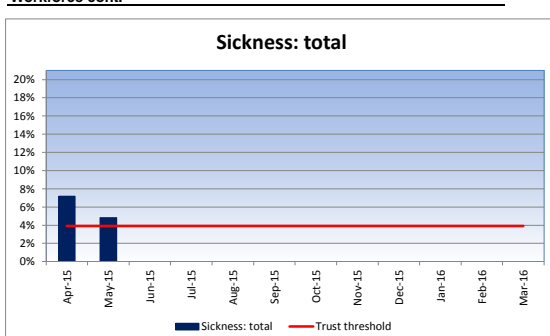
### Incident reporting



### Workforce



### Workforce cont.



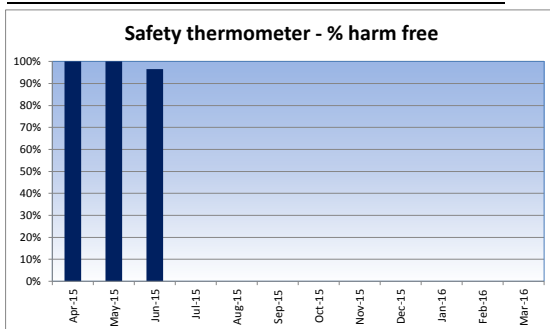
Vacancies + gaps reported in the April Chief Nurse report are recorded in the March section

Note, sickness data for the reporting month is not available at the time of publication

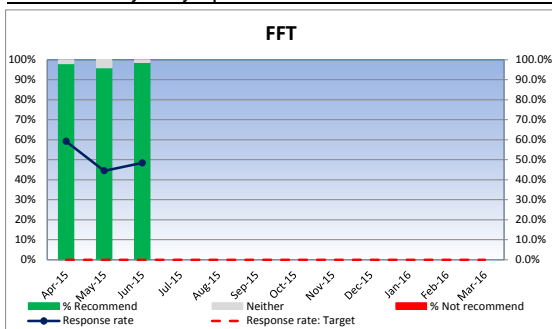
## Quality and Safety Dashboard - June 15

Ward: **Littondale**

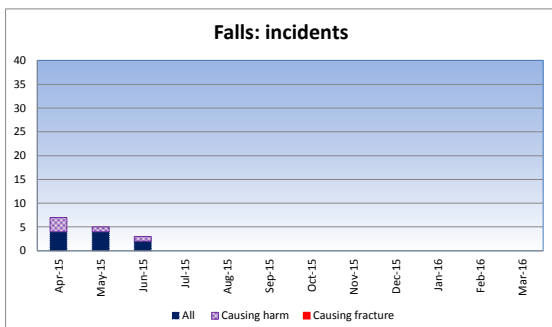
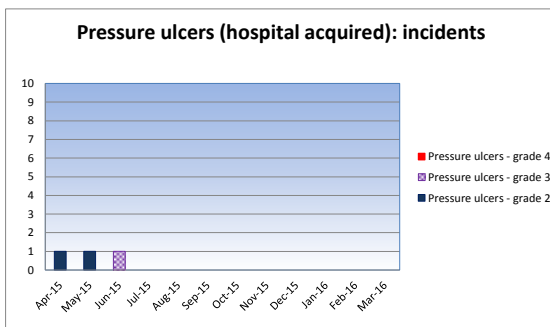
### National QUIN indicators



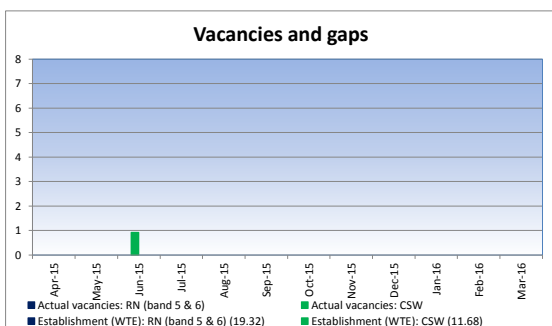
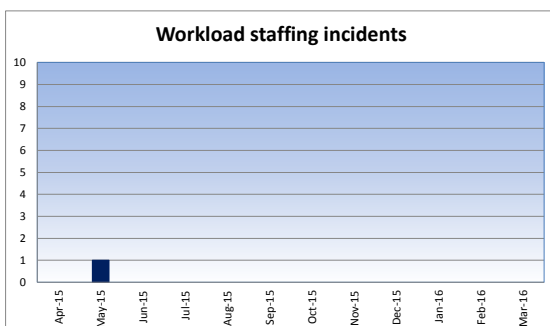
### Friends and family survey: Inpatients



### Incident reporting

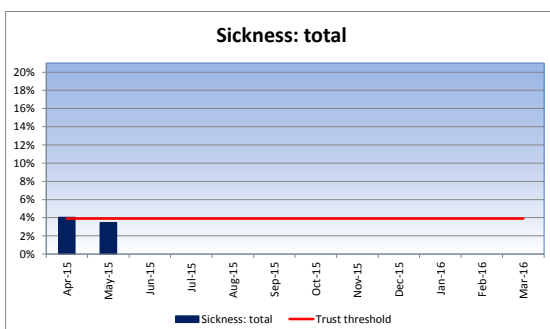


### Workforce



vacancies + gaps reported in the April CNI nurse report are recorded in the march section

### Workforce cont.

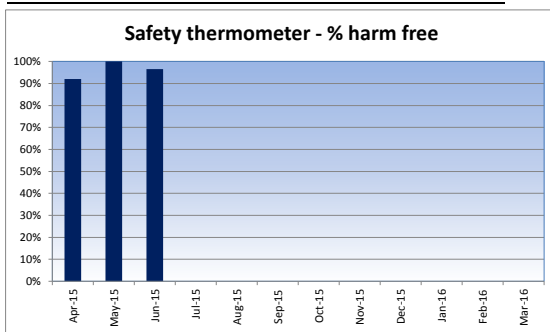


Note, sickness data for the reporting month is not available at the time of publication

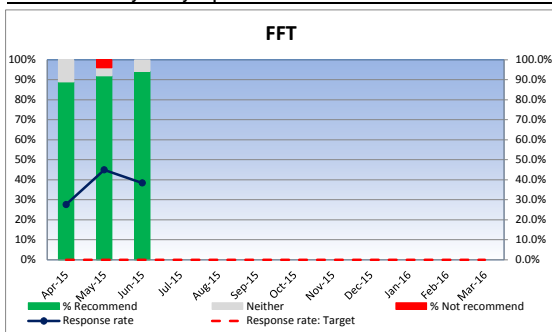
## Quality and Safety Dashboard - June 15

Ward: **Nidderdale**

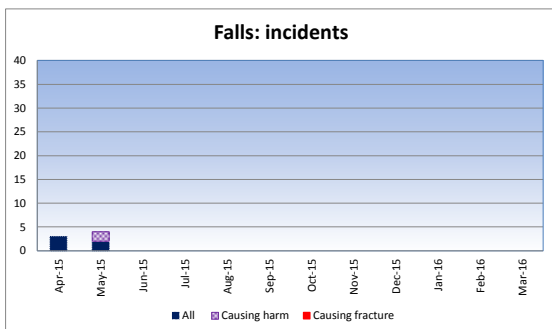
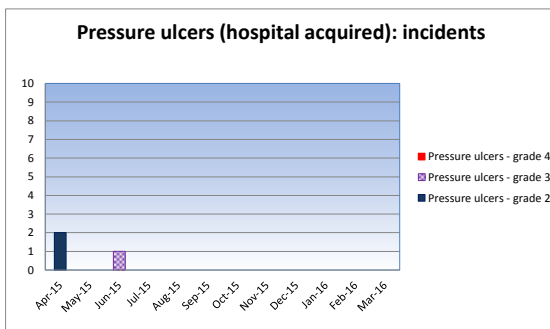
### National CQUIN indicators



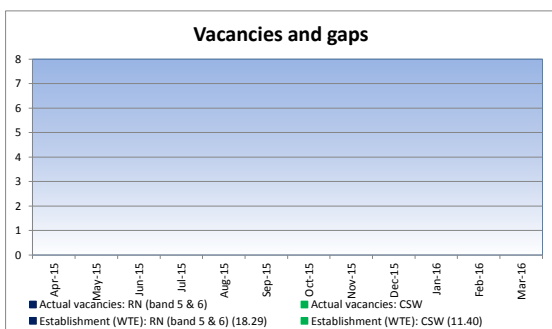
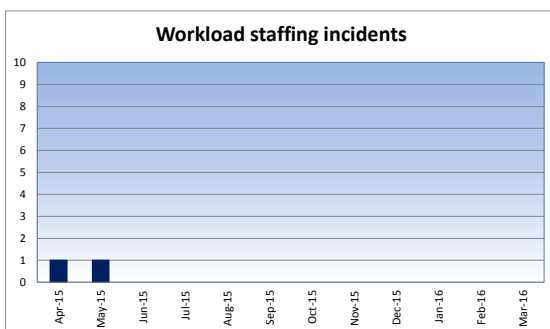
### Friends and family survey: Inpatients



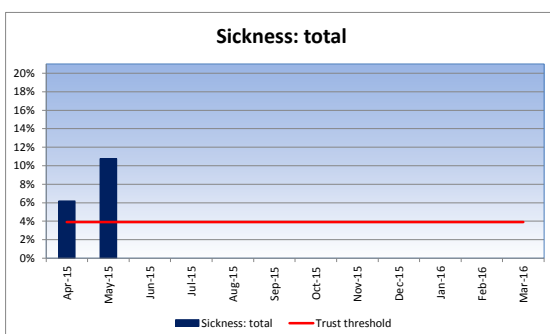
### Incident reporting



### Workforce



### Workforce cont.



Note, sickness data for the reporting month is not available at the time of publication

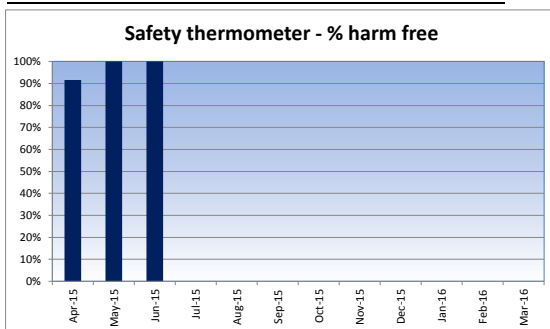
Vacancies + gaps reported in the April Chief Nurse report are recorded in the March section



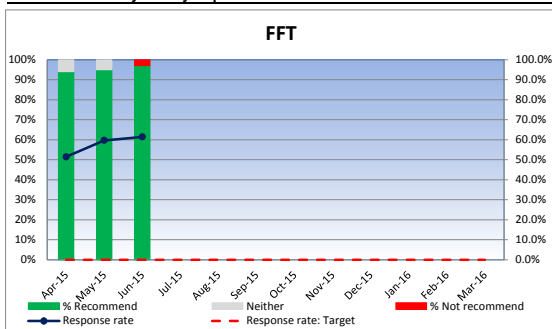
## Quality and Safety Dashboard - June 15

