Table of Contents

This page has been left blank

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

**On: Wednesday 24 February 2016**

**Start: 0900 Finish: 1300**

**In: The Boardroom, Harrogate District Hospital, Lancaster Park Road, Harrogate HG2 7SX**

## AGENDA

| Item No | Item | Lead | Paper Number |
|---|---|---|---|
| **0845** | **Director of Infection Prevention and Control Update – Dr Richard Hobson** | | |
| **0900** | **General Business** | | |
| **1.0** | **Welcome and Apologies for absence:**<br>*To receive any apologies for absence:*<br>**Dr Natalie Lyth** | Chairman – Mrs Sandra Dodson | |
| **2.0** | **Declarations of Interest and Board of Directors Register of Interests**<br>*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* | Chairman – Mrs Sandra Dodson | 2.0 |
| **3.0** | **Minutes of Board of Directors meeting held on 27 January 2016**<br>*To review and approve the Minutes* | Chairman – Mrs Sandra Dodson | 3.0 |
| **4.0** | **Review of Actions schedule and Matters Arising**<br>*To review the actions schedule and provide updates on progress of actions to the Board of Directors.* | Chairman – Mrs Sandra Dodson | 4.0 |
| **0915 - 1045** | | | |
| | **Overview** | Chairman – Mrs Sandra Dodson | |
| **5.0** | **Report by the Chief Executive**<br>*To be considered and any Board directions defined* | Chief Executive – Dr Ros Tolcher | 5.0 |
| **6.0** | **Integrated Board Report**<br>*To be considered for comment* | Chief Executive – Dr Ros Tolcher | 6.0 |
| **7.0** | **Report by the Director of Finance**<br>*To be considered for comment* | Director of Finance/Deputy Chief Executive – Mr Jonathan Coulter | 7.0 |
| **7.1** | **CIP 2015-16 and 2016-17 Updates**<br>*To be considered and noted by the Board* | Director of Finance/Deputy Chief Executive – Mr Jonathan Coulter | 7.1 |
| **7.2** | **Operational Plan 2016-17**<br>*To be considered and noted by the Board* | Director of Finance/Deputy Chief Executive – Mr Jonathan Coulter | 7.2 |
| **1045 – 1100** | **BREAK** | | |
| **8.0** | **Oral Reports by Directorates**<br>*i. Urgent, Community and Cancer Care* | Clinical Director – Mr Andrew Alldred | |

| | | | |
|---|---|---|---|
| | *ii Elective Care*<br>*iii Integrated Care* | Clinical Director – Dr Kat Johnson<br>Chief Operating Officer – Mr Robert Harrison | |
| **9.0** | **Report by Chairman of Quality Committee**<br>*To include Minutes from meeting dated 6 January 2016* | Chairman – Mrs Lesley Webster, Non-Executive Director | |
| **10.0** | **Report by the Medical Director**<br>*To be considered for comment* | Medical Director – Dr David Scullion | 10.0 |
| **11.0** | **Report by the Chief Nurse**<br>*To be considered for comment* | Chief Nurse – Mrs Jill Foster | 11.0 |
| **12.0** | **Report by the Chief Operating Officer**<br>*To be considered for comment* | Chief Operating Officer – Mr Robert Harrison | 12.0 |
| **13.0** | **Report by the Director of Workforce and Organisational Development**<br>*To be considered for comment* | Director of Workforce and Organisational Development – Mr Phillip Marshall | 13.0 |
| **14.0** | **Proposed Amendments to the Constitution of the Trust**<br>*To receive and **approve** proposed amendments remitted by the Council of Governors* | Chairman – Mrs Sandra Dodson | 14.0 |
| **1215 - 1300** | | | |
| **15.0** | **Reports:**<br>*To receive reports from Board Committees:*<br>*i. Finance Committee*<br><br>*ii. Audit Committee* | Committee Chairman - Mrs Maureen Taylor, Non-Executive Director<br><br>Committee Chairman – Mr Chris Thompson, Non-Executive Director | 15.0<br><br>15.1 |
| **16.0** | **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**<br>*To receive an update on any matters reported to regulators.* | Chairman – Mrs Sandra Dodson | |
| **17.0** | **Patient Story**<br>*To receive and consider an account of care in the Trust* | Mrs Tracy Campbell – Head of Nursing Integrated Care Directorate | |
| **18.0** | **Any Other Relevant Business**<br>*By permission of the Chairman* | Chairman – Mrs Sandra Dodson | |
| **19.0** | **Council of Governors' Meeting Minutes**<br>*To receive the Minutes of the meeting of the Council of Governors' dated 4 November 2015* | Chairman – Mrs Sandra Dodson | 19.0 |
| **20.0** | **Board Evaluation** | Chairman – Mrs Sandra Dodson | |
| **21.0** | **Confidential Motion**<br>**The Chairman to move:**<br>*'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'.* | | |

Harrogate and District NHS
NHS Foundation Trust

## BOARD OF DIRECTORS – REGISTERED DECLARED INTERESTS

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

The register is maintained by the Foundation Trust Office.

| Name | Position | Interests Declared |
|---|---|---|
| Mrs Sandra Dodson | Chairman | 1. Partner in Oakgate Consultants<br>2. Trustee of Masiphumelele Trust Ltd (A charity raising funds for a South African Township.)<br>3. Trustee of Yorkshire Cancer Research<br>4. Chair 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:<br>1. Northern Consortium UK Limited (Chairman)<br>2. Ahead Partnership (Holdings) Limited<br>3. Ahead Partnership Limited<br>4. Swinsty Fold Management Company Limited<br>5. Acumen for Enterprise Limited<br>6. 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<br>2. Chair, Safeguarding Board, Diocese of York<br>3. Member – Council of University of Leeds<br>4. Member – Council of NHS Staff College (UCLH)<br>5. Associate – Good Governance Institute<br>6. Associate - Capsticks |
| Dr David Scullion | Medical Director | None |
| Mrs Maureen Taylor | Non-Executive Director | None |
| 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 | 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<br>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<br>3. Director of Newcastle Building Society, and of its wholly owned subsidiary IT company – Newcastle Systems Management Limited<br>4. Member, Leeds Kirkgate Market Management Board |
| Mrs Lesley Webster | Non-Executive Director | None |
| Mr Andrew Alldred | Clinical Director UCCC | None |
| Dr Kat Johnson | Clinical Director EC | None |
| Dr Natalie Lyth | Clinical Director IC | None |
| Dr David Earl | Deputy Medical Director | 1. Private anaesthetic work at BMI Duchy hospital |
| Dr Claire Hall | Deputy Medical Director | 1. Trustee, St Michael's Hospice Harrogate |
| Mrs Joanne Harrison | Deputy Director W & OD | None |
| Mr Jordan McKie | Deputy Director | 1. Familial relationship with NMU Ltd, a company providing services to the NHS. |
| Mrs Alison Mayfield | Deputy Chief Nurse | None |
| Mr Paul Nicholas | Deputy Director Performance and Infomatics | None |

**February 2016**

**3.0**

Harrogate and District NHS
NHS Foundation Trust

**Report Status: Open**

## BOARD OF DIRECTORS

Minutes of the Board of Directors' meeting held on Wednesday 27 January 2016 at 9.00am in the Boardroom, Harrogate District Hospital, Lancaster Park Road, Harrogate.

**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 P Marshall, Director of Workforce and Organisational Development
Professor S Proctor, Non-Executive Director
Dr D Scullion, Medical Director
Mrs M Taylor, Non-Executive Director
Mr C Thompson, Non-Executive Director
Dr R Tolcher, Chief Executive
Mr I Ward, Non-Executive Director
Mrs L Webster, Non-Executive Director

**In attendance:**
Mrs J Crewe, Operational Director, Urgent, Community and Cancer Care Directorate
Dr D Earl, Joint Deputy Medical Director
Dr K Johnson, Clinical Director, Elective Care Directorate
Dr N Lyth, Clinical Director, Integrated Care Directorate

Mr A Forsyth, Interim Head of Corporate Affairs (Minutes)

Three Governors of the Trust, two members of the public

<u>For the pre-brief only</u>

Ms K Barnett, Operational Director, Integrated Care
Mr D Plews, Deputy Director, Partnerships and Innovation

### Project Management Briefing

Ms Barnett and Mr Plews outlined the aims and objectives of the Project Management Office. There were four workstreams, with a number of projects underway, many of them clinically led. In order to realise both the desired outcomes and make savings these needed to proceed at pace. There was a central communication cell which provided weekly updates on the projects, with a programme management office for co-ordination and administration. Amongst the key measures being examined were the number of occupied bed days, where reduced non-elective demand could reduce the number of beds, despite the projected demographic changes; reduced length of stay and increased staff efficiency, through management of sickness absence, improved retention, the use of special leave and benchmarking against best practice workforce indicators.

A Clinical Transformation Board dashboard was under development, supported by a risk register and a range of indicators.

Professor Proctor asked about the influence of patient feedback on the work. Ms Barnett replied that this was considered and was visible at project rather than programme level. Mrs Dodson wondered about the transferability of the model; Mr Plews said that it was envisaged that there would be something transferable which would pull together key information. Ms Barnett noted that the project teams welcomed challenge back to help them focus their work.

Mrs Dodson thanked Ms Barnett and Mr Plews for their informative update. She expressed the thanks and best wishes of the Board to Ms Barnett, who was shortly to leave the Trust to take up a new role at another Trust.

Mrs Dodson welcomed members and visitors to the meeting. She particularly welcomed two new Governors and Dr Earl.

**1. Apologies for Absence**

Mr N McLean, Non-Executive Director and Mr A Alldred, Clinical Director, Urgent, Community and Cancer Care.

**2. Declarations of Interest**

There were no declarations of interest relevant to items on the agenda for the meeting. Professor Proctor stated that she was now the Chairman of the Safeguarding Board for the Diocese of York and Mr Thompson indicated that he had some amendments to his annual declaration which he would update outside the meeting.

**Action: Mr Forsyth**

**3. Minutes of the meeting of the Board of Directors on 25 November 2015**

3.1 The draft Minutes of the meeting were accepted as a true record, subject to the following amendments:

| | | |
|---|---|---|
| Minute 5.11 Line 4: | **Delete:** | 'to use the Trust GPs in ED' |
| | **Insert:** | 'to use the GP OOHs service where possible' |
| Minute 6.6 Line 12: | **Delete:** | 'Ventous' |
| | **Insert:** | 'Ventouse' |
| Minute 6.6 Line 12: | **After:** | 'Professor' |
| | **Insert:** | 'Proctor' |
| Minute 11.4 Line 2: | **After:** | 'Director Visit to' |
| | **Insert:** | 'ED' |
| Minute 13.8 Line 2: | **Delete:** | 'to National Insurance rates' |

## 4. Review of Actions Schedule and Matters Arising

Action 1 – Mrs Foster said that this action was being taken forward as part of the Quality Charter work. Dr Tolcher noted that an implementation plan was being developed. This would focus initially on Quality of Care Champions and recognition of individual members of staff who go the extra mile. Board action complete.

Action 2 – Included in Dr Lyth's report at Item 8 of the Agenda. Board action complete.

Action 3 – The figures have been adjusted. Board action complete.

Action 4 – Mrs Dodson reported that she had written to Mr Leinhardt. Board action complete.

Action 5 – Mr Ward had been briefed. Board action complete.

Action 6 – Mrs Foster had included these figures in her report at Item 11 of the Agenda. Board action complete.

Action 7 – Mr Marshall had included this update in his report at Item 13 of the Agenda. Board action complete.

Action 8 – This had been considered and it had been decided that inclusion as a risk to the Trust was not justified. Board action complete.

Action 9 – Clinical sustainability will be included in the agenda for the 23 February Board Strategy session. Board action complete.

There were no other Matters Arising.

Mrs Dodson said that the Non-Executive Directors had identified three key areas which they expected to be the underlying themes of the meeting – the Sustainability and Transformation Plan (STP), especially around operations and risks for the Trust, recruitment, both nursing and medical and the GP OOHs service. In the latter case the aspirations for the service 2016-17 and when the norm would be achieved were key areas.

## 5. Report by the Chief Executive

5.1 Dr Tolcher's report had been circulated in advance of the meeting and was taken as read. She said that she wished to draw the Board's attention to some significant issues.

5.2 Dr Tolcher started by noting the three key areas outlined by Mrs Dodson and said that the first two would be discussed at a number of stages in the meeting through the lenses of finance, quality and sustainability. She drew attention to the completion of the Well-Led Review, which had been both enlightening and encouraging. A draft Action Plan had been developed and would be discussed in the closed session of the meeting. Once agreed it would be presented in a future public session. The Trust had been commended for its self-assessment which had shown insight and close alignment with the Deloitte assessment. Mrs Dodson said that the final report would be presented at the Council of Governors' meeting on 6 February.

5.3 Dr Tolcher noted that there had been a flurry of national communications from NHS England (NHSE), NHS Improvement/Monitor and the Care Quality Commission (CQC) in recent weeks. She said that much of this was crystallising what was expected of providers and the system both by the year-end and beyond. Delivering the Forward View was key to this and whilst there was a clear vision there also appeared to be a mismatch between the visioners and the rule makers. The Five Year Forward View was a visionary document predicated upon integration of health and social care and based upon natural communities. Health and Social care organisations have been asked to agree transformational footprints which will have individual Sustainability and Transformation Plans (STPs) but these need to be based upon existing CCG footprints thereby perpetuating some unhelpful boundaries.

5.4 The Trust was expected to develop a one-year Operational Plan, the draft of which was due by 8 February, and a five-year STP with other local partners. The aim was to achieve financial balance and clinical sustainability, with all the system resources working together. The national emphasis is on returning all providers to a position of sustainability by making place-based plans. The requirement was that the NHS provider sector must not be in a greater deficit than £1.8bn by the end of this financial year. It was 'intensely important' not to exceed this figure according to Monitor.

5.5 Conversations were underway about the local transformation footprint ('Place') in which the Trust would operate. There was likely to be a single STP for Harrogate but the Trust would also be part of the West Yorkshire system, within which it was part of the Urgent and Emergency Care Vanguard project. Harrogate and Rural District Clinical Commissioning Group (HaRD CCG) would be bidding for national funding based on its population. The Trust, however, would need to be part of this and also the bids for Leeds, Darlington, Middlesbrough and County Durham.

5.6 Turning to the allocation of transitional funding and the requirement to agree a control total; Mr Thompson said that he had looked at all the assumptions and thought that they would not require a significant shift in approach. He believed that there would be a credibility issue if there were major changes. The funding availability was good but would the centre make further changes in the run up to 2017-18 – was there the potential for similar conversations at this time next year? Dr Tolcher responded that the Trust could only work within the rules this year – monies available this year would not be spent but would strengthen the balance sheet. Mr Coulter noted that the value of the transitional funding was approximately equivalent to the shortfall in outturn over the previous two years. He said that the CEO of NHS Improvement had delivered a settlement and the £1.8bn extra funding had been shared fairly around providers. It was vital that the DoH delivered the right figures to the Treasury at year-end and providers must play their major part. Establishing fairness and financial balance was important and the NHS must demonstrate that it can deliver what is required. The requirements for the Trust were not extreme although huge challenges remained.

5.7 Mrs Webster wondered whether the definition of 'Place' would restrict the Trust's ability to grow contracts outside it. Dr Tolcher said that this would not be the case. It would drive efficiency, to the benefit of patients. Mr Coulter added that the existing bilateral arrangements with Tees, Esk and Wear Valley (TEWV), York, Leeds and Airedale would be unaffected. Mrs Dodson asked about specialist hospitals; Dr Tolcher said that these would have wider relationships but would not set the 'Place'. Mr Harrison added that they would have different 'Place' membership but would plan around Leeds.

5.8 Turning to the agency cap, Mrs Dodson said that the Trust had worked hard to implement it. Mr Marshall emphasised that only agencies on the framework would be used, with no payment higher than the cap levels. Internal escalation processes were in place. He would be writing to the nursing agencies to confirm the Trust's position. Mr Marshall noted the strength of working with the West Yorkshire Association of Acute Trusts (WYAAT) in applying the agency cap. There was, however, some evidence of other Trusts using Harrogate-based staff at higher than the capped rates.

5.9 Discussing the £4.6m being offered to the Trust, Dr Tolcher said that this was a low-risk option; in the worst case it would remain on the balance sheet and then be handed back to the Treasury at some point in the future. Mr Thompson felt that the Trust should absolutely take the sum. Mr Coulter said that in order to release the funding in 2017-18 the Trust would have to realise a £2.2m surplus in 2016-17. In his view the Trust could deliver the £6.8m control total required – other providers had real challenges. Mrs Webster wondered about the implications on quality of care from not doing so. Dr Johnson expressed nervousness about the practicalities of delivering activity whilst not exceeding the agency cap – what would happen if there were no locums available except at escalated rates? Dr Tolcher said that patient safety would always come first. Compliance with the agency cap rules was a core condition for the STP but breaching for patient safety reasons might be necessary. Dr Johnson said that there was a need for everyone to own the process and it would be challenging. Mrs Dodson said that the agency cap was a lever to change behaviour, which was needed, and only part of the methodology. Dr Johnson agreed that it was a lever to provide money to invest in services 12 months ahead, which was an incentive for better patient care and greater job satisfaction for clinicians.

5.10 Dr Scullion was not sure that the funding issues were fully understood by the clinicians. This was short-term pain for long-term gain and the Trust was well-placed, better than many others, to take advantage of the offer. This simple message needed to be communicated to clinicians. Mrs Taylor said that the issue had been discussed at the Finance Committee meeting in the context of how the £4.6m might be spent in future. Mr Ward wondered what the implications of not achieving the £2.2m surplus would be. Mr Coulter said that quarterly reports would be required, showing compliance with financial and other requirements. Providers had until 8 February to accept or decline the offer. Mrs Dodson asked what would happen if more than 50% said no and Dr Tolcher said that was an unknown. Mr Harrison emphasised the need for clinical buy-in and the leadership role of the consultant body. The influencers needed to understand that they had a significant role to play. Dr Tolcher said that she had spoken at the recent Consultants' Forum and there was a need to keep these conversations going. Mr Harrison said that at the Integrated Care Directorate Board the clinical leads had described the challenges of providing cover without breaking agency rates.

5.11 Professor Proctor asked about the level of understanding of the proposals within the GP community. Dr Tolcher said that she did not think that the GPs knew about the offer and the caveats attached to it. It was about achieving more for less within a balanced plan. New Models of Care (NMC) were very much inextricably linked with it but the precise offer was not high on their radar.

5.12 In summing up, Mrs Dodson said that Mr Mackey, CEO of NHS Improvement, had achieved a good deal which was clear and spelt out the idea of success. Capping agency rates provided teeth to change behaviour and the whole proposal would flush out the unsustainable providers. She argued that there was no reason for the Trust to refuse the

offer. Participation could be a game changer for the Trust. The proposal that the Trust accept the offer was **approved** by the Board *nem con.*

5.13 Mr Coulter noted that the Trust would need to maintain a risk rating of 3 or better in Q1, Q2 and Q3 of 2016-17. With the extra funding this would be guaranteed in 2017-18.

5.14 Moving on to the joint letter from CQC and NHS Improvement, Dr Tolcher said that this alignment was designed to balance finance and quality and would give Trusts more authority to have safe staffing ratios by self-determination, rather than centrally determined arbitrary ratios. On the Harrogate Clinical Board she said that the Trust would work with the HaRD CCG on elective activity. The rigid control total previously discussed must deliver the plan, with realistic activity assumptions the work of the Clinical Board could lead to significant changes to pathways. This may mean that historical performance is a less reliable predictor of future activity and introduce some risk in to the forward capacity plan. The CCG will also have some QIPP schemes, the detail of which is currently unknown.

5.15 Dr Tolcher was pleased to report that the first NMC pilot sites (at Knaresborough, Green Hammerton and Boroughbridge) would go 'live' on 1 February. Phased implementation of workforce recruitment was proceeding. The local GP event had been attended by at least one representative from every GP practice in the area. The positive message was that there was a shared ambition for patient care. There was some anxiety from the GPs about a perceived increase in their workload and it was important to share the numbers from the pilot sites as early as possible so that honest and realistic demand assumptions can be made. This anxiety could be an obstacle to the success of the system. Some misunderstandings (eg the role of pharmacists in practices) had also been exposed; this will be addressed.

5.16 On the Vanguard work, Dr Tolcher said that the deadline for submission of the second Value Proposition (VP2) had been extended. Some assumptions in VP1 were not valid and the estimated cost of the New Care Model had increased. The Harrogate Health Transformation Board (HHTB) had agreed that despite this, the VP2 must not exceed VP1 and this had made the challenge bigger. Managing the model back to the original envelope was proving to be a complex task. There was a need for greater innovation and work was in train, adopt learning from other sectors eg work with care homes, whilst protecting patient safety and sustainability. Mr Thompson said that he was reassured by the commitment of Primary Care. Dr Tolcher noted that there were improved relationships with Yorkshire Health Network (YHN) and Mr Coulter confirmed that it was important to differentiate between the relationship with practices and with the YHN. Discussions with the latter had been much improved of late, especially around the NMC pilot sites.

5.17 Turning to the report on the Senior Management Team meeting, Dr Tolcher said that there had been 25 cases of *Clostridium difficile* in the year of which Root Cause Analysis (RCA) had found lapses of care in four cases. An external review by Public Health England (Yorkshire and Humber) had re-affirmed that there had been no instances of patient to patient transfer, as proved by ribotyping, which showed that good practices were in place. The higher number of cases appeared to be due to greater case ascertainment due to better screening and testing. Dr Scullion said that the four cases were nevertheless important and that antibiotic stewardship needed to be improved, with more regular review measures, consultant leadership and peer pressure. Mrs Foster said that whilst the *C. difficile* figures were disappointing she was satisfied that patients were safe. Mr Thompson was reassured by the outcomes of the RCA of cases but he was concerned about RCA 'fatigue'. Mrs Foster said that whilst they did take a lot of resource,

the teams were committed and findings were robust, so she was not concerned by RCA 'fatigue'.

5.18 Mrs Dodson noted that the Microbiology Department was now up to establishment with the recruitment of Dr Jenny Child, who had a background of significant public health and clinical leadership; her experience and knowledge would be valuable. Mr Harrison said that the annual ambition for *C. difficile* cases in the Trust was usually capped at the previous year but avoidable cases were now the focus and it was important to learn from all cases, including those regarded as unavoidable. Mrs Webster said that the Quality Committee was keeping a close watch on the number of cases and whilst the Trust was under the ambition for avoidable cases, keeping the ambition low was an incentive to improve. Mr Harrison believed that this was a similar position to that of MRSA, with a focus on the avoidable cases. The HaRD CCG has discretion to change the ambition in the base contract. It is notable that the incidence of *C. difficile infections* has also increased in Primary Care.

5.19 Dr Tolcher sought the agreement of the full Board to the arrangement whereby the Chairman had approved the delegation to Mr Harrison of responsibility to sign off returns to NHS Improvement in respect of Agency Cap compliance; this was **approved** by the Board *nem con.*

5.20 Turning to the Corporate Risk Register (CRR), Dr Tolcher pointed out that the likelihood of CR5 (nurse staffing) had increased and the overall risk rating had therefore been increased, making it the top-scoring corporate risk. Mrs Dodson noted the relationship between the Board Assurance Framework (BAF) and the CRR, with the latter providing the strategic view of risk.

5.21 Dr Tolcher moved on to the subject of readiness for the forthcoming CQC inspection. She said that the Trust had prepared comprehensively and all the conditions were in place for a successful inspection. The workforce had embraced the need for organisational readiness and would have honest conversations about the Trust, of which they were justly proud. Good housekeeping had taken place, including updating policies on the Intranet. There would be plenty of opportunity for engagement as the inspection team would travel far and wide across the Trust. Dr Tolcher explained that she had delivered a governance presentation to the inspection team core service leads on the previous day; this was a new departure which allowed the team to understand the structure of the Trust and had covered risk management, incidents, Duty of Candour, Rapid Process Improvement Workshops, the Quality Committee and the Well-Led Review. It had been a positive meeting, with the Lead Inspector saying that the team was looking forward to and excited by the inspection. Dr Tolcher believed that everything was now in place.

## 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 it was important to concentrate on the key issues and invited questions. Mr Ward noted that there was a high number of pressure ulcers under RCA and that cases in the community made up around 50% of the total. Mrs Foster said that this was under review but that all the RCAs were within the external 60-day deadline. Such investigations needed to be concluded quickly and she would be reducing the internal deadline for completion to 25 days. She was looking at the timeline to reduce the burden on staff. Mrs Dodson was keen to understand the number of category 3 and 4

pressure ulcers against the numbers for last year and Mrs Foster said that there had been 27 hospital-acquired ulcers last year against 29 in the year to date. The target was to reduce the number by 50% by year-end, although she believed that better understanding and reporting meant that numbers this year may be higher. Mrs Dodson responded by clarifying that there had been a 43% reduction overall in category 2, 3 and 4 ulcers to date.

6.3 Dr Tolcher echoed Mrs Foster, saying that more diligence and better scoring were identifying more cases this year. Mrs Foster said that the overall aim remained prevention and the minimising of tissue damage. She believed that every possible measure was in place for avoidable pressure ulcers, including a diligent RCA when one occurred. There was slow, incremental progress on prevention. She was not confident about the recording of pressure ulcers in the community in prior years. Increased awareness and education, and an improved Tissue Viability Nurse (TVN) service to homes in the community would help. However, there would continue to be an issue around shared care in the community, where HDFT was not responsible for 24-hour care of patients. Mr Harrison said that there needed to be differentiation between avoidable Trust pressure ulcers and those for other agencies.

6.4 Mrs Crewe said that the proportion of patients developing pressure ulcers in their own homes was small – the majority were developed in care homes. The TVN service was very stretched and work was needed on the care of those patients. Mrs Foster said that arrangements were being made for the briefing of GPs and care home staff on tissue viability. Professor Proctor said that it would be helpful for the Quality Committee to be briefed on the learning around category 3 and 4 pressure ulcers, especially that for the system as a whole. Mrs Webster said that a paper was expected at the next Quality Committee meeting – she wondered whether the Trust could produce a guidance booklet on pressure ulcers, similar to that produced by the Infection Prevention and Control team; Mrs Crewe said that this was already in hand. Mr Marshall suggested that Health Education (Yorkshire and Humber) might support this with some funding.

6.5 Moving on, Mr Thompson noted that, with the growth of services in the community, he was revisiting the dearth of information about them in the Integrated Board Report (IBR). Dr Tolcher asked what progress was being made with the development of national community outcome indicators and Mrs Crewe said that progress had slowed down, with refinement of the metrics to provide evaluation proving to be a challenge. Mr Coulter said that there were already a lot of community metrics in the IBR as most indicators covered not just acute services. Dr Lyth said that there should be more indicators around community services for children and Dr Tolcher said that more specific indicators were needed.

6.6 Mrs Webster asked about the implications, if any, for the Trust of the recent case in France concerning the clinical research trial which had caused at least one death. Dr Scullion said that there was good governance around research in the Trust; most of the trials in which the Trust was involved were national trials. He would arrange for a briefing on the governance around clinical research. There was not an enormous risk and incidents were confined to minor issues with individual patients.

**Action: Dr Scullion**

6.7 Mrs Dodson was concerned about the GP OOHs service Key Performance Indicators (KPIs) which remain red-rated, and sought assurance about how it was to progress – were the issues systemic or behavioural? Mrs Crewe replied that detailed reports were being taken to the Quality Committee and actions were in place to improve

the position of patients. The Trust was not an outlier, using the data collected, despite the red rating. The increased scrutiny of the service was proving to be valuable. A detailed audit plan was in place to gain the data needed to provide more assurance. The outcomes would be reflected both at Quality Committee and at the Board. It was important to understand the performance of the service – there were no obvious hotspots – and it was not yet possible to decide whether the issues were systemic or behavioural. There was, however, a significant concern about data quality in relation to the whole pathway and the Trust was working closely with the Yorkshire Ambulance Service to address these. It is apparent also that KPI definition is interpreted variously in differing Trusts making benchmarking unreliable. Mrs Crewe was confident that patients were not being harmed.

6.8 Mr Harrison said that the National Quality Requirements were clear but that there were data quality issues to be solved and further benchmarking was needed. Mrs Dodson replied that there was a lack of clarity as to why the indicators in the IBR were red. Mrs Webster said that the Quality Committee was receiving regular reports (the next one was due in April 2016) and that the indicators had been red in the long-term. A huge volume of activity was underway, which was not recorded in the narrative of the IBR. There should be a timescale giving visibility of the change, and the Committee must be assured that the data quality was accurate. Dr Tolcher said that the Trust owed a duty of care to patients and was talking to other providers. The service needed to be safe – the Board needed a clear statement on safety for assurance. The action was to bring a report to the April Board, through the Quality Committee, to provide the assurance that the service was safe.

**Action: Mr Alldred**

## 7. Report by the Director of Finance

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

7.2 Mrs Dodson said that she wished to take this report, the update on the Cost Improvement Programme (CIP), the report on the Business Plan 2016-17 and the paper on Strategic Key Performance Indicators (KPIs) together. Mr Coulter noted that the issue of the Wheelchair Service was under discussion with the commissioners of the service. Non-Elective income was down in the last three months in the order of £150,000 per calendar month compared with last year. The reduction of length of stay and the implementation of the FLIP project had been factors in this, but patient outcomes had been improved.

7.3 On the CIP the news was very positive. £9.5m had been actioned (against the mandated £8.8m requirement) and the full CIP target would be delivered. The level of non-recurrent measures was over one-third and efforts were underway to convert as much of this as possible to recurrent.

7.4 Mr Coulter said that the CoSR of 3 would be maintained for the next 12 months and that the Q4 plan was most important. He had full buy-in from the Directorates; work on rostering, for example, could yield thousands of pounds of savings. March was normally a month with high income and the extra day in February would also contribute to income. There were two non-recurrent issues in-year – the mobilisation costs for Darlington, Durham and Middlesbrough and the slippage round the Vanguard project. He was forecasting a small year-end surplus overall and he would quantify this in the Monitor return around a series of measures. However, the Trust was not delivering the plan and was currently in deficit. He had been approached that day by BBC Look North because

the Trust was the only one of 15 in Yorkshire and Humber not to be forecasting a year-end deficit, but had declined to make a statement.

7.5 Mr Ward said this was an encouraging forecast and asked whether the improvements from the FLIP project and reduced length of stay were factored into the projections. Mr Harrison said that the Directorates were finalising activity plans and would take this into account. It was a matter of having a line of sight about what might happen in-year; the impact of the FLIP project had been stark. Dr Tolcher said that the use of historical trends in activity forecasting was no longer helpful; reducing length of stay, Clinical Board initiatives and the Quality Improvement Programme all directly impacted on the profitability of activity. Mr Harrison emphasised that it was more about how demand was managed and the impact on the price and income. Dr Tolcher said that spreading the footprint of the Trust would mean a greater market share but the Trust would not bid for work which would not make a contribution. Growth in revenue is only attractive if it makes a positive contribution.

7.6 Moving on, Professor Proctor asked about the position with debtors, recalling the position at the same point in 2014-15. Mr Coulter said that this stood at £3.5 - £4m, which was greater than normal but better than last year. It consisted largely of commissioned overtrades and reciprocal arrangements with York. Mrs Dodson asked that a report be prepared for the Finance Committee and then brought to the Board.

**Action: Mr Coulter**

7.7 Professor Proctor asked about the position with the Carter report. Mr Coulter said that the questionnaire had been signed off and returned and the requested data supplied. The final report had not yet been received. It was possible that management costs would be capped and Carter had also proposed a measurement of nursing hours per patient day. Mr Harrison said that there had been an Estates/Facilities event and that an Estates dashboard was in development.

7.8 Mr Thompson found the situation with the FLIP project to be bizarre. It was more efficient, and patient outcomes were better, yet the Trust was being penalised. Was there any room to push back on this, he wondered? Mr Harrison said that the Trust was doing the right thing and that the HaRD CCG agreed that Payment by Results does not work. The Trust would not change the decision and would have to plan for the unexpected consequences of the change. It was important to understand the costs which were being saved, eg escalation capacity and Dr Scullion commented that the real advantages could not be seen on the balance sheet.

7.9 Mrs Taylor was concerned about the implications of a ‘small surplus’ on the capital programme for 2016-17. Mr Coulter said that the plan had been reviewed and where possible projects slowed or delayed. In-year capital spend was behind plan as a direct consequence. All projects had been risk assessed and would happen, but not as quickly as planned. Dr Tolcher said that specific decisions around Estates had been made for 2016-17.

7.10 Moving on Mr Coulter said that the background to the Business (Operational) Plan had already been covered. The Plan was looking to achieve a £3.2m surplus and would now have to achieve a £2.2m surplus to release the additional funding. There would be no change to the CIP for 2016-17. Service prioritisation measures would be held until the CIP was achieved, with the exception of Estates measures. There was potentially £200,000 available for staffing investment. Mrs Webster asked how confident Mr Coulter was that the activity levels for 2016-17 would be reached and Mr Coulter said that the Finance

Committee was examining this in detail. She also wondered about the transformation work not delivering or doing so but not realising the planned income – she was concerned about how the Trust would remain sustainable. Mrs Dodson said that this was assurance which the Finance Committee would receive through detailed work, including work on the unpredictable unintended consequences.

7.11 Mr Harrison said that there was potential for different models of contract to allow movements of funding to where it was needed. Some funding had been added to the community contract for 2015-16. This was due to a rise in activity rather than a higher payment for it. Rising demand had been met within the same financial envelope. A review of CATT was underway with the HaRD CCG but this must not detract from the service. Dr Tolcher said that using CATT meant that the CCG was having more work done for the same cost.

7.12 Turning to the CIP for 2016-17 Mr Coulter said that £9.4m had been identified of which £6.7m was assessed as low or medium risk, as of the end of the previous week. This was based on full establishment and included £1m for medical staffing costs and £750,000 for maternity contingency agency costs.

7.13 Mrs Dodson sought and received **approval** for the submission of the quarterly report to Monitor and a Continuity of Service risk rating of 3, and for the Trust to agree to take the funding offered by NHS Improvement for 2016-17.

7.14 Mr Coulter reminded the Board that the draft Operational Plan would be submitted by 8 February and the final Plan by 11 April, the latter requiring Board approval. The HaRD CCG would respond about the definition of 'Place' required.

7.15 Finally Mr Coulter noted that the Strategic KPIs would now include those for Darlington, Durham and Middlesbrough to ensure that this significant business development met the requirement of the commissioners. The Board will review the Strategic KPIs on a biannual basis.