Ward: **Oakdale**

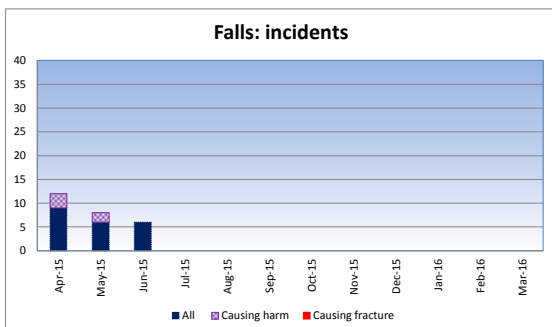
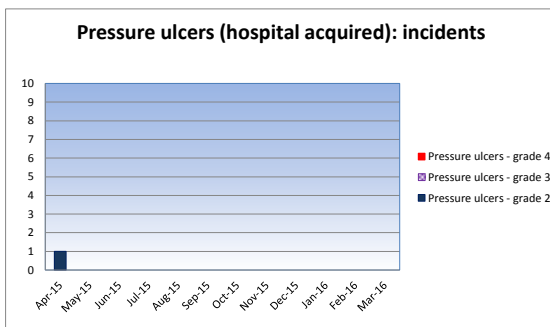
### National QUIN indicators



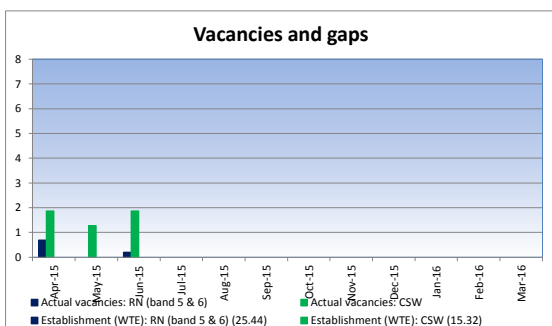
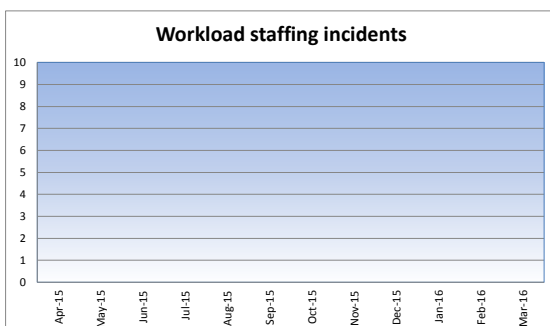
### Friends and family survey: Inpatients



### Incident reporting

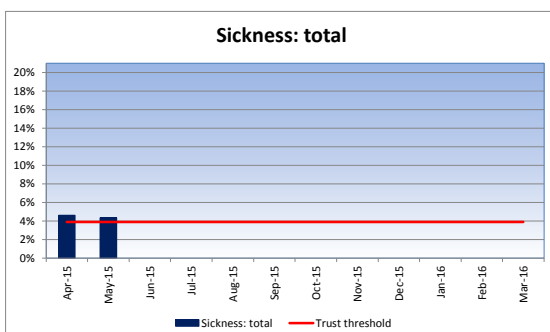


### Workforce



Vacancies + gaps reported in the April Chief Nurse report are recorded in the March section

### Workforce cont.

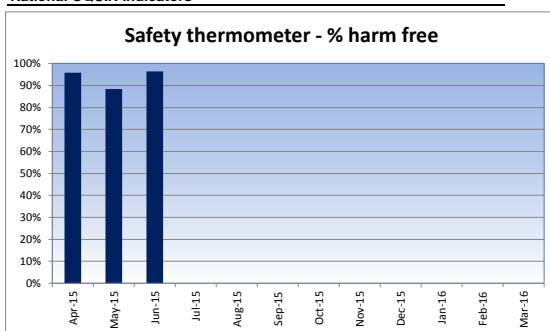


Note, sickness data for the reporting month is not available at the time of publication

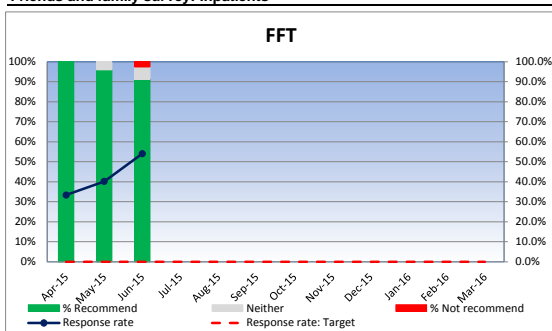
## Quality and Safety Dashboard - June 15

Ward: **Wensleydale**

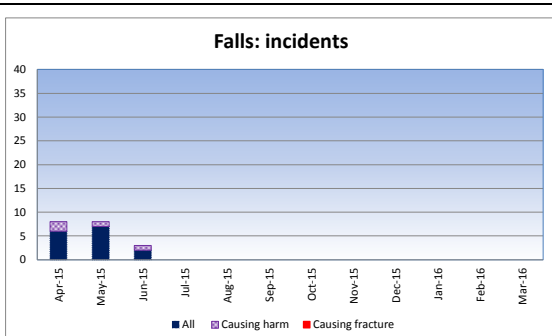
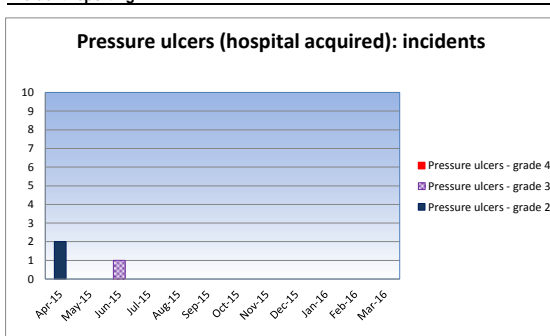
### National QUIN indicators



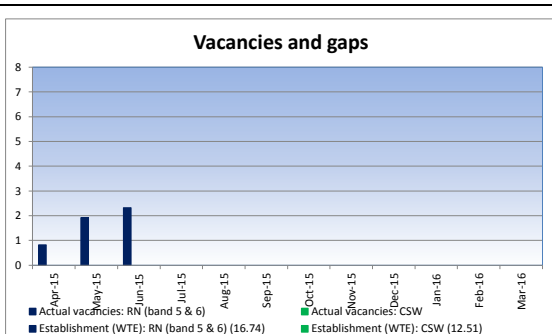
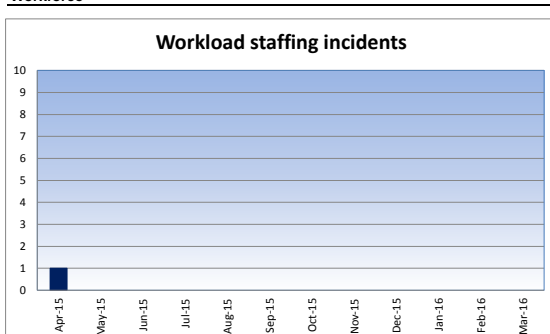
### Friends and family survey: Inpatients



### Incident reporting

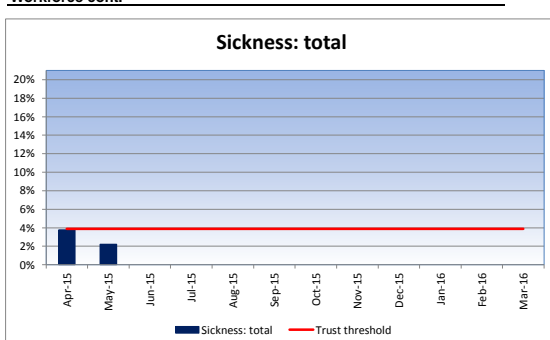


### Workforce



Vacancies + gaps reported in the April Chief Nurse report are recorded in the March section

### Workforce cont.

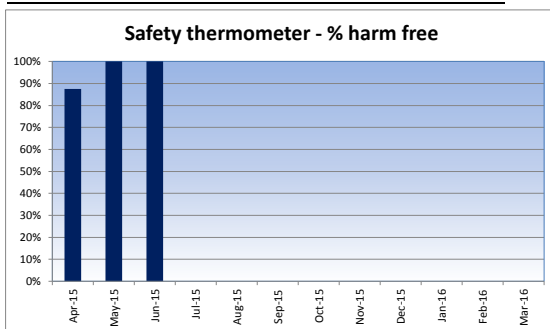


Note, sickness data for the reporting month is not available at the time of publication

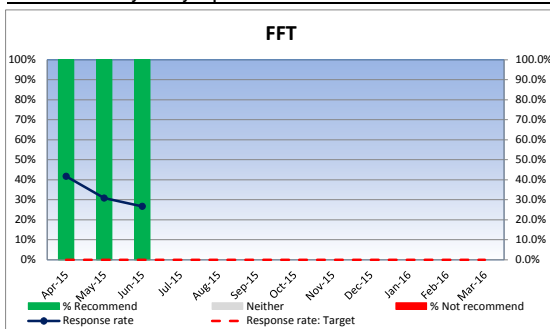
## Quality and Safety Dashboard - June 15

Ward: Trinity

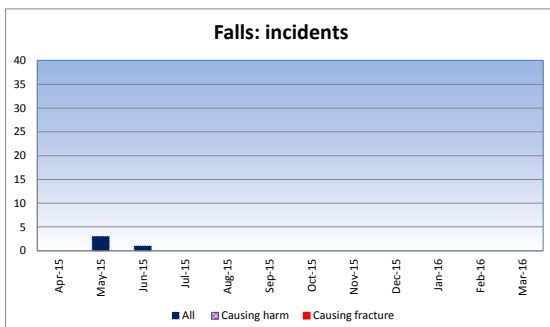
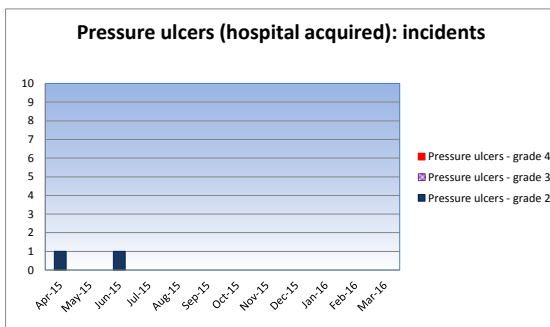
### National QUIN indicators



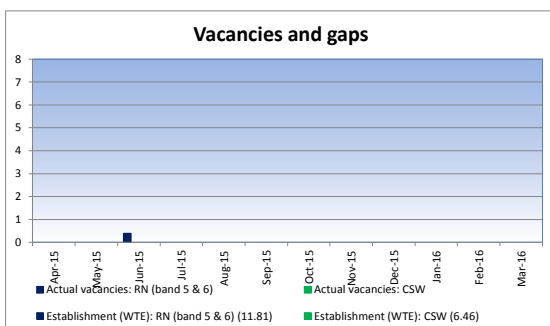
### Friends and family survey: Inpatients



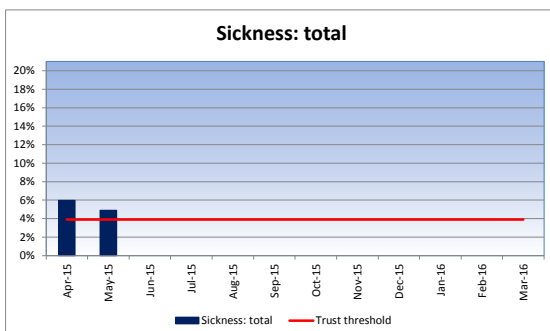
### Incident reporting



### Workforce



### Workforce cont.



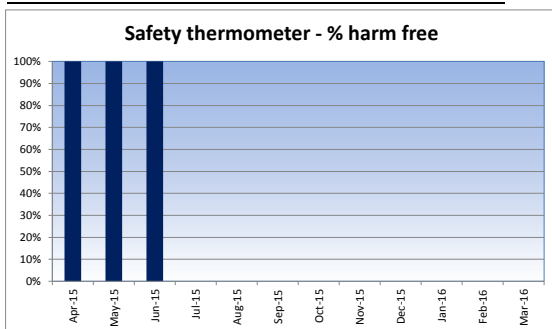
Note, sickness data for the reporting month is not available at the time of publication

Vacancies + gaps reported in the April Chief Nurse report are recorded in the March section

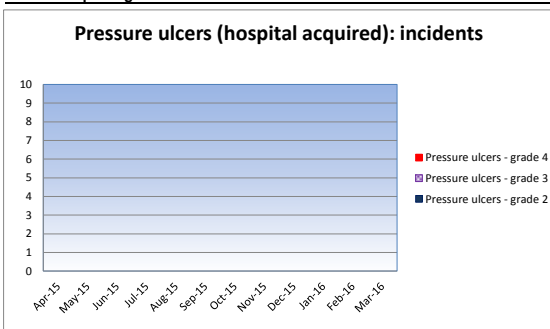
## Quality and Safety Dashboard - June 15

Ward: Woodlands

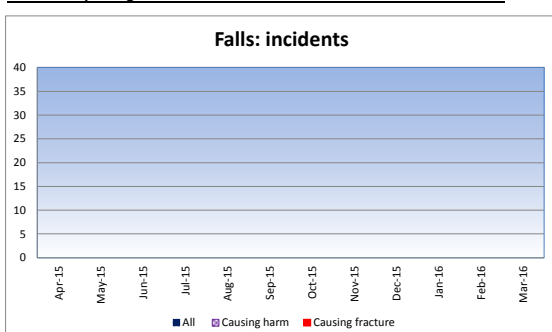
### National QUIN indicators



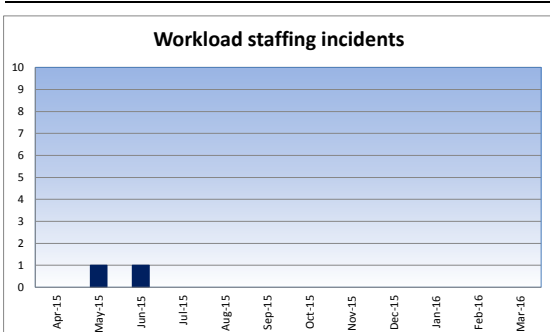
### Incident reporting



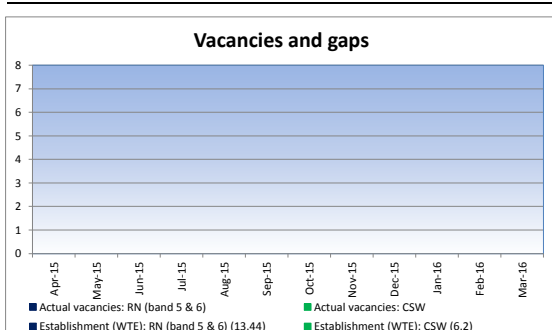
### Incident reporting cont.



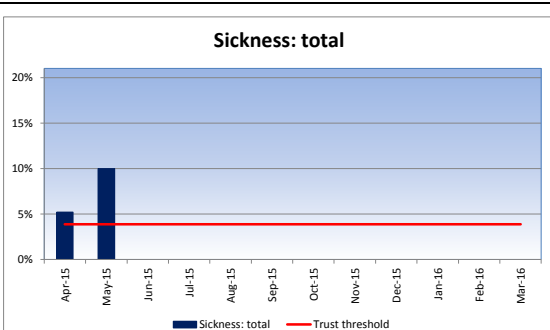
### Workforce



### Workforce cont.



Vacancies + gaps reported in the April Chief Nurse report are recorded in the March section

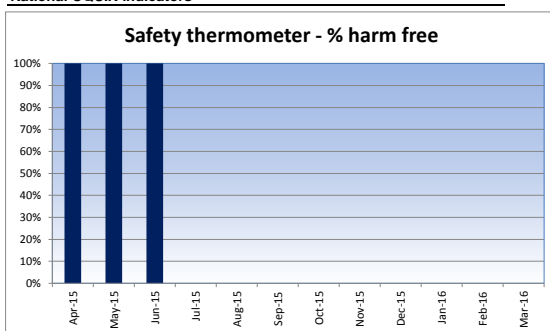


Note, sickness data for the reporting month is not available at the time of publication

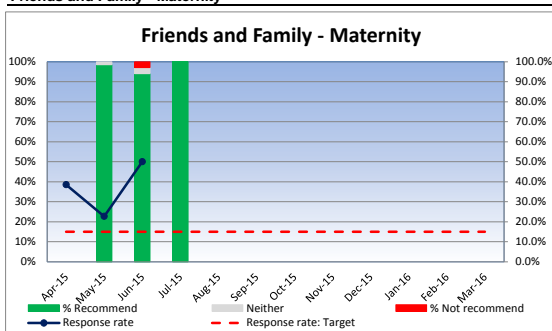
## Quality and Safety Dashboard - June 15

Ward: Pannal

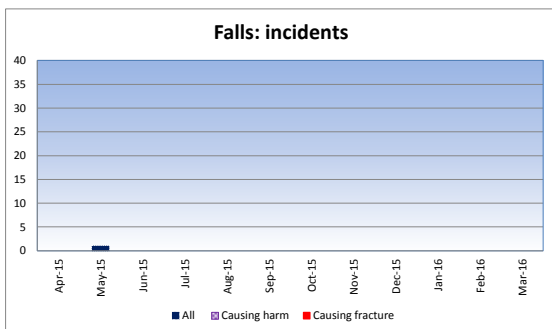
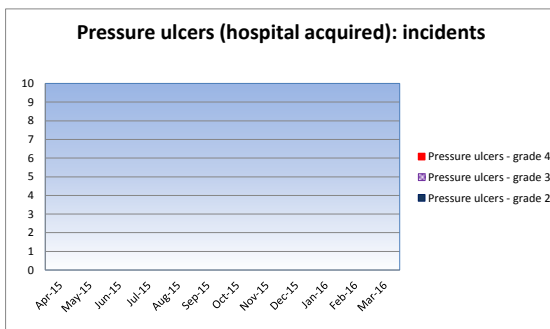
### National QUIN indicators



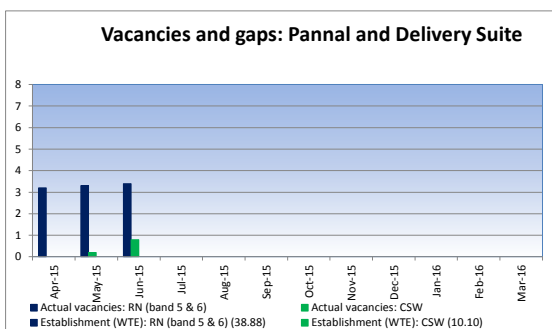
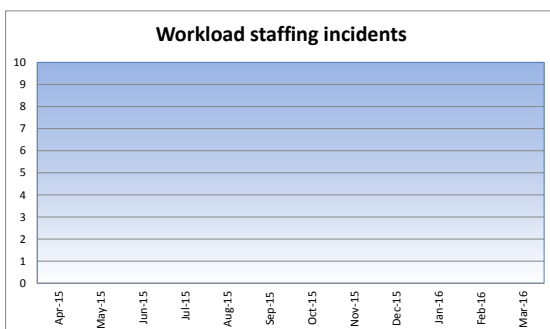
### Friends and Family - Maternity



### Incident reporting

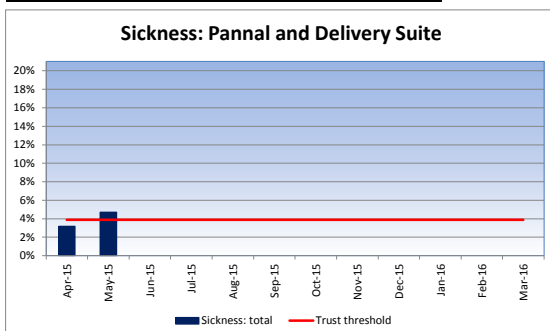


### Workforce



Vacancies + gaps reported in the April Chief Nurse report are recorded in the March section

### Workforce cont.

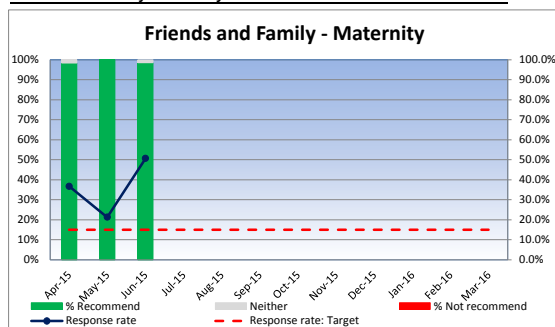


Note, sickness data for the reporting month is not available at the time of publication

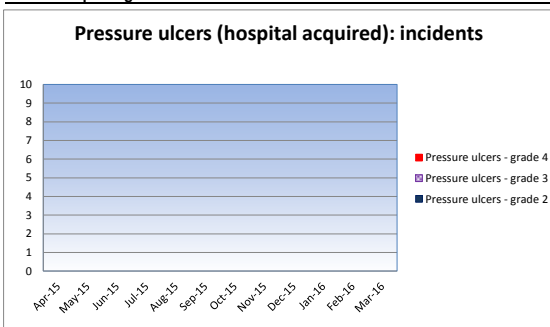
## Quality and Safety Dashboard - June 15