**Action: Mr Coulter**

**8. Oral reports by Directorates**

8.1 Mrs Crewe said that there were funding pressures on the Wheelchair Service and that there had been a change of team leader; Sammy Lambert would now manage the team from Scarborough. The introduction of the first three pilot sites for NMC was hugely supported by staff; new staff and new roles were being taken up with enthusiasm around the innovative new roles and the assistive technology. She noted that there would be extra beds at both Station View and in Trinity ward from 1 February. Mrs Crewe assured the Board about the grip on and monitoring of pressure ulcers in the community. A new Clinical Lead for community services was to be recruited. Mrs Dodson noted the positivity of the NMC staff and that they were keen to start working in the new model.

8.2 Dr Johnson reported the establishment of a new outreach service at Alwoodley (North Leeds), providing paediatric and ENT services, paediatric trauma and orthopaedics and some gynaecology services. There was also a new shoulder orthopaedic service. The outreach service would open in May and was 60% new business. There would be increased sessions at Wharfedale Hospital and a new colorectal surgeon (Mr Farooq) had been appointed from September. On the Clinical Board there had been good engagement in reviewing the elective care specialties. Dr Johnson said that her highest risk remained medical staffing and there would be two Core Trainee gaps in Deanery provision from

February – this would put pressure on both other staff and on the agency spend. She planned to examine closely who was being employed to fill gaps and see if there were any alternatives to the system in use. It was important to look after the Middle Grade doctors who were providing much of the cover. Dr Johnson reported that the 18-week position was improving as a result of pathway reviews. Clinical Leads and General Managers were now meeting on a monthly basis to discuss their budgets, as a way of strengthening clinical leadership.

8.3 Mr Ward asked whether there were any opportunities to expand services in Darlington, Durham and Middlesbrough and Dr Johnson replied that the challenge was in providing capacity for the Leeds areas and there were no developed relationships with these northern areas. Mr Harrison said that there were closer appropriate providers; there were challenges with travelling time but that work would be undertaken in the north east to review services for transformation and the position could change but not now.

8.4 Dr Lyth reported that a prospective audit of readmissions had established that of 60 cases none had been avoidable readmissions. They were all new, unrelated problems, exacerbation or planned day care. None were due to a failure of care by the Trust. She noted that things were moving in the right direction with TEWV towards a reciprocal arrangement around mental health provision. A Deanery visit had taken place on 26 January and a draft report would be available (to check for factual accuracy) within two weeks. She was pleased to note that the trial of falls sensors had been successful and that they would be rolled out to appropriate wards. Three Band 6s had been appointed for the 0 – 5 Children's Service and they would work specifically with teenage parents. Mobilisation for Darlington, Durham and Middlesbrough was moving apace and making very positive progress. There was an issue about Health Visitors working with children who were not registered with a GP in the Trust area, where GP practices and local authority boundaries did not coincide.

8.5 Mrs Webster asked about the counting of avoidable readmissions. Dr Tolcher said that the commissioners set the parameters and the Trust was not paid for them. In her view it was about the quality of care – an RCA would be undertaken for an avoidable readmission but these were very uncommon. Mr Harrison said that the parameters were absolute number and percentage of all admissions and that these were standardised against national expectations. The measures needed to be looked at together.

**9. Report by the Chairman of the Quality Committee**

9.1 Mrs Webster reported on the December and January meetings. The risks were the cap on agency spending and nurse staffing levels particularly in the Integrated Care Directorate. The next meeting would receive an update on pressure ulcers.

**10. Report by the Medical Director**

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

10.2 Dr Scullion said that the summary paper on mortality, prepared by Ms McDonald and Mr Nicholas, was in the Reading Room, and had been discussed at the SMT meeting. The review of mortality at Ripon had revealed no lapses in care although there had been some recommendations around care out of hours and some inconsistencies about care during the day. Dr Tolcher said that she had articulated this to the CQC at the governance presentation. Was the Trust an outlier and was this statistical issue or something else? It

was important to look at the explanations and at the cohort. Mrs Dodson said that the Trust should not be prepared to accept this even within the expected range and must be absolutely sure that it was providing safe care. Dr Scullion replied that the Board has reviewed the information and he had oversight. The structured casenote review training from Professor Hutchinson had been attended by 22 staff and there was the possibility that it would be rolled out nationally, with avoidable deaths being reported at DoH level. The challenge was now to move to a new focused casenote review for overarching themes and good practice and sharing this across the region.

10.3 Moving on Dr Scullion reported an encouraging improvement in the use of the WHO Checklist although there was more to do, including streamlining the forms. Other areas had started to use a modified process, including the dental service. Dr Tolcher said that the target was 100% compliance and asked how the Trust compared with other Trusts. Dr Earl said that he agreed that the target should be 100% and that regionally the results were 'terrible'. There was the potential to start the system all over again.

10.4 Finally Dr Scullion said that he wanted to highlight the retirement of Dr Bill Hulse, who had been at the Trust for many years, and the move of Miss Tracy Jackson, who was leaving to take up a consultant gynaecology post in Leeds. He also confirmed that Mr Jon Conroy had been asked to take part in the national orthopaedics group supporting Lord Carter.

**10.1 Quarterly Claims Report**

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

10.1.2 Mr Thompson said that the report provided rich information and he had found it very useful. He noted that the NHS Litigation Authority was holding an increasing balance and it could be at the March 2015 level by year-end. Dr Scullion said that this was only an estimate and it was out of the Trust's hands. Mr Coulter confirmed that the annual CNST premium for the Trust had increased by 11% against a national average of 17%. Dr Scullion said that this largely reflected the work on 'Sign Up To Safety' around obstetrics.

**11. Report by the Chief Nurse**

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

11.2 Mrs Foster undertook to report back when Director Inspections which had been rated red were re-inspected.

**Action: Mrs Foster**

11.3 Moving to nurse recruitment, Mrs Foster said that there were currently 35 full time vacancies and 12 gaps (mostly on Byland and Jervaulx wards). These were being mitigated in a number of ways, including through elective releases, use of non-front line staff, block bookings for agency staff, the over-employment of Care Support Workers (CSWs) in some areas, keeping beds empty where possible, consideration for discharge to Ripon and an incentive scheme (for those committing to work more than three extra shifts). Uptake for the latter had been good and full staffing had been achieved over the previous weekend.

11.4 A recruitment event had been staged using a social media company (Face the Music) and NHS Jobs. Job offers had been made to all 23 candidates, 11 for immediate start, 11 to students available from September and one for a Return to Work. Mr Ward wondered what progress had been made over the past six and 12 months, across overseas recruitment and new initiatives. He asked that this be included in Mrs Foster's February report.

**Action: Mrs Foster**

Mrs Foster said that the Trust needed to be seen as the Yorkshire and Humber employer of choice for nurses and midwives. The Trust was building relationships with Leeds Beckett, York and Bradford Universities and hoped to recruit from Leeds Beckett in March. A further recruitment event using Face the Music was planned for February. Mrs Dodson said that it was important to contextualise the efforts being made, not use them as a blunt instrument and Dr Tolcher emphasised the power of the personal touch with the existing Trust workforce as part of the solution. Walking around the wards sent a powerful message. The campaign for the previous recruitment event had been outstanding with 23 candidates attending from 25 enquirers. Mrs Foster thanked all those who had helped with the event, including the HR staff, who had given up their own time to support it.

11.5 Commenting on the actual v planned nurse staffing Mrs Foster said that on one night Jervaulx ward had 69% trained staff, which had been the lowest ever. It had been boosted by over doubling the number of trained CSWs on the ward and having some beds empty. Overall the percentage of trained staff elsewhere was positive, given the challenges. The risk to patient safety was being assessed at least twice daily and Mrs Foster said she was not allowing 'pools' of bank and/or agency staff to work together, to reduce the risk and thus spread them over all wards.

11.6 Professor Proctor said that the work in hand was impressive but wondered how long it could be kept up. The Trust needed to understand the longer-term implications including how it would manage risk and the impact on business development. There could be an opportunity to capitalise on the Trust's West Yorkshire footprint. Mr Marshall said that he had already met with his counterparts and he was looking at more direct recruitment and putting CSWs into nurse training programmes. He was not 'fishing' in the national or international pool and could guarantee candidates a job at the end of their training. Professor Proctor said that she hoped to see actual numbers in the Nursing and Midwifery Strategy.

11.7 Moving on, Dr Tolcher said that the recent LETB event around the future clinical workforce had highlighted risks related to the significant number of registered nurses on the cusp of retirement, for which staff in new roles would be required in two to three years' time. She considered that the Trust needed to identify these and retain them until the new staff were trained and available. This would need to be done specialist area by specialist area, taking into account age profiles and whether this was viable in each case.

11.8 Mrs Foster noted that the new senior nurse rota was operating well and took the onus off bed managers when nurse staffing issues arose. She commented that revalidation for nurses and midwives was now less than three months away. The Trust was supporting individuals through a series of roadshows, in both the community and acute areas, and providing information for confirmers, who would usually be the line managers. The roadshows had been well received and were dispelling myths which had been taking hold.

11.9 Turning to the Equality Delivery System 2 (EDS2), which had been introduced to the Board in September 2015, Mrs Foster said that a self-assessment was due by the end of January, and annually thereafter. The Trust must show evidence that it is accessible for those with protected characteristics. A cross-section of services had been assessed and the Trust had been assessed as 'developing', which is where she believed it needed to be. It was important to see whether any service users were being disadvantaged. A stakeholder event had been held where the self-assessment had been described as robust and thorough and outcomes had been agreed. The EDS2 objectives for 2016-17 would be included in the next report.

11.10 Mrs Taylor was disappointed because she felt that it was likely that the Trust was achieving some of the outcomes but Mrs Foster countered this by highlighting that evidence was lacking. The criteria were strict and providing a service did not mean that evidence was available. Dr Tolcher said that there were unexplained differences in BME admissions in, for example, diabetes. Mrs Foster said that EDS2 would be developed over a three to five year timeline and the Trust should be achieving some of the outcomes by the time of the 2017 report, although it would need to interrogate all services to provide the necessary evidence. There would not be league tables associated with the outcomes, as far as she was aware. Dr Scullion said that this was a continuous not a discrete process. Following a question from Dr Tolcher, Mrs Foster agreed to bring an update to the Board in July, and the Board **approved** the EDS2 self-assessment without further comment.

**Action: Mrs Foster**

**11.1 Patient Safety Visits – Annual Report**

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

11.1.2 Mrs Foster said that the report had been discussed extensively at SMT and it had been agreed that there would be more visits in the community. Mr Marshall noted that a planned visit to Selby MIU had been cancelled.

**12. Report by the Chief Operating Officer**

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

12.2 Mr Harrison reported that there had been delay to the Carbon Energy Fund project with Imtech following the discovery of a manufacturing fault with the new boiler which had resulted in the doors of the boiler melting at temperatures of greater than 500°C. The Swedish manufacturers were investigating this with Imtech. The total in-year savings would not therefore be realised. The facilities management contract was for 12 months and the Trust had not yet paid anything (except against the KPIs); in May 2016 Imtech would take responsibility and the Trust would pay nothing. The contingency boiler remained in place. Otherwise Mr Harrison reported the contract as proceeding well.

12.3 Mr Harrison drew attention to the Statement of Readiness at paragraph 3.1 of his report, which needed to be reported to the HaRD CCG. He had added it to the Emergency Preparedness Readiness Report which the Board had approved previously.

12.4 Mr Harrison described governance in Q3 as difficult but the Trust had achieved a green rating across the board. This was **approved** by the Board *nem con.*

12.5 Mrs Dodson expressed the thanks of the Board to Mr Harrison and his team for the way in which the recent major incident had been handled, especially coming as it did on the day following the industrial action by junior doctors. Mr Harrison said that a debrief had been held and lessons identified, amongst which was the resilience of the Information Technology team.

12.6 Mr Thompson was nervous about the long-term ability of Imtech to deliver the contract following its' recent change of ownership. Mr Harrison said that he was not concerned at this stage and pointed out some of the early benefits which were already in place, including the improved lighting.

**13. Report by the Director of Workforce and Organisational Development**

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

13.2 Mr Marshall said that completed exit interviews had revealed relocation and work/life balance as being the two major causes for staff leaving the Trust. Dr Tolcher was concerned about the number of nurses expressing concerns about their work/life balance on leaving.

**14. Report from the Chairman of the Finance Committee**

14.1 Mrs Taylor reported that the Committee would now be meeting every two months routinely and additionally as required. The Board **approved** the revised Terms of Reference for the Finance Committee.

**14.1 Report from the Chairman of the Audit Committee**

14.1.1 Mr Thompson presented the Terms of Reference and said that the Committee had decided that membership should not include a Deputy Medical Director as a permanent member. The Terms of Reference reflected changes made as the result of the establishment of the Quality Committee. The Board of Directors **approved** the Terms of Reference for the Audit Committee, subject to being rewritten in accordance with the template adopted after the Governance review of 2015.

**Action:** Secretary to the Audit Committee through **Mr Thompson**

14.1.2 Mr Thompson said that he was pleased to note the great improvement in executing audit recommendations following concerted effort by both the SMT and managers. Dr Tolcher said that SMT would now focus on the speed of responses to draft audit reports.

14.1.3 Turning to the annual survey for Audit Committee effectiveness, Mr Thompson said he was disappointed with the response rate of 22 from 64 and asked those involved to please respond when asked in future. Mrs Dodson re-emphasised the importance of responding but Mr Harrison described the timescale for response as short. There was discussion about whether some of the questions were appropriate and/or fit for purpose and Mr Thompson said that he would examine whether there could be improvements to the questions before the next survey.

**Action: Mr Thompson**

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

15.1 Mrs Dodson noted that two responses would be forwarded to NHS Improvement/Monitor as a result of decisions taken at the meeting.

**16. Any Other Business**

16.1 There was no other relevant business.

**17. Board Evaluation**

17.1 Mrs Dodson asked whether the Board considered the meeting to have progressed the strategic aims of the Trust. Dr Tolcher said that much of the business had been discussed under her report and revisited later in the meeting.

17.2 Mr Ward said that timetabling for a 12.30pm finish was not realistic and the timetable should be extended to 1pm. Dr Tolcher suggested realistic timings, item by item, should be appended to the Agenda.

17.3 Mrs Webster said that the Directorate reports had been pithy whilst Professor Proctor felt that all three of the key issues identified by the Chairman at the beginning of the meeting, had been addressed. Dr Earl considered the discussion around community services to have been good.

**18. 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 1.12pm.

This page has been left blank

Harrogate and District NHS
NHS Foundation Trust

# HDFT Board of Directors Actions Schedule – February 2016

## 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 of completion/progress update | Confirm action Complete |
|---|---|---|---|
| Bring National Quality Board report to the Board (8.6) | Mrs Jill Foster – Chief Nurse | November 2015 | Complete |
| Medical Director paper on HSMI and SHMI to be placed in Reading Room (6.8) | Mr Andrew Forsyth – Interim Head of Corporate Affairs | November 2015 | Complete |
| Convey thanks of Board to team involved in executing FLIP project (8.7) | Dr Natalie Lyth – Clinical Director, Integrated Care Directorate | November 2015 | Complete |
| Report on Ocean's Blue – Barnacles work with Ward Managers/Line Managers (5.12) | Mr Phillip Marshall – Director of Workforce and Organisational Development | November 2015 | Complete |
| Refresh plan for reducing ophthalmology patient backlog (5.13) | Mrs Barron – Operational Director, Elective Care Directorate | November 2015 | Complete |
| Increase the number of Patient Safety Visits to community services (10.7) | Mrs Jill Foster – Chief Nurse | November 2015 | Complete |
| Examine whether 10 unexpected claims (of 21) could or should have been anticipated (11.1.2) | Dr David Scullion – Medical Director | November 2015 | Complete |
| Draft Minutes of Board meetings to be published in advance of final papers (17.2) | Mr Andrew Forsyth – Interim Head of Corporate Affairs | November 2015 | Complete |
| Update the Board on progress with review and archiving of policies (5.16) | Dr Ros Tolcher – Chief Executive | November 2015 | Complete |
| Investigate potential for HDFT to instigate Beacon Wards scheme (4.0) | Mrs Foster - Chief Nurse | January 2016 (September 2015) | Complete |
| Update report on reducing avoidable admissions (4.1.7) | Dr Lyth – Clinical Director, Integrated Care | January 2016 | Complete |
| Adjust report to show true figures without distortion from advance cash payment (5.33) | Mr Coulter – Director of Finance | January 2016 | Complete |

| | | | |
|---|---|---|---|
| Write to thank Mr Leinhardt for his service as Clinical Lead for Strategy (5.39) | Mrs Dodson - Chairman | January 2016 | Complete |
| Brief Mr Ward re actions taken around Ripon Hospital (11.4) | Mr Alldred – Clinical Director, Urgent, Community and Cancer Care Directorate | January 2016 | Complete |
| Provide figures for non-statutory actual v planned nurse staffing figures eg ED, community, paediatrics, maternity (11.6) | Mrs Foster – Chief Nurse | January 2016 | Complete |
| Provide update on staff turnover and exit questionnaire information (13.6) | Mr Marshall – Director of Workforce and Organisational Development | January 2016 | Complete |
| Consider whether changes in NI payments from 1 Apr 2016 should be recorded as a risk to the Trust (13.8) | Mr Coulter – Director of Finance | January 2016 | Complete |
| Consider inclusion of clinical sustainability in future Board strategy session (17.4) | Mr Forsyth – Interim Head of Corporate Affairs | January 2016 | Complete |

# HDFT Board of Directors Actions Schedule – Outstanding Actions

## February 2016

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.

| Ref | Meeting Date | Item Description | Director/Manager Responsible | Date due to go to Board or when a confirmation of completion/ progress update is required | Detail progress and when item to return to Board if required |
|---|---|---|---|---|---|
| 1 | November 2015 | Integration of Footprint and sustainability to be covered at February strategy session (5.24) | Mr Coulter – Director of Finance | **February 2016** | |
| 2 | January 2016 | Report back routinely to the Board on outcome of re-inspections after Red Director Inspections (11.2) | Mrs Foster – Chief Nurse | **February 2016 *et seq*** | |
| 3 | January 2016 | Ensure reviewed and approved Terms of Reference for Audit Committee are in new format (14.1.1) | Secretary to Committee through Mr Thompson – Non-Executive Director | **February 2016** | |
| 4 | January 2016 | Reflect trend in recruitment processes over last 12 months in routine Report (11.4) | Mrs Foster – Chief Nurse | March 2016 | |
| 5 | January 2016 | Arrange for briefing on the governance around clinical research trials in the Trust (6.6) | Dr Scullion – Medical Director | March 2016 | |
| 6 | January 2016 | Prepare report for Board on debtors through Finance Committee (7.6) | Mr Coulter – Director of Finance | March 2016 | |
| 7 | January 2016 | Bring report to Board through Quality Committee to demonstrate that GP OOH service is safe for patients (6.8) | Mr Alldred – Clinical Director, Urgent Community and Cancer Care | April 2016 | |

| | | | | | |
|---|---|---|---|---|---|
| 8 | November 2015 | Report on number of emergency and elective Caesarean sections performed (6.6) | Dr Johnson – Clinical Director, Elective Care Directorate | May 2016 | |
| 9 | January 2016 | Update Board on progress with EDS2 action plan (11.10) | Mrs Foster – Chief Nurse | July 2016 | |
| 10 | January 2016 | Board to review Strategic KPIs on biannual basis (7.15) | Mr Coulter – Director of Finance | July 2016 | |
| 11 | January 2016 | Review and revise questions in annual Audit Committee survey (14.1.3) | Mr Thompson – Chair Audit Committee – Non-Executive Director | November 2016 | |

| Report to the Trust Board of Directors: 24 February 2016 | Paper No: 5.0 |
|---|---|

| Title | Report from Chief Executive |
|---|---|
| Sponsoring Director | Dr Ros Tolcher |
| Author(s) | Dr Ros Tolcher |
| Report Purpose | To update the Board of Directors on significant strategic, operational and performance matters |

**Key Issues for Board Focus:**

- The first cut of our Operating Plan for 2016/17 has been submitted
- Value Propositions in respect of the Harrogate and West Yorkshire Vanguards have been submitted to NHS England.
- Work has commenced with partners to develop a local Sustainability and Transformation Plan (STP) based on the Harrogate and Rural District Footprint.
- The number of C. difficile cases recorded now stands at 30. There are no instances of patient to patient transfer.

| Related Trust Objectives | |
|---|---|
| 1. To deliver high quality care | Yes |
| 2. To work with partners to deliver integrated care | Yes |
| 3. To ensure clinical and financial sustainability | Yes |

| Risk and Assurance | |
|---|---|
| Legal implications/ Regulatory Requirements | |

**Action Required by the Board of Directors**

- The Board is requested to **note** the strategic and operational updates

## 1.0 MATTERS RELATING TO QUALITY AND PATIENT EXPERIENCE

### Patient Safety Visits

Reports on Patient Safety Visits and Director Inspections are covered in the Chief Nurse report.

## 2.0 STRATEGIC UPDATE

### 2.1 Delivering the Forward View: NHS Planning guidance 2016/17-2020/21

The draft Operational Plan for the Trust was submitted on 8 February and work continues to develop the final version which is due to is submitted on 11 April, following consideration by the Board.

### 2.2 CQC Inspection

The on-site phase of the inspection was completed on 5 February and the CQC inspection chair and manager debriefed Sandra Dodson, Jill Foster, Rob Harrison and I that afternoon. It will be at least the end of April before we receive the draft report and ratings from the CQC.

In their verbal feedback, the CQC inspection team stated that staff across the organisation had been open, transparent and welcoming. They described staff as 'impressive' with a strong sense of positivity and family feel. The CQC also received more than 600 comments cards from our patients and people using community services, the great majority of which were positive.

Some further unannounced visits have taken place since the inspection week. As is normal at this stage of an inspection there to be a number of lines of enquiry which remain open and we are continuing to respond to information requests.

I would like to record my thanks to colleagues across the organisation who worked hard to prepare for the inspection; engaged positively in the inspection process and went out of their way to welcome the inspectors. Staff spoke with pride about their work and there was minimal disruption to service delivery.

### 2.3 National communications received and acted upon.

#### 2.3.1 Carter Report

The report by Lord Carter on operational productivity and efficiency has been published and the Trust is now considering how to respond to the challenges it presents.

#### 2.3.2 Developing Sustainability and Transformation Plans (STPs) to 2021

A joint letter from NHS England and NHS Improvement has been received setting out in more detail the timetable and requirements for the development of the STP. It states that Sustainability and Transformation Plans (STPs) will be place-based, multi-year plans built around the needs of local populations. They will help ensure that the investment secured in the Spending Review does not just prop up individual institutions for another year, but is used to drive a genuine and sustainable transformation in patient experience and health outcomes over the longer-term. STPs are not an end in themselves, but a means to build and strengthen local relationships, enabling a shared understanding of where we are now, our ambition for 2020 and the concrete steps needed to get us there.

The letter lays out a series of actions required of Trusts both before and after Easter, and details of national support which is available. Mr Coulter will cover in more detail how the Trust will take this forward.

## 3.0 WORKING IN PARTNERSHIP

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

The second Value Proposition (VP2) for the Vanguard Programme has now been submitted, following agreement at the Harrogate Health Transformation Board on 5 February.

Representatives of the NHS England New Care Models team visited the Trust on 10 February for the PACs Quarterly review. We were able to feedback on some of the early wins from the pilot site and explain in detail how the Calderdale framework is being used to help define new roles. Bidding for transitional funding via the VP2 is a competitive process and NHSE highlighted the fact that the sum of bids received considerably exceeds resources available. It is likely therefore that some sites will not receive their full amount requested. We were asked to start to consider how the new model could be implemented if the funding were to fall short of our 'ask'.

### 3.2 West Yorks Urgent and Emergency Care Vanguard

The first Value Proposition for this scheme has also been submitted. HDFT, alongside the other Acute Trusts in the Vanguard, is contributing to the Acute Service Models work stream. There are additional work streams relating to Primary Care; Mental Health and 'Hear, See and Treat'. A further six enabler work streams cover system leadership; workforce; West Yorkshire care record; engagement and consultation; intelligence led priorities and new payment models.

The final version of this VP and the Harrogate VP2 will be placed in the Reading Room.

### 3.3 Industrial Action by Junior Doctors

The majority of junior doctors at the Trust joined the industrial action which took place on 10 February. Contingency planning meant that a relatively small number of outpatient appointments had to be cancelled and the Trust was able to completely avoid cancelling any elective procedures. Mr Marshall will cover this in more detail in his report. As Board members will be aware the Secretary of State has decided subsequently to impose the new contract on junior doctors.

### 3.4 Harrogate Health Transformation Board

The Harrogate Health Transformation Board met on 17 February. A formal Letter of Agreement has been signed off which sets out the commitment of partners to work together to secure our common vision.

A new phase of public engagement is now planned, starting in the pilot area and rolling out to the other sites which are now due to go live in June.

The partnership is currently tendering for formal legal support. A recent workshop on potential contractual and delivery vehicles has helped inform thinking and this work will be taken forward with the successful bidder.

The HHTB will provide the governance and oversight for agreeing the local STP. I have completed 12 months as chair of the HHTB and have agreed to continue in this role for a further six months.

## 4.0 FINANCIAL POSITION

The Trust reported a deficit in January of £61k, £157k behind plan. This is before the consolidation of charitable funds. The year to date deficit therefore increased to £750k.

The year to date variance to plan currently stands at £2,638k. This relates to the Acute contract income £1,395k (1.3%) adverse variance and the adverse variance for non NHS clinical income of £334k.

Pay expenditure is £940k ahead of plan and continues to be a significant pressure.

The Trust CIP position is positive with 95% of plans actioned so far. Following review of plans in January there is now a risk adjusted planning gap of £191k against the Trust internal plan.

The Trust currently has a favourable cash position of £14.7m, £6.5m ahead of plan. Despite this positive position, the Trust expects to end the year £3m behind plan which is predominantly a result of the current financial position.

Detail in relation to the finance position and the impact upon our Monitor risk rating is contained with the Integrated Board Report and the report from the Finance Director.

## 5.0 SENIOR MANAGEMENT TEAM (SMT) MEETING

The SMT met on 17 February. Key issues discussed and for noting by the Board of Directors are as follows:

- The number of cases of C. difficile detected has risen to 30. The clustering of cases with dissimilar ribotypes has brought a new focus on the potential role of environmental factors. The Infection Prevention and Control team (IPC) and our consultant microbiologists are reviewing this. A new programme of planned maintenance deep cleaning is proposed and the use of UV Light is being explored. RCA has found no evidence of patient to patient transfer and only four cases of potential lapses in care.
- Specialty level analysis of mortality rates continues. No concerns emerging.
- Directorates have been asked to maintain strong financial controls through to year end in order to achieve our forecast surplus.
- Progress on completing actions agreed following serious incidents requiring investigation (SIRIs) was reviewed. Some of these are behind plan and Clinical Directors are committed to correcting this position. A further update will be received next month.
- A progress report on mobilisation of the new Durham, Darlington and Middlesbrough contracts was received.
- The draft Communications and Marketing Strategy was approved. This will be brought to the Board of Directors development session next month.
- Progress on CIP planning for 2016/17 was discussed. The risk adjusted total stands at 66% of the plan and work over the next two months will be designed to raise this to 100%. Sign off of Quality Impact Assessments by the Chief Nurse and Medical Director is currently underway.
- An update on progress in respect of actions agreed following the Kate Lampard Report into themes following the Savile Investigations was received. All actions are on plan.

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

## 6.0 BOARD ASSURANCE AND CORPORATE RISK

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

### 6.1 Board Assurance Framework (BAF)

The Board Assurance Framework was reviewed by the Executive Directors on 16 February 2016. No new risks were added and none removed. All risks have comprehensive Action Plans to address the Gaps in Controls; there were no changes in Progress Scores. A number of new Key Controls have been added, as a result of the completion of Action Plans. Four risks (BAFs# 6, 7, 11 and 13) are currently assessed as having achieved their target risk score.

The score for one risk, BAF#1 (lack of skilled medical nursing and clinical staff), has been increased from Amber 9 to Red 12, following reconsideration of the likelihood of the risk being realised.

The risk recorded at BAF#16 (buildings safety) was not reviewed in detail at the meeting on 16 February and remains unchanged. It will be examined in the context of the removal of a similar risk from the CRR (see below).

The Board will examine BAF#1 in detail at the Board Strategy day on 23 February, and BAF#2 at the Board Development session on 24 February, as part of the detailed review of all risks in the BAF across the year.

The strategic risks are as follows:

| Ref | Description | Risk score | Progress score |
|---|---|---|---|
| **BAF#1** | Lack of Medical, Nursing and Clinical staff | ***Red 12*** | *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 12* | *unchanged at 2* |
| **BAF#5** | Service Sustainability | *Amber 8* | *unchanged at 2* |
| **BAF#6** | Understanding the market | *Amber 8* | *unchanged at 2* |
| **BAF#7** | Lack of robust approach to new business | *Yellow 4* | *unchanged at 2* |
| **BAF#8** | Visibility and reputation | *Amber 8* | *unchanged at 1* |
| **BAF#9** | Failure to deliver the Operational Plan | *Red 12* | *unchanged at 2* |
| **BAF#10** | Loss of Monitor Licence to operate | *Amber 10* | *unchanged at 2* |
| **BAF#11** | Risk to current business | *Yellow 4* | *unchanged at 1* |
| **BAF#12** | External funding constraints | *Yellow 4* | *unchanged at 2* |
| **BAF#13** | Focus on Quality | *Amber 8* | *unchanged at 2* |
| **BAF#14** | Delivery of integrated models of care | *Amber 8* | *improved at 2* |
| **BAF#15** | Misalignment of strategic plans | *Amber 8* | *improved at 2* |
| **BAF#16** | Assurance of building safety in non-HDFT ov premises | *Red 12* | *unchanged at 2* |

Key to Progress Score on Actions:

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

6.2 **Corporate Risk Register (CRR)**

The CRR was reviewed at the monthly meetings of the Corporate Risk Review Group on 12 February 2016. There were no new risks to add to the register and three risks were removed. The mitigated score for one risk (CR5: nurse staffing) remains the top scoring risk.

The risks that were removed were:

- **CR63: Patient harm due to failure to identify and manage mental health and mental capacity needs**
  The risk score was reduced to C4 x L2 = 8 with a progress score of 1, following the initial positive feedback from the CQC inspection. The Urgent, Community and Cancer Care Directorate will continue to manage any on-going risk.

- **CR64: Harm to Ophthalmology Patients**
  The risk score was reduced to C4 x L2 = 8, following a reduction to 1383 in the backlog as of 8 February. The risk assessment of overdue patient follow-up has been completed and there are no high risk patients within that group. The risk of patient harm has therefore been reduced. The Elective Care Directorate will continue to manage any on-going risk. The progress score for this risk has returned to 2.

- **CR3: Risk of harm to patients and staff due to gaps in assurance on building safety at non-HDFT owned premises**
  Comprehensive information was now being received from NHSPS for a number of sites and the Deputy Director of Estates was confident that there was no longer a gap in assurance.

The top-scoring risk remains:

**CR5 - Risk of patient harm due to lack of experienced qualified nurses due to a national shortage in registered nurses**.
Risk score was increased in January to C3 x L5= 15 due to significant concerns raised by trained staff on the medical wards. Strengthened controls have been put in place and the risk for patients is being closely managed.

There are currently no risks with progress behind plan.

## 7.0 ROYAL VISIT

The Trust was pleased to welcome Their Royal Highnesses Prince Charles, Prince of Wales and Camilla, Duchess of Cornwall on a visit to the Sir Robert Ogden Macmillan Centre on 18 February. HRH Prince Charles met with staff and service users and praised the work of the Trust in delivering an accessible and highly valued service. The Lord Lieutenant of North Yorkshire and representatives of Macmillan Cancer Support and Sir Robert Ogden were also in attendance.

Dr Ros Tolcher
Chief Executive
February 2016

| Report to the Trust Board of Directors: 24 February 2016 | Paper No: 6.0 |
|---|---|

| Title | Integrated Board Report |
|---|---|
| Sponsoring Director | Dr. Ros Tolcher, Chief Executive |
| Author(s) | Rachel McDonald, Head of Performance & Analysis |
| Report Purpose | For information and consideration |

**Key Issues for Board Focus:**

- Agency spend in relation to pay spend has increased to 4.5% in January.
- Both mortality measures (HSMR and SHMI) reduced this month.
- At the end of January, the number of hospital acquired C. diff cases was 25, of which four were deemed to be due to a lapse in care.
- Performance against the A&E 4 hour standard was below the required 95% level in January at Trust level and for Harrogate ED.
- The proportion of patients waiting less than 18 weeks improved in January with all specialties above the 92% standard.

| Related Trust Objectives | |
|---|---|
| 1. To deliver high quality care | **Yes** |
| 2. To work with partners to deliver integrated care | **Yes** |
| 3. To ensure clinical and financial sustainability | **Yes** |

| | |
|---|---|
| **Risk and Assurance** | 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. |
| **Legal implications/ Regulatory Requirements** | 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**
To **note** current performance.