Ward: **Delivery Suite**

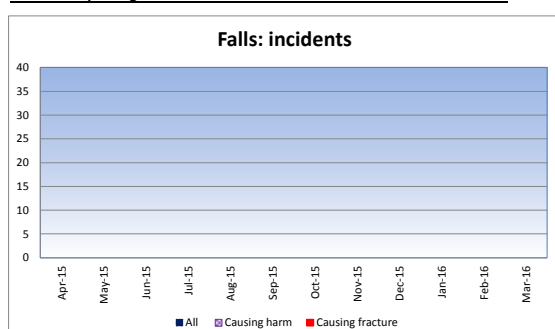
**Friends and Family - Maternity**



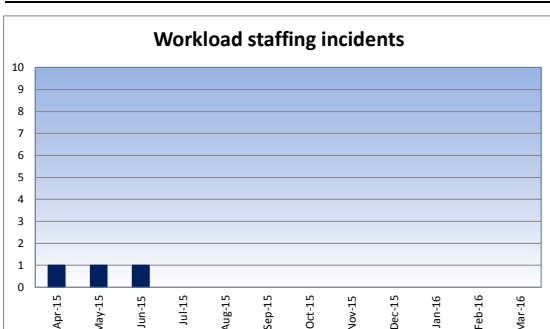
**Incident reporting**



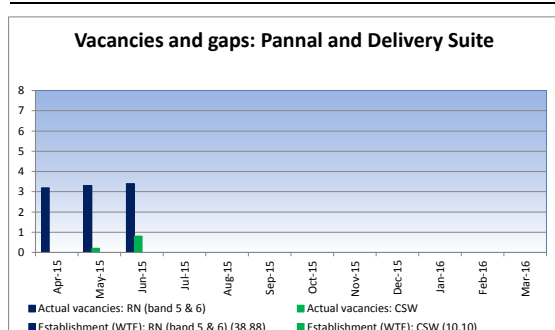
**Incident reporting cont.**



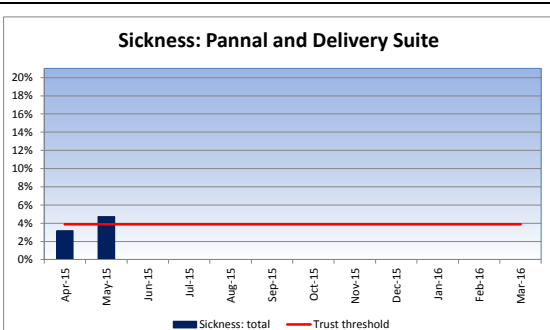
**Workforce**



**Workforce cont.**



Vacancies + gaps reported in the April Chief Nurse report are recorded in the March section

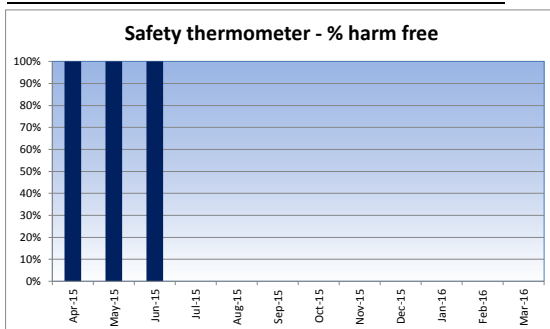


Note, sickness data for the reporting month is not available at the time of publication

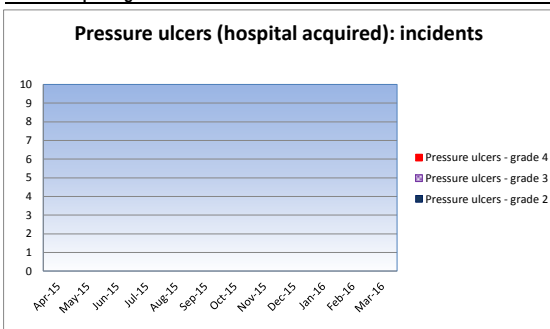
## Quality and Safety Dashboard - June 15

Ward: SCBU

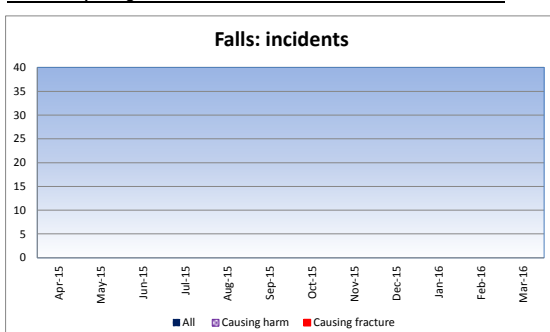
### National QUIN indicators



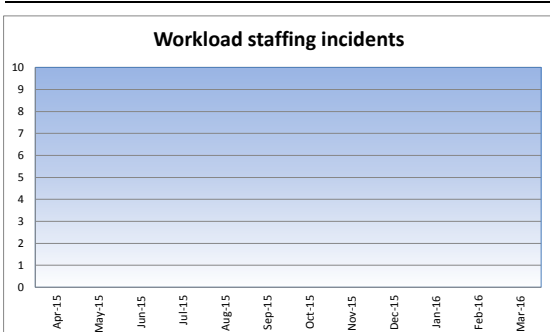
### Incident reporting



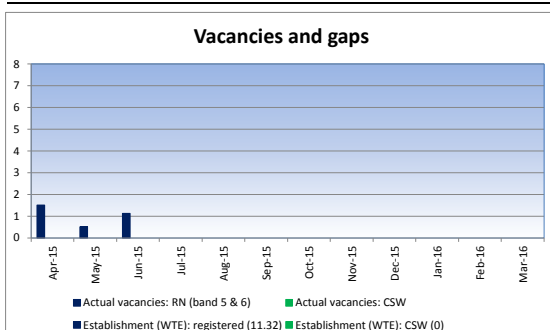
### Incident reporting cont.



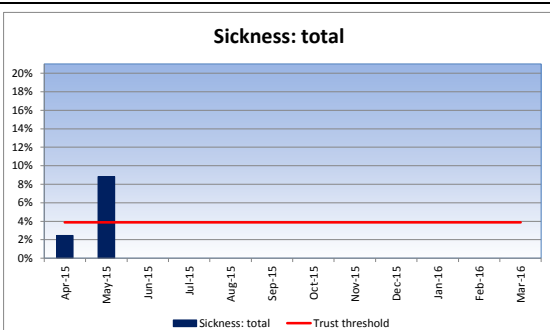
### Workforce



### Workforce cont.



Vacancies + gaps reported in the April Chief Nurse report are recorded in the March section



Note, sickness data for the reporting month is not available at the time of publication

Community- Fast response	Ripon- Outpatients	Hospital- wards can view their individual data	Main hospital- Outpatients	Main hospital- Therapy services
CFRRT Harrogate	Ripon Hospital	AMU Bolton	Cardio-Resp Centre	Therapy services
CFRRT Rural	Trinity Ward - Ripon	AMU Fountains	CDC	Child Development Centre / :
Community Fast Response & Rehab Team		Bolton escalation ward	Dermatology	
Harrogate FRT	<b>Community- Children's services</b>	Byland	Elmwood	<b>Main hospital-Other department</b>
Ripon - FRT	Specialist nurse team	CAT	Maxillofacial	Other
		CCU	Medical Outpatients	Pharmacy
		CIA	Occ Therapy	Phlebotomy
<b>Community- Health visitor</b>	<b>Community- Other</b>	CLWS	OPD Clinical Investigations Area	Podiatry
Scarborough	HMP Askham Grange	Coronary care unit	OPD East Waiting	Medical records
Children - Craven	Catterick OOH	Day surgery unit	OPD East Waiting / Surgical OP	Radiology
Children - Scarborough COAST	Colburn Joint Equipment Store	Delivery Suite	OPD North Waiting	Switchboard
Children - Selby Tadcaster	Dental - Cornlands Road Clinical	Emergency department	OPD Ophthalmology/ ENT	Antenatal clinic
Craven	Dental - Settle Health Centre	Endoscopy	OPD Physiotherapy	CT Scanning Department
Hambleton and Richmond	Jennyfield HC	Farndale	OPD Podiatry	Ear, Nose, Throat Clinic
Harrogate CHS	Joint Equipment Store - Colburn, Knaresborough	Granby	OPD Podiatry/ Therapy Services	X-Ray Room
Selby & York Child Health	New Joint equipment store	Harlow	OPD West Waiting	Theatre
	Northallerton Prison	ITU	OPD West Waiting / Eye Clinic	ENT
<b>Community- Midwifery</b>	Northway Dental clinic, Scarborough	Jervaulx	Ophthalmic OP	Cardiology
Community midwifery	OOH	Lascelles	Orthopaedic OP	Oral Surgery Department
	OOH - Harrogate Hospital	Littondale	Orthopaedic OPD	19 Wetherby Road
<b>Community- Stroke</b>	OOH - Selby Hospital	Macmillan dales unit	Outpatients	50 Lancaster Park Road
Community stroke team	OOH - York A&E Dept	Sir Robert Ogden Macmillan Centre	Physiotherapy Dept	Anaesthetic room
	Podiatry - Acomb Health Centre	Nidderdale	Surgical OP	Blood Transfusion
<b>Community- Therapy services</b>	Podiatry - Bedale Clinic	Oakdale	Urology Clinic	Chemical Pathology
Continence Service	Podiatry - CUE	PAAU	Waiting area	Clinical Coding
Patients home	Podiatry - Harrogate	Pannal	West Waiting	Dermatology Clinic
	Podiatry - Harrogate	SCBU		Disposal room
<b>Selby- MIU</b>	Podiatry - West Ayton GP	Swaledale	<b>Main hospital- grounds</b>	Haematology
Selby MIU	Podiatry - Whitby Hospital	Trinity	car park	Histopathology
	Podiatry - York Hospital	Wensleydale	Corridor	Microbiology
<b>Ripon- MIU</b>	Podiatry Clementhorpe	Women's unit	Filing Room	Occupational Therapy
Ripon MIU	Podiatry Scarborough Hosp	Woodlands	Front Entrance	Stop Smoking Service
	Podiatry -Spring Hill	Theatre	Garden	Willaston Crescent
	Podiatry -White Cross Court		Hospital Grounds	
	Podiatry-Fysche Hall	<b>Virtual wards - data can be viewed individually</b>	Kitchen	
	Scarborough joint equipment store	HARROGATE NORTH INTEGRATED COMMUNITY CARE TEAM	Lift	
	Selby/York Dental practices	HARROGATE SOUTH INTEGRATED COMMUNITY CARE TEAM	Office	
	York Joint equipment store			



York Wheelchair Service	KNARESBOROUGH & BOROUGHBRIDGE INTEGRATED COMMUNITY CARE TEAM	Stairs
Zetland House	RIPON & RURAL INTEGRATED COMMUNITY CARE TEAM	

SLT

<b>Report to the Trust Board of Directors: 22<sup>nd</sup> July 2015</b>	<b>Paper No: 9.0</b>
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<b>Title</b>	<b>Report from Chief Operating Officer</b>
<b>Sponsoring Director</b>	Robert Harrison, Chief Operating Officer
<b>Author(s)</b>	Rachel McDonald, Head of Performance & Analysis Jonathan Green, Information Analyst
<b>Report Purpose</b>	For information

## Key Issues for Board Focus:

- Board is required to approve the Trust's Q1 governance rating submission to Monitor and the IG toolkit baseline submission.
- Staffing levels on wards are concerning – both medical and nursing – caused by a combination of sickness, annual and maternity leave, deanery gaps, and one-to-one care being required.
- There is concern regarding capacity to see 2WW cancer referrals within the 14 day time frame, particularly in Breast and Dermatology.

## Related Trust Objectives

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

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

## Action Required by the Board of Directors

That the Board of Directors note the information provided in the report.