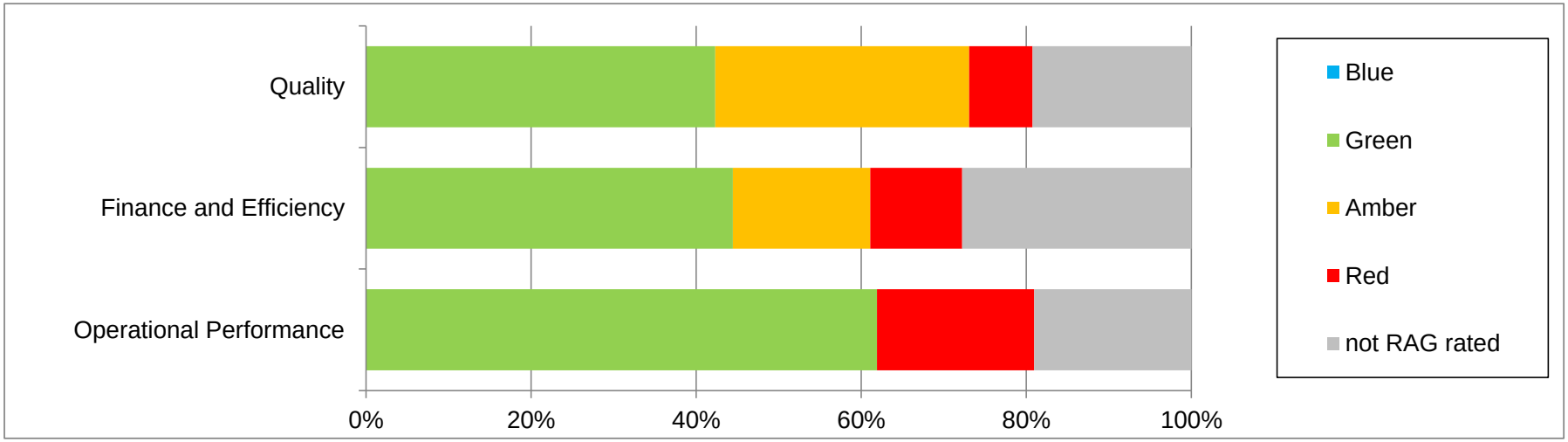
This page has been left blank

# Integrated board report - January 2016

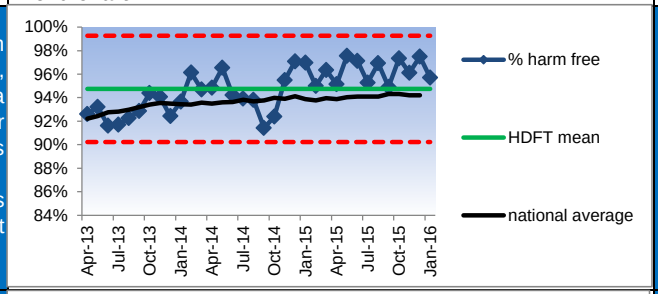
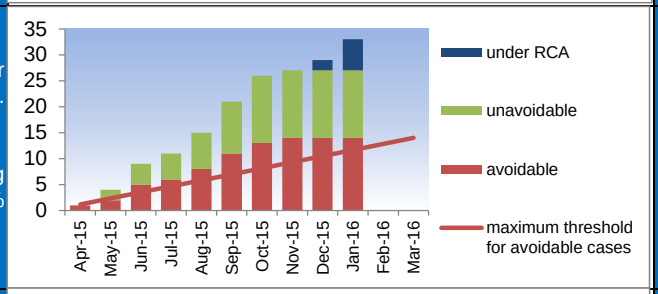
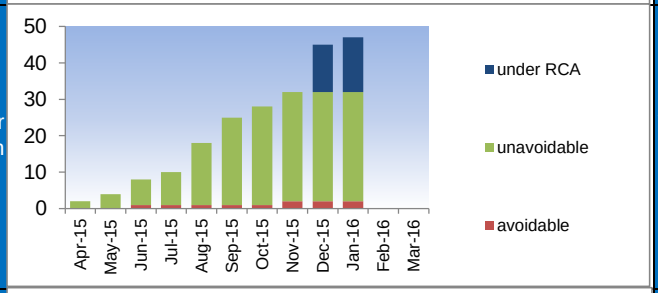
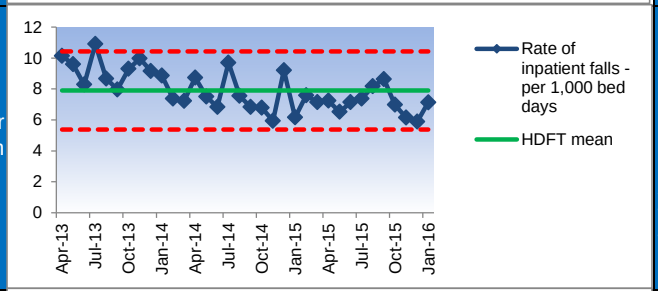
## Key points this month

1. Agency spend in relation to pay spend has increased to 4.5% in January.
2. Both mortality measures (HSMR and SHMI) reduced this month.
3. At the end of January, the number of hospital acquired C. diff cases was 25, of which 4 were deemed to be due to a lapse in care.
4. Performance against the A&E 4 hour standard was below the required 95% level in January at Trust level and for Harrogate ED.
5. The proportion of patients waiting less than 18 weeks improved in January with all specialties above the 92% standard.

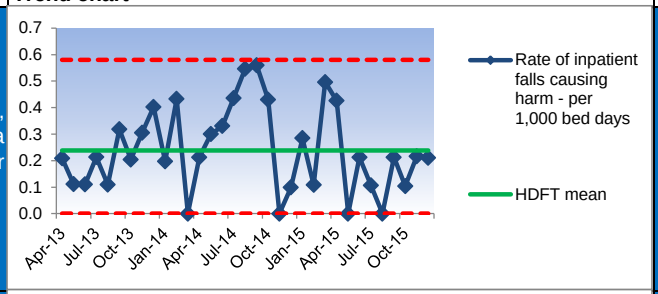
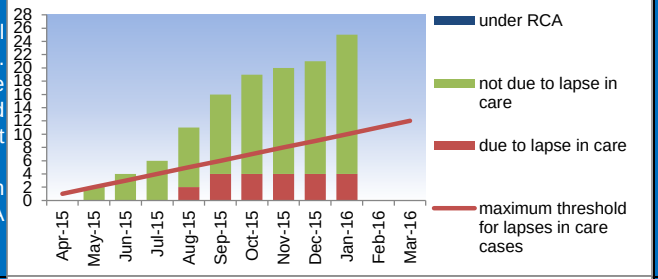
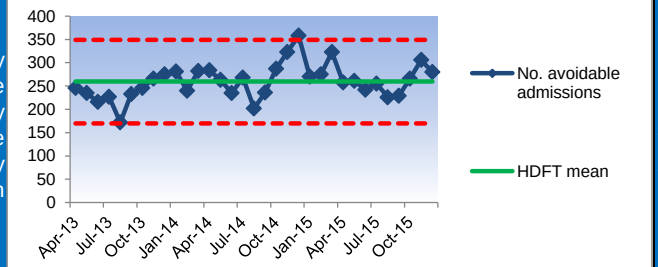
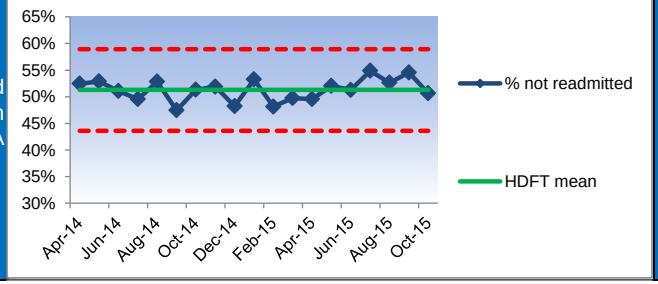
## Summary of indicators



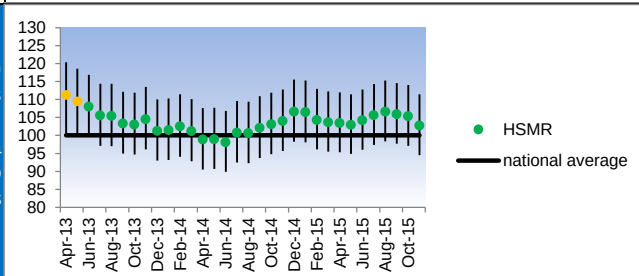
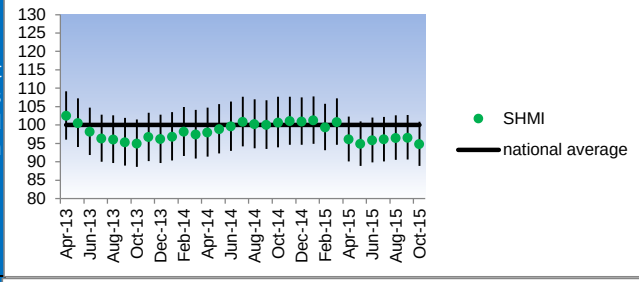
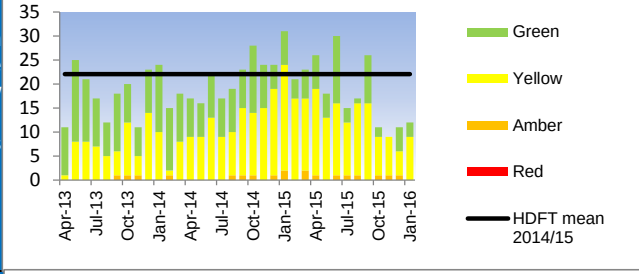
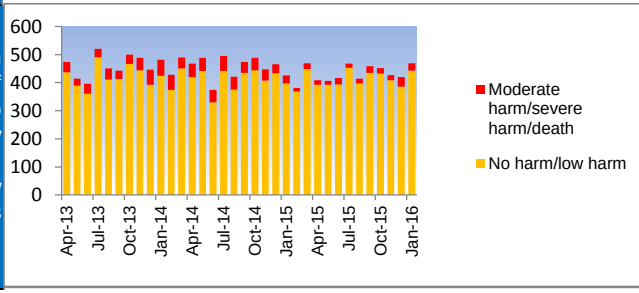
# Quality - January 2016

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Safety thermometer - harm free care** | Measures the percentage of patients receiving harm free care (defined as the absence of pressure ulcers, harm from a fall, urine infection in patients with a catheter and new VTE) in the Safety Thermometer audits conducted once a month. The data includes hospital and community teams. A high score is good. Whilst there is no nationally defined target for this measure, a score of 95% or above is considered best practice. |  | The harm free percentage for January was 95.7%, a decrease on last month but remaining above 95%. The latest available national data shows that HDFT consistently remains above the national average of 94.2%. |
| **Pressure ulcers - hospital acquired** | The chart shows the cumulative number of grade 3 or grade 4 hospital acquired pressure ulcers in 2015/16. The data includes hospital teams only.<br><br>A maximum threshold of 14 avoidable cases during 2015/16 has been locally agreed. This reflects a 50% reduction on last year's figure. |  | As at end January, there were 33 hospital acquired grade 3 or grade 4 pressure ulcers year to date, of which 14 were deemed avoidable, 13 unavoidable and 6 were still under root cause analysis (RCA). |
| **Pressure ulcers - community acquired** | The chart shows the cumulative number of grade 3 or grade 4 community acquired pressure ulcers in 2015/16. The data includes community teams only. |  | As at end January, there were 47 community acquired grade 3 or grade 4 pressure ulcers year to date, of which 2 were deemed avoidable, 30 unavoidable and 15 were still under root cause analysis (RCA). |
| **Falls** | The number of inpatient falls expressed as a rate per 1,000 bed days. The data includes falls causing harm and those not causing harm. A low rate is good. |  | The rate of inpatient falls was 7.1 per 1,000 bed days in January, an increase on the previous month but below the average HDFT rate during 2014/15.<br><br>A trial of falls sensors was carried out on Byland and Jervaulx wards during December and this will now be rolled out to other ward areas. |

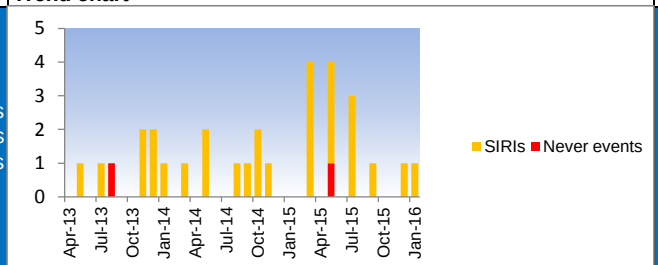
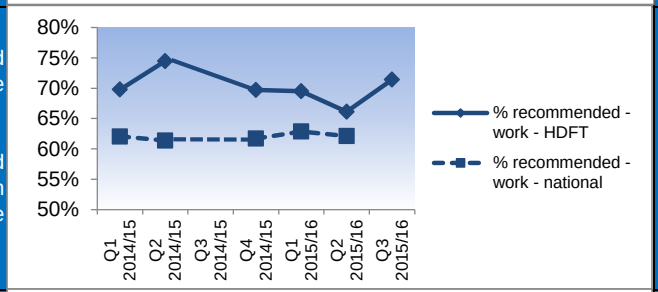
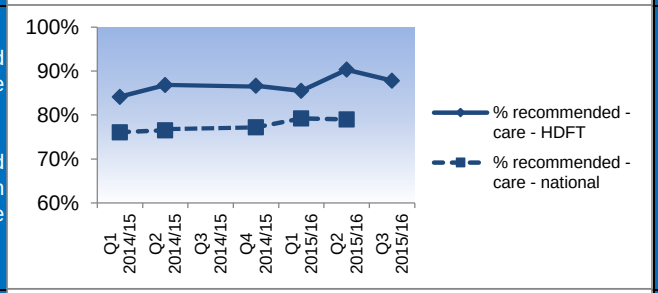
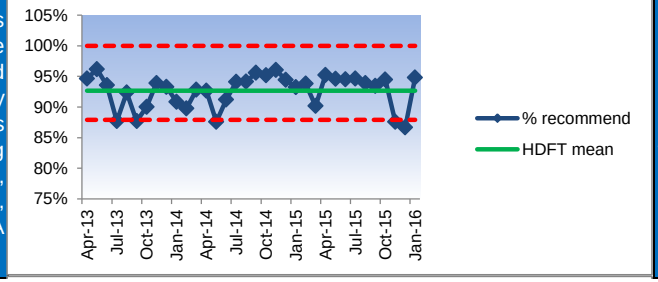
# Quality - January 2016

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Falls causing harm** | The number of inpatient falls causing significant harm, expressed as a rate per 1,000 bed days. The data includes falls causing moderate harm, severe harm or death. A low rate is good. |  | The rate of inpatient falls causing significant harm was 0.20 per 1,000 bed days in January, a slight reduction on the previous month and below the average HDFT rate during 2014/15.<br><br>There have been 16 inpatient falls causing moderate or severe harm in 2015/16 to date, of which 14 resulted in a fracture. |
| **Infection control** | The chart shows the cumulative number of hospital acquired C. difficile cases during 2015/16. HDFT's C. difficile trajectory for 2015/16 is 12 cases. Cases where a lapse in care has been deemed to have occurred would count towards the Monitor risk assessment framework.<br>Hospital acquired MRSA cases will be reported on an exception basis. HDFT has a trajectory of 0 MRSA cases for 2015/16. |  | There were 4 cases of hospital acquired C. difficile reported in January, bringing the year to date total at end January to 25 cases. RCA results indicate that 4 cases were deemed to be due to a lapse in care and 21 were not. 21 of the 25 RCAs completed have been discussed and agreed with the CCG. Significant improvements have been made in the timeliness of completing root cause analyses (RCAs) with an average time to RCA of 16 days in January.<br>No cases of hospital acquired MRSA have been reported in 2015/16 to date. |
| **Avoidable admissions** | The chart shows the number of avoidable emergency admissions to HDFT as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require admission. Conditions include pneumonia and urinary tract infections in adults and respiratory conditions in children. |  | The number of avoidable admissions decreased in December 2015, and is significantly lower than last December. The chart demonstrates some seasonality with this metric, so we would expect to see more avoidable admissions occurring over the winter period in the next few months.<br>An admission avoidance/urgent care project group has been established and the Trust is working with HARD CCG to develop care models and pathways that support patients to stay in their own home and reduce the risk of hospital admissions. |
| **Reducing readmissions in older people** | The chart shows the proportion of older people aged 65+ who were still at home 91 days after discharge from hospital into rehabilitation or reablement services. A high figure is good.<br>*This indicator is in development.* |  | For patients discharged in October, 51% were still in their own home at the end of January, a decrease on the previous month. |

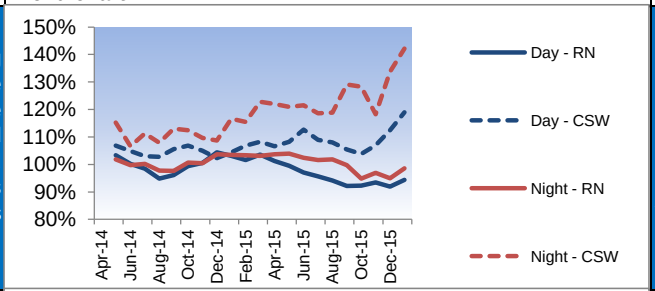
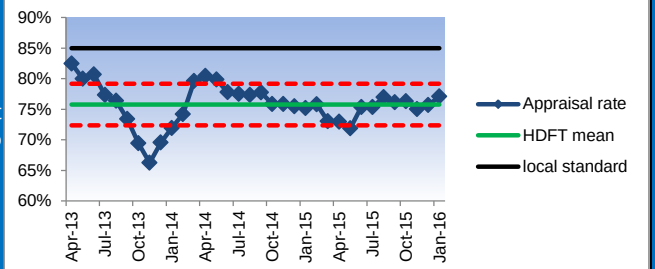
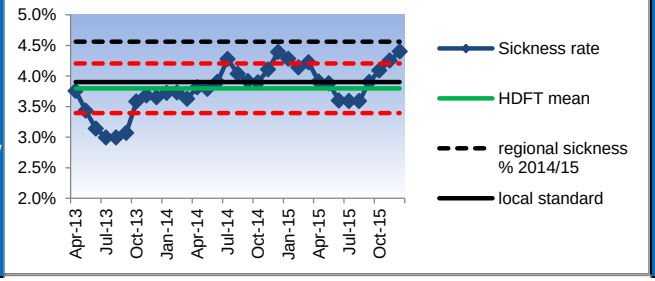
# Quality - January 2016

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Mortality - HSMR** | The Hospital Standardised Mortality Ratio (HSMR) looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care. A low figure is good. |  | HDFT's HSMR decreased in November to 102.74. It is above the national average but within expected levels. At specialty level, the same 3 specialties (Geriatric Medicine, Respiratory Medicine and Gastroenterology) have a standardised mortality rate above expected levels.<br>The HED system idenitfied an increase in mortality for patients with a primary diagnosis of septicaemia in November. The Medical Director has commissioned a clinical case note review of these deaths. |
| **Mortality - SHMI** | The Summary Hospital Mortality Index (SHMI) looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care. A low figure is good. |  | HDFT's SHMI decreased in October to 94.73 - this is below the national average and the lowest level reported in the last 3 years. At specialty level, 2 specialties (Geriatric Meidicine and Gastroenterology) have a standardised mortality rate above expected levels and looking at the data by site, Ripon hospital has a higher than expected mortality rate. |
| **Complaints** | The number of complaints received by the Trust, shown by month of receipt of complaint. The criteria define the severity/grading of the complaint with green and yellow signifying less serious issues, amber signifying potentially significant issues and red for complaints related to serious adverse incidents.<br>The data includes complaints relating to both hospital and community services. |  | 12 complaints were received in January (none of which were classified as amber or red) compared to 11 last month. |
| **Incidents - all** | The chart shows the number of incidents reported within the Trust each month. It includes all categories of incidents, including those that were categorised as "no harm". The data includes hospital and community services.<br>A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture |  | There were 469 incidents reported in January. The number of incidents reported each month remains fairly static but the proportion classified as moderate harm, severe harm or death has reduced during 2015/16.<br>The latest published national data (for the 6 month period to end March 2015) showed that acute trusts reported an average ratio of 25 no harm/low harm incidents for each incident classified as moderate harm, severe harm or death (a high ratio is better). HDFT's local reporting ratio for 2015/16 to date is 19.0. |

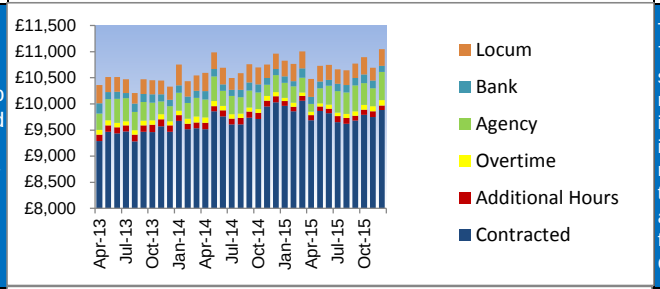
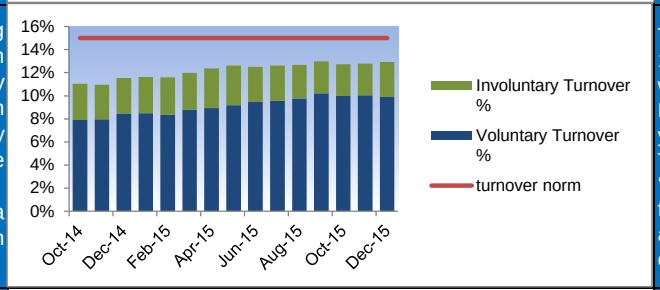
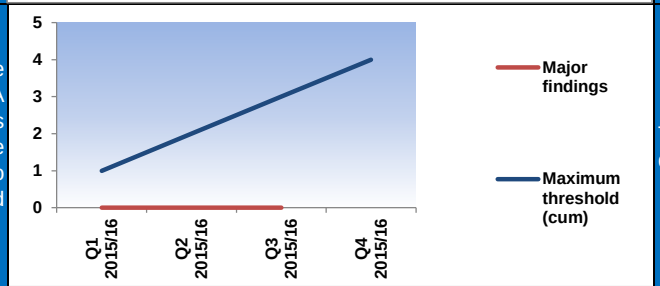
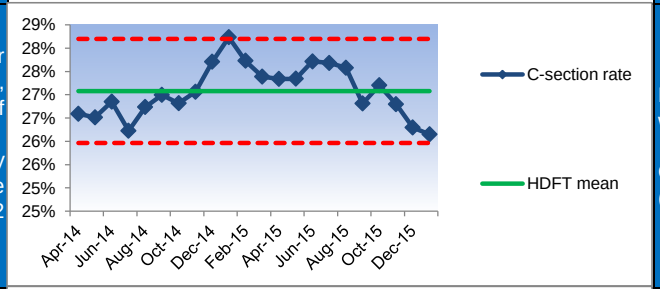
# Quality - January 2016

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Incidents - SIRIs and never events** | The chart shows the number of Serious Incidents Requiring Investigation (SIRIs) and Never Events reported within the Trust each month. The data includes hospital and community services. |  | There was 1 SIRI reported in January. There were no never events reported this month. |
| **Friends & Family Test (FFT) - Staff - % recommend as a place to work** | 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.<br><br>The chart shows the percentage of staff that would recommend the Trust as a place to work. A high percentage is good. The Trusts aim is to feature in the top 20% of Trusts nationally. |  | *There is no update of this data this month.*<br>In Q3 2015/16, all staff within HDFT were surveyed. 71% of staff surveyed would recommend the Trust as a place to work, compared to the most recently published national average of 62%. 12% of HDFT staff would not recommend the Trust as a place to work to friends and family compared to the most recently published national average of 19%. Q3's results will be triangulated with the Staff Survey results to develop an action plan for implementation across the Trust |
| **Friends & Family Test (FFT) - Staff - % recommend as a place to receive care** | The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organisation they work in.<br><br>The chart shows the percentage of staff that would recommend the Trust as a place to work. A high percentage is good. The Trusts aim is to feature in the top 20% of Trusts nationally. |  | *There is no update of this data this month.*<br>In Q3 2015/16, all staff within HDFT were surveyed. 71% of staff surveyed would recommend the Trust as a place to work, compared to the most recently published national average of 62%. 12% of HDFT staff would not recommend the Trust as a place to work to friends and family compared to the most recently published national average of 19%. Q3's results will be triangulated with the Staff Survey results to develop an action plan for implementation across the Trust |
| **Friends & Family Test (FFT) - Patients** | The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of hospital and community services including inpatients, day cases, outpatients, maternity services, the emergency department, some therapy services, district nursing, community podiatry and GP OOH. A high percentage is good. |  | The reduced performance in November and December was caused by a change in the recorded message used for the automated phone call surveys which resulted in some patients being unsure how to respond to the FFT question. Once this was identified as an issue, the original phone call message was reinstated in late December and in January, the % recommending has returned to previous levels (94.8%). The latest published national average for % recommend is 92.9%. |

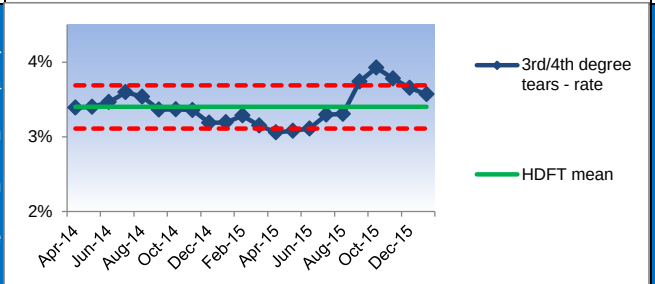
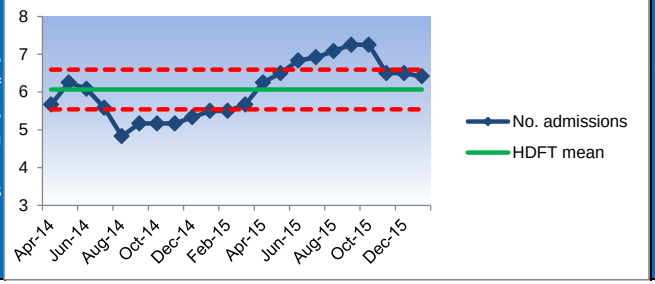
# Quality - January 2016

<table>
<tr><th>Indicator</th><th>Description</th><th>Trend chart</th><th>Interpretation</th></tr>
<tr><td>Safer staffing levels</td><td>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.</td><td> 
</td><td>Registered nurse/midwife (RN) staff levels increased in January. Overall staffing compared to planned was at 105.5%, compared to 101.3% last month. Care support worker (CSW) staffing at night remains very high compared to plan - this is reflective of the increased need for 1-1 care for some inpatients.<br>A significant focus is being placed on recruitment of RN staff including open events and targeted recruitment campaigns including the use of social media.</td></tr>
<tr><td>Staff appraisal rates</td><td>The chart shows the staff appraisal rate over the most recent rolling 12 months. The Trusts aims to have 85% of staff appraised. A high percentage is good.</td><td> 
</td><td>The locally reported cumulative appraisal rate for the 12 months to end January 2016 was 77.1%, an increase on the previous month. Data from the 2015 national staff survey suggested that 85% of HDFT staff had been appraised within the last 12 months.<br>HR Business Partners will be confirming the target of 95% at Clinical Directorate boards. The Values based appraisal was launched last month. Roll out is continuing with briefing sessions across the hospital and community sites.</td></tr>
<tr><td>Mandatory training rates</td><td>The table shows the most recent training rates for all mandatory elements for substantive staff. A high percentage is good.</td><td>
<table>
<tr><th>Competence Name</th><th>Total Employees</th><th>% Completed</th></tr>
<tr><td>Equality and Diversity - General Awareness</td><td>3439</td><td>95</td></tr>
<tr><td>Fire Safety Awareness</td><td>3439</td><td>90</td></tr>
<tr><td>Health & Safety</td><td>1440</td><td>99</td></tr>
<tr><td>Infection Prevention & Control 1</td><td>662</td><td>100</td></tr>
<tr><td>Infection Prevention & Control 2</td><td>2724</td><td>88</td></tr>
<tr><td>Information Governance: Introduction</td><td>3176</td><td>88</td></tr>
<tr><td>Information Governance: Beginners</td><td>262</td><td>85</td></tr>
<tr><td>Safeguarding Children & Young People L1</td><td>3439</td><td>93</td></tr>
</table>
</td><td>The data shown is for end January. The overall training rate for mandatory elements for substantive staff is 92%, compared to 91% last month.<br><br>The Information Governance toolkit requires us to achieve 95% for both information governance training elements. Both remain below the standard - all management teams have been tasked with focusing on this area through Operational Delivery Group to ensure delivery of the 95% standard by the end of March.</td></tr>
<tr><td>Sickness rates</td><td>Staff sickness rate - includes short and long term sickness.<br>The Trust has set a threshold of 3.9%. A low percentage is good.</td><td> 
</td><td>HDFT's staff sickness rate increased to 4.4% in December 2015, which usually occurs during winter months. There is focussed attention on long term sickness cases and completion of return to work interviews remains a key priority for all areas. Drop in sessions continue in Elective Care Directorate alongside the development of Health and Wellbeing initiatives to compliment the SHU wellness assessments.</td></tr>
</table>

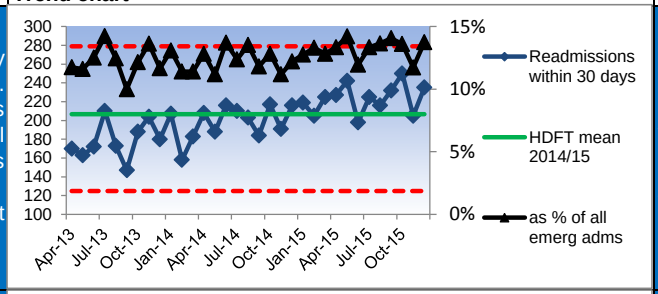
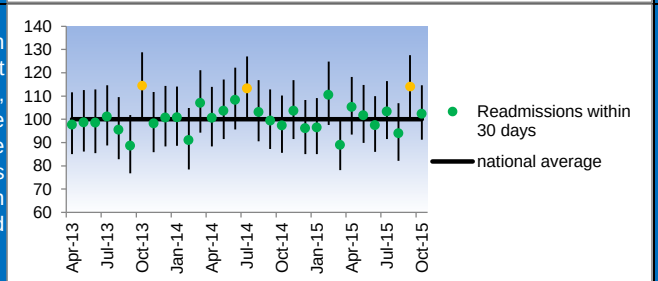
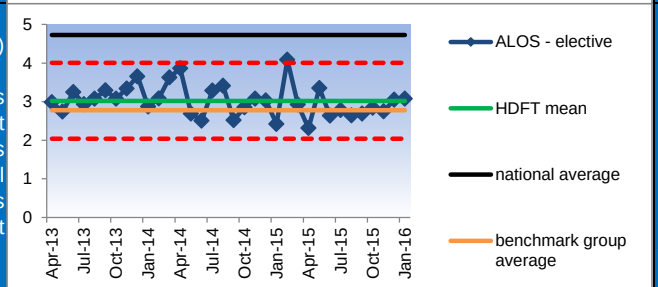
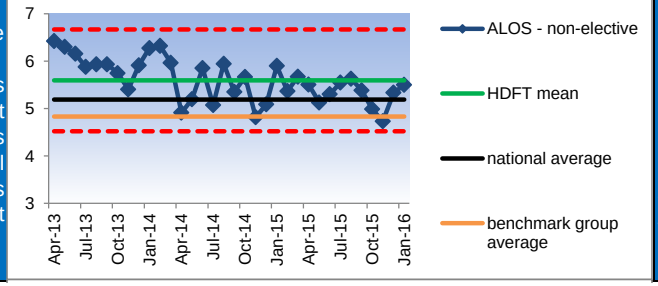
# Quality - January 2016

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Temporary staffing expenditure - medical/nursing /other** | The chart shows staff expenditure per month, split into contracted staff, overtime and additional hours and temporary staff. Lower figures are preferable.<br>*The traffic light criteria applied to this indicator is currently under review.* |  | The proportion of spend on temporary staff during 2015/16 to date is 7.6%, compared to 7.2% last year. It is to be noted that the total staffing spend is in line with budgeted spend in month. However concern remains regarding the number of registered nurse vacancies and the impact this is having on agency spend. Sickness will also be a driver of increased use of temporary and agency staff. Registered Nurses have recently been added to the National Shortage Occupation List given that the current demand is greater than supply nationally. An open day as part of a strategic recruitment campaign is due to take place; a further review of vacancies and next steps is to be undertaken by the Chief Nurse after this event. |
| **Staff turnover rate** | The chart shows the staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. The turnover figures include both voluntary and involuntary turnover. Voluntary turnover is when an employee chooses to leave the Trust and involuntary turnover is when the employee unwillingly leaves the Trust.<br>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 increased slightly to 12.9% for the rolling 12 months to December 2015 (compared to 12.8% last month), with 9.9% voluntary turnover and 3.0% involuntary turnover. HDFT's turnover rate has generally increased over the last two years but remains below the turnover norm of 15%.<br>The Exit questionnaire return has been reviewed and the 'other/unknown' voluntary resignation reason has been removed from the form to enable more informative data to be gathered about the reasons why people are leaving the Trust. Exit interview completion remains an area of focus as return rates remain low. |
| **Research internal monitoring** | The Trust internally monitors research studies active within the Trust. The department mirrors the MHRA categorisation of critical, major and other findings (departures from legislative or GCP requirements). The department has set a standard of no critical and no more than four major findings per annum. Major and other findings are non-notifiable and dealt with locally. |  | There were no critical or major findings reported in the year to date. |
| **Maternity - Caesarean section rate** | The caesarean section rate is determined by a number of factors including ability to provide 1-1 care in labour, previous birth experience and confidence and ability of the staff providing care in labour.<br>The rate of caesarean section can fluctuate significantly from month to month - as a result we have amended the presentation of this indicator this month to show a 12 month rolling average position. |  | HDFT's C-section rate for the 12 months ending January 2016 was 26% of deliveries, the lowest level for some time.<br><br>Of the C-sections carried out in January, 53% were elective (planned) and 47% were non-elective (emergency). |

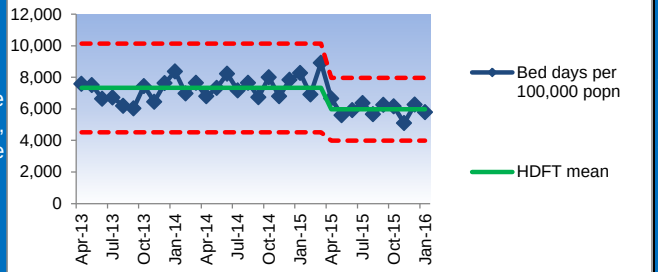
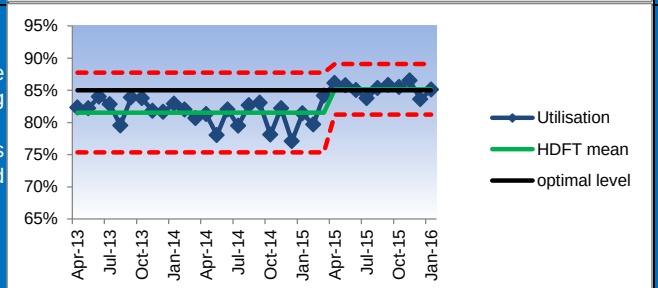
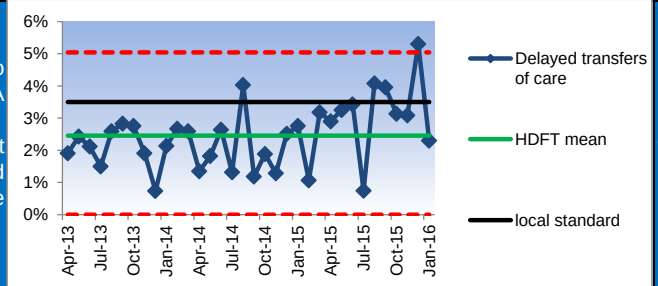
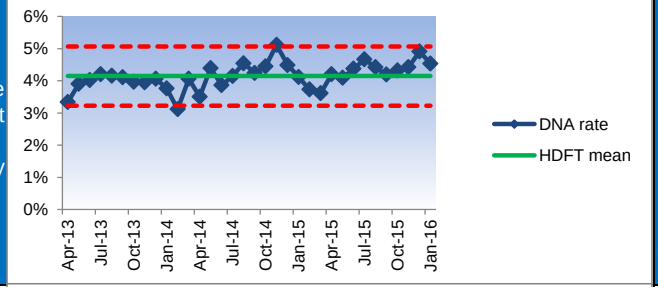
# Quality - January 2016

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Maternity - Rate of third and fourth degree tears** | Third and fourth degree tears are a source of short term and long term morbidity. A previous third degree tear can increase the likelihood of a woman choosing a caesarean section in a subsequent pregnancy.<br>Recent intelligence suggested that HDFT were an outlier for third degree tears with operative vaginal delivery. Quality improvement work is being undertaken to understand and improve this position and its inclusion on this dashboard will allow the Trust Board to have sight of the results of this. |  | We have amended the presentation of this indicator this month to show a 12 month rolling average position. The rate of 3rd/4th degree tears reduced to 3.4% of deliveries in the 12 month period ending January 2016.<br><br>The maternity team carry out a full review of all cases of 3rd/4th degree tears. Consideration is currently being made to a clinical re-audit of 3rd/4th degree tears occurring with normal deliveries. |
| **Maternity - Unexpected term admissions to SCBU** | This indicator is a reflection of the intrapartum care provided. For example, an increase in the number of term admissions to special care might reflect issues with understanding of fetal heart rate monitoring in labour.<br>We have amended the presentation of this indicator this month to show a 12 month rolling average position. |  | The chart shows the number of babies born at greater than 37 weeks gestation who were admitted to the Special Care Baby Unit (SCBU). The maternity team carry out a full review of all term admissions to SCBU.<br><br>There were 5 term admissions to SCBU in January, no change on last month. The average number per month over the last 12 months is 7. |

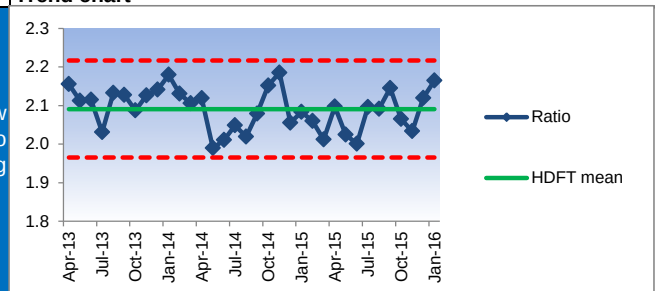
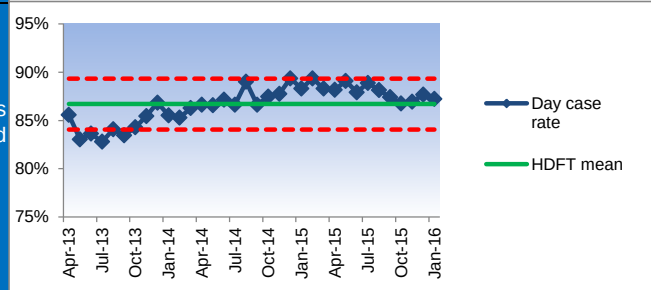
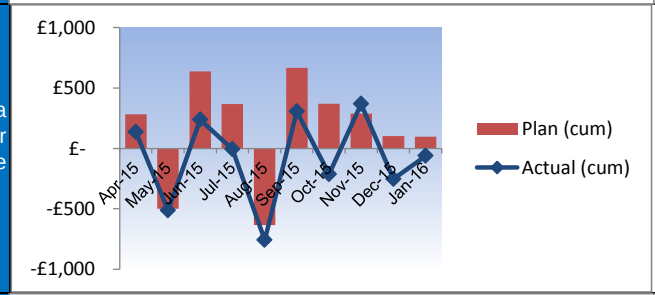
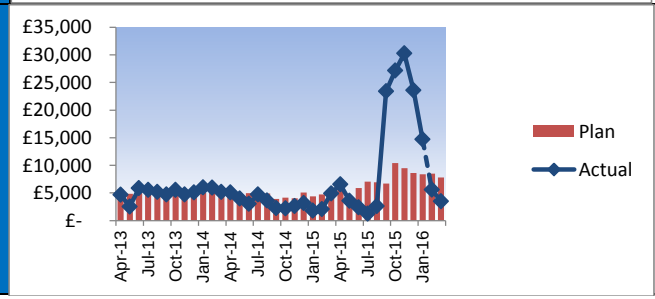
# Finance and Efficiency - January 2016

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Readmissions** | % of patients readmitted to hospital as an emergency within 30 days of discharge (PbR exclusions applied). To ensure that we are not discharging patients inappropriately early and to assess our overall surgical success rates, we monitor the numbers of patients readmitted. A low number is good performance.<br>This data is reported a month behind so that any recent readmissions are captured in the data. |  | The number of readmissions increased in December, both actual numbers and as a percentage of all emergency admissions.<br>An audit of 60 patient notes was undertaken in November 2015 - the findings indicated that no patients from the sample were readmitted to hospital due to failure to prepare for discharge on the initial admission. The main reasons for readmission were new medical problems, exacerbation of existing medical problem or planned investigations, treatments or reviews. |
| **Readmissions - standardised** | This indicator looks at the standardised readmission rate within 30 days. The data is standardised against various criteria including age, sex, diagnosis, comorbidites etc. The standardisation enables a more like for like comparison with other organisations. The national average is set at 100. A low rate is good - rates below 100 indicate a lower than expected readmission rate and rates above 100 indicate higher than expected readmission rate. |  | The standardised readmission rate for HDFT for Oct-15 (latest data available) was 102.4, a decrease on the previous month. This is just above the national average but within expected levels. |
| **Length of stay - elective** | Average length of stay in days for elective (waiting list) patients. The data excludes day case patients.<br>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 Jan-16 was 3.1 days, a slight increase on the previous month. A focus on sustainably reducing this through the Planned Care Transformation programme is underway, which includes reducing the number of patients admitted the day before surgery.<br>Two average lines have been added to the chart (national average and the average for a group of similar benchmarked trusts). These will enable us to understand where HDFT sit and whether our actions have an impact compared to other Trusts. |
| **Length of stay - non-elective** | Average length of stay in days for non-elective (emergency) patients.<br>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 Jan-16 was 5.5 days, an increase on the previous month. An increase in non-elective length of stay is often seen during the winter months.<br><br>Two average lines have been added to the chart (national average and the average for a group of similar benchmarked trusts). These will enable us to understand where HDFT sit and whether our actions have an impact compared to other Trusts. |

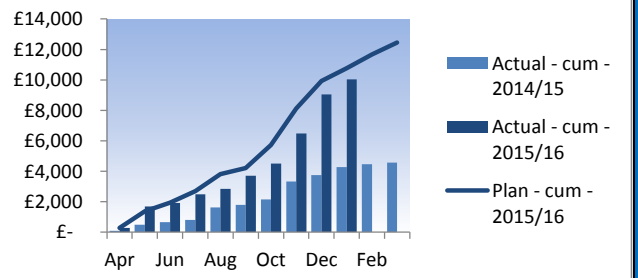
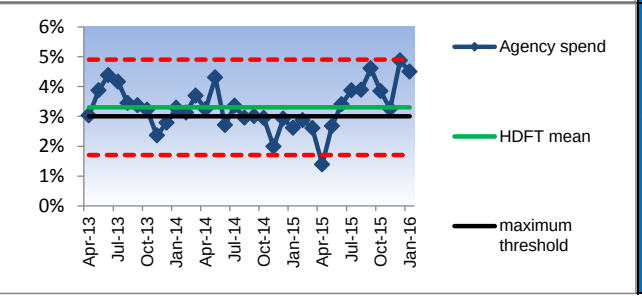
# Finance and Efficiency - January 2016

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Non-elective bed days** | The charts shows the number of non-elective (emergency) bed days at HDFT for patients aged 18+, per 100,000 population. The chart only includes the local HARD CCG area. A lower figure is preferable. |  | As can be seen, the number of non-elective bed days for patients aged 18+ has remained fairly static over the last two years. Further analysis of this new indicator will be completed to look at the demograghic changes during this period and the number of admissions for this group will assist in understanding this further. |
| **Theatre utilisation** | The percentage of time utilised during elective theatre sessions only (i.e. those planned in advance for waiting list patients).<br>A higher utilisation rate is good as it demonstrates effective use of resources. A utilisation rate of around 85% is often viewed as optimal. |  | Theatre utilisation increased to 85.1% in January 2016.<br><br>The utilisation calculation has been reviewed with Elective Care Directorate and amended to give a more accurate picture of elective list utilisation. The calculation now excludes Main Theatre 2 (emergency theatre) and operating lists that are planned not to go ahead due to annual leave or study leave etc.. The data has been refreshed back to April 2015. |
| **Delayed transfers of care** | The proportion of patients in acute hospital beds who are medically fit for discharge but are still in hospital. A low rate is preferable.<br>A snapshot position is taken at midnight on the last Thursday of each month. The maximum threshold shown on the chart (3.5%) has been agreed with the CCG. |  | Delayed transfers of care reduced to 2.3% when the snapshot was taken in January, below the maximum threshold of 3.5% set out in the contract. |
| **Outpatient DNA rate** | Percentage of new outpatient attendances where the patient does not attend their appointment, without notifying the trust in advance.<br>A low percentage is good. Patient DNAs will usually result in an unused clinic slot. |  | The DNA rate decreased to 4.5% in January. The content of the appointment reminder text message sent to patients is being reviewed with a view to including the actual cost of a missed appointment.<br>DNA rates at outreach clinics continue to be monitored to ensure that they are not significantly higher than clinics on the main site. During Q3, the DNA rate for first outpatient appointments at outreach clinics was 5.1%, compared to 4.5% on the main Harrogate site. Directorate teams will be asked to focus on why offsite rates are higher if this persists. |

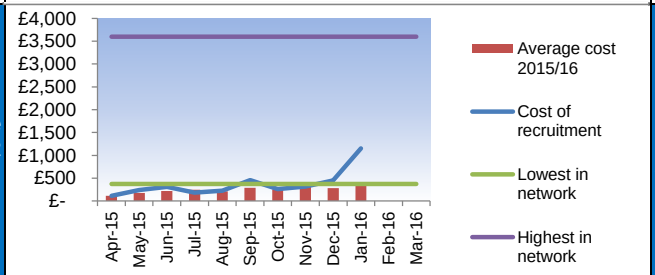
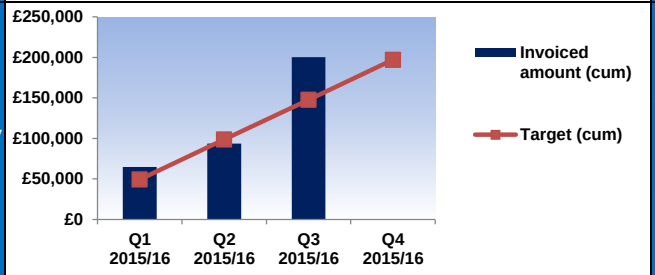
# Finance and Efficiency - January 2016

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Outpatient new to follow up ratio** | The number of follow-up appointments per new appointment. A lower ratio is preferable. A high ratio could indicate that unnecessary follow ups are taking place. |  | Actions with HARD CCG continue and are on plan. |
| **Day case rate** | The proportion of elective (waiting list) procedures carried out as a day case procedure, i.e. the patient did not stay overnight.<br>A higher day case rate is preferable. |  | The Day Surgery Transformation group continues their work and are on plan. |
| **Surplus / deficit and variance to plan** | Monthly Surplus/Deficit (£'000s). In some months, a deficit is planned for. This indicator reports positive or adverse variance against the planned position for the month. |  | The Trust reported a deficit in January of £61k, £157k behind plan. This is before the consolidation of charitable funds. The year to date deficit therefore increased to £750k. Cost control and activity planning measures need to deliver as planned to ensure that a year end surplus is achieved. |
| **Cash balance** | Monthly cash balance (£'000s) |  | The increase in cash is positive, however, as the profile suggests there will be no more monthly contract payments in relation to the acute contract with HaRD CCG, only overtrade payments which are yet to be finalised. This will be carefully managed until the end of the financial year |

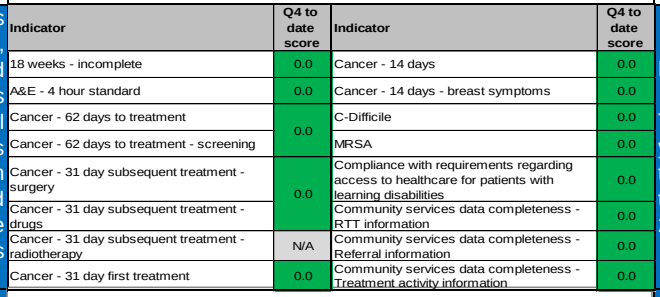
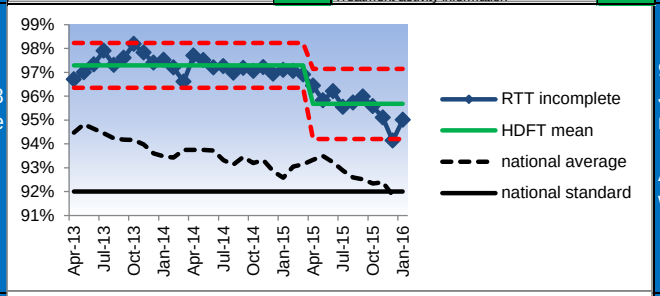
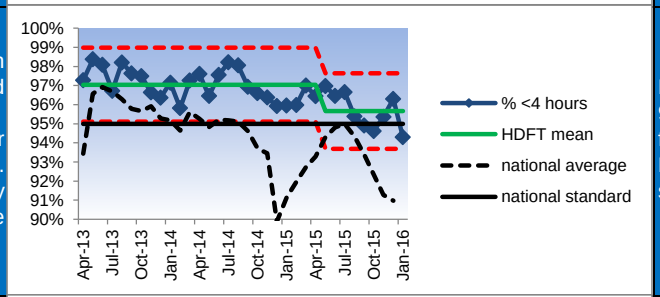
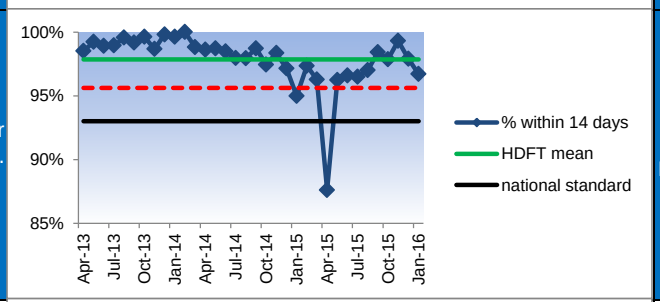
# Finance and Efficiency - January 2016

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Monitor continuity of services risk rating** | The Monitor Continuity of Services (CoS) risk rating now includes four components, as illustrated in the table to the right. An overall rating is calculated ranging from 4 (no concerns) to 1 (significant concerns). This indicator monitors our position against plan. | <table><tr><th>Element</th><th>Plan</th><th>Actual</th></tr><tr><td>Capital Service Capacity rating</td><td>4</td><td>3</td></tr><tr><td>Liquidity rating</td><td>4</td><td>3</td></tr><tr><td>I&E Margin rating</td><td>3</td><td>2</td></tr><tr><td>I&E Margin Variance rating</td><td>2</td><td>2</td></tr><tr><td>Financial Sustainabiltiy Risk Rating</td><td>3</td><td>3</td></tr></table> | The Trust will report a risk rating of 3 for the year to January. This is in line with the Trust plan.<br><br>Despite still being a 3, the Trust's current position means this is weaker than initially planned. |
| **CIP achievement** | Cost Improvement Programme (CIP) performance outlines full year achievement on a monthly basis. The target is set at the internal efficiency requirement (£'000s). This indicator monitors our year to date position against plan. |  | 95% of plans have been actioned by directorates. A further 3% of plans are in place at present following risk adjustment. |
| **Capital spend** | Cumulative Capital Expenditure by month (£'000s) |  | Capital Expenditure is behind plan. This is due to a delay in relation to the Carbon Energy Fund Scheme. All other schemes are on plan. Work is currently underway to estimate what plans can safely be deferred/delayed as a result of the Trust's financial position. |
| **Agency spend in relation to pay spend** | Expenditure in relation to Agency staff on a monthly basis as a percentage of total pay bill. The Trust aims to have less than 3% of the total pay bill on agency staff. |  | At 4.5% of the Trust's pay bill, agency expenditure remains high. Detailed work is ongoing with Clinical Directorates to reduce total agency spend and ensure compliance with the agency cap. |

# Finance and Efficiency - January 2016

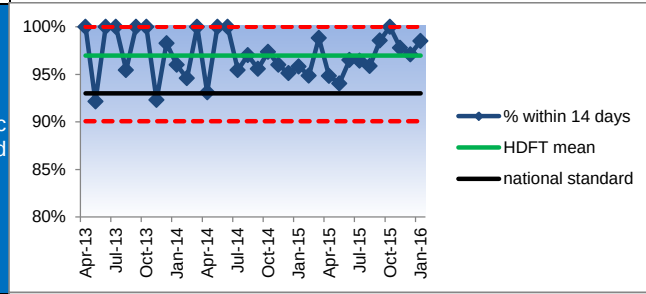
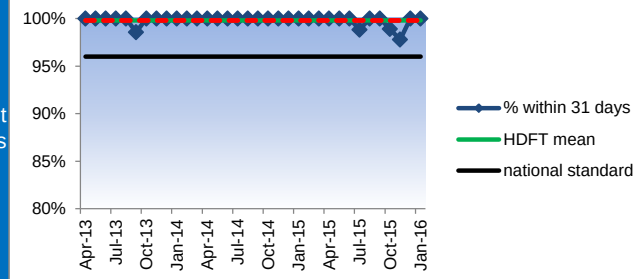
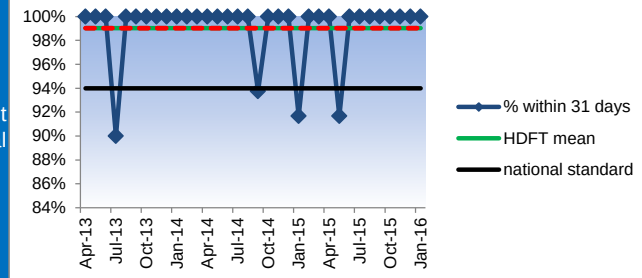
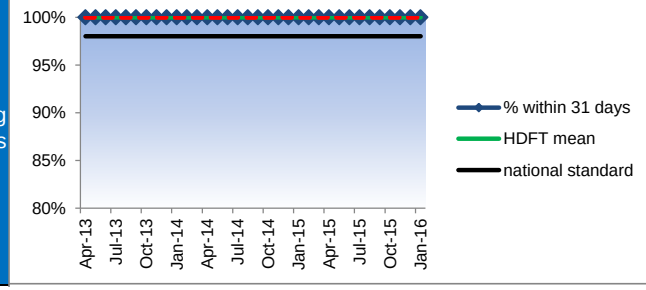
| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Research - Cost per recruitment** | Cost of recruitment to NIHR adopted studies. The Research department has a delivery budget of £69,212 per month. A low figure is preferable. |  | The Research department has a delivery budget of £69,212 per month. The Yorkshire and Humber Clinical Research Network calculate the cost of recruitment at each NHS site. It is desired that HDFT return a cost of recruitment that is in line with previous years. |
| **Research - Invoiced research activity** | Aspects of research studies are paid for by the study sponsor or funder. |  | As set out in the Research & Development strategy, the Trust intends to maintain its current income from commercial research activity and NIHR income to support research staff to 2019. Each study is unique. Last year the Trust invoiced for a total of £223k. |

# Operational Performance - January 2016

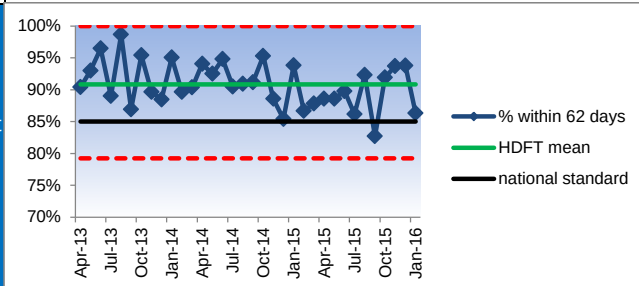
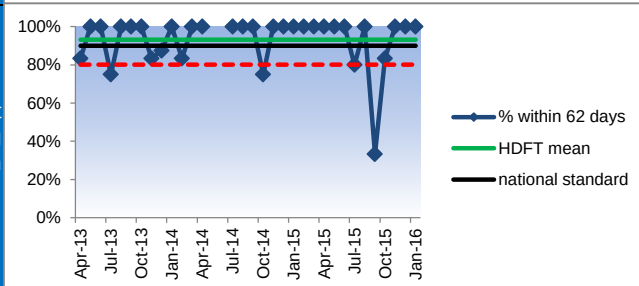
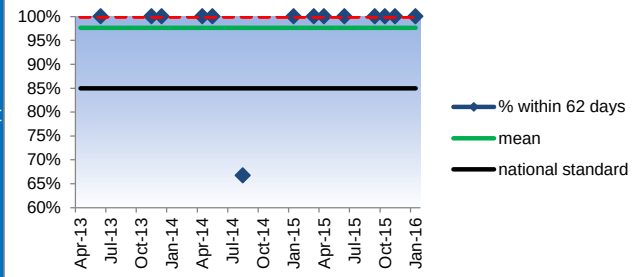
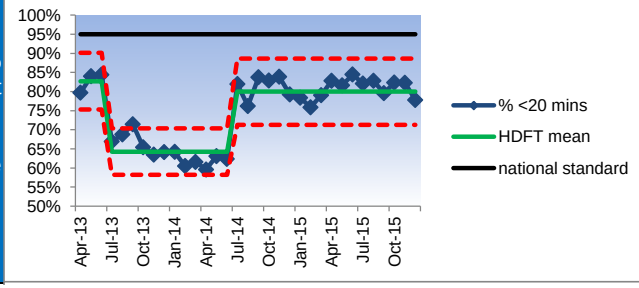
| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Monitor governance rating** | Monitor use a variety of information to assess a Trust's governance risk rating, including CQC information, access and outcomes metrics, third party reports and quality governance metrics. The 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. An amended Risk Assessment Framework was published by Monitor in August 2015 - updated to reflect the changes in the way that the 18 weeks standard is monitored. |  | HDFT's provisional governance rating for Q4 to date is Green.<br><br>The Trust reported 25 cases of hospital acquired C. difficile year to date at end January. Provisional RCA results indicate that 21 of these cases were not due to lapses in care and therefore these would be discounted from the trajectory for 2015/16. |
| **RTT Incomplete pathways performance** | Percentage of incomplete pathways waiting less than 18 weeks. The national standard is that 92% of incomplete pathways should be waiting less than 18 weeks.<br>A high percentage is good. |  | 95.0% of patients were waiting 18 weeks or less at the end of January, an increase on last month and remaining above the required national standard of 92%.<br><br>At specialty level, all specialties achieved the 92% standard with Trauma & Orthopaedics showing an improved position. |
| **A&E 4 hour standard** | Percentage of patients spending less than 4 hours in Accident & Emergency (A&E). The operational standard is 95%.<br>The data includes all A&E Departments, including Minor Injury Units (MIUs). A high percentage is good. Historical data for HDFT included both Ripon and Selby MIUs. In agreement with local CCGs, York NHSFT are reporting the activity for Selby MIU from 1st May 2015. |  | HDFT's overall Trust level performance for January 2016 was 94.3%, below the required 95% standard. This includes data for the Emergency Department at Harrogate and Ripon MIU. Performance for Harrogate ED was also below the 95% standard at 93.4%. |
| **Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals** | Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%.<br>A high percentage is good. |  | Delivery at expected levels. |

| Indicator | Q4 to date score | Indicator | Q4 to date score |
|---|---|---|---|
| 18 weeks - incomplete | 0.0 | Cancer - 14 days | 0.0 |
| A&E - 4 hour standard | 0.0 | Cancer - 14 days - breast symptoms | 0.0 |
| Cancer - 62 days to treatment | 0.0 | C-Difficile | 0.0 |
| Cancer - 62 days to treatment - screening | | MRSA | 0.0 |
| Cancer - 31 day subsequent treatment - surgery | 0.0 | Compliance with requirements regarding access to healthcare for patients with learning disabilities | 0.0 |
| Cancer - 31 day subsequent treatment - drugs | | Community services data completeness - RTT information | 0.0 |
| Cancer - 31 day subsequent treatment - radiotherapy | N/A | Community services data completeness - Referral information | 0.0 |
| Cancer - 31 day first treatment | 0.0 | Community services data completeness - Treatment activity information | 0.0 |

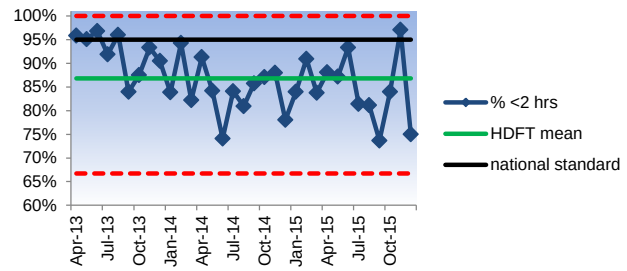
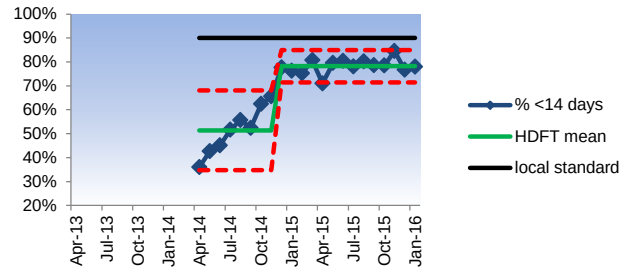
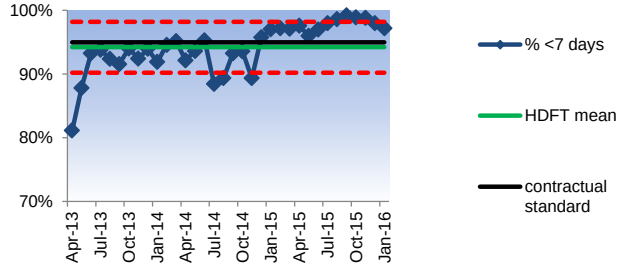
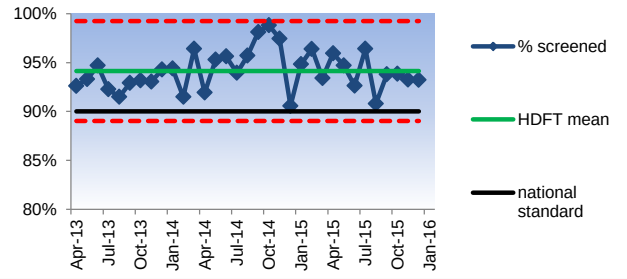
# Operational Performance - January 2016

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Cancer - 14 days maximum wait from GP referral for symptomatic breast patients** | Percentage of GP referrals for breast symptomatic patients seen within 14 days. The operational standard is 93%. A high percentage is good. |  | Delivery at expected levels. |
| **Cancer - 31 days maximum wait from diagnosis to treatment for all cancers** | Percentage of cancer patients starting first treatment within 31 days of diagnosis. The operational standard is 96%. A high percentage is good. |  | Delivery at expected levels. |
| **Cancer - 31 day wait for second or subsequent treatment: Surgery** | Percentage of cancer patients starting subsequent surgical treatment within 31 days. The operational standard is 94%. A high percentage is good. |  | Delivery at expected levels. |
| **Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug** | Percentage of cancer patients starting subsequent drug treatment within 31 days. The operational standard is 98%. A high percentage is good. |  | Delivery at expected levels. |

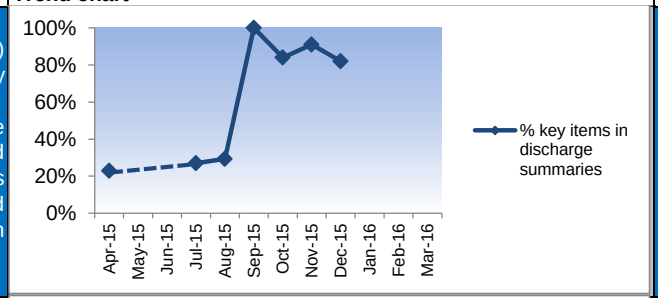
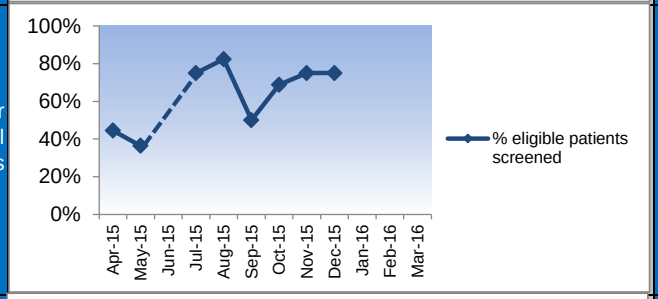
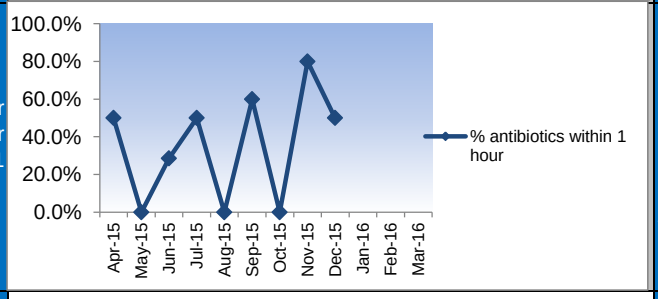
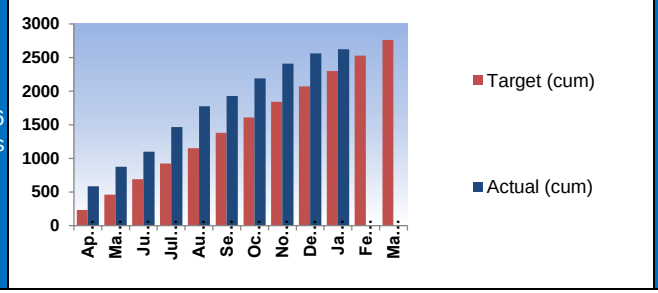
# Operational Performance - January 2016

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Cancer - 62 day wait for first treatment from urgent GP referral to treatment** | Percentage of cancer patients starting first treatment within 62 days of urgent GP referral. The operational standard is 85%. A high percentage is good. |  | Trust total delivery at expected levels.<br><br>Of the 11 cancer sites treated at HDFT, 6 had performance above 85% in January and 5 had performance below 85% - colorectal (2.5 breaches), gynaecological (0.5 breach), other (1 breach), upper gastrointestinal (0.5 breach) and urological (2 breaches). |
| **Cancer - 62 day wait for first treatment from consultant screening service referral** | Percentage of cancer patients starting first treatment within 62 days of referral from a consultant screening service. The operational standard is 90%. A high percentage is good. |  | Delivery at expected levels. |
| **Cancer - 62 day wait for first treatment from consultant upgrade** | Percentage of cancer patients starting first treatment within 62 days of consultant upgrade. The operational standard is 85%. A high percentage is good. |  | Delivery at expected levels. |
| **GP OOH - NQR 9** | NQR 9 (National Quality Requirement 9) looks at the % of GP OOH telephone clinical assessments for urgent cases that are carried out within 20 minutes of call prioritisation.<br>The data presented excludes Selby and York as these do not form part of the HDFT OOH service from April 2015. A high percentage is good. |  | *There is no update of this data this month.*<br>Performance in December 2015 was at 77.8%, below the 95% standard. This is a continued trend and the service have been requested to do further work to improve the performance in this area. |

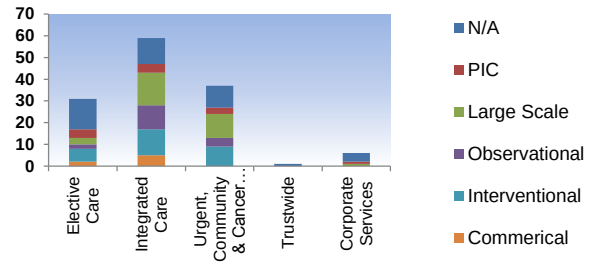
# Operational Performance - January 2016

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **GP OOH - NQR 12** | NQR 12 (National Quality Requirement 12) looks at the % of GP OOH face to face consultations (home visits) started for urgent cases within 2 hours. The data presented excludes Selby and York as these do not form part of the HFT OOH service from April 2015. A high percentage is good. |  | *There is no update of this data this month.* Performance in December 2015 was at 75.0%, a decrease on last month and remaining below the 95% standard. The direct booking of face to face contacts into OOH clinic slots by NHS111 commenced recently, it is anticipated this will strengthen performance against this measure. |
| **Health Visiting - new born visits** | The number of babies who had a new born visit by the Health Visiting team within 14 days of birth. Data is not available for 2013/14. A high percentage is good. |  | As can be seen from the chart, the performance on this metric improved significantly during 2014/15 - this was partly due to improved data capture over this period.<br><br>In January, 78.0% of babies had a new born visit within 14 days of birth. |
| **Community equipment - deliveries within 7 days** | The number of standard items delivered within 7 days by the community equipment service. A high percentage is good. |  | Performance above expected levels. |
| **CQUIN - dementia screening** | The proportion of emergency admissions aged 75 or over who are screened for dementia within 72 hours of admission (Step 1). Of those screened positive, the proportion who went on to have an assessment and onward referral as required (Step 2 and 3). The operational standard is 90% for all 3 steps. A high percentage is good. |  | Recurrent achievement of this standard. Ongoing monitoring. No new actions identified. |