## **1.0 REFERRAL TO TREATMENT (RTT)**

### **1.1 Changes to RTT reporting**

NHS England has recently sent notification to all NHS providers and commissioners that the admitted and non-admitted RTT standards will be abolished within the next few months, and that the incomplete standard will become the sole measure of patients' constitutional right to start treatment within 18 weeks. This means that from now, no provider or commissioner will receive any form of sanction for failing the admitted or non-admitted standards. However, patients' legal right to start non-emergency consultant-led treatment within 18 weeks of referral is unchanged, and the collection and submission of information to NHS England on admitted (unadjusted) and non-admitted pathways will continue alongside the information on incomplete pathways in the short term.

### **1.2 RTT Audiology performance**

The 18 weeks position in Audiology is being monitored closely following poor performance in April and May. A PTL (Patient Tracking List) is being provided to the Audiology team to ensure appropriate bookings, and a recruitment campaign for admin/booking staff is under way.

## **2.0 ELDERLY CARE CONSULTANT COVER**

One consultant is currently on maternity leave and one will be on maternity leave from the end of August. Locum cover has been difficult and expensive to source, but the Trust has secured a 6PA locum who will start as an NHS locum in mid-September to cover the latest maternity leave. The Integrated Care directorate is continuing to work on a solution for the current locum issue and have an option of securing an individual who could work across CAT and Elderly Care.

## **3.0 JUNIOR MEDICAL STAFF**

Junior medical staff cover in Integrated Care has been challenging due to the number of vacancies carried during this rotation and the level of sickness. The rota for registrars from August has been re-designed and the directorate will directly appoint some trust doctors to support the rota cover. The Trust expects to see reliance on locum cover in this area to significantly reduce in the autumn.

## **4.0 CHOOSE & BOOK TELEPHONE APPOINTMENT LINE (TAL)**

There have been high numbers of patients on TAL for Ophthalmology, Dermatology and T&O. Action plans have been submitted to the Deputy Director of Performance and Informatics, and a Task and Finish Group has been established which has representation from the clinical directorates.

## **5.0 TWO WEEK WAIT (2WW) SUSPECTED CANCER REFERRALS**

The volume of 2WW suspected cancer referrals continues to be a challenge particularly in Breast and Dermatology. It is anticipated that these pressures will be exacerbated in the coming months as a result of the over 70s campaign for breast patients. This is currently being managed by the utilisation of ad hoc clinic capacity, but plans are in place to implement a more robust plan. These include the proposed recruitment of a Radiology locum for Saturday working, and the development of a specific Dermatology clinic so that patients will be aware of their appointment time at the point of GP referral.

## **6.0 EMERGENCY DEPARTMENT (ED) AUDITS**

The Royal College of Emergency Medicine carried out two audits at Harrogate Emergency Department (ED);

### Initial Management of the Fitting Child

Overall, the Trust performed well with the exception of one standard relating to the provision of information leaflets to parents/carers including safety advice for all children discharged from ED which had not been provided in the cases reviewed as part of the audit (sample size 33).

### Mental Health

The Trust performed below average on a number of measures for this audit, including two fundamental standards:

- The proportion of self-harm patients having a risk assessment in ED;
- Having an appropriate facility for the assessment of mental health patients in ED.

It should be noted that only 7 cases were reviewed as part of the audit so the results may not be representative. The audit noted that a psychiatric liaison service was in place and all patients audited had been assessed by a mental health practitioner within one hour.

The results of both audits have been reviewed by the Medical Director and Chief Nurse and sent to the Acute and Cancer Care Directorate for consideration and development of an action plan.

## **7.0 COMMUNITY SERVICES ACTIVITY**

There has been increased activity recorded across all community teams. There were 440 face to face patient contacts per calendar day across the district nursing teams in June 2015 compared to 350 contacts per day in June 2014.

As of April 2015, two new specialist nursing teams have been trained and are inputting onto Systmone: the TB and New Entrants Assessment Team, and the Specialist Palliative Care Nurses. This helps account for the increases in activity from April on the previous months. In June 2015 there were 41 contacts per day, compared to 28 contacts per day in March.

Concerns have been raised locally at the Operation Delivery Group (ODG) with regards to potential loss of district nursing staff to Leeds Teaching Hospitals (LTHT) as a result of LTHT recruiting district nurses at a banding level higher than at HDFT. However, the full extent of this is not yet known.

## **8.0 CARBON AND ENERGY FUND**

The Carbon and Energy fund project commenced work on the HDH site on the 6<sup>th</sup> May and operational responsibility for the primary heat and chilled water systems transferred to Imtech Inviron on the 8<sup>th</sup> June. Over the course of July work to install the chilled water ring main, high voltage distributions system and LED lighting will gather pace, overall the project is on programme.

The liaison between the Trust and Imtech is working well with weekly meetings to discuss, progress, technical matters and any concerns either party has. As part of the projects communication strategy updates are reported weekly via the daily bulletin, team brief and a meeting has been held with the Trusts Communication Manager to discuss how the project should be communicated to the wider public.

## **9.0 IM & T UPDATE**

Several areas of work continue within the IT Department, including a significant PC replacement programme, core network upgrade and replacement, and the continued virtualisation of computer servers and data storage.

We are currently in discussions with Yorkshire and Humber Commissioning Support Unit (CSU) to agree handover of contracts and equipment that make up the community IT infrastructure.

Automatic escalation has recently gone live with Patienttrack and the project team continues to work closely with the wards and services.

## **10.0 SERVICE ACTIVITY**

For 2015/16 to date at the end of June, elective admissions from all commissioners were 7.3% above plan. For Leeds North and West CCG, follow-up outpatient appointments were 4.9% below plan, elective admissions were 18.6% above plan, and ED attendances were 4.3% above plan.

## **11.0 WAITING TIMES IN PODIATRY**

At the end of June there were 68 patients whose wait for an appointment was over 20 weeks. This compares to 302 at the end of March 2015. All patients over 20 weeks have been invited to phone for an appointment which should result in a further reduction as they either phone to agree appointment date or do not respond to the invite.

The service has worked hard to increase the number of new patient slots while maintaining the commitment to ongoing treatment for patients with long term foot conditions. A business case for recruitment for an additional member of staff is being worked up by the Acute & Cancer Care Directorate and this would provide additional capacity on an ongoing basis.

## **12.0 FOR APPROVAL**

### **12.1 Information Governance Baseline Submission**

Within the Information Governance toolkit, the Trust is required to carry out self-assessments of their compliance against the IG requirements and to submit this information to the Health and Social Care Information Centre. Changes to the assessment methodology have impacted HDFT's performance with the baseline submission for 2015/16 at 83% compared to 84% for the final submission for 2014/15; however, this remains above the required standard.

### **12.2 Monitor Risk Assessment Framework**

At the end of Quarter 1 HDFT's governance rating is **Green**. Board is required to approve this as the rating to be submitted to Monitor.

<b>Report to the Trust Board of Directors:</b> <b>22<sup>nd</sup> July 2015</b>	<b>Paper No: 10.0</b>
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<b>Title</b>	Monthly Finance Report
<b>Sponsoring Director</b>	Director of Finance
<b>Author(s)</b>	Finance Department
<b>Report Purpose</b>	Review of monthly financial position

**Key Issues for Board Focus:**

The attached report contains information on the following –

1. The Efficiency Programme performance of the Trust.

With 75% of the internal target actioned and a further 14% of plans in place the Trust has made an extremely positive start the year. Despite this performance there is still work to do to close the gap and plan for future years.

2. Continuity of services risk rating

The paper includes an overview of the Q1 submission of 4 which is ahead of the Trusts plan. This is a result of a slightly improved liquidity position.

3. Reference costs

There is some supporting information included in relation to the approval of the reference cost submission for 2014/15.

**Related Trust Objectives**

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

<b>Risk and Assurance</b>	There is a risk to delivery of the 2015/16 financial plan if budgetary control is not improved. Mitigation is in place through regular monthly monitoring, and discussions on improving this process are ongoing.
<b>Legal implications/ Regulatory Requirements</b>	Continuity of services risk rating submission to monitor.

### **Action Required by the Board of Directors**

The Board of Directors is asked to

- Note performance against the cost improvement programme
- Approve the continuity of services risk rating to monitor
- Confirm the items highlighted in relation to the 2014/15 reference cost submission



# Efficiency Update

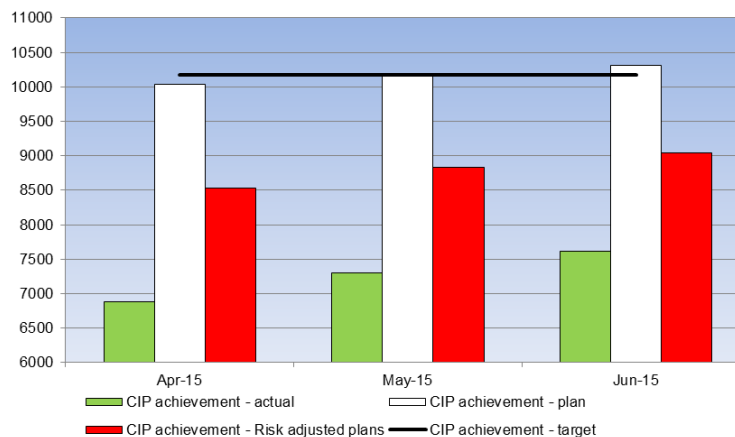
- The Efficiency Target for the Trust was developed in the planning process. Internally the cost improvement target (CIP) is set at £10.2m, whereas externally the Trust is reporting against a £8.8m target. The target is internally higher in order to provide opportunity for service and capital developments, as well as resilience for the organisation against the external target.
- This target was subsequently split to directorates based on the size of their budget. Plans have then been developed by the directorates with implementation occurring following a Quality Impact Assessment. This process continues as more plans are developed.
- Directorate performance is reviewed monthly, with a risk adjusted methodology in place to assess plans.

- As outlined in the following table, directorates have actioned £7.6m of savings with plans in place for a further £1.4m following risk adjustment.
- The £9m of risk adjusted plans is a positive position against the Trusts external target, however, work needs to continue in order to reach the £10.2m target that would provide the investment required for service developments.

Summary	Target	Actioned	Low	Medium	High	Total	%	Risk Adjust	%
Acute Care	2,823,600	1,951,844	102,357	270,558	496,050	2,820,809	100%	2,364,740	84%
Elective Care	3,165,500	2,315,900	221,100	175,253	614,347	3,326,600	105%	2,789,017	88%
Integrated Care	2,800,200	2,148,800	162,000	392,100	0	2,702,900	97%	2,616,380	93%
Corporate	1,463,600	1,191,960	0	43,080	228,600	1,463,640	100%	1,272,144	87%
<b>Total</b>	<b>10,252,900</b>	<b>7,608,504</b>	<b>485,457</b>	<b>880,991</b>	<b>1,338,997</b>	<b>10,313,949</b>	<b>101%</b>	<b>9,042,280</b>	<b>88%</b>
Target		10,179,000				10,179,000		10,179,000	
<b>Variance</b>		<b>-2,570,496</b>				<b>134,949</b>	<b>101%</b>	<b>-1,136,720</b>	<b>89%</b>
Target less ETO benefit		8,779,000				8,779,000		8,779,000	
<b>Variance</b>		<b>-1,170,496</b>				<b>1,534,949</b>	<b>117%</b>	<b>263,280</b>	<b>103%</b>

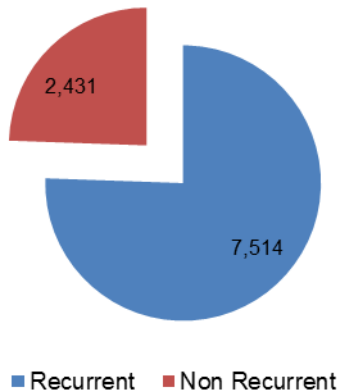
- The graph to the right demonstrates the increase in both plans being developed and actioned over the previous months. The Trust has now £0.5m of additional, risk adjusted plans in place when compared to April.