# Operational Performance - January 2016

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **CQUIN - Acute Kidney Injury** | Percentage of patients with Acute Kidney Injury (AKI) whose discharge summary includes four defined key items.<br>The aim of this national CQUIN is to improve the provision of information to GPs for patients diagnosed with AKI whilst in hospital. The target for the CQUIN is to achieve at least 90% of required key items included in discharge summaries by Q4 2015/16. A high percentage is good. |  | The Trust recently submitted Q3 results to NHS England and HARD CCG. Overall 86% of key items were included in discharge summaries for the sampled AKI patients during Q3, a significant improvement on last quarter and above the improvement trajectory agreed with the CCG.<br>Further work is required to ensure this performance is sustained and the required 90% compliance is achieved for Q4. |
| **CQUIN - sepsis screening** | Percentage of patients presenting to ED/other wards/units who met the criteria of the local protocol and were screened for sepsis. A high percentage is good. |  | The Trust recently submitted Q3 results to NHS England and HARD CCG. Overall 72% of patients presenting to ED/other wards/units who met the criteria of the local protocol were screened for sepsis during Q3, an improvement on last quarter and above the improvement trajectory agreed with the CCG.<br>The Trust is required to achieve 90% compliance by Q4 which will be challenging. Continued work to raise awareness with medical and nursing staff is planned. |
| **CQUIN - severe sepsis treatment** | 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. A high percentage is good. |  | The Trust recently submitted Q3 results to NHS England and HARD CCG. A sample of 57 case notes from Q3 patients with a coded diagnosis of sepsis were reviewed. Of these, 9 had evidence of severe sepsis, Red Flag sepsis or septic shock, 6 of which were prescribed antibiotics within an hour. This gives an overall performance of 55% for Q3, compared to 44%.<br>The Trust is required to achieve 90% compliance by Q4 which will be challenging. Continued work to raise awareness with medical and nursing staff is planned. |
| **Recruitment to NIHR adopted research studies** | The Trust has a recruitment target of 2,750 for 2015/16 for studies adopted onto the NIHR portfolio. This equates to 230 per month. A higher figure is good. |  | Recruitment has been good to date. Currently recruitment stands at 322 over its target year to date. The department currently has an online study which recruits very well - 56% of recruits in 2015/16 have been via this route. |

# Operational Performance - January 2016

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Directorate research activity** | The number of studies within each of the directorates - included in the graph is Trustwide where the study spans directorates. The Trust has no specific target set for research activity within each directorate. It is envisaged that each clinical directorate would have a balanced portfolio. |  | The directorate research teams are subject to studies that are available to open. The 'type of study', Commercial, Interventional, Observational, Large scale, Patient Identification Centre (PIC) or N/A influence the activity based funding received by HDFT. Each category is weighted dependant on input of staff involvement. N/A studies are those studies which are not on the NIHR portfolio. They include commercial, interventional, observational, large scale, PIC, local and student projects. They do not influence the recruitment target. |

**Indicator traffic light criteria**

| Section | Indicator | Further detail | Proposed traffic light criteria | Rationale/source of traffic light criteria |
|---|---|---|---|---|
| Quality | Safety thermometer - harm free care | % harm free | Blue if latest month >=97%, Green if >=95% but <97%, red if latest month <95% | National best practice guidance suggests that 95% is the standard that Trusts should achieve. In addition, HDFT have set a local stretch target of 97%. |
| Quality | Pressure ulcers - hospital acquired | No. grade 3 and grade 4 avoidable hospital acquired pressure ulcers | Green if no. avoidable cases is below local trajectory year to date, red if above trajectory year to date. | A maximum threshold of 14 avoidable cases during 2015/16 has been locally agreed. This reflects a 50% reduction on last year's figure. |
| Quality | Pressure ulcers - community acquired | No. grade 3 and grade 4 community acquired pressure ulcers | tbc | tbc |
| Quality | Falls | IP falls per 1,000 bed days | Blue if YTD position is a reduction of <=50% of HDFT average for 2014/15, Green if YTD position is a reduction of between 20% and 50% of HDFT average for 2014/15, Amber if YTD position is a reduction of up to 20% of HDFT average for 2014/15, Red if YTD position is on or above HDFT average for 2014/15. | |
| Quality | Falls causing harm | IP falls causing moderate harm, sever harm or death, per 1,000 bed days | | Locally agreed improvement trajectory based on comparison with HDFT performance last year. |
| Quality | Infection control | No. hospital acquired C.diff cases | Green if below trajectory YTD, Amber if above trajectory YTD, Red if above trajectory at end year or more than 10% above trajectory in year. | NHS England, Monitor and contractual requirement |
| Quality | Avoidable admissions | The number of avoidable emergency admissions to HDFT as per the national definition. | tbc | tbc |
| Quality | Reducing readmissions in older people | The proportion of older people 65+ who were still at home 91 days after discharge from hospital into rehabilitation or reablement services. | tbc | tbc |
| Quality | Mortality - HSMR | Hospital Standardised Mortality Ratio (HSMR) | Blue = better than expected (95% confidence interval), Green = as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval). | |
| Quality | Mortality - SHMI | Summary Hospital Mortality Index (SHMI) | | Comparison with national average performance. |
| Quality | Complaints | No. complaints, split by criteria | Blue if no. complaints in latest month is below UCL, Green if below HDFT average for 2014/15, Amber if above HDFT average for 2014/15, Red if above UCL. In addition, Red if a new red rated complaint received in latest month. | Locally agreed improvement trajectory based on comparison with HDFT performance last year. |
| Quality | Incidents - all | Incidents split by grade (hosp and community) | Blue if latest month ratio places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25% | Comparison of HDFT performance against most recently published national average ratio of low to high incidents. |
| Quality | Incidents - 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 | % staff who would recommend HDFT as a place to work | Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%. | |
| Quality | Friends & Family Test (FFT) - Staff | % staff who would recommend HDFT as a place to receive care | | Comparison with performance of other acute trusts. |
| Quality | Friends & Family Test (FFT) - Patients | % recommend, % not recommend - combined score for all services currently doing patient FFT | Green if latest month >= latest published national average, Red if < latest published national average. | Comparison with national average performance. |
| Quality | Safer staffing levels | RN and CSW - day and night overall fill rates at trust level | Green if latest month overall staffing >=100%, amber if between 95% and 100%, red if below 95%. | The Trusts aims for 100% staffing overall. |
| Quality | Staff appraisal rate | Latest position on no. staff who had an appraisal within the last 12 months | Annual rolling total - 85% green. Amber between 70% and 85%, red<70%. | Locally agreed target level based on historic local and NHS performance |
| Quality | Mandatory training rate | Latest position on the % staff trained for each mandatory training requirement | Blue if latest month >=95%; Green if latest month 75%-95% overall, amber if between 50% and 75%, red if below 50%. | Locally agreed target level - no national comparative information available until February 2016 |
| Quality | Staff sickness rate | Staff sickness rate | Green if <3.9% , amber if between 3.9% and regional average, Red if > regional average. | HDFT Employment Policy requirement. Rates compared at a regional level also |
| Quality | Temporary staffing expenditure - medical/nursing/other | Expenditure per month on staff types. | tbc | tbc |
| Quality | Staff turnover | Staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. | Green if remaining static or decreasing, amber if increasing but below 15%, red if above 15%. | Based on evidence from Times Top 100 Employers |
| Quality | Research internal monitoring | No. critical or major findings reported | Green if <1 per quarter (cumulative) | Locally agreed target. |
| Quality | Maternity - Caesarean section rate | Caesarean section rate as a % of all deliveries | Green if <25% of deliveries, amber if between 25% and 30%, red if above 30%. | tbc |
| Quality | Maternity - Rate of third and fourth degree tears | No. third or fourth degree tears as a % of all deliveries | Green if <3% of deliveries, amber if between 3% and 6%, red if above 6%. | tbc |
| Quality | Maternity - Unexpected term admissions to SCBU | Admissions to SCBU for babies born at 37 weeks gestation or over. | tbc | tbc |
| Finance and efficiency | Readmissions | No. emergency readmissions (following elective or non-elective admission) within 30 days. | Green if latest month < HDFT average for 2014/15, Red if latest month > HDFT average for 2014/15. | Locally agreed improvement trajectory based on comparison with HDFT performance last year. |
| Finance and efficiency | Readmissions - standardised | Standardised emergency readmission rate within 30 days from HED | Green = better than expected or as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval). | Comparison with national average performance. |
| Finance and efficiency | Length of stay - elective | Average LOS for elective patients | Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%. | |
| Finance and efficiency | Length of stay - non-elective | Average LOS for non-elective patients | | Comparison with performance of other acute trusts. |

| Section | Indicator | Further detail | Proposed traffic light criteria | Rationale/source of traffic light criteria |
|---|---|---|---|---|
| Finance and efficiency | Non-elective bed days for patients aged 18+ | Non-elective bed days at HDFT for HARD CCG patients aged 18+, per 100,000 population | Improvement trajectory to be agreed. | Improvement trajectory to be agreed. |
| Finance and efficiency | Theatre utilisation | % of theatre time utilised for elective operating sessions | Green = >=85%, Amber = between 75% and 85%, Red = <75% | A utilisation rate of around 85% is often viewed as optimal. |
| Finance and efficiency | Delayed transfers of care | % acute beds occupied by patients whose transfer is delayed - snapshot on last Thursday of the month. | Red if latest month >3.5%, Green <=3.5% | Contractual requirement |
| Finance and efficiency | Outpatient DNA rate | % first OP appointments DNA'd | Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%. | Comparison with performance of other acute trusts. |
| Finance and efficiency | Outpatient new to follow up ratio | No. follow up appointments per new appointment. | | |
| Finance and efficiency | Day case rate | % elective admissions that are day case | | |
| Finance and efficiency | Surplus / deficit and variance to plan | Monthly Surplus/Deficit (£'000s) | Green if on plan, amber <1% behind plan, red >1% behind plan | Locally agreed targets. |
| Finance and efficiency | Cash balance | Monthly cash balance (£'000s) | Green if on plan, amber <10% behind plan, red >10% behind plan | Locally agreed targets. |
| Finance and efficiency | 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. | Green if rating =4 or 3 and in line with our planned rating, amber if rating = 3, 2 or 1 and not in line with our planned rating. | as defined by Monitor |
| Finance and efficiency | CIP achievement | Cost Improvement Programme performance | Green if achieving stretch CIP target, amber if achieving standard CIP target, red if not achieving standard CIP target. | Locally agreed targets. |
| Finance and efficiency | Capital spend | Cumulative capital expenditure | Green if on plan or <10% below, amber if between 10% and 25% below plan, red if >25% below plan | Locally agreed targets. |
| Finance and efficiency | Agency spend in relation to pay spend | Expenditure in relation to Agency staff on a monthly basis (£'s). | Green if <1% of pay bill, amber if between 1% and 3% of pay bill, red if >3% of pay bill. | Locally agreed targets. |
| Finance and efficiency | Research - Cost per recruitment | Cost of recruitment to NIHR adopted studies | Green if on or above plan, amber if less than 10% behind plan YTD, red if > 10% behind plan YTD. | Locally agreed targets. |
| Finance and efficiency | Research - Invoiced research activity | | to be agreed | |
| Operational Performance | Monitor governance rating | Trust performance on Monitor's risk assessment framework. | As per defined governance rating | as defined by Monitor |
| Operational Performance | RTT Incomplete pathways performance | % incomplete pathways within 18 weeks | Green if latest month >=92%, Red if latest month <92%. | NHS England |
| Operational Performance | A&E 4 hour standard | % patients spending 4 hours or less in A&E. | Blue if latest month >=97%, Green if >=95% but <97%, red if latest month <95% | NHS England, Monitor and contractual requirement of 95% and a locally agreed stretch target of 97%. |
| Operational Performance | Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals | % urgent GP referrals for suspected cancer seen within 14 days. | Green if latest month >=93%, Red if latest month <93%. | NHS England, Monitor and contractual requirement |
| Operational Performance | Cancer - 14 days maximum wait from GP referral for symptomatic breast patients | % GP referrals for breast symptomatic patients seen within 14 days. | Green if latest month >=93%, Red if latest month <93%. | NHS England, Monitor and contractual requirement |
| Operational Performance | Cancer - 31 days maximum wait from diagnosis to treatment for all cancers | % cancer patients starting first treatment within 31 days of diagnosis | Green if latest month >=96%, Red if latest month <96%. | NHS England, Monitor and contractual requirement |
| Operational Performance | Cancer - 31 day wait for second or subsequent treatment: Surgery | % cancer patients starting subsequent surgical treatment within 31 days | Green if latest month >=94%, Red if latest month <94%. | NHS England, Monitor and contractual requirement |
| Operational Performance | Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug | % cancer patients starting subsequent anti-cancer drug treatment within 31 days | Green if latest month >=96%, Red if latest month <96%. | NHS England, Monitor and contractual requirement |
| Operational Performance | Cancer - 62 day wait for first treatment from urgent GP referral to treatment | % cancer patients starting first treatment within 62 days of urgent GP referral | Green if latest month >=85%, Red if latest month <85%. | NHS England, Monitor and contractual requirement |
| Operational Performance | Cancer - 62 day wait for first treatment from consultant screening service referral | % cancer patients starting first treatment within 62 days of referral from a consultant screening service | Green if latest month >=90%, Red if latest month <90%. | NHS England, Monitor and contractual requirement |
| Operational Performance | Cancer - 62 day wait for first treatment from consultant upgrade | % cancer patients starting first treatment within 62 days of consultant upgrade | Green if latest month >=85%, Red if latest month <85%. | NHS England, Monitor and contractual requirement |
| Operational Performance | GP OOH - NQR 9 | % telephone clinical assessments for urgent cases that are carried out within 20 minutes of call prioritisation | Green if latest month >=95%, Red if latest month <95%. | Contractual requirement |
| Operational Performance | GP OOH - NQR 12 | % face to face consultations started for urgent cases within 2 hours | Green if latest month >=95%, Red if latest month <95%. | Contractual requirement |
| Operational Performance | Health Visiting - new born visits | % new born visit within 14 days of birth | Green if latest month <=95%, Amber if between 90% and 95%, Red if <90%. | Contractual requirement |
| Operational Performance | Community equipment - deliveries within 7 days | % standard items delivered within 7 days | Green if latest month >=95%, Red if latest month <95%. | Contractual requirement |
| Operational Performance | CQUIN - dementia screening | % emergency admissions aged 75+ who are screened for dementia within 72 hours of admission | Green if latest month >=90%, Red if latest month <90%. | CQUIN contractual requirement |
| Operational Performance | CQUIN - Acute Kidney Injury (AKI) | % patients with AKI whose discharge summary includes four defined key items | to be agreed with CCG during Q2 2015/16 | CQUIN contractual requirement |
| Operational Performance | CQUIN - sepsis screening | % patients presenting to ED/other wards/units who met the criteria of the local protocol and were screened for sepsis | to be agreed with CCG during Q2 2015/16 | CQUIN contractual requirement |
| Operational Performance | CQUIN - severe sepsis treatment | % 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 | to be agreed with CCG during Q2 2015/16 | CQUIN contractual requirement |
| Operational Performance | Recruitment to NIHR adopted research studies | No. patients recruited to trials | Green if above or on target, red if below target. | |
| Operational Performance | Directorate research activity | The number of studies within each of the directorates | to be agreed | |

This page has been left blank

| Report to the Trust Board of Directors: 24 February 2016 | Paper No: 7.0 |
|---|---|

| | |
|---|---|
| **Title** | Report by the Director of Finance |
| **Sponsoring Director** | Jonathan Coulter, Director of Finance |
| **Author(s)** | Finance Department |
| **Report Purpose** | Review of the Trusts financial position |

**Key Issues for Board Focus:**

1. The Trust reported a deficit in January of £61k, £157k behind plan.
2. The year to date deficit therefore increased to £750k before the consolidation of charitable funds.
3. The Trust will report a continuity of services risk rating of 3. Although this is at planned levels, the current I&E position means that it is a weaker 3 than planned.

Note - The information in this report supports the financial information contained in the Integrated Board Report.

| **Related Trust Objectives** | |
|---|---|
| 1. To deliver high quality care | Yes |
| 2. To work with partners to deliver integrated care | Yes |
| 3. To ensure clinical and financial sustainability | Yes |

| | |
|---|---|
| **Risk and Assurance** | 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. |
| **Legal implications/ Regulatory Requirements** | |

**Action Required by the Board of Directors**

The Board of Directors is asked to **consider and note** the contents of this report.

This page has been left blank

# 2015/16 Financial Position to January

## Financial Performance

- The Trust reported a deficit in January of £61k, £157k behind plan. This is before the consolidation of charitable funds. The year to date deficit therefore increased to £750k.

- The year to date variance to plan currently stands at £2,638k. This relates to –
  - Acute contract income £1,395k (1.3%) adverse variance.
  - Adverse variance for non NHS clinical income of £334k.
  - Pay expenditure is £940k ahead of plan and continues to be a significant pressure.

- The trust CIP position is positive with 95% of plans actioned so far. Following review of plans in January there is now a risk adjusted planning gap of £191k against the Trust internal plan.

- The Trust cash position is outlined on page 7. The Trust currently has a favourable cash position of £14.7m, £6.5m ahead of plan. Despite this positive position, the Trust expects to end the year £3m behind plan which is predominantly a result of the current financial position.

## Monitor Financial Sustainability Risk Rating (FSRR)

- The table below outlines the Trusts FSRR for the year to January

| Jan – 16 | Plan | Actual |
|---|---|---|
| Capital Service Capacity rating | 4 | 3 |
| Liquidity rating | 4 | 3 |
| I&E Margin rating | 3 | 2 |
| I&E Margin Variance rating | 2 | 2 |
| **Financial Sustainability Risk Rating** | **3** | **3** |

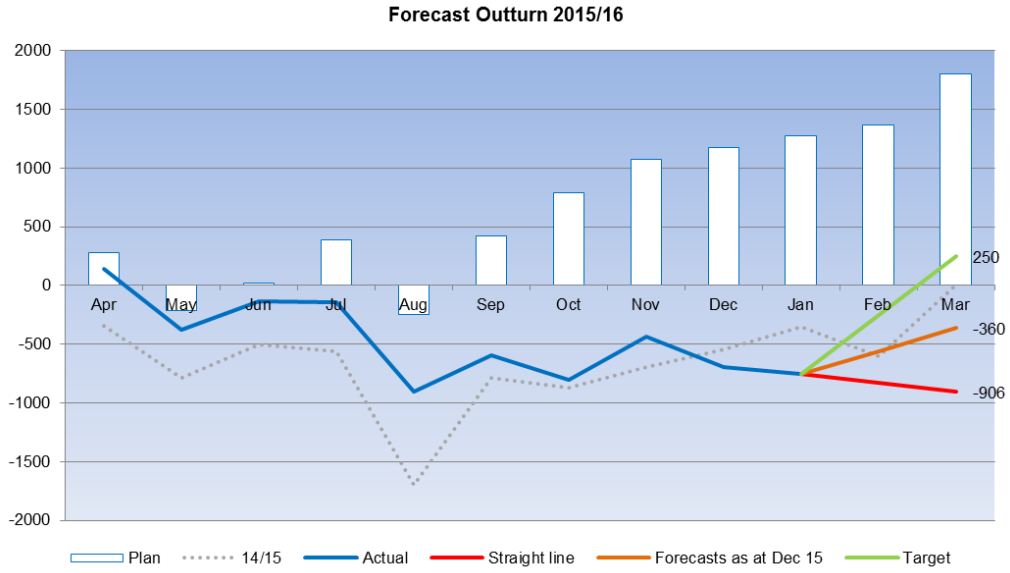
- As demonstrated above this is at planned levels, however, the adverse I&E position of the Trust means that this is a weaker 3 than planned.

# 2015/16 Financial Position Continued

## Forecast Outturn

- As described above the Trust is currently reporting a deficit position as a result of a number of financial pressures this financial year. Recovery plans from earlier in the financial year have had an impact but not to the levels expected.

- The graph below outlines the cumulative position by month. The orange line represents previous directorate forecasts for the year. These would result in a year end deficit of £360k. Subsequent work has been undertaken to support a target of £250k surplus for 2015/16, building on directorate recovery plans and potentially utilising the Mobilisation reserve.




- Although 2015/16 has been a challenging year, it is important that the Trust ends the year in surplus at the level described. Discussions at SMT and Finance and Activity meetings will focus on ensuring areas meet activity plans while controlling costs. I will feedback the outcome of these discussions at the Board.

- Improving the run rate clearly benefits 2015/16 but is also important to enable the Trust to start 2016/17 positively.

# Overview Income & Expenditure Position

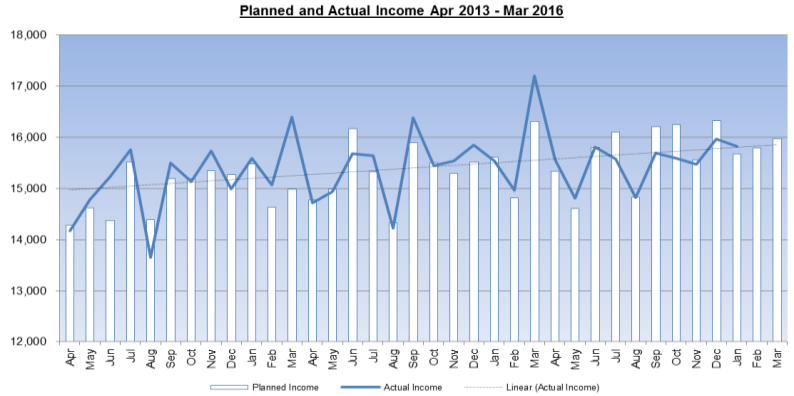
| | Budget | | Actual | Cumulative | Change in | January |
|---|---|---|---|---|---|---|
| | Annual Budget £000 | Proportion To Date £000 | To Date £000 | Variance £000 | Variance £'000 | Actuals £'000 |
| **INCOME** | | | | | | |
| **NHS Clinical Income (Commissioners)** | | | | | | |
| NHS Clinical Income - Acute | 134,246 | 111,557 | 110,162 | (1,395) | (48) | 11,293 |
| NHS Clinical Income - Community | 38,529 | 31,889 | 31,639 | (250) | (104) | 3,088 |
| System Resilience & Better Care Funding | 569 | 528 | 458 | (70) | (35) | 15 |
| **Non NHS Clinical Income** | | | | | 0 | |
| Private Patient & Amenity Bed Income | 1,854 | 1,543 | 1,347 | (196) | (40) | 115 |
| Other Non-Protected Clinical Income (RTA) | 523 | 436 | 298 | (138) | (10) | 33 |
| **Other Income** | | | | | 0 | |
| Non Clinical Income | 12,633 | 10,505 | 10,971 | 465 | 375 | 1,269 |
| Hosted Services | 230 | 230 | 255 | 25 | 14 | 14 |
| **TOTAL INCOME** | **188,584** | **156,687** | **155,129** | **(1,558)** | **151** | **15,828** |
| **EXPENSES** | | | | | | |
| **Pay** | | | | | | |
| Pay Expenditure | (127,614) | (106,640) | (107,581) | (940) | (361) | (11,030) |
| **Non Pay** | | | | | 0 | |
| Drugs | (12,157) | (11,593) | (11,482) | 110 | 48 | (1,198) |
| Clinical Services & Supplies | (17,107) | (14,546) | (15,087) | (541) | 37 | (1,382) |
| Other Costs | (16,981) | (14,640) | (15,954) | (1,314) | (271) | (1,697) |
| | | | | | 0 | |
| | | | | | 0 | |
| **Reserves :** Pay | (1,187) | 0 | 0 | 0 | 0 | 0 |
| Pay savings targets | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Reserves | (3,523) | (1,339) | 0 | 1,339 | 218 | 0 |
| High Cost Drugs | (699) | 0 | 0 | 0 | 0 | 0 |
| Non Pay savings targets | 42 | 0 | 0 | 0 | 0 | 0 |
| **Other Finance Costs** | (18) | (15) | (10) | 5 | 1 | (0) |
| **Hosted Services** | (239) | (239) | (257) | (18) | (16) | (16) |
| **TOTAL COSTS** | (179,482) | (149,011) | (150,370) | (1,359) | (343) | **(15,323)** |
| **EBITDA** | **9,102** | **7,675** | **4,758** | **(2,917)** | **(191)** | **505** |
| Profit / (Loss) on disposal of assets | 0 | 0 | 0 | 0 | 2 | 2 |
| Depreciation | (4,763) | (3,969) | (3,807) | 163 | 18 | (379) |
| Interest Payable | (59) | (49) | (77) | (28) | (14) | (19) |
| Interest Receivable | 20 | 16 | 43 | 26 | 5 | 6 |
| Dividend Payable | (2,500) | (2,000) | (1,907) | 93 | 9 | (191) |
| **Net Surplus/(Deficit) before donations and impairment** | **1,800** | **1,674** | **(989)** | **(2,663)** | **(171)** | **(75)** |
| Donated Asset Income | 0 | 0 | 239 | 239 | 14 | 14 |
| Impairments re Donated assets | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments re PCT assets | 0 | 0 | 0 | 0 | 0 | 0 |
| **Net Surplus/(Deficit)** | **1,800** | **1,674** | **(750)** | **(2,424)** | **(157)** | **(61)** |
| Consolidation of Charitable Fund Accounts | 0 | 0 | (214) | (214) | 0 | 0 |
| **Consolidated Net Surplus/(Deficit)** | **1,800** | **1,674** | **(964)** | **(2,638)** | **(157)** | **(61)** |

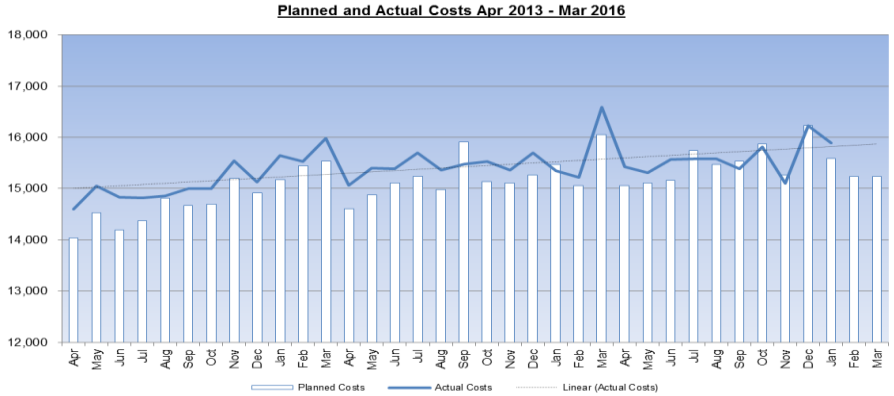
# Overview Total Directorate Position

**For the month ending 31st January 2016**

| 2014/15 Actual £000 | Opening Budget £000 | | Annual Budget £000 | Workforce | | | In Month | | | Cumulative | | Variance (o.s)/u.s £000 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Budget wte | Contracted wte | Actual wte | Budget £000 | Actual £000 | Variance £000 | Budget £000 | Actual £000 | |
| 2,169 | 1,274 | Non-Comissioner Income | 1,374 | | | | 115 | 77 | (38) | 1,179 | 1,132 | (47) |
| (36,721) | (34,989) | Pay | (32,710) | 826.08 | 792.58 | 775.22 | (2,545) | (2,904) | (359) | (27,382) | (28,288) | (906) |
| (9,172) | (2,947) | Non-Pay | (8,135) | | | | (685) | (770) | (85) | (7,557) | (7,810) | (254) |
| **(43,724)** | **(36,662)** | **Total Integrated Care Directorate** | **(39,472)** | **826.08** | **792.58** | **775.22** | **(3,115)** | **(3,597)** | **(482)** | **(33,759)** | **(34,966)** | **(1,207)** |
| 3,180 | 1,764 | Non-Comissioner Income | 3,455 | | | | 288 | 293 | 6 | 2,975 | 2,983 | 8 |
| (29,388) | (28,642) | Pay | (32,943) | 809.52 | 705.38 | 698.60 | (2,848) | (2,804) | 45 | (27,358) | (27,042) | 316 |
| (12,671) | (7,202) | Non-Pay | (11,941) | | | | (1,161) | (1,150) | 11 | (10,515) | (11,205) | (690) |
| **(38,879)** | **(34,080)** | **Total Acute & Cancer Care Services Directorate** | **(41,429)** | **809.52** | **705.38** | **698.60** | **(3,721)** | **(3,661)** | **61** | **(34,899)** | **(35,264)** | **(365)** |
| 1,360 | 1,457 | Non-Comissioner Income | 1,554 | | | | 132 | 109 | (23) | 1,281 | 1,224 | (57) |
| (43,027) | (40,216) | Pay | (43,506) | 913.31 | 893.43 | 865.66 | (3,682) | (3,715) | (33) | (36,591) | (36,939) | (347) |
| (13,347) | (9,307) | Non-Pay | (13,303) | | | | (1,137) | (1,131) | 6 | (11,504) | (11,912) | (408) |
| **(55,014)** | **(48,066)** | **Total Elective Care Directorate** | **(55,255)** | **913.31** | **893.43** | **865.66** | **(4,686)** | **(4,737)** | **(51)** | **(46,815)** | **(47,627)** | **(812)** |
| **(19,852)** | **(18,471)** | **Corporate (Clinical)** | **(16,485)** | **452.63** | **438.41** | **449.93** | (1,393) | (1,380) | 13 | (13,701) | (13,885) | (184) |
| (157,469) | (137,279) | **Total Clinical Spend** | (152,640) | 3001.54 | 2829.80 | 2789.41 | (12,916) | (13,375) | (459) | (129,174) | (131,742) | (2,569) |
| **(7,626)** | **(7,802)** | **Corporate (inc. CNST)** | (12,179) | **151.27** | **147.10** | **148.48** | (1,011) | (1,045) | (35) | (10,037) | (10,082) | (45) |
| **(27,478)** | **(26,273)** | **Total Corporate Position** | **(28,664)** | **603.90** | **585.51** | **598.41** | **(2,404)** | **(2,426)** | **(21)** | **(23,738)** | **(23,967)** | **(229)** |
| 165,503 | 165,941 | **Commissioner Income** | 172,775 | | | | 14,570 | 14,398 | (172) | 143,973 | 142,256 | (1,717) |
| (388) | (19,158) | **Central** | (6,156) | | (19.62) | (19.62) | (547) | (52) | 495 | (3,089) | (1,421) | 1,668 |
| **21** | **1,702** | **Total before donations & impairments** | **1,800** | **3,152.81** | **2,957.28** | **2,918.27** | **96** | **(75)** | **(171)** | **1,674** | **(989)** | **(2,663)** |
| 5,297 | 0 | **Donations for Capital Expenditure** | 0 | | | | | 14 | 14 | 0 | 239 | 239 |
| (3,340) | 0 | **Impairments on Donated assets** | 0 | | | | | | 0 | 0 | 0 | 0 |
| (1,305) | | **Impairments on PCT assets** | 0 | | | | | | 0 | 0 | 0 | 0 |
| **672** | **1,702** | **Trust reporting position** | **1,800** | **3,152.81** | **2,957.28** | **2,918.27** | **96** | **(61)** | **(157)** | **1,674** | **(750)** | **(2,424)** |
| 457 | | **Charitable funds consolidation** | 0 | | | | | | 0 | 0 | (214) | (214) |
| **1,129** | **1,702** | **Total Trust reported position** | **1,800** | **3,152.81** | **2,957.28** | **2,918.27** | **96** | **(61)** | **(157)** | **1,674** | **(964)** | **(2,638)** |

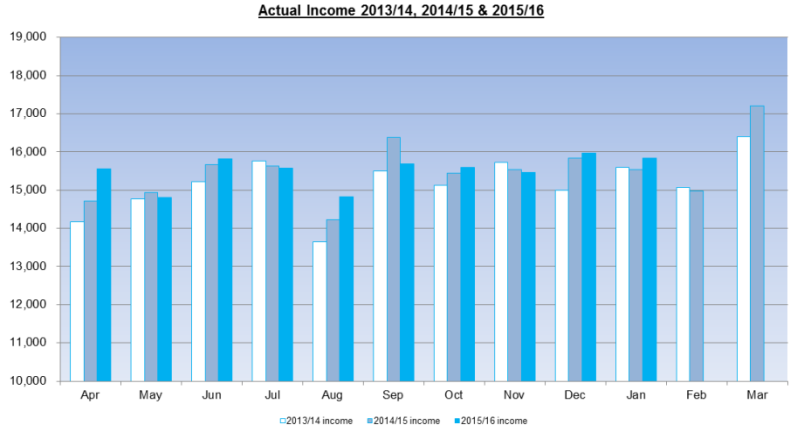
# Income & Expenditure Run Charts

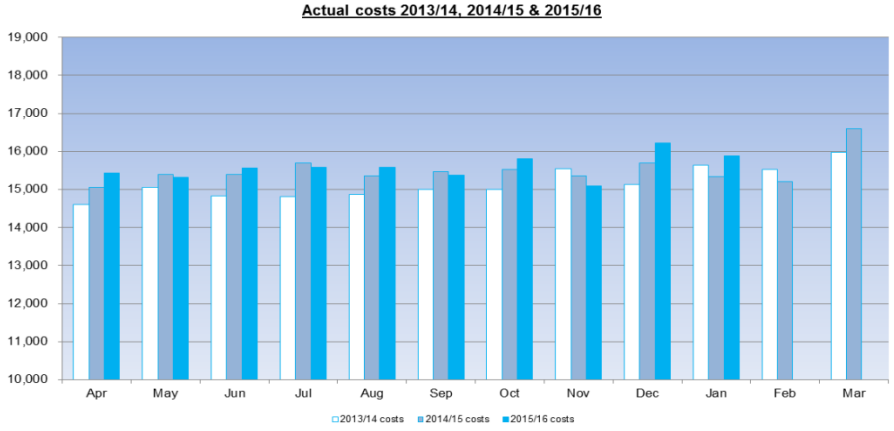


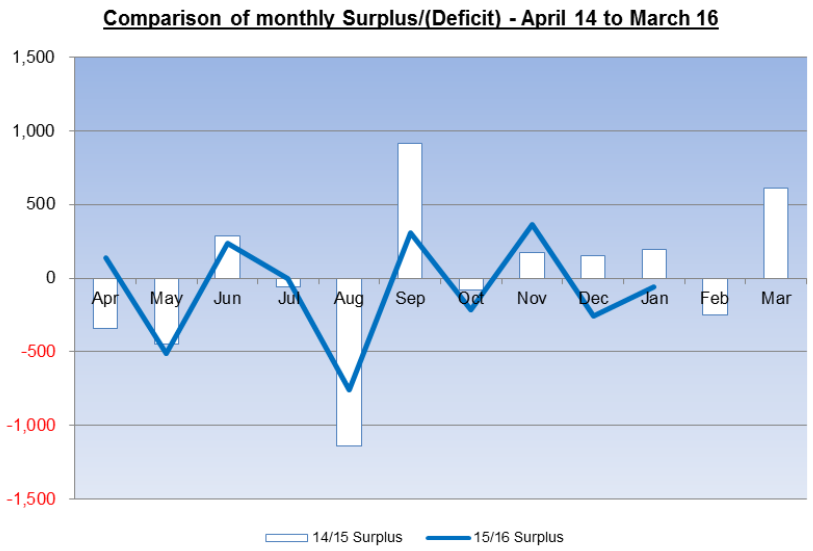

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2013/14 income plan | 14,287 | 14,617 | 14,369 | 15,513 | 14,383 | 15,188 | 15,199 | 15,349 | 15,277 | 15,473 | 14,637 | 14,978 |
| 2013/14 income actual | 14,171 | 14,778 | 15,227 | 15,755 | 13,653 | 15,502 | 15,130 | 15,731 | 14,987 | 15,588 | 15,073 | 16,395 |
| **2013/14 variance** | **-116** | **161** | **858** | **242** | **-730** | **314** | **-69** | **382** | **-290** | **115** | **436** | **1,417** |
| 2013/14 % variance | -0.8% | 1.1% | 6.0% | 1.6% | -5.1% | 2.1% | -0.5% | 2.5% | -1.9% | 0.7% | 3.0% | 9.5% |
| | | | | | | | | | | | | |
| 2014/15 income plan | 14,779 | 14,981 | 16,165 | 15,325 | 14,332 | 15,901 | 15,506 | 15,293 | 15,523 | 15,606 | 14,809 | 16,305 |
| 2014/15 income actual | 14,717 | 14,945 | 15,674 | 15,637 | 14,221 | 16,388 | 15,451 | 15,533 | 15,845 | 15,539 | 14,967 | 17,201 |
| **2014/15 variance** | **-62** | **-36** | **-491** | **312** | **-111** | **487** | **-55** | **240** | **322** | **-67** | **158** | **896** |
| 2014/15 % variance | -0.4% | -0.2% | -3.0% | 2.0% | -0.8% | 3.1% | -0.4% | 1.6% | 2.1% | -0.4% | 1.1% | 5.5% |
| | | | | | | | | | | | | |
| 2015/16 income plan | 15,335 | 14,610 | 15,799 | 16,105 | 14,830 | 16,202 | 16,245 | 15,554 | 16,329 | 15,677 | 15,793 | 15,969 |
| 2015/16 income actual | 15,564 | 14,802 | 15,810 | 15,578 | 14,826 | 15,689 | 15,595 | 15,467 | 15,968 | 15,828 | | |
| **2015/16 variance** | **229** | **192** | **11** | **-527** | **-4** | **-513** | **-650** | **-87** | **-361** | **151** | | |
| 2015/16 % variance | 1.5% | 1.3% | 0.1% | -3.3% | 0.0% | -3.2% | -4.0% | -0.6% | -2.2% | 1.0% | | |