CIP achievement and plans by month (2015/16)

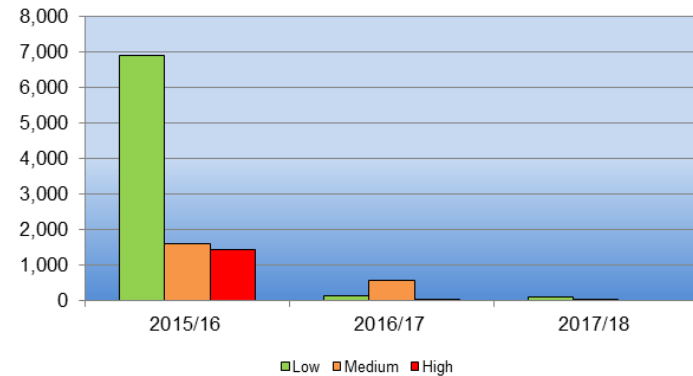


# Efficiency Update

- The Recurrent – Non-recurrent split of £7.5 to 2.4m should be noted as being positive in comparison to 14/15 (the Trust ended the year with an approx. 50:50 split). This will, however, present a carry forward issue for 16/17. Further work is required for future years with support from the Transformation and Business Development agendas.

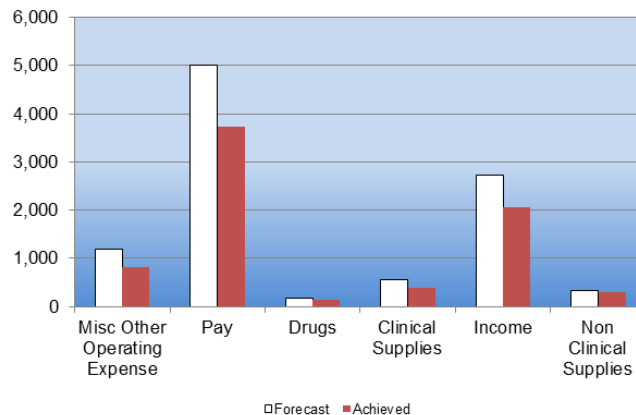


**CIP Financial Risk**

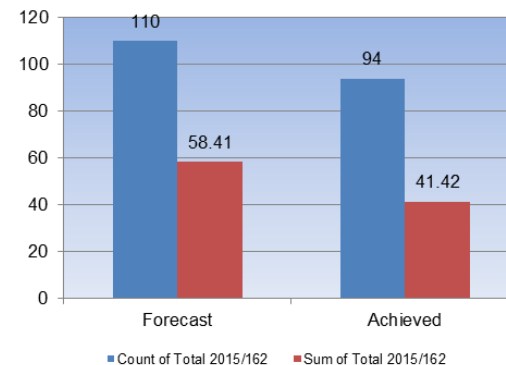


- Pay and Income are high value areas for the plans developed to date. The graph below demonstrates that of the plans identified many of been actioned (75% of Pay and 76% of Income) but work needs to continue in these areas. Particular focus is on the reduction in WTE which is positive to date but further plans are to be implemented.

**CIP Catagories - Forecast and Achieved**

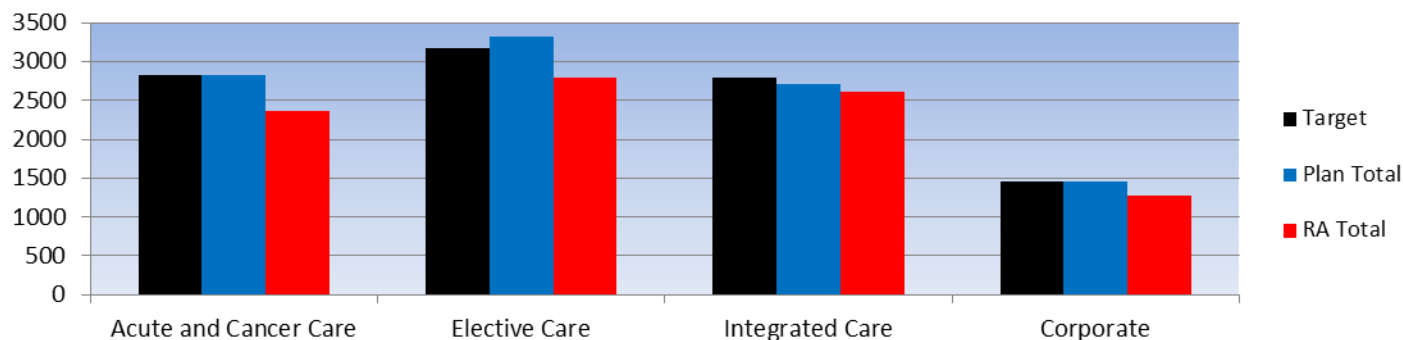


**Impact to WTE  
(No. of schemes effecting WTE and WTE reduction)**



# Efficiency Update

## Directorate Position



## Key issues in each directorate –

Directorate	Issues
Acute and Cancer Care	The directorate have been working to reduce the risk for those schemes which are classified as high.
Elective Care	Challenging work in relation to reducing premium rate expenditure continues in the directorate and remains high risk. Current focus is on reducing the in week element of this expenditure. There has been some positive steps in this area with waiting list spend being lower than planned.
Integrated Care	The directorate has made a positive start to the financial year. Pressure on the bed position has impacted on the inpatient workstream. Work is ongoing to support this increase in activity.
Corporate	Following the Quality Impact Assessment process plans in relation to HPV cleaning and beverage rounds were removed or redesigned. Work has been underway to replace these but the risk assessment demonstrates that plans still need to be identified.

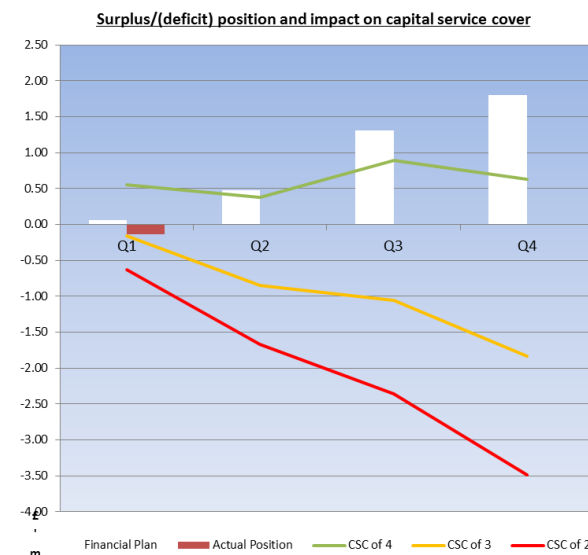
- Finance and Activity meetings with the directorates will continue to review CIP plans, with focus on actioning identified plans and closing the planning gap. Where hard schemes have been identified these will be supported to drive forward delivery.
- The Trust has made a positive start to the financial year in relation to the efficiency programme with a significant number of plans identified and actioned. The amount of schemes actioned non recurrently has significantly reduced in comparison to 2014/15 and the position is improving on a monthly basis. This momentum must continue, focusing on delivering the internal plan for 2015/16 as well as developing schemes for 2016/17 and beyond.

# Continuity of Services Risk Rating

- The Monitor Continuity of Services (CoS) risk rating is made up of two components, liquidity and capital service cover. An overall rating is calculated ranging from 4 (no concerns) to 1 (significant concerns).
- The table below shows the quarterly plan and performance of the Trust-

	Q1	Q2	Q3	Q4	Full Year
<b>Planned Rating</b>	<b>3</b>	<b>4</b>	<b>4</b>	<b>4</b>	<b>4</b>
Actual Rating – Capital Service Cover	3				
Actual Rating – Liquidity	4				
<b>Actual Rating – Consolidated Rating</b>	<b>4</b>				

- The positive variance against plan is a result of an improved liquidity position, however, the plan was already close to being a 4 in this area.
- Capital Service Cover is reported at the planned level of 3, however, a marginally higher deficit would have resulted in a 2 for this metric, reducing the continuity of services risk rating to 3. The graph on the right outlines the estimated surplus/(deficit) required for each level of this rating.
- It should be noted that the changes to the Risk Assessment Framework which have recently been consulted on would have resulted in the Trust reporting a rating of 3. We are still awaiting the outcome of this consultation.



# Reference Cost Submission

## Section 5 - Overall Conclusion

The Board will be aware that the Trust has submitted Reference Cost information for many years. For the Reference Costs relating to 2014/15, the Board is required to confirm that –

- Costs have been prepared with due regard to the principles and standards set out in Monitor's Approved Costing Guidance
- Appropriate costing and information capture systems are in operation
- Costing teams are appropriately resourced to complete the Reference Cost return accurately within the timescales set out in the Reference Cost guidance
- Procedures are in place such that the self-assessment quality checklist will be completed at the time of the Reference Cost return.

The Internal Audit Team have undertaken an audit of the process and the conclusion is outlined on the right. A significant assurance opinion has been issued.

This Internal Audit review found that appropriate systems were in place for the management of the reference costing process.

In 2014 the Trust implemented CostMaster which is a patient level information and costing system (PLICS). CostMaster enables the production of reference costs based on cost and income data uploaded from the general ledger and activity data uploaded from source feeder systems. We can confirm, from a walkthrough and sample testing, that controls are in place to ensure the principles and guidance set out in Monitor's Approved Costing Guidance have been applied in order to produce reference costs for 2014/15.

The Trust has a number of controls in place which we found to be working effectively to ensure the completeness and accuracy of activity data recorded on the costing system. These include an annual clinical coding audit of data recorded on source systems to ensure that best practice quality processes are followed. A reconciliation and review process is also in place to confirm the financial cost quantum uploaded from the general ledger.

A formal management timetable was established for the production of 2014/15 reference costs. This set out key tasks to be completed in order to ensure that the Trust achieves initial reference cost submission by 24 July 2015 and Finance Director sign-off of the final submission by 30 July 2015 in accordance with DH Guidance. The Trust expects to submit the initial submission and sign off of the final submission by the required dates.

At the time of our review, the Trust has not yet completed the self-assessment quality checklist, which is a mandated element of the submission. The self-assessment quality checklist requires that reference cost data is benchmarked where possible against national data for individual unit costs and for activity volumes. The commencement of benchmarking data has been delayed until w/c 6 July 2015 due to delays uploading activity and final ledger costs. Consequently, benchmarking data was not available for review during this audit.