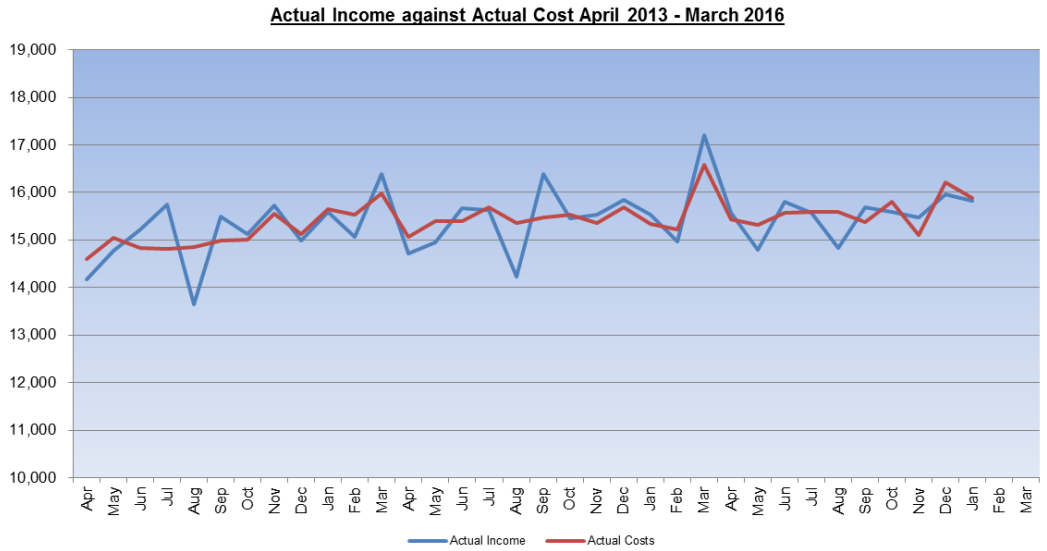
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2013/14 expenditure plan | 14,039 | 14,523 | 14,197 | 14,368 | 14,808 | 14,665 | 14,700 | 15,203 | 14,908 | 15,172 | 15,450 | 15,535 |
| 2013/14 expenditure actual | 14,598 | 15,051 | 14,825 | 14,814 | 14,861 | 14,994 | 15,001 | 15,546 | 15,126 | 15,641 | 15,530 | 15,983 |
| **2013/14 variance** | **559** | **528** | **628** | **446** | **53** | **329** | **301** | **343** | **218** | **469** | **80** | **448** |
| 2013/14 % variance | 4.0% | 3.6% | 4.4% | 3.1% | 0.4% | 2.2% | 2.0% | 2.3% | 1.5% | 3.1% | 0.5% | 2.9% |
| | | | | | | | | | | | | |
| 2014/15 expenditure plan | 14,602 | 14,875 | 15,107 | 15,236 | 14,983 | 15,912 | 15,128 | 15,105 | 15,268 | 15,465 | 15,052 | 16,051 |
| 2014/15 expenditure actual | 15,058 | 15,394 | 15,387 | 15,695 | 15,362 | 15,476 | 15,533 | 15,358 | 15,695 | 15,346 | 15,214 | 16,591 |
| **2014/15 variance** | **456** | **519** | **280** | **459** | **379** | **-436** | **405** | **253** | **427** | **-119** | **162** | **540** |
| 2014/15 % variance | 3.1% | 3.5% | 1.9% | 3.0% | 2.5% | -2.7% | 2.7% | 1.7% | 2.8% | -0.8% | 1.1% | 3.4% |
| | | | | | | | | | | | | |
| 2015/16 expenditure plan | 15,052 | 15,109 | 15,164 | 15,739 | 15,466 | 15,536 | 15,873 | 15,267 | 16,229 | 15,581 | 15,239 | 15,239 |
| 2015/16 expenditure actual | 15,427 | 15,314 | 15,572 | 15,584 | 15,584 | 15,384 | 15,806 | 15,099 | 16,222 | 15,890 | | |
| **2015/16 variance** | **375** | **205** | **408** | **-155** | **118** | **-152** | **-67** | **-168** | **-7** | **309** | | |
| 2015/16 % variance | 2.5% | 1.4% | 2.7% | -1.0% | 0.8% | -1.0% | -0.4% | -1.1% | 0.0% | 2.0% | | |



# Income & Expenditure Run Charts



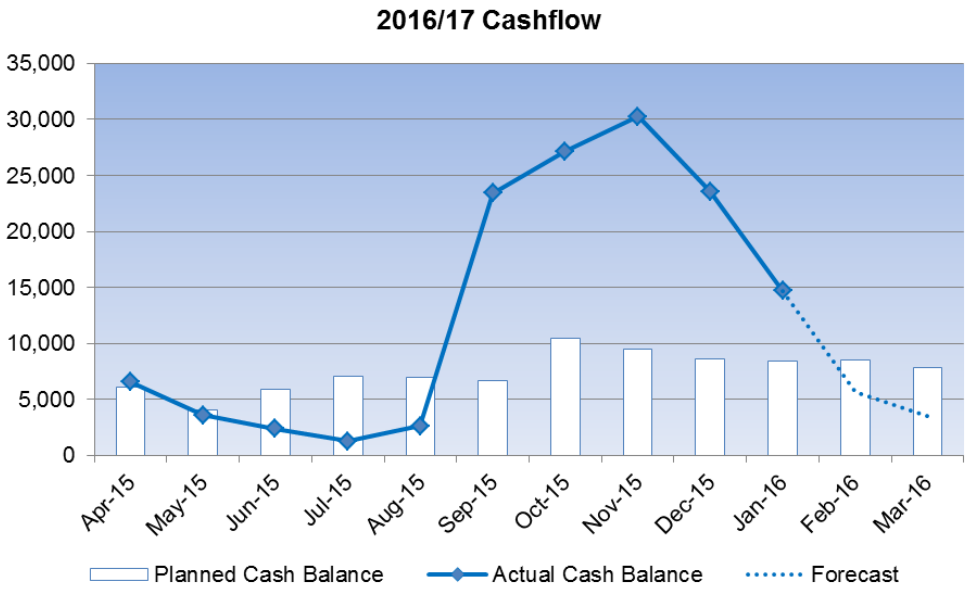

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2013/14 income | 14,171 | 14,778 | 15,227 | 15,755 | 13,653 | 15,502 | 15,130 | 15,731 | 14,987 | 15,588 | 15,073 | 16,395 |
| 2014/15 income | 14,717 | 14,945 | 15,674 | 15,637 | 14,221 | 16,388 | 15,451 | 15,533 | 15,845 | 15,539 | 14,967 | 17,201 |
| 2015/16 income | 15,564 | 14,802 | 15,810 | 15,578 | 14,826 | 15,689 | 15,595 | 15,467 | 15,968 | 15,828 | 0 | 0 |
| 2013/14 costs | 14,598 | 15,051 | 14,825 | 14,814 | 14,861 | 14,994 | 15,001 | 15,546 | 15,126 | 15,641 | 15,530 | 15,983 |
| 2014/15 costs | 15,058 | 15,394 | 15,387 | 15,695 | 15,362 | 15,476 | 15,533 | 15,358 | 15,695 | 15,346 | 15,214 | 16,591 |
| 2015/16 costs | 15,427 | 15,314 | 15,572 | 15,584 | 15,584 | 15,384 | 15,806 | 15,099 | 16,222 | 15,890 | 0 | 0 |
| 13/14 Surplus | -427 | -273 | 402 | 941 | -1,208 | 508 | 129 | 185 | -139 | -53 | -457 | 412 |
| 14/15 Surplus | -341 | -449 | 287 | -58 | -1,141 | 912 | -82 | 175 | 150 | 193 | -247 | 610 |
| 15/16 Surplus | 137 | -512 | 238 | -6 | -758 | 305 | -211 | 368 | -254 | -62 | | |

# Cash Management

- The Trust reported a cash balance of £14.7m at the end of January, £6.5m ahead of plan.

- As demonstrated in the graph below, the Trust expects to end the year with a balance of £3.5m. The significant change is a result of the expected payment profile previously discussed at Board

| Dec-15 | £ |
|---|---|
| NHS HARROGATE RURAL DISTRICT CCG | 1,245,786 |
| YORK TEACHING HOSPITALS NHS FOUNDATION TRUST | 971,496 |
| NHS ENGLAND | 917,512 |
| TEES, ESK & WEAR VALLEY NHSFT | 631,975 |
| NORTH YORKSHIRE COUNTY COUNCIL | 572,081 |
| **Total** | **4,338,850** |
| Total as a Percentage of outstanding debts | 59% |




| | 0 to 30 Days £000 | 31 to 60 Days £000 | 61 to 90 Days £000 | Over 91 Days £000 | Total £000 |
|---|---|---|---|---|---|
| NHS Debts | 1,819 | 354 | 493 | 4,052 | 6,718 |
| Insurance Companies | 108 | 31 | 25 | 29 | 193 |
| Other | 289 | 39 | 42 | 81 | 451 |
| **Totals** | 2,216 | 424 | 560 | 4,162 | 7,362 |

This page has been left blank

| Report to the Trust Board of Directors: 24 February 2016 | Paper No: 7.1 |
|---|---|

| | |
|---|---|
| **Title** | Cost Improvement Programme Update |
| **Sponsoring Director** | Director of Finance |
| **Author(s)** | Finance Department |
| **Report Purpose** | For information |

**Key Issues for Board Focus:**

1. In 2015/16, Directorates have actioned £9.7m of efficiencies. This is extremely positive.

2. Plans are currently in place for 91% of the 2016/17 target, however, work needs to continue to close the planning gap and improve the risk adjusted figure which current stands at 69%.

3. The work over the coming years will be supported by the information that the Trust is currently agreeing as part of the national review into hospital efficiency undertaken by Lord Carter.

| **Related Trust Objectives** | |
|---|---|
| 1. To deliver high quality care | Yes |
| 2. To work with partners to deliver integrated care | Yes |
| 3. To ensure clinical and financial sustainability | Yes |

| | |
|---|---|
| **Risk and Assurance** | There is a risk to delivery of the 2016/17 financial plan if a robust cost improvement plan is not put in place with the appropriate quality impact assessment process. |
| **Legal implications/ Regulatory Requirements** | |

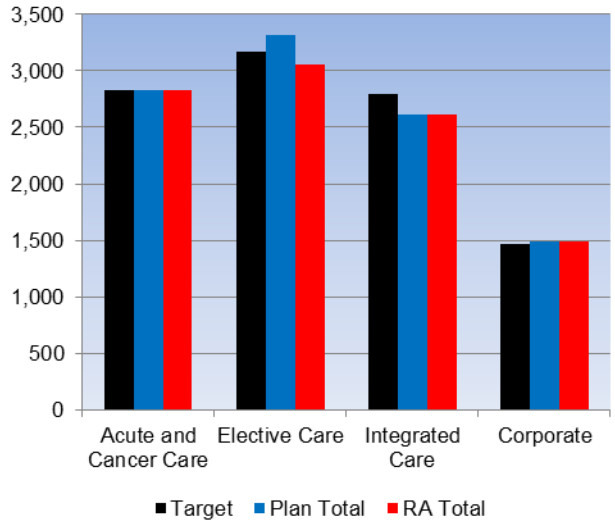
**Action Required by the Board of Directors**

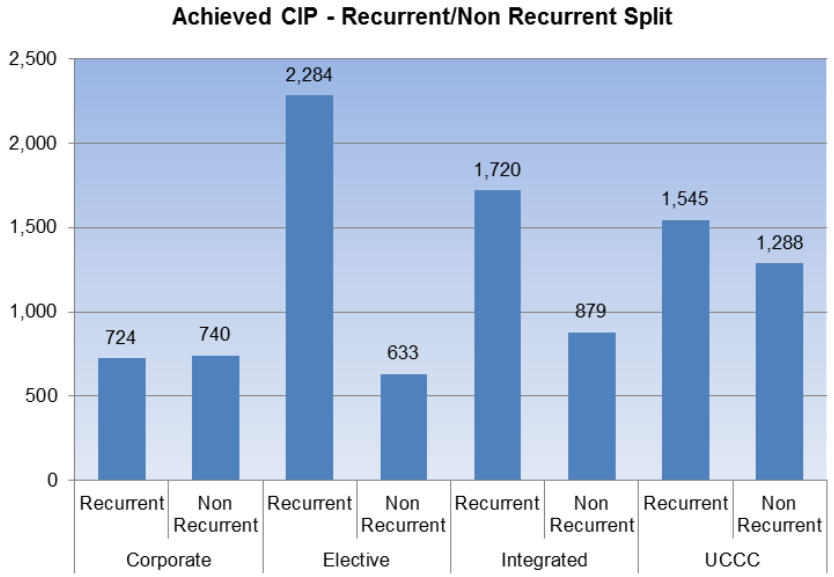
The Board of Directors is asked to **note** the contents of this report

This page has been left blank

# 2015/16 Efficiency Update

- Performance against the cost improvement programme (CIP) in 2015/16 remains extremely positive with £9.7m of plans actioned in directorates. This is the full year effect of plans that are in place.
- Schemes are place for 98% of the full year target following risk adjustment, a reduction on the previous months forecast of 100%.
- The amount of CIP achieved non recurrently has steadily grown over the year and now stands at 36% of achievement.

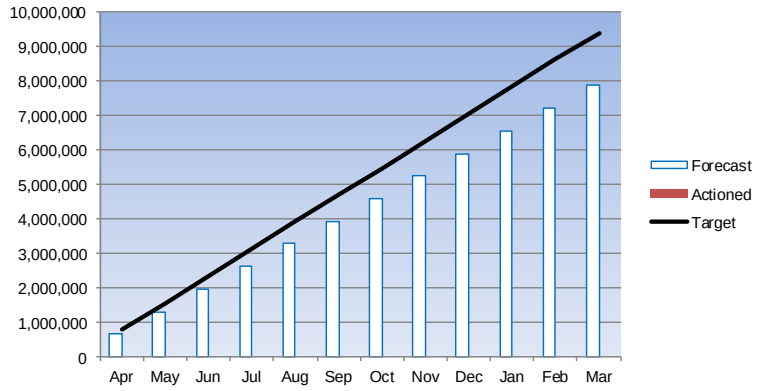



| Summary | Target | Actioned | Low | Medium | High | Total | % | Risk Adjust | % |
|---|---|---|---|---|---|---|---|---|---|
| Acute Care | 2,823,600 | 2,832,230 | 0 | 0 | 0 | 2,832,230 | 100% | 2,832,230 | 100% |
| Elective Care | 3,165,500 | 2,852,450 | 108,335 | 49,569 | 310,200 | 3,320,554 | 105% | 3,057,063 | 97% |
| Integrated Care | 2,800,200 | 2,598,700 | 17,192 | 0 | 0 | 2,615,892 | 93% | 2,615,032 | 93% |
| Corporate | 1,463,600 | 1,429,560 | 21,000 | 43,080 | 0 | 1,493,640 | 102% | 1,483,974 | 101% |
| **Total** | **10,179,000** | **9,712,940** | **146,527** | **92,649** | **310,200** | **10,262,316** | **101%** | **9,988,300** | **98%** |
| | | | | | | | | | |
| Target | | 10,179,000 | | | | 10,179,000 | | 10,179,000 | |
| | | | | | | | | | |
| **Variance** | | **-466,060** | | | | **83,316** | **101%** | **-190,700** | **98%** |
| Target less ETO benefit | | 8,779,000 | | | | 8,779,000 | | 8,779,000 | |
| | | | | | | | | | |
| **Variance** | | **933,940** | | | | **1,483,316** | **117%** | **1,209,300** | **114%** |

# 2016/17 Efficiency Planning

## Trustwide Cost Improvement Programme

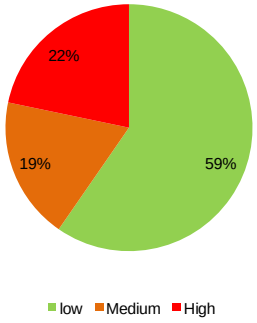



| Summary | Target | Actioned | Low | Medium | High | Total | Total %age | Risk Adjust | Risk Adj %age |
|---|---|---|---|---|---|---|---|---|---|
| Trustwide | 9,400,000 | 0 | 5,085,359 | 1,591,115 | 1,852,385 | 8,528,859 | 91% | 6,474,460 | 69% |
| | % age of target | | 54% | 17% | 20% | | | | |

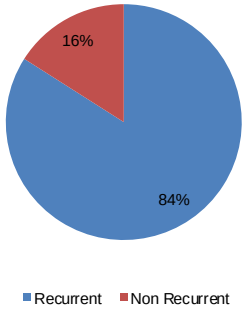
**Top 10 schemes** Top 10 as % of schemes - 34%

| No. | Scheme | Value | Risk |
|---|---|---|---|
| 1 | Maternity Review | 400,000 | low |
| 2 | Business Development 1 | 350,000 | low |
| 3 | Corporate Services Review | 336,960 | low |
| 4 | Staffing Reviews R | 315,000 | low |
| 5 | Staffing Reviews NR | 300,000 | low |
| 6 | Respiratory and Cardiology Review | 300,000 | low |
| 7 | Carbon Energy Fund | 266,000 | low |
| 8 | Review Inpatient Workstream | 252,300 | High |
| 9 | Business Development 2 | 200,000 | Medium |
| 10 | Biosimilar Change - Rheumatology | 200,000 | Medium |

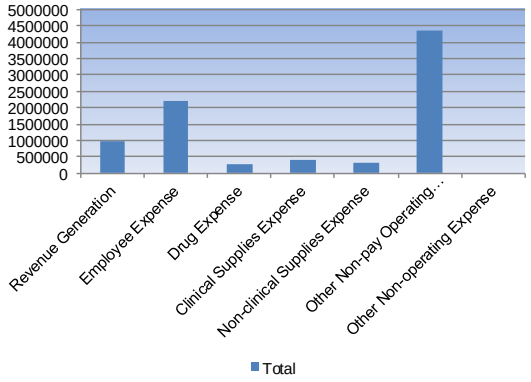
**CIP schemes by Risk**



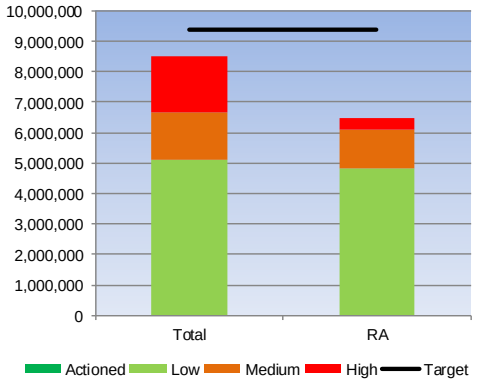

**Recurrent V Non Recurrent Plans**




**Efficiency Category**




**Risk Profile**

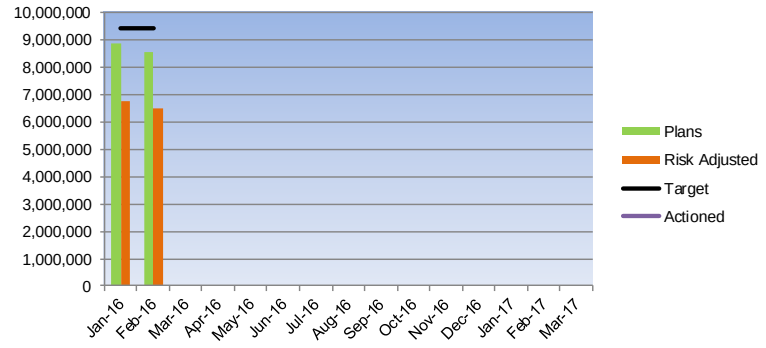




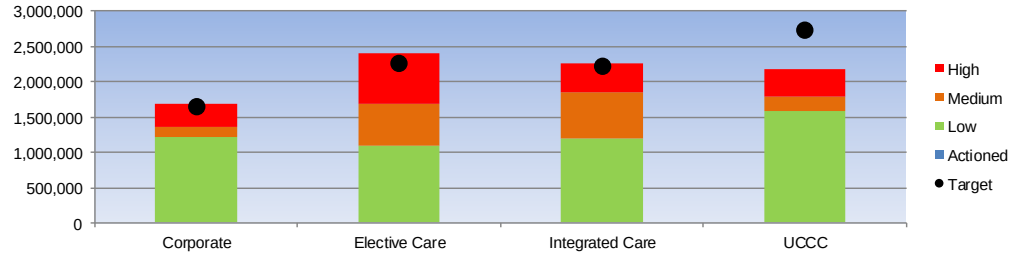

You matter most

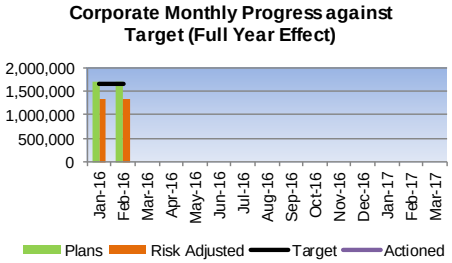
# 2016/17 Efficiency Planning

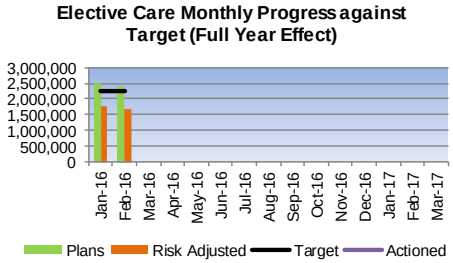
## Trustwide Cost Improvement Programme

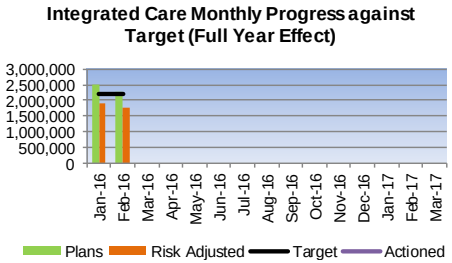


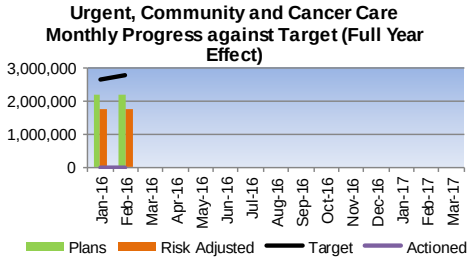

| Summary | Target | Actioned | Low | Medium | High | Total | Total %age | Risk Adjust | Risk Adj %age |
|---|---|---|---|---|---|---|---|---|---|
| Corporate | 1,650,100 | 0 | 1,214,360 | 141,915 | 331,500 | 1,687,775 | 102% | 1,333,474 | 81% |
| Elective Care | 2,269,800 | 0 | 1,097,000 | 584,800 | 725,385 | 2,407,185 | 106% | 1,655,067 | 73% |
| Integrated Care | 2,218,164 | 0 | 1,196,100 | 660,400 | 402,300 | 2,258,800 | 102% | 1,745,075 | 79% |
| UCCC | 2,743,800 | 0 | 1,577,899 | 204,000 | 393,200 | 2,175,099 | 79% | 1,740,844 | 63% |

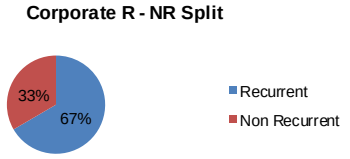


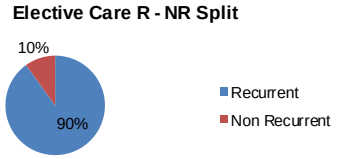



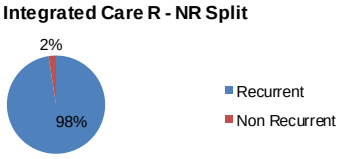



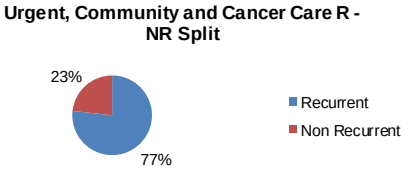



This page has been left blank

| Report to the Trust Board of Directors: 24 February 2016 | Paper No: 7.2 |
|---|---|

| | |
|---|---|
| **Title** | Operational Plan 2016/17 |
| **Sponsoring Director** | Jonathan Coulter, Director of Finance |
| **Author(s)** | Jonathan Coulter / Jordan McKie /Angie Gillett |
| **Report Purpose** | For Information |

**Key Issues for Board Focus:**

- Current position regarding the development of the plan
- Sustainability and Transformation funding and conditions
- Current position regarding the negotiations on the 2016/17 contract with HaRD CCG
- Current position in relation to finalising the Cost improvement programme

| **Related Trust Objectives** | |
|---|---|
| 1. To deliver high quality care | Yes |
| 2. To work with partners to deliver integrated care | Yes |
| 3. To ensure clinical and financial sustainability | Yes |

| | |
|---|---|
| **Risk and Assurance** | Quality, finance and performance risks are addressed through the development of the Operational Plan. |
| **Legal implications/ Regulatory Requirements** | The Trust is developing the Operational Plan for March 2016 in readiness for the new financial year and submission to Monitor in April 2016. |

**Action Required by the Board of Directors**

The Board of Directors is asked to **note** the work that is on-going in relation to finalising the Operational Plan with particular focus on:

- Firming up the cost improvement programme
- Finalising the Quality Priorities
- Continuing discussions with the CCG to agree a contract by the end of March 2016
- Refining the Draft Operational Plan for 2016/17 for submission to Monitor in April 2016

## 1. Introduction

1.1 As the Board of Directors will be aware the draft Operational Plan for 2016/17 was submitted to Monitor on 8 February, having previously been discussed at the Finance Committee on 4 February 2016.

1.2 As part of the submission to Monitor we highlighted a number of points that will need to be addressed prior to the final submission of the plan in April 2016. The key points were as follows

- Negotiations with our local CCG in respect of a contract for 2016/17, in particular an assessment of their QiPP assumptions which we have yet to discuss in detail.
- Our efficiency programme, which will be finalised with all QIA undertaken in advance of approval by the Board at the end of March 2016.
- Further work on the workforce profiling across the year within the detailed templates as plans in relation to our Vanguard project and the transfer of staff from Durham, Darlington and Middlesbrough are finalised.
- Sensitivity analysis in relation to the S&T funding as rules in relation to this are confirmed
- Our quality priorities for 2016/17, as we are going through a consultation process at present involving stakeholders and our Governors.

## 2. Current Position

### Initial Monitor Discussion

2.1 A call was held with Monitor on 16 February 2016, largely to discuss our Q3 return. We also briefly discussed our 2016/17draft plan and we will receive formal feedback over the next few weeks.

### Sustainability and Transformation Funding

2.2 As discussed at the last Board of Directors meeting, we confirmed to Monitor that we would like to accept the offer of the Sustainability and Transformation Fund totalling £4.6m for HDFT and commit to delivering a control total of a surplus of £6.8m in 2016/17.

2.3 As part of this commitment, we will need to maintain our current levels of performance in relation to A&E, Cancer and 18 weeks. We have been asked to provide a first draft of trajectories for these areas for submission by 19 February 2016. The receipt of any funding will be dependent on the meeting these standards.

2.4 Further guidance is due shortly in terms of how achievement will be monitored and the rules in relation to accessing the S&T funding.

### Contract Negotiations with HaRD CCG

2.5 Contract negotiations are on-going with HaRD CCG. In order to meet their financial plan, the CCG have identified a requirement to deliver a QiPP programme in the region of £6m. We have not yet seen the detail of these plans or the planned impact upon the Trust. A further update, if available will be provided to the Board at the meeting.

2.6 The CCG shared some commissioning intentions last week and I will brief the Board on the detail of these discussions at the meeting.

2.7 The deadline for the agreement of contracts is the end of March 2016and we have been asked to escalate any issues that we believe cannot be resolved quickly.

### Quality Priorities

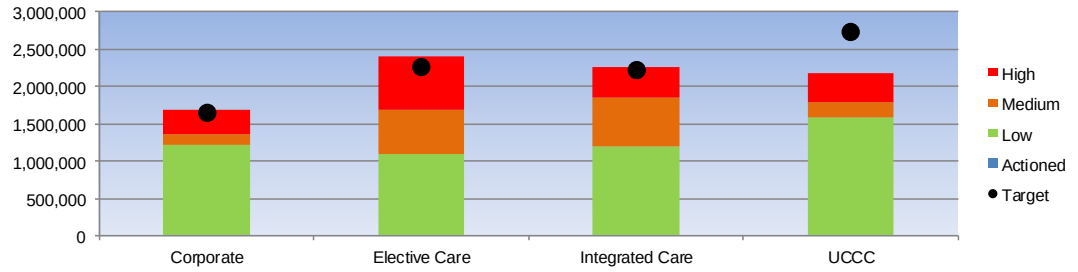
2.8 The quality priorities for 2016/17 are being developed and will be considered at SMT in March 2016.

### Cost Improvement Programme

2.9 The agreement of the cost improvement programme is on-going and Directorates are actively working to finalise the details. A summary of the current position is detailed below

| Summary | Target | Actioned | Low | Medium | High | Total | Total %age | Risk Adjust | Risk Adj %age |
|---|---|---|---|---|---|---|---|---|---|
| Trustwide | 9,400,000 | 0 | 5,085,359 | 1,591,115 | 1,852,385 | 8,528,859 | 91% | 6,474,460 | 69% |
| | % age of target | | 54% | 17% | 20% | | | | |

| Summary | Target | Actioned | Low | Medium | High | Total | Total %age | Risk Adjust | Risk Adj %age |
|---|---|---|---|---|---|---|---|---|---|
| Corporate | 1,650,100 | 0 | 1,214,360 | 141,915 | 331,500 | 1,687,775 | 102% | 1,333,474 | 81% |
| Elective Care | 2,269,800 | 0 | 1,097,000 | 584,800 | 725,385 | 2,407,185 | 106% | 1,655,067 | 73% |
| Integrated Care | 2,218,164 | 0 | 1,196,100 | 660,400 | 402,300 | 2,258,800 | 102% | 1,745,075 | 79% |
| UCCC | 2,743,800 | 0 | 1,577,899 | 204,000 | 393,200 | 2,175,099 | 79% | 1,740,844 | 63% |




### Directorate Plans

2.10 Directorates are in the process of finalising their Directorate plans for the end of March 2016 in readiness for budgets to be signed off and issued for the new financial year.

### Governor meetings

2.11 Regular meetings with the Governor working group on business planning continue to be held, with the next scheduled for the 22 February. To date there has been good engagement, with Governors taking a keen interest in the development and content of the plan.

## 3. Next steps

3.1 Over the coming weeks work will continue to: -

- Firm up the cost improvement programme
- Finalise the quality priorities

- Continue discussions with the CCG to agree a contract by the end of March 2016
- Continue to refine the Draft Operational plan for 2016/17 for submission to Monitor in April 2016

## 4. Conclusion

4.1 The Board of Directors is asked to note the work that is on- going in relation to finalising the Operational Plan.

Harrogate and District NHS
NHS Foundation Trust

| | |
|---|---|
| **Report to the Trust Board of Directors:**<br><br>**24 February 2016** | **Paper No: 10.0** |

| | |
|---|---|
| **Title** | **Report by the Medical Director** |
| **Sponsoring Director** | Medical Director - Dr David Scullion |
| **Author(s)** | Dr David Scullion |
| **Report Purpose** | To update the Board on current clinical issues |

**Key Issues for Board Focus:**

- Improved mortality data
- A periodic update on revalidation
- The importance of pre-employment checks
- Consultant appointment

| **Related Trust Objectives** | |
|---|---|
| 1. To deliver high quality care | YES |
| 2. To work with partners to deliver integrated care | YES |
| 3. To ensure clinical and financial sustainability | YES |

| | |
|---|---|
| **Risk and Assurance** | The Report provides assurance on clinical matters |
| **Legal implications/ Regulatory Requirements** | None |

**Action Required by the Board of Directors**

The Board of Directors is requested to **receive and consider** the Report

**Report by the Medical Director - February 2016**

1. **Mortality:**

The crude mortality rate continues to decline. The 12 month rolling average is at 1.16%. This local decline mirrors a trend in the acute sector across the NHS.

Both SHMI and HSMR have deceased this month (94.73 and 102.74, no alerts). HSMR is at its lowest level since September 2014. A recent CUSUM alert has flagged sepsis deaths at 3.4 (expected 2.45). Numbers are small. I have arranged to retrieve a sample of relevant hospital notes (five) and will be liaising with Dr Earl on a structured case note review.

CQUIN data on identifying patients with severe sepsis have improved, though there is further improvement necessary. A number of initiatives are in place that should facilitate this.

2. **Revalidation update**:

I continue to work closely with Dr Gray, the Trust's Responsible Officer, to ensure that he is aware of all relevant issues around his recommendations for revalidation to the General Medical Council (GMC). Whilst doctors are required to have undertaken a satisfactory medical appraisal in the 12 months previous to their revalidation date, recommendations are made as close to the required date in order to ensure that the most up to date information is being used when making them.

As of 31 January 2016, GMC figures show that Dr Gray has made 188 revalidation recommendations, of which 153 have been recommendations to revalidate the doctor and 35 have been to defer revalidation, due either to the doctor having insufficient evidence to support a recommendation to revalidate or because the doctor was participating in an ongoing process. No recommendations have been made beyond the required date, making HDFT one of only 40% of the Designated Bodies in Yorkshire and Humber in this position.

3. **Pre-employment checks**:

I have received a letter from NHS England (also copied to Responsible Officers and HR Directors) emphasising the importance of robust pre-employment checks for locum doctors, permanent staff and honorary contract holders. Arrangements for ensuring such checks are in place lie not only with the employing organisation as a whole, but are also clearly stated in the legislative regulations for Responsible Officers. The letter has been sent on the back of a number of recent incidents and highlights areas on which checks and information flows should focus:

- Robust checks by locum agencies on individuals' identity, qualifications and experience.
- Organisations employing locums using only reputable locum agencies, utilising the SLA to support the appropriate governance of the doctors and regularly auditing the compliance of agencies against the NHS Employment checks standards.
- More consistent use of exit information when locums leave employment.
- Better sharing of information between organisations, including those where the doctor works and all locum agencies through which a doctor is employed, particularly where there are concerns about a locum doctor.
- Improved induction, integration into clinical teams, mentoring, supervision and performance monitoring arrangements for locums.
- Ensuring whole scope of practice appraisals for all doctors including locums.

NHS England are currently finalising documents to share across organisations linked to improving the inputs to medical appraisal which will provide significant guidance regarding governance to services.

4. **Mental Capacity Training**:

A further training half day was delivered in January by Helen Kingston from DAC Beachcroft. This followed on from the first, well-received session, before Christmas. The latest session was attended by over 70 staff members, and feedback has also been that this was well-received. Additional local roll out of learning has taken place in parallel. Soft intelligence from CQC on this subject is that visiting inspectors were impressed with the level of knowledge of ward staff on this subject. I hope this will be reflected in the final report feedback. The most recent CRRG meeting has downscaled the numerical risk rating.

There is still a potential for further learning events, and possibly more focused training on the legal aspects of delivering high quality care to patients with learning difficulties.

5. **Operational Productivity in Acute Hospitals:**

I have received, via the CEO, a letter from the National Leads for Clinical Quality and Clinical Productivity. Both are senior clinicians engaged by the DoH to assist with the implementation of the Carter Review recommendations.

Much of the work will be a continuation of that already in progress (Getting it Right First Time, and The Model Hospital), though there is a clear stated intention in the letter to expand this work into other specialties such as General and Vascular Surgery, and Ophthalmology.

Trust Medical Directors have been identified as key leaders to help meet the challenges and drive change at local level. Detailed information at present is scarce, but I anticipate an invitation to discuss the process in more detail with the national Leads. I will feed back to the Board as necessary.

6. **Junior Doctors' industrial action**:

The break-up of negotiations and failure to achieve complete agreement is regrettable. Both sides appear to have backed themselves into a corner from which a face-saving escape for either side is difficult to identify. The Trust awaits developments from the BMA on behalf of its members. Escalation of industrial action seems likely.

7. **Consultant appointments:**

An excellent appointment was made to the post of Consultant Histopathologist on 11 February. The offer was accepted subject to the outcome of a forthcoming job interview for the applicant's spouse, a clergyman. Our Histopathologists are praying for divine intervention.

Further appointments are scheduled for Haematology, Gastroenterology, Neurology and Community Paediatrics.

This page has been left blank

| Report to the Trust Board of Directors: 24 February 2016 | Paper No: **11.0** |
|---|---|

| | |
|---|---|
| **Title** | Chief Nurse Report |
| **Sponsoring Director** | Chief Nurse |
| **Author(s)** | Jill Foster |
| **Report Purpose** | To receive and note contents of the report |

**Key Issues for Board Focus:**

1. To note the results of the director inspection visits
2. To review the complaints process key performance indicators
3. Focus continues on ensuring safe staffing levels and robust recruitment campaigns
4. The Trust has undergone a peer review of the neonatal service by the Yorkshire and Humber Neonatal Operational Delivery Network

| **Related Trust Objectives** | |
|---|---|
| 1. To deliver high quality care | Yes |
| 2. To work with partners to deliver integrated care | Yes |
| 3. To ensure clinical and financial sustainability | Yes |

| **Risk and Assurance** | |
|---|---|
| **Legal implications/ Regulatory Requirements** | No additional risks |

**Action Required by the Board of Directors**

The Board of Directors are asked to:

- To **note** the results of the Director inspection visits
- To **review and approve** the complaints process key performance indicators
- To note the actions being undertaken to ensure safe nurse staffing levels and robust recruitment campaigns
- To be **aware** of the feedback and results from the peer review of the neonatal service by the Yorkshire and Humber Neonatal Operational Delivery Network

**Directors Inspections 2015 - 2016**

| Date | Ward/Dept | Risk Rating | Critical Issues | Review Date | Outcome | Critical Issues |
|---|---|---|---|---|---|---|
| 09/06/15 | Farndale | Red | No VIP scores<br>No nurse in charge badge | 13/07/15 | Green | Good evidence on review |
| 12/06/15 | Wensleydale | Red | No VIP scores | 13/07/15 | Green | Good evidence on review |
| 01/07/15 | Nidderdale | Green | | | | |
| 13/07/15 | Littondale | Green | | | | |
| 06/08/15 | AMUF | Green | | | | |
| 28/08/15 | Trinity | Red | No cannula documentation<br>no VIP scores | 22/10/15 | Green | Good evidence upon review |
| 21/09/15 | ED | Amber/ Red | Emergency doors not working<br>General fabric to the environment | 11/02/15 | Amber | General fabric to the environment |
| 13/10/15 | Jervaulx | Green | | | | |
| 16/11/15 | Byland | Red | Failed due to no VIP scores | 26/02/2016 | TBC | |
| 03/11/15 | Granby | Green | | | | |
| 08/12/15 | Oakdale | Red | Cleanliness soiled toilet seat | 24/12/15 | Green | |
| 21/12/15 | Woodlands | Green | | | | |
| 05/01/16 | Theatres | Red | Medicine cupboard unattended & open | TBC | TBC | |
| 29/01/16 | Day Surgery | Red | Cleanliness<br>Medicine Fridge open<br>Patient call bell issues.<br>No nurse in charge badge worn | TBC | TBC | |
| 11/02/16 | Nidderdale | Green | | | | |

**Patient Safety Visits**

There has been no patient safety visits in January 2016. This was due to the number of peer to peer inspection visits being undertaken prior to the CQC visit.

Patient safety visits for 2016/17 are being planned with particular regard to increase the number of patient safety visits in the community.

**Complaints**

Since the last report on complaints activity for the month of December 2015, the number of complaints received this month is the same. The Trust received 12 complaints in December 2015 and 12 in January 2016. In January 2015 the Trust received 31 complaints.

Of the 12 complaints received in January 2016, nine were graded Yellow and three Green.

Learning from Patient Experience - Proposed metrics to measure patient experience of the complaints process:

Purpose: Metrics to be developed to enable the measurement of Patient Experience so that the Board via the Learning from Patient Experience Group can be assured that we are handling complaints in an effective and responsive manner and learning from them

| **Metric** | **Detail** |
|---|---|
| Response Times for complaints | 95% of cases should meet the initial deadline set at the outset of the complaint |
| Number of complaints | Number of complaints compared with the average of complaints received the previous year. The IBR metric will be used (*Blue if number complaints in latest month is below UCL, Green if below HDFT average for 2014/15, Amber if above HDFT average for 2014/15, Red if above UCL. In addition, Red if a new red rated complaint received in latest quarter)* |
| Number of reopened complaints | The number of cases that that are re-opened as a % of the total.<br>*NB we will now only be closing a complaint once dialogue between the complainant and the PET indicate that local resolution is complete and we have addressed their concerns. We will amend the process box to show those cases which have received a response but that we are currently in dialogue with regards their satisfaction with the response* |
| Number of cases investigated by the PHSO | We will report this as a % of all complaints received |
| Number of cases upheld by the PHSO following investigation | Out of those cases referred for investigation by the PHSO the number that is found to be upheld will be reported. This again will be as a % of all complaints received |
| Number of Actions developed as a result of complaints and how many completed within target date | Visual representation of the number of actions completed within target date as a percentage. Suggest that 75% of actions should be completed within deadline set |
| Measurement of the satisfaction of complainants | This will include the handling of the complaint as well as the response to the issues raised. It is likely that this will be measured as part of a survey and then this data will be represented graphically. |

**Nurse Recruitment**

The Registered Nurse (RN) and Care Support Worker recruitment campaign continues across all areas of the Trust. Since 1 September 2015 68 RNs have commenced in the Trust. There are 17 RNs with planned start dates and 12 RNs currently waiting start dates. 25 CSWs have commenced in the Trust since 1 January 2016, 12 CSW's have start dates and a further 14 are currently waiting to agree a start date.

In the in-patient areas, staffing the Frail Elderly Unit continues to remains a risk where currently there are 7.81 WTE registered nurse vacancies on Byland and 5.23 WTE registered nurse vacancies on Jervaulx. The situation continues to be monitored daily. There are a number of mitigating actions remaining in place which were discussed at last month's Board meeting.

Work continues to secure Registered Nurses for our workforce. Recruitment events are planned for 23 February 2016 in the hospital and 27 February 2016 in the community and we are working with a social media company 'Face the Music' to advertise this and promote our current campaign. We will be attending open days at Bradford University and York University in March 2016.

Work is being undertaken to look back over the last 18 months at the recruitment of nursing and midwifery staff to identify trends. I will report the findings of this exercise in March.

**Actual vs Planned Staffing - inpatient areas**

The table below summarises the average fill rate on each ward during **January 2016.** The fill rate is calculated by comparing planned staffing hours and actual staffing achieved.

| | Jan-2016 | | | |
|---|---|---|---|---|
| | 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 | 96% | 121% | 101% | 152% |
| Byland | 89% | 139% | 95% | 217% |
| CATT | 97% | 107% | 117% | 122% |
| Farndale | 93% | 124% | 102% | 145% |
| Granby | 105% | 128% | 100% | 152% |
| Harlow | 107% | 102% | 100% | - |
| ITU/HDU | 103% | - | 99% | - |
| Jervaulx | 84% | 145% | 81% | 235% |
| Lascelles | 91% | 108% | 100% | 100% |
| Littondale | 100% | 123% | 100% | 155% |
| Maternity Wards | 84% | 77% | 99% | 86% |
| Nidderdale | 101% | 106% | 99% | 116% |
| Oakdale | 96% | 109% | 96% | 140% |
| Special Care Baby Unit | 99% | 96% | 100% | - |
| Trinity | 95% | 125% | 100% | 158% |
| Wensleydale | 83% | 107% | 100% | 102% |
| Woodlands | 104% | 111% | 90% | 117% |
| **Trust total** | **94%** | **119%** | **99%** | **142%** |

On the medical wards Jervaulx and Byland where the RN fill rate was less than 100% against planned; January's actual staffing levels has improved on both Byland and Jervaulx for RNs

on both day and night shifts compared to December 2015. On Byland, on day shifts there has been an improvement from 82% to 89% and on nights the improvement has been from 82% to 95%. On Jervaulx, on day shifts there has been an improvement from 83% to 84% and night shifts from 69% to 81%.

On Granby ward the increase in care staff hours above plan was to support the opening of additional escalation beds in January, as required.

In January the planned staffing levels on Lascelles remain adjusted to reflect the closure of two beds on the unit in response to staff sickness and vacancies in this area.

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. For the Special Care Baby Unit (SCBU) although the daytime 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 January this is reflected on the wards; Acute Medical Unit (AMU), Byland, CATT, Farndale, Jervaulx, Littondale, Nidderdale, Oakdale and Trinity wards.

On Wensleydale ward although the daytime RN hours were less than planned in January the ward occupancy levels varied throughout the month which enabled staff to assist in other areas.

The staffing complement for the children's ward, Woodlands, is designed to reflect varying levels of occupancy. Although the night time RN staffing levels are less than 100% in January, 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 Yorkshire & Humber Neonatal Operational Delivery Network (Y&H NODN) Peer Review of Neonatal Services at HDFT**

On 17 February 2016 the Yorkshire & Humber Neonatal Operational Delivery Network visited to undertake a peer review of the Trust's Neonatal Services. The Y&H NODN is the largest network in the country and is looking to gain an overarching picture of neonatal services across the region prior to the national requirement to survey all services commencing in 2017.

We are the first neonatal service in the region to undergo such a review and the feedback on the day was positive; in fact they said we have set the standard very high for those who follow. There were no issues of concern and particularly commented on

- The comprehensive information booklet for parents
- The continual use of parents feedback and publishing it on the unit
- The approach to the Morecombe Bay inquiry which they determined as comprehensive, detailed and reaching an excellent standard

They were not concerned but asked us to consider

- Data quality input to national database and completion of all fields
- Age profile of nursing staff

A written report is expected within six weeks.

**Jill Foster**
**Chief Nurse**
**February 2016**

This page has been left blank

| | |
|---|---|
| **Report to the Trust Board of Directors: 24 February 2016** | **Paper No: 12.0** |

| | |
|---|---|
| **Title** | **Report from Chief Operating Officer** |
| **Sponsoring Director** | Robert Harrison, Chief Operating Officer |
| **Author(s)** | Rachel McDonald, Head of Performance & Analysis<br>Jonathan Green, Information Analyst |
| **Report Purpose** | For information and consideration |

**Key Issues for Board Focus:**

1. **The results of the inpatient survey 2015 have recently been received – a summary is presented in this report.**
2. **The wheelchair service is struggling to meet demand and is currently over budget. Discussions with commissioners continue.**
3. **The Trust recently participated in a regional workshop on cancer pathways that transfer between providers.**

| **Related Trust Objectives** | |
|---|---|
| 1. To deliver high quality care | Yes |
| 2. To work with partners to deliver integrated care | Yes |
| 3. To ensure clinical and financial sustainability | Yes |

| | |
|---|---|
| **Risk and Assurance** | The report provides detail on significant operational issues and risks to the delivery of national performance standards, including the Monitor Risk Assessment Framework |
| **Legal implications/ Regulatory Requirements** | The Trust is required to report its performance against the Monitor Risk Assessment Framework on a quarterly basis and to submit performance data routinely 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 NATIONAL INPATIENT SURVEY 2015

621 HDFT inpatients discharged in July participated in the 2015 National Inpatient Survey carried out by Picker Institute Europe. The HDFT response rate was 52%, compared to a national average of 45%.

Of the 621 HDFT inpatients who responded to the survey, 36% of patients were on a waiting list / planned in advance and 60% came as an emergency or urgent case. 53% of HDFT respondents were aged 70+.

Picker highlighted the following positive points for HDFT:

- 87% rated care at HDFT as 7+ out of 10.
- 85% of respondents felt they were treated with respect and dignity.
- 83% always had confidence and trust in Doctors.
- 98% felt their room or ward was very/fairly clean.
- 98% felt the toilets and bathrooms were very/fairly clean.
- 91% felt there was always enough privacy when being examined or treated.

The survey contained 65 questions in total. In 18 out of the 65 questions, HDFT scored significantly better than average, about the same as average for 46 questions and significantly below average for 1 question - 'Not asked to give views on quality of care' where 73% of HDFT patients agreed with this question compared to 69% national average. In the section relating to admissions to hospital, HDFT attained a score of significantly better than average for 6 out of the 7 questions.

Compared to last year's results, HDFT had improved upon the previous year in 28 out of 62 questions (that remained the same in both surveys), remained the same for 12 questions and gained a lower score in 22 questions. However in only 1 question was it deemed that HDFT had performed significantly worse than the previous year – "Hospital: not offered a choice of food" - 22% of patients felt they were not offered a choice of food in 2015 compared to 17% in 2014.

At present, the full national data set is not available so it is not possible to see how HDFT ranks compared to other Trusts.

## 2.0 WHEELCHAIR SERVICES

The demand for wheelchairs and associated equipment, in particular specialist seating, has continued to grow and the service is unable to deliver appropriate equipment in a timely way due to the cost outstripping the resources available. The service has been prioritising based on clinical need. However, in order to provide a safe service for users and in line with HDFTs approach to delivering quality services, the team have issued wheelchairs and equipment to meet clinical need, with a current financial position of £158k over budget.

Two service improvement workshops were held in Autumn 2015 looking at implications of the Wheelchair Charter, which was supported by NHS IQ and involved wheelchair users. At the workshop, representatives of the CCG publicly confirmed that there should not be any delays in provision because of budgetary constraints. The current situation has been raised with the CCG regularly through the bi-weekly telephone conferences, and has been passed onto the CCG contracting managers to agree the solution to the financial position.

## 3.0 CANCER PATHWAYS - INTER-PROVIDER TRANSFER (IPT) WORKSHOP

Alongside a national drive to improve 62 day cancer performance and cancer patient experience, colleagues from Urgent, Community & Cancer Care Directorate and Information Services attended a workshop at Leeds Teaching Hospitals in January, the purpose of which was to develop a collaborative cross-region strategy for those cancer patients whose care is shared between secondary and tertiary providers.

From April 2016, the Cancer Waiting Times (CWT) dataset will include the date of inter-provider transfer (IPT), which means that performance data will be available on IPT waits, which in turn could potentially facilitate the re-allocation of 62 day breaches for those patients whose care was transferred to the tertiary centre 38 days or more into their pathway. General Managers for each of the Directorates have been re-briefed on the day 38 target and implications for failing to meet this. We continue to monitor 14 days, 31 days, 38 days, and 62 days on the weekly report.

The workshop provided an excellent opportunity for each local cancer team to share their experiences and knowledge, and also contribute to the development of a formal policy on IPTs, the aim of which will be to improve the experiences and outcomes for patients whose cancer care is shared between providers in our region.

## 4.0 CARBON AND ENERGY FUND

The electrical works in Strayside Wing have progressed well and the new switchboard, transformers and standby generator have been installed and commissioned. This work has now removed one of the significant risks that we had on the site in respect of a non-maintainable transfer switch. Correspondingly this has been removed from the estates risk register.

The internal lighting replacement works are also progressing well with approximately 45% of the fittings now replaced. As the old fittings are removed they are tested for electrical consumption and compared with the new fittings to verify the expected saving. To date these savings are in the order of £14,000 per month which is in-line with the calculations prepared as part of the design proposal.

With regard to the remedial works that were required to the first new boiler that was installed in December, further works have been required and this will result in a further proving period in February before the second new boiler will be installed.

## 5.0 SERVICE ACTIVITY

Variances above or below 3% are as follows:

For 2015/16 to date at the end of January, no HDFT activity was more than 3% above or below plan.

For Leeds North and West CCG, follow-up outpatient appointments were 6.2% below plan and elective admissions were 7.6% above plan for the year to date.

## 6.0 FOR APPROVAL

There are no items for approval this month

This page has been left blank

| | |
|---|---|
| **Report to the Trust Board of Directors: 24 February 2016** | **Paper No:** **13.0** |

| | |
|---|---|
| **Title** | **Workforce and Organisational Development Update** |
| **Sponsoring Director** | Director of Workforce and Organisational Development |
| **Author(s)** | Director of Workforce and Organisational Development |
| **Report Purpose** | 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

| **Related Trust Objectives** | |
|---|---|
| 1. To deliver high quality care | YES |
| 2. To work with partners to deliver integrated care | YES |
| 3. To ensure clinical and financial sustainability | YES |

| | |
|---|---|
| **Risk and Assurance** | Any identified risks are included in the Directorate and Corporate Risk Registers |
| **Legal implications/ Regulatory Requirements** | 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** and comment on the update on matters specific to Workforce, Training and Education, Service Improvement and Innovation and Organisational Development.

**Key Messages for February 2016**

## a) Job Planning

Below are the job planning figures for Consultants and SAS Grades as at 16 October 2015.

| OCTOBER 2015 JOB PLANNING CENTRAL REPORT – CONSULTANTS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Directorate** | **Number of Consultants** | **Job Plans within 12 months** | **%** | **Job Plans older than 12 months** | **%** | **Number of Consultant with no Job Plans recorded** | **%** |
| Urgent, Community and Cancer Care | 23 | 21 | 91% | 2 | 9% | 0 | 0% |
| Elective Care | 58 | 20 | 34% | 22 | 38% | 16 | 28% |
| Integrated Care | 37 | 14 | 38% | 8 | 22% | 15 | 40% |
| **Total** | **118** | **55** | **47%** | **32** | **27%** | **31** | **26%** |

| OCTOBER 2015 JOB PLANNING CENTRAL REPORT - SAS GRADES | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Directorate** | **Number of SAS Doctors** | **Job Plans within 12 months** | **%** | **Job Plans older than 12 months** | **%** | **Number of SAS Doctors with no Job Plans recorded** | **%** |
| Urgent, Community and Cancer Care | 7 | 2 | 29% | 0 | 0% | 5 | 71% |
| Elective Care | 41 | 5 | 12% | 2 | 5% | 34 | 83% |
| Integrated Care | 2 | 0 | 0% | 0 | 0% | 2 | 0% |
| **Total** | **50** | **7** | **14%** | **2** | **5%** | **41** | **81%** |

Since this date we have been actively working towards improving these figures and over the page are the latest figures as at 31 January 2016 so that we can identify how these have changed in the 4 month period.

| JANUARY 2016 JOB PLANNING CENTRAL REPORT - CONSULTANTS | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Directorate** | **Number of Consultants** | **Job Plans within 12 months** | **%** | **Job Plans older than 12 months** | **%** | **Number of Consultant with no Job Plans recorded** | **%** |
| UCCC | 24 | 20 | 83.33% | 3 | 12.50% | 1 | 4.17% |
| Elective Care | 58 | 34 | 58.62% | 14 | 24.14% | 10 | 17.24% |
| Integrated Care | 38 | 37 | 97.37% | 1 | 2.63% | 0 | 0.00% |
| **Total** | **120** | **91** | **75.83%** | **18** | **15.00%** | **11** | **9.17%** |

| JANUARY 2016 JOB PLANNING CENTRAL REPORT - SAS GRADES | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Directorate** | **Number of SAS Doctors** | **Job Plans within 12 months** | **%** | **Job Plans older than 12 months** | **%** | **Number of SAS Doctors with no Job Plans recorded** | **%** |
| UCCC | 5 | 5 | 100.00% | 0 | 0.00% | 0 | 0.00% |
| Elective Care | 38 | 6 | 15.79% | 3 | 7.89% | 29 | 76.32% |
| Integrated Care | 2 | 2 | 100.00% | 0 | 0.00% | 0 | 0.00% |
| **Total** | **45** | **13** | **28.89%** | **3** | **6.67%** | **29** | **64.44%** |

### b) Mobilisation of Darlington, Durham and Middlesbrough Contracts

Consultation is on-going with staff transferring as part of the Middlesbrough, Durham and Darlington contracts. Some areas of concern remain, particularly in relation to; the transfer of payroll information into ESR, the decision by County Durham and Darlington Foundation Trust not to provide the Employee Liability Information before the 28 day deadline and the issuing of HDFT identification passes on 1 April 2016. Discussions are continuing with current providers to resolve these outstanding areas.

### c) Appraisal completion

Following the launch of the Trust's values and associated behavioural framework last year, we have in January 2016 launched the revised Values based Appraisal toolkit. The new tools within the kit are focused on values underpinning the culture of the organisation and along with incorporating feedback received over a number of months we have streamlined the process to ensure that it walks staff through the appraisal process in a logical and easy manner.

In line with Trust policy it is mandatory that all staff receive an annual appraisal with a recommendation being that a 6 month review is incorporated. Since the introduction of the pay progression policy and the link to the successful completion of appraisal and objectives we have seen a rise in appraisal compliance. Further to this the new process includes mandatory managerial objectives including: all staff having had an appraisal in the last 12 months and staff compliance with mandatory training and processing of pay progression in a timely manner.

The initial feedback is overwhelmingly enthusiastic and the renewed toolkit and focus will assist in raising appraisal rates towards our 95% completion target.

### d) Mandatory and Essential Skills

As a Trust we are currently standing at an overall percentage compliance of 90%, at 1 February 2016 for Mandatory and Essential Skills training completion. This is a fantastic achievement and represents the focus that all staff have had on this – thank you.
To support us in reaching 95% please encourage all your staff to access their Personal Training Account and ensure they are up to date with all their Mandatory and Essential Skills training.

All queries regarding accessing Mandatory and Essential Skills training can be directed to the Learning & Development Team by emailing: learning&development@hdft.nhs.uk.

### e) Junior Doctors Industrial Action

During the 24 hour period of industrial action by junior doctors that commenced at 8.00 am on 10 February 2016 approximately two thirds of the junior doctors scheduled to work participated in the industrial action.
Many people across the Trust stepped up to allow the maintenance of an almost full level of service while respecting the right of colleagues to take industrial action. All surgery went ahead with no cancellations but a small number of outpatient appointments had to be re-scheduled.

### f) Agency Caps

On 15 October 2015, Monitor and the NHS Trust Development Authority published further rules on NHS Trusts securing staff via approved framework agreements. The new rules effectively cap the rates at which NHS Trusts can secure Agency staff. As you may be aware the capped rates were effective as of 23 November 2015 with 2 further reductions on 1 February 2016 and 1 April 2016.

As the NHS faces huge financial challenges we are required to implement these new rates, and we are working with all of our current suppliers to reduce the rates that we pay agency staff to bring them into line with the new capped rates. We are also working with other providers in the local area to ensure that we adopt a consistent approach to implementation. We still have the option to pay above the current capped rates until 31 March 2016 (and potentially beyond), where required for patient safety reasons and this is reported to Monitor on a weekly basis.

Harrogate and District NHS
NHS Foundation Trust

| | |
|---|---|
| **Report to the Trust Board of Directors: 24 February 2016** | **Paper No: 14.0** |

| | |
|---|---|
| **Title** | **Proposed Amendments to the Trust Constitution** |
| **Sponsoring Director** | Chief Executive – Dr Ros Tolcher |
| **Author(s)** | Ms Angie Colvin, Foundation Trust Membership Manager |
| **Report Purpose** | **For the information and approval of the Trust Board following agreement from the Council of Governors** |

**Key Issues for Board Focus:**

- The Trust Constitution requires amendment to reflect the increased catchment area in which the Trust operates and some other minor changes
- More than half of the Council of Governors voting voted to approve the proposed amendments at the Council of Governors' meeting on 6 February 2016
- The Constitution requires more than half of the members of the Board of Directors voting to approve the proposed amendments

| **Related Trust Objectives** | |
|---|---|
| **1. To deliver high quality care** | **Yes** |
| **2. To work with partners to deliver integrated care** | **Yes** |
| **3. To ensure clinical and financial sustainability** | **Yes** |

| | |
|---|---|
| **Risk and Assurance** | None |
| **Legal implications/ Regulatory Requirements** | None |

**Action Required by the Board of Directors**

The Board of Directors is requested to **approve** the proposed amendments

## Introduction

The Constitution of HDFT was updated in line with the requirements of the Health and Social Care Act 2012 and brought into effect on 1 April 2013. It was subsequently updated, with minor changes, to the current version dated 4 February 2015. Since then there have been a number of changes both in the way the Trust operates and the regulations which it is required to observe. This paper details the amendments which are now proposed to ensure that the Constitution remains up to date and fit for purpose.

The Constitution Review Working Group considered these proposed amendments, in accordance with its Terms of Reference, at its meeting on 7 December 2015. The Constitution states:

*27.1 No amendment shall be made to this constitution unless:*

*27.1.1 More than half of the members of the Council of Governors of the trust voting approve the amendments; and,*

*27.1.2 More than half of the members of the Board of Directors of the trust voting approve the amendments.*

The proposed amendments are presented to the Board of Directors for discussion and approval as stated above. They were submitted to the meeting of the Council of Governors on 6 February and approved *nem con* by those Governors present.

## The Proposed Amendments

1. The proposed amendments are as follows:

   Section 1 re interpretation and definition of 'Secretary'. Following the recent appointment of a 'Company Secretary' the term 'Secretary' and 'Deputy Director of Corporate Affairs' would be replaced with 'Company Secretary' throughout the document.

2. Section 7.2 re public constituency boundaries. Following a detailed discussion regarding the Trust's public constituency boundaries at the meeting on 7 December 2015, and referred to in the minutes at Appendix A, it is proposed to increase the number of public constituencies to six, increasing the Council of Governors by one additional public Governor to represent the interests of a membership covering 'The Rest of England'. At section 7.2.2 the Constitution states the minimum number of members in each of the public constituencies and it was agreed that there should be a minimum of 50 members in the Rest of England. If approved, the Constitution would be amended where there is any reference to the public constituencies and their representative Governors, including sections 7.2, 11.2 and Annex A.

3. Section 15 re Annual Members' Meeting/Nominations Committee:

   Paragraph 15.2.9 renumber to 15.2.10 and replace 15.2.9 to read:

*'a report on the activities of the Nominations Committee within the previous year.'*

4. Section 16.2 re Nominations Committee

   Paragraph 16.2.2 now to read:

   *'The Council of Governors will establish and set the terms of reference for a Nominations Committee. That committee, chaired by a Governor, will recommend to the full Council of Governors no more than one individual per Non-Executive vacancy for appointment to the Board of Directors.'*

5. In addition, the Constitution Review Working Group discussed the terminology of the Vice Chair with regards to a possible change of name to Deputy Chair. The Chairman proposed that the Board of Directors would retain a Vice Chairman as the Council of Governors had a Deputy Chairman and the Group agreed. The Constitution at section 16.5 will therefore **not** be amended.

The Board of Directors is recommended to **discuss and approve** the proposed amendments and note the minutes of the meeting of the Constitution Review Working Group on 7 December 2015 at Appendix A.

**Next steps**

If approved, the amended Constitution will be submitted to Monitor and the vacancy for a public Governor for The Rest of England will be included in the election scheduled for spring 2016.

**Appendix A**

Harrogate and District NHS
NHS Foundation Trust

**MINUTES OF THE HDFT CONSTITUTION REVIEW WORKING GROUP**
**Held on 7 December 2015 in the**
**Board Room, Trust HQ, 3rd Floor,**
**Harrogate District Hospital**

**Present:**

Mrs Sandra Dodson, Chairman (Chair)
Mr Michael Armitage, Public Governor
Mrs Angie Colvin, Corporate Affairs and Membership Manager
Mr Andrew Forsyth, Interim Head of Corporate Affairs
Mrs Pat Jones, Public Governor
Mr Neil McLean, Non-Executive Director
Mr Peter Pearson, Public Governor
Mrs Joyce Purkis, Public Governor
Dr. Ros Tolcher, Chief Executive
Rev. Dr Mervyn Willshaw, Deputy Chair of Governors/Public Governor
Mrs Fiona Wilson, Staff Governor

## 1. Welcome and apologies for absence

Mrs Dodson welcomed everyone and explained that the purpose of the meeting was to consider the proposed amendments to the Constitution. Mrs Dodson also confirmed that any amendments to the Constitution in relation to the powers or duties of the Council of Governors must be put to the vote of the members and approved at the Annual Members' Meeting, but on this occasion, the proposed amendments would not affect this requirement.

Apologies were received from Ms Pamela Allen, Public Governor, Mrs Cath Clelland, Public Governor, Mrs Sarah Crawshaw, Stakeholder Governor, Mrs Liz Dean, Public Governor, Cllr John Ennis, Stakeholder Governor, Mrs Jane Hare, Public Governor, Mr Rob Harrison, Chief Operating Officer, Mrs Jane Hedley, Public Governor, Mrs Sally Margerison, Staff Governor and Mr Phillip Marshall, Director of Workforce and Organisational Development.

## 2. Terms of Reference

The group reviewed the Terms of Reference and agreed them, subject to the following amendments:

2. Membership

Three public Governors
Delete Deputy Director of Corporate Affairs and replace with Company Secretary

3. Quorum

The quorum shall be six members including at least three Governors.

5. Group Purpose

To review the Constitution of the Trust for:

- Statutory changes arising from any legislation;
- General changes to the Constitution required by regulatory bodies;
- Changes due to inaccuracies or changes of title/organisation; and,
- Any other matters agreed by the Group.

## 3. Proposed amendments to the Constitution

### 3.1 Section 1 re interpretation and definition of 'Secretary'

Following the recent appointment of a 'Company Secretary' the Group agreed that the term 'Secretary' and 'Deputy Director of Corporate Affairs' would be replaced with 'Company Secretary' throughout the document.

### 3.2 Section 7.2 re public constituency boundaries

Mrs Dodson clarified the main purpose of the meeting was to review the Trust's public constituency boundaries. Discussion had taken place throughout the year regarding Trust membership reflecting our service users and the Trust expanding services into Leeds and, more recently, outside North Yorkshire.

A recent review of the 444 Affiliates, (people who currently engage with the Trust but who were unable to become members due to age or residency outside the current public constituency boundaries) demonstrated that these people reside all over the country, in fact as far as China!

Mrs Dodson therefore proposed that, rather than define a further public constituency boundary, the Group consider an additional public Governor to represent the interests of 'The Rest of England'.

Mrs Colvin added that the Affiliates would be a target audience for the new Rest of England Governor, but that the Trust would actively promote using a variety of methods including the website and social media.