One of the five costing principles in Monitor's guidance requires stakeholder engagement, including engaging clinicians and operational managers in the reference cost process and more general costing processes. During 2014/15 the Trust has commenced rolling out the use of CostMaster for Service Line Reporting, with an initial focus on inpatient and outpatient areas prior to being extended to community service areas. The costing team has engaged with some clinicians and operational staff as part of this rollout process and further engagement is expected in relation to the validation of costs as part of this year's reference cost exercise. There is an expectation that clinicians and operational staff will become increasingly involved in costing as the rollout of CostMaster for Service Line Reporting continues.

Overall, this Internal Audit has found that the Trust has effective systems and controls in place to ensure the completeness and accuracy of reference cost data. We do note that at the time of the audit the 2014/15 exercise had not been fully completed and our assurance is based on the data available.

We therefore offer an opinion of **Significant Assurance** in relation to the robustness of reference cost processes and the systems in place to ensure effective scrutiny of reference costs by management.

Corporate importance of the system	High
Overall corporate risk of system	Amber/Green

The auditor is grateful for assistance received from management and staff during the audit.

Head of Internal Audit:	Helen Kemp-Taylor
Audit Manager:	Tom Watson
Auditor:	John Roberts
Date:	14 July 2015

<b>Report to the Trust Board of Directors: 22 July 2015</b>	<b>Paper No: 11.0</b>
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<b>Title</b>	<b>Workforce and Organisational Development Update</b>
<b>Sponsoring Director</b>	Director of Workforce and Organisational Development
<b>Author(s)</b>	Director of Workforce and Organisational Development
<b>Report Purpose</b>	To provide a summary of performance against key workforce matters

**Key Issues for Board Focus:**

This report provides information on the following areas:

- a) Workforce Performance Indicators
- b) Training, Education and Organisational Development
- c) Service Improvement and Innovation

Key messages are included at the front of this report.

<b>Related Trust Objectives</b>	
1. Driving up quality	Through the pro-active management of workforce matters, including recruitment, retention and staff engagement
2. Working with partners	By working with NHS England and the Yorkshire and Humber LETB on standards of education, training and leadership at the Trust
3. Integrating care	By the delivery of multi-disciplinary learning and development interventions. Also, via service innovation and improvement initiatives
4. Growing our business	By ensuring we have the right number of staff with the right skills in place to continue with the delivery of high quality services

<b>Risk and Assurance</b>	Any identified risks are included in the Directorate and Corporate Risk Registers
<b>Legal implications/Regulatory Requirements</b>	Health Education England and the Local Education and Training Board have access to the Trust's workforce data via the Electronic Staff Records system. Providing access to this data for these organisations is a mandatory requirement for the Trust

**Action Required by the Board of Directors**

The Board is asked to **note** the update on matters specific to Workforce, Training and Education, Service Improvement and Innovation and Organisational Development.

## Key Messages for July 2015

### a) Department of Health Connecting Programme

Harrogate and District NHS Foundation Trust (HDFT) has been a partner of the Department of Health Connecting Programme for the last two years, assisting Senior Civil Servants to connect with frontline services. This has created a number of opportunities for the Trust. This year, for example, HR Colleagues at HDFT have influenced the National Agenda through our participation with the Connecting Programme, namely the content of the Staff Survey 2015. In addition, NHS Employers have been commissioned by the Department of Health to begin a new work stream focussed on presenteeism; a challenge identified by HR in line with the HDFT staff survey results in 2014, and raised to the Head of Employment Services within the Strategy and External Relations Directorate at the Department of Health as part of the Connecting Programme. The Department of Health has also worked very closely with the Acute and Cancer Care Directorate, as part of the New Model of Care Programme to provide analytical capacity and system modelling guidance. The Department of Health have offered to continue their support until autumn 2015.

Following on from our proposal to use the Connecting Programme to work collaboratively with the Department on the New Models of Care Programme, the Trust was invited to join a discussion with leads of Connecting in July to discuss the shape of the Programme across England in year three. The aim of the session was to explore how Connecting can improve health and care policy and evidence the impact. The Department are looking to match more closely the policy leads to the parts of the health and social care system they are responsible for, and in partnership with providers, undertake more 'deep dives' to really understand the system.

The Department are keen for the Trust to continue to be involved in shaping this methodology, following on from our fresh approach to the Connecting Programme and the positive results we have had this year.

### b) Job Plan Compliance – Career Grade Medical Staff

Data as of 1 July 2015

Directorate	Number of Consultants within the Directorate	Number of Consultants with a Job Plan within the last year	Percentage Compliance
Acute and Cancer Care	23	20	86.96%
Elective Care	56	20	35.71%
Integrated Care	31	7	22.58%

Directorate	Number of SAS Grades within the Directorate	Number of SAS Grades with a Job Plan within the last year	Percentage Compliance
Acute and Cancer Care	7	0	0.00%
Elective Care	43	3	6.98%
Integrated Care	2	0	0.00%

A Job Plan is considered complete once the signed job plan has been received by the medical staffing team for storage on personal files.

Historically, it should be noted that many Specialty and Associate Specialist (SAS) doctors have had their job plan determined by the working rota within their department. This, in effect, was a job plan. However, in order to ensure full compliance with the national terms and conditions of service for these staff groups an individually tailored job plan with agreement of specific objectives should be agreed and signed with each SAS doctor. Directorates are aware of their obligations in this regard following a recent audit and the requirements to complete job plans has been widely communicated. A new job plan policy for consultant and SAS doctors will be agreed shortly in support of this requirement.

### c) Progress on conditions issued by Health Education Yorkshire & the Humber to improve quality of medical training

Health Education Yorkshire and the Humber visited the Trust in February 2015. Subsequently the Trust was issued with a report on their findings regarding the quality of education received by trainee doctors in Medicine, Surgery and Obstetrics and Gynaecology, measured against the General Medical Council's standards for training.

The Trust was issued with eight specific conditions spread across both Elective and Integrated Care Directorates, along with timescales and the requirements needed to meet the standards. Details of the evidence required were also provided in the report.

The conditions were shared with Clinical Directors and Operational Directors. To date the Trust has made the following progress:

#### Elective Care Directorate

Condition	Date Due	Summary	Condition met
1	30/06/15	Appropriate supervision in clinics	Evidence to be submitted to HEYH
3	31/07/15	Job planning to allow Consultants to undertake WPBAs	Future date
4	30/09/15	Undermining	Future date
5	30/09/15	Improve Specialty Induction Standards	Awaiting approval of evidence by HEYH



6	31/05/15	Handover – Surgery	Awaiting approval of evidence by HEYH
8	30/09/15	Access to specialist clinics/lists to complete curriculum requirements	Future date

#### Integrated Care Directorate

Condition	Date Due	Summary	Condition met
1	30/06/15	Appropriate supervision in clinics	Evidence to be submitted to HEYH
2	30/04/15	Increase in Gastroenterology Consultant Ward Time	Evidence subject to QA and then to be submitted to HEYH
4	30/09/15	Undermining	Future date
5	30/09/15	Improve Specialty Induction standards	Awaiting approval of evidence by HEYH
6	31/05/15	Improvement in medical handover	Evidence to be submitted to HEYH
7	30/09/15	Better rota management to improve specialty training (less cross cover)	Future date
8	30/09/15	Access to specialist clinics/lists to complete curriculum requirements	Future date

A further meeting is being arranged between the Director of Medical Education and the Directorate representatives to ensure the required progress is made.

#### **d) Emergency Department Speciality Doctor Rota and Redesign Implementation**

Work is on-going within the Emergency Department to implement the recommendations of the Speciality Doctor Rota review and redesign.

The Certificate for Entry for Specialist Registration (CESR) programme has now been advertised to recruit new Specialty Doctors on a number of occasions. The rota has four gaps and we have recruited to two of these positions. As such we are now progressing with international recruitment again with the CESR rotation included with a view to filling the remaining two vacant posts by September 2015. If successful then it is hoped that the new arrangements will be implemented with effect from January 2016.

#### **e) NHS Library Services**

The Library at HDFT is continuing to improve year on year in line with the Library Quality Assurance Framework (LQAF). The letter confirming the assessment is attached at Appendix 1.

## **f) Nominations for Regional Leadership Awards**

### **About the Awards**

Great leaders are everywhere in the health service and we want to recognize them here at HDFT. The NHS Leadership Recognition Awards celebrate leaders at all levels and across all professions who have ultimately improved people's health, the public's experience of the NHS and those leaders who we are truly proud to work alongside.

We want to celebrate and reward staff who have gone above and beyond their role to make a difference. We are looking for compassionate leaders – leaders who demonstrate kindness, integrity, courage, trust, empathy and commitment and show emotional intelligence, respect, who listen, are positive, reflective, balanced and non-judgmental.

Mandy Mallory, School Nurse at the Trust and last year's finalist for the Emerging Leader of the Year Award said:

'I felt very humbled to be nominated and was even more overwhelmed by the fact I had the respect of my colleague who made the nomination. The awards are held in very high regard and it was such a surprise to get to the final three from so many nominations from all over the Yorkshire and Humber region. So don't hesitate. If you work with someone that you think deserves the recognition, please take time to participate and complete your nomination form now'.

The Trust is currently seeking nominations for the Regional Leadership Awards. Attached is a promotional leaflet regarding the Awards.

Dr Ros Tolcher  
Chief Executive  
Harrogate and District NHS Foundation Trust  
**Sent Via Email**

22 June 2015

Dear Dr Tolcher

**NHS Library Services:**

I am writing to provide you with an update and overview of library and knowledge services that are assured through the Learning and Development Agreement (LDA) and give the wider context of quality services to patients, learners and staff within your organisation. You will know that our local arrangements link directly to the national NHS Library Quality Assurance Framework (LQAF).

**Context to NHS Library Quality Assurance Framework (LQAF):** The NHS Library Quality Assurance Framework (LQAF) was created in April 2010 and is an annual tool to underpin the quality assessment and improvement of NHS Library Services and is embedded in the clinical placement experience requirements within the Learning and Development Agreement.

You will be pleased to hear that your organisation has continued to improve and has consistently scored above this percentage. A decision was made therefore not to conduct a peer review in 2014. I would encourage you however, to continue to support Helen Weir to retain their involvement in the LETB network and to share and learn from good practice. This will become increasingly important as we move to embed Health Education England's One Vision and work more closely with our North Geography colleagues in Health Education North West and North East.

Each NHS Library Service completes an annual self-assess against the [NHS Library Quality Assurance Framework](#), which is a national, standardised framework for assessment. Each self assessment is then reviewed and validated by the local Library Services Lead and a decision is made to undertake a visit to the library service. The results for your organisation are given in the table below.

Year of assessment	2012	2013	2014
% score	78%	78%	88%

Your organisation has continued to make year on year improvements and I am aware that an action plan has been drawn up to address the issues identified in the 2014 LQAF. Your Library Manager has also been involved in supporting our local LETB strategy as well as involvement in national meetings which have contributed to the publication of the new five year strategy for library and knowledge services.