Mr McLean commented that he was a member of another Trust through a similar 'Rest of England' public constituency and felt that this method provided Trusts with a positive, outward looking approach to their membership.

The group discussed how a public Governor would represent the interests of a membership residing across the rest of England.

Dr Tolcher highlighted that from April 2016 the Trust had been awarded three major new contracts for Children's Services in Middlesbrough, Durham and Darlington and this would mean nearly 500 new community staff with family and friends who would be able to join the membership.

Rev. Dr Willshaw also raised the point that this would open up the opportunity for interested and skilled Non-Executive Director applicants.

Mr Forsyth was pleased that by expanding the public constituency boundaries, this would encourage a diverse membership.

The Group also discussed the option of reviewing the current public constituency boundaries but, following a detailed discussion, agreed to increase the number of public constituencies to six, and increase the Council of Governors by one additional public Governor to represent the interests of a membership covering 'The Rest of England'. The Constitution states at 7.2.2 the minimum number of members in each of the public constituencies and the Group agreed that there should be a minimum of 50 members in the Rest of England.

Further to Dr Tolcher's previous comments, Mrs Wilson enquired how an increase in approximately 500 staff would impact on the current number of Staff Governors.

Mrs Colvin confirmed that the current staff membership stood at 3,581, and summarised as follows:

- Medical Practitioners, one Staff Governor – 358 members
- Non-Clinical, one Staff Governor – 998 members
- Nursing and Midwifery, two Staff Governors – 1,414 members
- Other Clinical, one Staff Governor – 811 members.

As the majority of additional staff would fall within the Nursing and Midwifery Staff Class and, we currently had two Staff Governors to represent the interests of these members, the numbers across the four classes remained proportionate and the Group agreed there was not a requirement at this stage to review further.

### 3.3 Section 15 re Annual Members' Meeting/Nominations Committee

It had come to light that the Terms of Reference for the Nominations Committee for recruitment and re-appointment of Non-Executive Directors stated the following, but was not reflected in the Constitution at item 15:

10.2 The Chair will attend the Annual Members' Meeting to report on the activities of the Nominations Committee in the previous twelve months.

The Group agreed to insert the following statement in the Constitution at 15.2.9:

15.2.9 a report on the activities of the Nominations Committee within the previous year.

The current statement at 15.2.9 regarding the results of elections and appointment to the Council of Governors would be re-numbered as 15.2.10.

### 3.4 Section 16.2 re Nominations Committee

Mrs Dodson proposed an amendment to the Constitution at item 16.2.2 to specify that a Governor would chair the Nominations Committee and this would also be reflected in the Terms of Reference for the Nominations Committee for recruitment and re-appointment of Non-Executive Directors at an appropriate time. The Group agreed this proposal.

### 3.5 Section 16.5 re Vice Chairman

It had been highlighted that at a previous Council of Governor meeting in April 2014, discussions were underway regarding the terminology of the Vice Chair with regards to changing the name to Deputy Chair.

Mrs Dodson confirmed she had undertaken some research which included looking at other Trusts and reviewing the Model Constitution. In order to retain clarity and close the loop on the outstanding item of discussion, Mrs Dodson proposed that the Board of Directors would retain a Vice Chairman and the Council of Governors would retain a Deputy Chairman. The Group agreed.

## 4. Any other business

There was no other business.

Mrs Dodson confirmed that next steps would include the proposals agreed by the Group to be submitted to the next Council of Governor

meeting in February 2016 followed by the Board of Directors meeting in February 2016 with submission of the amended Constitution to Monitor and the inclusion of a public Governor for The Rest of England with the scheduled election in the spring.

Mrs Dodson thanked everyone for attending and closed the meeting.

Harrogate and District NHS
NHS Foundation Trust

**15.0**

# Board Committee report to the Board of Directors

| | |
|---|---|
| **Committee Name:** | Finance Committee |
| **Committee Chair:** | Maureen Taylor |
| **Date of last meeting:** | 4th February 2016 |
| **Date of Board meeting for which this report is prepared** | 24th February 2016 |

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

1. The Committee met to consider the draft Operational Plan which has to be submitted to NHS Improvement (Monitor) on 8th February 2016.
2. The plan is submitted as a draft with the final plan due in April.
3. The plan has been prepared in the context of the 5 year forward View as well as reflecting the NHS Improvement objectives and the national "must do" initiatives.
4. A report on the draft plan was discussed at the Full Board of Directors meeting in January. The Finance Committee went through each section of the plan and scrutinised the assumptions and methodologies used in preparing the plan seeking assurances that they were robust, realistic and deliverable.

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

- The plan assumes that the Trust will deliver a surplus of £6.8m being an underlying surplus of £2.2m and £4.6m additional Sustainability and Transformation funding.
- The additional funding is providing on acceptance of the following conditions:
  - We agree to a control total of delivering a surplus of £6.8m
  - We agree to compliance with the Agency Cap rules, and work to deliver the Carter Review savings
  - We deliver the access standards relating to 18 weeks, A&E and ambulance waits
  - We produce an agreed STP
- If these conditions are not met the Sustainability and Transformation funding could be at risk.
- Underpinning the plan is the requirement for efficiency savings of

£8.2m 93% of which has been identified. The internal Trust CIP target is £9.4m.

- The plan has been prepared without sight of the plans of HaRD CCG and this represents a risk to the delivery of the plan. Hopefully when the final plan is submitted in April, this risk will be addressed.

**Matters for decision**

- None

**Action Required by Board of Directors:**
To **note** the report.

15.1

# Board Committee report to the Board of Directors

| | |
|---|---|
| **Committee Name:** | Audit Committee |
| **Committee Chair:** | Chris Thompson |
| **Date of last meeting:** | Thursday 28th January 2016 |
| **Date of Board meeting for which this report is prepared** | Wednesday 24th February 2016 |

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

1. The Committee considered a number of minor changes to the Trust accounting policies to reflect certain requirements specified by the centre. The Trust is not proposing to make any substantive changes this year although following the implementation of Financial Reporting Standard 102, there will be some changes required to the way in which investment gains and losses incurred by the Charitable Trust are reflected in the HDFT Group financial statements.
2. The detailed year end accounting and reporting timetable was reviewed and approved by the Committee.
3. Following discussion of the latest Internal Audit Periodic Update Report, the Committee has asked to be kept informed of progress made in the following areas:
    a. Improving the controls around the charging and collection of income from overseas patients (circa £30k to £50k per annum)
    b. Patient Access Policy – improving the controls around processing details for those patients who do not attend or cancel scheduled appointments
    c. Resilience of IT capabilities.
4. The annual review of the effectiveness of Internal Audit was considered. The conclusion of the Committee was that IA do operate in a cost effective and efficient manner, but it was disappointed by the relatively low number of responses received from auditees. It was agreed that for next year's survey the number of questions would be reduced and more time would be allowed for responses.
5. KPMG presented their proposals for the 2015/16 external audit. Their fee proposal of £55k (2015 - £57.5k) was agreed. There was a very useful discussion around KPMG's analysis of consistent weaknesses noted at failing NHS FT's – these include the following:
    a. Lack of discipline around the completion of account reconciliations
    b. Weak controls around segregation of duties and approval of journals
    c. Inadequate purchasing controls
    d. Ineffective CIP governance and challenge
    e. Lack of understanding around underlying cash flows

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

There were no new risks identified and discussed by the Committee which are to be brought

to the attention of the Board. The Committee did welcome a discussion around the clarification of the risk registers held at departmental, directorate, corporate and strategic levels.

## Matters for decision

There are no matters that require a decision to be taken by the Board

## Action Required by Board of Directors:

No specific actions identified.

Harrogate and District NHS
NHS Foundation Trust

# Council of Governors

Minutes of the public Council of Governors' meeting held on 4 November 2015 at 17:45 hrs at St. Aidan's Church of England High School, Oatlands Drive, Harrogate.

**Present:**

Mrs Sandra Dodson, Chairman
Ms Pamela Allen, Public Governor
Mr Michael Armitage, Public Governor
Cllr. Bernard Bateman, Stakeholder Governor
Dr Sally Blackburn, Public Governor
Mrs Cath Clelland, Public Governor
Mrs Angie Colvin, Corporate Affairs and Membership Manager
Mr Jonathan Coulter, Director of Finance/Deputy Chief Executive
Mrs Emma Edgar, Staff Governor
Mrs Jill Foster, Chief Nurse
Mrs Jane Hare, Public Governor
Mr Robert Harrison, Chief Operating Officer
Mrs Jane Hedley, Public Governor
Mrs Sally Margerison, Staff Governor
Mr Peter Pearson, Public Governor
Prof. Sue Proctor, Non-Executive Director
Mrs Joyce Purkis, Public Governor
Dr Daniel Scott, Staff Governor
Mrs Maureen Taylor, Non-Executive Director
Mrs Lesley Webster, Non-Executive Director
Rev. Dr Mervyn Willshaw, Public Governor/Deputy Chair of Council of Governors
Mrs Fiona Wilson, Staff Governor
Dr Jim Woods, Stakeholder Governor

**In attendance:** 8 members of the public

## 1. Apologies for absence and introductions

Apologies were received from Mrs Carol Cheesebrough, Staff Governor, Dr Sarah Crawshaw, Stakeholder Governor, Mrs Liz Dean, Public Governor, Cllr John Ennis, Stakeholder Governor, Mr Andrew Forsyth, Interim Head of Corporate Affairs, Mrs Pat Jones, Public Governor, Mr Phillip Marshall, Director of Workforce and Organisational Development, Mr Neil McLean, Non-Executive Director, Mrs Joanna Parker, Stakeholder Governor, Mr Andy Robertson, Public Governor, Dr David Scullion, Medical Director, Mr Chris Thompson, Non-Executive Director, Dr Ros Tolcher, Chief Executive, Mr Ian Ward, Non-Executive Director and Mr Paul Widdowfield, Communications and Marketing Manager.

Mrs Dodson offered a warm welcome to the members of the public. She welcomed questions for item 9 on the agenda and asked for these to be submitted during the break.

Mrs Dodson commented that some members of staff would be using BoardPad during the meeting; an electronic meeting and document system as opposed to hard copy papers.

## 2. Minutes of the last meeting, 29 July 2015

The minutes of the last meeting were agreed as a true and accurate record subject to the following amendments:

A minor spelling error on page 2, item 2, fifth paragraph - amend an to and.

Page 8, item 6, seventh paragraph – amend salaried to salaries.

## 3. Matters arising and review of actions schedule

Mrs Dodson went through the outstanding actions on the schedule at Paper 3.0.

Item 1, Governors continued to be invited to consultant interview presentations.

Items 2 and 3 would be covered during the meeting.

Item 4, Mrs Colvin had circulated a copy of the Non-Executive Directors' updated objectives to all Governors.

Mrs Wilson asked for a further update in relation to the gynaecological oncology service at the Sir Robert Ogden Macmillan Centre. Mr Harrison responded, confirming that the Trust was unsuccessful in recruiting a Consultant Oncologist in Gynaecology and the way forward now was to work in partnership with York Teaching Hospital with the hope that a joint post would prove more attractive. Discussions were currently underway and it was hoped that the post would be advertised as soon as possible.

### 3.1 Update on Non-Executive Director 360 degree feedback pilot

Mrs Dodson provided an update on Non-Executive Director 360 degree feedback; a pilot commissioned by Health Education Yorkshire and the Humber to develop an innovative 360 degree feedback approach to support leadership development for Non-Executive Directors. This was progressing well and meetings were being set up between Non-Executive Directors and key people, including Governors, who would act as responders.

## 4. Declaration of interests

There were no declarations of interests received.

### 4.1 Council of Governors' Declaration of Interests

Mrs Dodson reminded Governors that they would be asked to sign a Declaration of Interest form on an annual basis but that the overall summary would be brought to each quarterly Council of Governor meeting as a standard item on the agenda. Governors were reminded that it was the

obligation of each individual Governor to inform the Trust in writing within seven days of becoming aware of the existence of a relevant or material interest.

## 5. Chairman's verbal update on key issues

Mrs Dodson confirmed that Mrs Dow, Deputy Director of Corporate Affairs, had elected to retire and had therefore stepped down from her role. On behalf of the Executive Team and the Council of Governors, Mrs Dodson commented that Mrs Dow would be missed and wished her well for the future. Mrs Dow would be attending the annual dinner with Governors in December. An advert for a new Company Secretary would be progressed and a Governor would be asked to participate in the appointment process.

In addition, Mrs Dodson also confirmed that Mrs Jane Farquharson, Stakeholder Governor representing the Voluntary Sector, had stepped down from her role as Governor due to other commitments. Mrs Dodson would now get in touch with Karen Weaver, Chief Executive of Harrogate and Ripon Centres for Voluntary Service to discuss a replacement as soon as possible.

## 6. Governor sub-committees

Mrs Dodson clarified the role of the two formal sub committees and the Patient and Public Involvement, Learning from Patient Experience Group and thanked Governors for their commitment and involvement.

### 6.1 Volunteering and Education

The report from the Volunteering and Education Governor Working Group, now chaired by Mrs Jane Hedley, had been circulated prior to the meeting and was taken as read.

Mrs Hedley highlighted the continued commitment of our volunteers and congratulated Mrs Fiona Tomlinson, Volunteer Co-ordinator. She reminded Governors about the Volunteers' Tea Party on Friday 18 December.

Mrs Hedley was delighted to report that the Corporate Secretarial team had made great progress with both the Education Liaison and Work Experience Programmes. Mr Neil McLean, Non-Executive Director, had joined the group and his experience in education would be most welcome.

Finally, Mrs Hedley thanked Rev. Dr Mervyn Willshaw for chairing the group for three years.

Mrs Dodson echoed Mrs Hedley's thanks to Rev. Dr Willshaw for his contribution and commitment to the group and also congratulated two volunteers who had recently won awards at the 2015 Harrogate and District Volunteering Oscars. Ann Burrell, who volunteers with her pat dogs, won the Care Volunteer of the Year and Carolyn Rothwell, who volunteers as a gardener won Wildlife Volunteer of the Year.

There were no questions for Mrs Hedley.

### 6.2 Membership Development and Communications

The report from the Membership Development and Communications Governor Working Group, chaired by Ms Allen, had been circulated prior to the meeting and was taken as read.

Ms Allen commented that it had been a busy autumn for Governors and members with the Medicine for Members event, Annual Members' Meeting, Open Event and the additional briefing meetings to inform members interested in the Governor Elections.

Ms Allen highlighted the Annual Members' Meeting, from her report, held on 3 September at the Pavilions of Harrogate. She was pleased to report that the event had been a huge success. The change in both format and venue provided the Trust with the opportunity to actively engage with key stakeholders including Harrogate and Rural District Clinical Commissioning Group, members and the general public. Feedback from participants was positive and the 'cabaret-style' seating promoted lively and enthusiastic discussions.

There were no questions for Ms Allen.

### 6.3 Patient and Public Involvement

The report from Mrs Purkis, on the last two meetings of the Learning from Patient Experience Group, had been circulated prior to the meeting and was taken as read.

Mrs Purkis highlighted the new style Patient Experience and Incident Report (Quarter 1, 2015/16) which had been submitted to the Group. This report included information from the 4C's – compliments, complaints, concerns and comments as well as Friends and Family Test, social media and internal incident data.

Mrs Dodson reiterated the importance of the Learning from Patient Experience Group and how valuable their role was in understanding, monitoring, challenging and seeking to improve the quality of experience of the Trust's service users.

There were no questions for Mrs Purkis.

## 7. Review of the effectiveness of Quality of Care Teams

Following feedback from a number of Governors on their experience with Quality of Care Teams in a variety of wards and departments, Mrs Foster provided an update on a review of the effectiveness of the Quality of Care Team model.

Mrs Foster confirmed that the results of the review demonstrated variability in the Quality of Care Teams across the organisation with some working extremely well and others not so well. Whilst Mrs Foster was pleased to report that good practice had been identified such as conference call meetings, the review had demonstrated some concerns and these were detailed in her paper.

The review findings had been discussed and actions agreed at Senior Management Team (SMT) on 21 October. A further update, with the results of these actions, would be reported back to SMT in December and brought back to Governors in February 2016.

***Action: Mrs Foster***

Mrs Hare stated that she had raised a concern previously regarding the fact that the Quality of Care Team she was assigned to had not had medical representation at a meeting in over three years. She asked if the Medical Director had been consulted as part of the review as this was not reflected in the paper.

Mrs Foster confirmed that this was an oversight and Dr Scullion was aware of the expectations of medical representation at the Quality of Care team meetings.

Rev. Dr Willshaw commented that he was assigned to the Quality of Care Team for the Sir Robert Ogden Macmillan Centre and he was pleased to report medical representation at those meetings. It was suggested that the Trust objectives and quality improvement priorities, referred to on page 2 of the paper, could be included in the Quality of Care Team Terms of Reference and agenda templates. Mrs Colvin would pass this information to Dr Wood to consider.

***Action: Mrs Colvin***

Mrs Purkis was also happy to inform colleagues that she was assigned to the Quality of Care Team for Emergency Department and this meeting was both chaired and represented well by medics.

In Mrs Jones's absence, Mrs Dodson confirmed that the Quality of Care Team for Woodlands Ward was also chaired by a medic.

Dr Blackburn was assigned to the community Health Visitors and School Nursing Quality of Care Team and reported that the team did not have any GP representation but she praised the efficiency of the team.

In response to a comment made by Dr Scott regarding the list of Quality of Care Teams specified in the paper, Mr Coulter confirmed that this list demonstrated where current Governors were assigned; there was in fact many other Quality of Care Teams across the Trust, both in the hospital and in community teams.

Mrs Dodson confirmed that Governors would receive a further update in the New Year.

**8. Update from the Chief Executive, including the Integrated Board Report**

In Dr Tolcher's absence, Mr Coulter, Deputy Chief Executive presented the following headlines:

<u>Current issues</u>

Mr Coulter highlighted current issues including: the Trust's Vision and Mission and how these linked to the strategic objectives, an update on the work towards new models of care, Ripon developments, ongoing business developments, quality, finance and performance and external reviews.

Vision, Mission and Objectives

Mr Coulter presented the Trust's draft Vision and Mission statements which were still being finalised:

Vision – To provide excellent healthcare every time.

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

The Vision and Mission linked to the Trust's three strategic objectives to deliver high quality care, work with partners to deliver integrated care and ensure clinical and financial sustainability.

Once finalised, the Vision and Mission statements would be launched across the organisation and would complement the staff values, objectives and goals.

New Care Model – a reminder

Mr Coulter presented two slides that Dr Tolcher had talked about in July reminding Governors about the two key strands of the New Care Model: new models of prevention and care – 'what we do' and enabling better care – 'how we do it', focussing on people being at the centre of the health and care system.

Progress update

Mr Coulter then went on to provide an update on progress confirming that the 'Value Proposition', setting out the resources required and the outcomes we would deliver in order to access the national transformation fund, had been submitted and approved. Funding had been agreed and this would be broken down over three years in order to implement new ways of working. Pilot schemes in Knaresborough and Boroughbridge were going ahead and recruitment for staff was underway. Work continued on support and infrastructure including IT, organisational development, contracts and pricing.

New Models of Care: key challenges

Partners continued to work together towards New Models of Care and Mr Coulter described some of the key challenges facing the health community in order to become self-sustainable after three years.

Ripon development

Mr Coulter reminded Governors that a number of partners were involved in the Ripon development including Harrogate and Rural District Clinical Commissioning Group, Harrogate and District NHS Foundation Trust, Harrogate Borough Council, North Yorkshire County Council, GPs and the voluntary sector. This project went hand in hand with New Models of Care to include a fit for purpose hospital and enhanced leisure facilities, all of which would aim to provide the best support for local people. A business case would be submitted to NHS England for outline approval in spring 2016 and Governors would continue to receive updates.

Business development

Mr Coulter explained how the business development supported the organisation's strategic objectives: improving quality, working with partners and, clinical and financial sustainability. He provided examples of each including, new alliances with Leeds Teaching Hospitals to support existing alliances with York Teaching Hospital NHS Foundation Trust and Airedale NHS Foundation Trust. The Trust was currently providing services in North and West Leeds and continuing to look at expanding the service catchment area and providing more services near the patient's home. Mr Coulter was pleased to report that the Trust had been awarded the contract to deliver children's services in Middlesbrough, a contract worth £35m over ten years, starting on 1 April 2016. Other bids were underway and Governors would be kept informed. Other news was that the Trust had not retained the Smoking Cessation service and staff were currently being supported in transferring to a different provider.

Quality Finance and Performance

Mr Coulter provided an overview of the Integrated Board Report highlighting data on falls, infection control, finance and performance. There had been a significant improvement over the last year in falls causing harm however, work was ongoing and the data continued to be closely monitored. The Trust's C. difficile infection target, set by The Department of Health for 2015/16, was 12 cases and we had recorded 16 cases up to the end of September. We were obliged to carry out a Root Cause Analysis on all our cases and discuss them with Harrogate and Rural District Clinical Commissioning Group. From the cases discussed so far, the CCG had agreed with us that there were only two cases in which a "lapse in care" had caused or contributed to the case.

Moving on to an overview of the financial position at the end of September, Mr Coulter confirmed we were £1.4m behind our plan and key areas of overspend continued to be ward nursing and medical staffing. Teams continued to work hard to maintain quality and safety whilst delivering the cost improvement programme.

Mr Coulter was pleased to report that the Trust was performing well against all the national performance standards however, the Trust's A&E 4 hour standard for September was 94.8%, below the required 95%. This had also been the case for October and therefore Mr Coulter confirmed that actions were being taken to rectify this. Focus continued on further improvements through the winter period, financial recovery and strengthened staffing levels, in particular on Woodlands Ward (Children's), Emergency Department, Therapists and acute medical wards.

Finally, Mr Coulter presented a slide on the various methods of assurance from the Care Quality Commission (CQC), Monitor, Staff and Patients. He highlighted that the CQC would be inspecting the Trust between 2 and 5 February 2016 and inspectors would be talking to patients, staff and Governors during their visit. Mr Coulter also confirmed that the Board had recently commissioned an outside company, Deloitte, to undertake an independent review of governance arrangements at the Trust against Monitor's Well-led Framework. This would include a review of Board papers and interviews with senior members of staff; Governors would also be asked to take part in the interview process. Deloitte would provide the Trust with a report following their review in mid-December. The Trust continued to receive valuable data from the Friends and Family and Staff Surveys as well as ongoing patient surveys, complaints and compliments.

At this stage in the meeting Mr Coulter invited Governors to ask questions about the Integrated Board Report.

Cllr Bateman stated that North Yorkshire County Council had invested in IT with the police and fire service doing the same and asked for further information regarding IT investment in healthcare. Mr Harrison confirmed there was ongoing IT investment and all partners were involved in the New Models of Care IT project group. The Trust retained its own IT strategy however, this would complement developments made through New Models of Care including appropriate shared access to patient records.

In answer to Cllr Bateman's second question regarding issues of bed blocking and costs related to this, Mr Harrison explained that the issue was often delayed transfer of care as opposed to bed blocking; namely Local Authority delays, patients being transferred within the NHS for continuing care and patient choice. The ability to get care packages in place and a reduction in the provision of home care had an impact on Trust community staff, who were supporting an ever increasing number of patients. New Models of Care and partnership working would aim to improve these issues. Mr Harrison added that a significant number of the delays were patients from Leeds due to ongoing issues with Leeds City Council.

Cllr Bateman commented about discharge communication and Mr Harrison was pleased to report that a significant amount of work was ongoing including a pilot on two wards where the pharmacist would be supporting the junior doctor with the patient discharge documentation.

Mr Ward provided assurance that following the scheduled Governor and Non-Executive Director meetings, any issues raised by Governors were discussed with the Board via a number of committees.

In response to Mrs Edgar's question about nurse vacancies, Mrs Foster confirmed that the Trust continued to actively promote vacancies and another recruitment event was taking place the following week. The last recruitment event, which took place on the same day as the Trust's Open Event on 24 September, had been a huge success with ten job offers to Registered Nurses and ten job offers to Healthcare Workers.

Mrs Hare asked how Non-Executive Directors were receiving assurance regarding the recurrent overspend on medical staffing and delivery of the cost improvement programme and asked, was the Trust setting the cost improvement programme too high to achieve.

Mrs Dodson confirmed that Non-Executive Directors were focussed on the cost improvement programme and asked Mrs Taylor to respond to this question under item 10.1 on the agenda.

Mr Coulter reiterated the ongoing financial challenge and confirmed that recovery actions were in progress however, the cost improvement programme was set as part of the annual planning cycle in order to make the necessary savings required year on year.

Mrs Clelland commented on the ongoing financial challenges and asked how this impacted on capital investments going forward over the next five years.

Mr Coulter confirmed that the Trust had a five year annual planning strategy and Governors were invited to meet on a regular basis with the Deputy Director of Planning and the Deputy Finance Director to discuss the finer detail of the Annual Plan. As part of the strategy, the Trust was looking at new endoscopy unit facilities and a second MRI scanner however, there was a need to deliver the efficiency programme in order to achieve these improvements.

Mrs Dodson moved to the tabled questions submitted during the break and prior to the meeting.

**9. Q&A session for members of the public and Governors**

**Mr Doveston, member of the public, submitted the following question:**

**"The NHS is renowned for poor standards of IT support, development and delivery. There are so many agencies in the loop; who is responsible for managing the implementation across the NHS?"**

Mr Harrison talked about both national and local healthcare IT systems and agreed that not all had been successful. Historically, the Trust had developed IT systems with the best supplier at the time however, going forward, work was underway and systems were being reviewed to work towards a collaborative approach and integrated IT. A site visit would take place in late November in order to work towards providing clinical solutions with appropriate and affordable IT and there was good sign-up from partners to work towards joint primary and secondary care records.

**Mrs Edgar, Staff Governor, submitted the following question:**

**"To what extent are Non-Executive Directors confident that the Trust Board can deliver New Models of care in the context of the current financial, staffing and service delivery pressures facing HDFT and the tight timescale set by NHS England?"**

Mrs Dodson commented that it was important to recognise the challenges ahead in order to deliver high quality care within the financial envelope. There was still a lot of work to do, but Mrs Dodson confirmed that she was assured in the Board's ability and the commitment of our partners to drive the project forward.

Mrs Webster reiterated the challenges of an ageing population and the need for change. She felt confident with ongoing discussions, particularly in terms of funding, staffing and IT and acknowledged the attendance of representatives from Harrogate and Rural District Clinical Commissioning Group (HaRD CCG) at the Trust's Annual Members' Meeting.

Prof. Proctor added how much the focus of Board discussions had changed in the last couple of years; the focus was much more on forward thinking with staff and public engagement. She acknowledged the commitment of Executive Directors in driving forward 'tomorrow's issues' and recognising financial risks which needed to be managed effectively.

Mr Coulter also stated that the Vanguard status provided the best opportunity going forward with New Models of Care and how much harder this would be without the support from the CCG and key partners.

**Mr Robertson, Public Governor, had submitted the following question:**

**"There has been recent national press coverage of WHSmith's charging policy at its hospital sites. Given that WHSmith operates on the Harrogate Hospital site, can Governors please be updated on what action the Trust has taken in relation to the issue and whether there is any feedback from WHSmith to the report."**

Mr Coulter confirmed that the Trust had written a letter to WHSmith following the national press coverage referred to in Mr Robertson's question. A response had been received and WHSmith wanted to reassure us that the vast majority of their products were actually the same price in both hospital and high street stores. This included all newspapers, magazines, books and stationery. For food and drinks, where prices may be different, they were very similar and often slightly cheaper in hospitals, reflecting the different sales mix and the resulting promotional approach which was designed to deliver best value to the customer. Going forward, WHSmith added that any high street stationery promotions would always be available in hospital stores and they would continue to monitor average selling prices across all ranges to ensure they remain aligned. They would also be introducing a new range of value greeting cards into their hospital stores.

**Mrs Hedley, Public Governor, submitted the following question:**

**"On behalf of the Patient Voice Group, having heard of several examples of patient's welfare being undermined by noisy and disruptive patients on the wards, could the Chief Nurse outline the procedure for dealing with this problem?"**

Mrs Foster thanked Mrs Hedley for her question and acknowledged the issues raised in relation to noise on the wards at night. She commented that it would not be possible to eliminate all the noise at night and highlighted a variety of reasons why patients could disturb others on the ward, including:

- Acute delirium;
- Cognitive deficit, eg Alzheimer's/Dementia, patients were in a strange place and were sometimes frightened;
- Patients with learning difficulties; and,
- Patients with a mental illness requiring physical care.

Mrs Foster confirmed that ward staff tried to do their best for everyone concerned with a number of solutions including, and where possible and safe to do so, treating the patient as quickly as possible, having their family, friend or carer present who would be a familiar face, using side rooms, however due to competing priorities for infection control or end of life care, this was not always possible. Ear plugs would also be available on the wards.

**Mrs Clelland, Public Governor, submitted the following question:**

**"How can we, the Governors and the Trust, be assured that Choose and Book is fit for purpose? I would like to request that the system is reviewed by those responsible/involved to ensure that the Choose and Book system is appropriate, efficient and cost effective for patient and the services provided by the Trust."**

Mrs Dodson confirmed that Choose and Book was a national system and not a local system, but asked Mr Harrison to respond.

Mr Harrison confirmed that the NHS e-Referral Service had replaced Choose and Book in June. He confirmed that when a patient sees a GP and is referred for an appointment with a healthcare provider, the patient is able to book their appointment and choose the date and time via this system. The GP may be able to book the appointment there and then with the patient or the patient can book the appointment at a later stage. The patient would be given an appointment request letter which includes a unique booking reference number and a list of hospitals or clinics to choose from. In addition, the patient would be given a password which would allow the booking to be made via the NHS e-Referral Service either by logging into NHS e-Referral Service online or over the phone using the appointment line.

Mr Harrison explained that outpatient slots were available through the system and this worked well where the capacity matched demand however, if demand was high, or where a speciality had a higher waiting time, the booking may not be able to be made online.

The Trust had a high number of patients using the e-Referral Service, a cost effective service which for the vast majority of patients worked well. Mr Harrison acknowledged the frustration that some patients had experienced, but reassured Governors that this was a small number and the Trust continued to work hard to add capacity to the system.

**Mr Pearson, Public Governor, submitted the following question:**

**"I have received expressions of concern about the state of District Nursing in the Ripon area (although it may have wider relevance). I was informed that changes in work patterns have led to nurses being required to make up to twenty visits a day, and in certain cases, work 8am to 8pm; that this is causing stress and absence through sickness and also that staff are considering resigning."**

Mrs Dodson thanked Mr Pearson for his question stating the importance of staff welfare and asked Mrs Foster to respond.

Mrs Foster acknowledged that teams were under pressure across all areas with an increase in community adult services activity. There had been a change in some shift patterns, working long shifts 8am – 8pm which could involve up to 20 visits per shift however, Mrs Foster assured Governors that these shifts were not compulsory and work patterns were to be determined. This period was unsettling for staff where potentially, through New Models of Care, there could be changes to their service and job role. Staff were kept regularly up to date via their team leaders and there would be no risk to any ones job.

Mrs Dodson reassured Governors that staff turnover was monitored and tracked at Board level.

**Dr Scott, Staff Governor, submitted the following question:**

**"In South Yorkshire an innovative alliance with the Fire Service is underway. The intention is to share skills in supporting vulnerable people in the community. As part of the Vanguard project have we explored partnering with services outside of traditional health and social care providers?"**

Mr Harrison confirmed that we were not as advanced as South Yorkshire however he was pleased to report that the voluntary sector was heavily involved as part of the Vanguard project. Discussions were taking place with Harrogate Borough Council, the Police and other agencies regarding support for people to access different services.

Cllr Bateman confirmed he was a member of the Fire Authority and was happy to help if needed.

## 10. Non-Executive Directors update including time for discussion

### 10.1 Update on the Finance Committee

Mrs Taylor, Chair of the Finance Committee, provided an overview of the Committee including the key duties which involved scrutinising the Trust's strategic financial plan. The Committee reports to the Board of Directors and Audit Committee and meet quarterly in line with Monitor external reporting requirements. Extra meetings had been scheduled in February and March 2016 in line with the planning timetable. Further to Mrs Hare's question earlier in the meeting, Mrs Taylor assured Governors that the Committee had recently scrutinised the annual Cost Improvement Programme and agreed that an ambitious programme was required in order to deliver the financial plan whilst ensuring that high quality of care continued to be maintained. Mrs Taylor also highlighted other areas of discussion from the last meeting which had focused on financial arrangements for repair or replacement of equipment and an area of concern raised by Governors regarding the condition of community premises. Following this discussion, the Committee felt a Patient Safety Visit should be carried out to look into the areas of concern.

Mr Coulter reiterated the huge financial challenge for the organisation and Mrs Dodson confirmed that it was both her and Dr Tolcher's view that the organisation would achieve a surplus by the end of the financial year.

There were no more questions for Non-Executive Directors and Mrs Dodson moved on to any other business.

## 11. Any other business

### 11.1 Council of Governor Elections 2015 update

Mrs Colvin provided an update regarding the Council of Governor Elections. The nominations had closed on Monday 2 November and the following number of nominations had been received:

- four nominations for the two Public Governor seats representing Harrogate and surrounding villages;
- one nomination for the Public Governor seat representing Knaresborough and East District;
- two nominations for the Staff Governor representing Medical Practitioners;
- three nominations for the Staff Governor representing Other Clinical; and,
- three nominations for the Staff Governor representing Non-Clinical.

The final date for candidate withdrawal was Thursday 5 November. Voting packs would be despatched on Tuesday 24 November with the close of election on Thursday 17 December. Mrs Colvin was pleased with the number of members interested in the elections and the number of nominations received.

Mrs Dodson thanked the Governors who would be leaving the Council at the end of the year. Mrs Cheesebrough, Staff Governor, Non-Clinical and Mrs Hare, Public Governor, Knaresborough and East District had both come to the end of their first term of office. Rev. Dr Willshaw, Public Governor, Harrogate and surrounding villages and also Deputy Chair and Lead Governor had served six years and Mrs Dodson thanked him for his dedication, hard work and support. Finally, Mrs Dodson thanked Mrs Wilson, Staff Governor, Other Clinical who had served for the maximum of nine years stating that she was a role model for all other Governors.

**11.2 Calendar of meetings 2016**

Mrs Colvin circulated the meeting dates for 2016.

**12. Date and time of next meeting**

Mrs Dodson thanked everyone for attending and confirmed the next meeting would take place on Saturday 6 February 2016 at 10.45 am at St. Aidan's High School in Harrogate.

This page has been left blank