**Tariff:** With the introduction of Tariff, historical Library funding from the LETB is no longer identified separately as a line in the LDA. The funding for libraries is now incorporated into the Tariff Placement rate. This is paid to your organisation and is based on recognised numbers of Health Education England (HEE) funded training grade doctor posts.

We are the Local Education and Training Board for Yorkshire and the Humber

### **Commendations**

I am pleased to commend your Library Team for continuing to provide a quality service.

In late 2014, the Knowledge for Healthcare Framework was published by Health Education England, this is a forward looking document which provides a five year strategy to modernise knowledge management and library services provided in NHS organisations. A copy of the framework can be found [here](#).

Nationally, a Programme Manager has been appointed and will be liaising with the LETB Library Lead and Library Service Managers in Yorkshire and the Humber over the next 12 months to implement the key recommendations of the Framework.

The local LETB arrangements have also now changed to reflect a single vision for HEE, with the three LETBs across the North of England working more closely together. For HEYH, the key contact is Mr David Stewart, Director of Health Libraries North West, Health Education North West.

Yours sincerely

*Mike Curtis sent by email*

**Mike Curtis**  
**LETB Director**

cc Helen Weir, Library Manager

# Regional NHS Leadership Recognition Awards 2015/16

Celebrating leaders in health and social care

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goes above and beyond their  
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This year's categories are:

- NHS Board/Governing Body of the Year
- NHS Development Champion of the Year
- NHS Emerging Leader of the Year
- NHS Patient Champion of the Year
- NHS Patient Leader of the Year
- NHS Mentor/Coach of the Year
- NHS Inspirational Leader of the Year
- NHS Leader of Inclusivity of the Year
- NHS Innovator of the Year
- NHS Leadership Recognition Award  
for outstanding collaborative leadership

Regional winners will then go on to be finalists in the prestigious national awards in 2016.

Find out more and nominate now at: [awards.leadershipacademy.nhs.uk](http://awards.leadershipacademy.nhs.uk)  
Entries close on 7th September 2016

**FINANCE COMMITTEE**  
**Tuesday 21st April 2015**  
**2:30 p.m.**

**Director of Finance Office, Trust HQ**

**Present:**

Mrs Lesley Webster,	Non Executive Director, (Chair)
Mr Jonathan Coulter,	Director of Finance,
Mr Chris Thompson,	Non Executive Director
Mrs Maureen Taylor,	Non Executive Director
Mr Ian Ward,	Non Executive Director
Mr Robert Harrison,	Chief Operating Officer
Mr Paul Nicholas,	Deputy Director of Performance & Information
Mr Jordan McKie,	Deputy Director of Finance (notes)

No	Item
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- |    |  |
|----|--|
| 1. | <u>Welcome and apologies</u><br>None to record |
|----|--|

2.	<u>Quarter 4 Position</u>
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Mr Coulter outlined Quarter 4 performance, in particular the positive performance within the quarter resulting in a year end surplus of £10k.

Mr Webster asked how this year-end performance compared to the required new financial year run rate for 2015/16, it was confirmed that this rate of both income and expenditure was in line with the required run rate for 15/16 plan, any case mix variance continues to be reflected going forwards.

Mr Coulter outlined the elements which had been funded in the 15/16 plan. These had recently been discussed with the directorates at the Finance and Activity meetings. Cost Pressures and medical staffing resilience were being addressed in the plan; however, CIP achievement remained a risk.

3.	<u>Cost Improvement Programme (CIP) Update</u>
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Mr McKie updated the group regarding the current CIP position, the planning gap and the risk adjusted value of plans in place. There was concern regarding the current gap.

Mr Coulter updated the committee about the discussions taking place with the directorates, in particular high risk elements around reducing the cost of premium rate expenditure to the Trust.

Mr Harrison updated the group regarding the Quarter 4 activity position and the

increase in activity in this area. IW questioned what analysis had been taken of this and how could it inform the future development of services in North Leeds. Mr Harrison described this was being undertaken, in particular focused on both Urology developments in Yeadon and Gastro work in Wharfedale.

Mr Thompson asked about the dip in Emergency Medicine activity in Q4 and the reasons behind this. Mr Harrison explained that the reduced activity was considered to be the result of the media attention around A&Es nationally, which advised people not to attend A&E unless in an emergency and that 15/16 plans had been adjusted to account for this.

Mrs Taylor asked about the variance analysis undertaken in directorates and the level of detail this went into. Mr Coulter confirmed this was in place.

Mr Coulter outlined an area of work being undertaken in relation to nursing establishments and rostering. It is considered this will not only contribute to the CIP programme but improve many of the issues which are outlined in a recent internal audit. It would be mid May before results of this activity can be predicted.

4. Phasing

Mr Harrison presented phasing options to the group. These had been developed using both financial and historic activity profiles. It was noted that there was not too great a variation between the methods.

Mr Ward asked how this accommodated staff flexibility. Mr Harrison outlined the phasing took into account holiday and elective changes as it was based on historic profiles.

Mr Harrison also confirmed the directorate had been consulted on this issue.

It was recommended to the group to use the activity based phasing for the annual plan. After a general discussion, all the committee agreed to proceed on this basis.

5. Transformation

The committee asked for future meetings to discuss large capital schemes and the links to the transformation schemes or regular renewal of contracts.

**Action – Amendments to Trust Standard Financial Instructions to include role of finance committee Action – Circulation of contract register for forward looking meetings.**

6. Contracting Update

Mr McKie updated the committee about the position of non HaRD contracts. Progress has been made with NHS England, however, discussions are ongoing regarding specialised commissioning. Broad agreement has been made with the



Leeds CCG's contract, , however, discussions are ongoing about developments and readmissions audit. HaRD contract discussions continue.

7. Any other Business

Mrs Webster described the changes to Non Executive Director profiles and that Mrs Taylor would be chairing the finance committee moving forward. The committee thanked Mrs Webster for her work in chairing the committee during its development.

8. Date and Time of Next Meeting

A decision was taken to re-arrange future meeting dates to create a more practical time period between these meetings and Board meetings in order to maintain the strategic focus of the Finance Committee activities.

Next Meeting will take place on Friday 10th July 2015, 10.30 am – 12.00 noon held in Director of Finance Office, Trust HQ.



## Terms of Reference

### Quality Committee

#### 1. Accountable to Board of Directors

The Quality Committee is a committee of the Board of Directors. As such it will act on behalf of the board to set strategy in relation to quality, oversee quality governance and seek assurances on the delivery of high quality care.

#### 2. Purpose of the Committee

The Quality Committee is the primary mechanism by which the Board gains assurance regarding the safety and quality of services. Its purpose is to do the following in relation to quality:

- Seek assurance on the systems and processes in place to deliver high quality care on behalf of the Board of Directors;
- Provide scrutiny of the outcomes of these systems and processes in relation to quality on behalf of the Board of Directors;
- Provide direction on behalf of the Board of Directors regarding the delivery of the Trusts quality improvement priorities and strategic objectives in respect of quality.
- Provide oversight and seek assurance on regulatory compliance.

The role of the Audit & Risk Committee is to take a view as to whether the arrangements for gaining assurance are effective.

#### 3. Responsibilities

The key responsibilities of the group are to:

- Set annual objectives and a plan of work;
- Report effectiveness against objectives and terms of reference at year end;
- Show leadership in setting a culture of continuous improvement in delivering high quality care;
- Oversee preparation of the Quality Account prior to approval by the Board of Directors and submission to Monitor;
- Review systems, processes and outcomes\* in relation to:
  - Delivery of the Trusts objectives in relation to quality and annual quality improvement priorities;
  - Quality performance and outcome measures relating to fundamental care, including the impact of cost improvement plans;
  - Staff metrics that impact on quality i.e. staff vacancies, statutory and mandatory training, induction, appraisal and sickness;
  - CQC registration and compliance with fundamental standards in acute and community services;
  - Organisational learning as a result of incidents, SIRIs, complaints, concerns and claims;

- Organisational learning and improvement as a result of patient and staff feedback from national and local surveys including FFT, and patient safety visits;
- Organisational learning and improvement in compliance with best practice and quality standards as a result of audit, NICE publications, national inquiries and reviews relating to quality by DH arms length bodies, regulators and professional bodies, inspections and peer reviews etc.
- Research and development, quality improvement and innovation, including rapid process improvement workshops and delivery of CQUIN.
- Receive key reports for example:
  - Infection prevention and control annual report;
  - Information governance toolkit annual report;
  - Caldicott report;
  - Local Supervising Authority audit report;
  - Maternity screening report;
  - Health and Safety annual report;
  - Patient experience including complaints, concerns and compliments annual report;
  - Staff survey as it relates to the quality of care.

\*Where possible, the committee will consider assurance in relation to the four domains defined in Monitor's: Well-led framework for governance reviews: guidance for NHS foundation trusts:

- Strategy and planning;
- Capability and culture;
- Process and structures;
- Measurement.

## 4. Membership

The core membership comprises:

<b>Title</b> <i>List members by title and indicate Chair and Deputy Chair</i>	<b>Deputy</b> <i>Deputies are welcome to attend any meetings</i>	<b>Attendance:</b> <i>Indicate if required for part meetings</i>
Lesley Webster (NED) – Chair		
Sue Proctor (NED)		
Neil McLean (NED)		
Chief Executive	Deputy Chief Executive	
Chief Nurse	Deputy Chief Nurse	
Medical Director	Deputy Medical Director	
Chief Operating Officer		
Director of Workforce and Organisational Development	Deputy Director of Workforce and Organisational Development	
Deputy Director of Governance		
Head of Risk Management	Clinical Effectiveness and NICE Manager / Risk and Complaints Manager	
Clinical Director ACC	Operational Director ACC	
Clinical Director IC	Deputy Clinical Director IC	
Clinical Director EC	Deputy Clinical Director EC	

Governors will be invited to attend. Attendance by other staff will be requested by the Chair.

## **5. Quorum**

The meeting will be quorate when 6 core members are in attendance to include a minimum of two NEDs (including the chair or nominate deputy).

## **6. Administrative support**

The corporate directorate will provide administrative support to arrange meetings, prepare agendas, circulate papers and draft minutes including a register of attendance to be agreed with the chair of the meeting prior to circulation as described below. Papers will be made available a minimum of 5 days prior to scheduled meetings.

An action log will be maintained, and a log of items reviewed throughout each 12 month period.

## **7. Frequency of meetings**

The meeting will be timetabled to take place monthly.

## **8. Communication**

Minutes including a register of attendance will be maintained. The draft minutes will be approved by the chair of the meeting and then shared with the members of the committee and the Board of Directors. The draft minutes will be reviewed and the final record agreed at the next meeting and then uploaded to the intranet.

## **9. Reporting**

The Quality Committee will present an annual report to the Board of Directors outlining its work against its duties set out in the terms of reference. The Quality Committee will make recommendations to the Board of Directors on any area within its remit where action or improvement is required. Member's attendance at Quality Committee meetings will be disclosed in the Trusts Annual Report.

## **10. Review**

The terms of reference will be reviewed annually.

## **11. Date**

1 July 2015