

**The meeting of the Board of Directors held in public will take place on  
 Wednesday 30 November 2016 in the Derwent Room, The Pavilions, Great  
 Yorkshire Showground, Harrogate, HG2 8NZ**

**Start: 8.30am      Finish: 12.15pm**

AGENDA			
Item No.	Item	Lead	Paper No.
<b>8.30am Patient Story – IN PRIVATE</b>			
<b>9.00am – 11.00am</b>			
	<b>Infection Prevention and Control update</b>	Dr J Child, Director of Infection Prevention and Control	-
<b>1.0</b>	<b>Welcome and Apologies for Absence</b> <i>To receive any apologies for absence</i>	Mrs S Dodson, Chairman	-
<b>2.0</b>	<b>Declarations of Interest and Register of Interests</b> <i>To declare any interests relevant to the agenda and to receive any changes to the register of interests</i>	Mrs S Dodson, Chairman	2.0
<b>3.0</b>	<b>Minutes of the Board of Directors meeting held on 26 October 2016</b> <i>To review and approve the minutes</i>	Mrs S Dodson, Chairman	3.0
<b>4.0</b>	<b>Review Action Log and Matters Arising</b> <i>To provide updates on progress of actions</i> 4.1 <i>Update on Community Services KPIs</i>	Mrs S Dodson, Chairman Dr N Lyth, Clinical Director	4.0 4.1
	<b>Overview by the Chairman</b>	Mrs S Dodson, Chairman	-
<b>5.0</b>	<b>West Yorkshire and Harrogate Sustainability and Transformation Plan (WYHSTP)</b> <i>To receive the plan for comment</i>	Dr R Tolcher, Chief Executive	5.0
<b>6.0</b>	<b>Report by the Chief Executive</b> <i>To receive the report for comment</i>	Dr R Tolcher, Chief Executive	6.0
<b>7.0</b>	<b>Integrated Board Report</b> <i>To receive the report for comment</i>	Dr R Tolcher, Chief Executive	7.0
<b>8.0</b>	<b>Report by the Finance Director</b> <i>To receive the report for comment</i>	Mr J Coulter, Deputy Chief Executive/ Finance Director	8.0
<b>8.1</b>	<b>Operational Planning 2017/18 and 2018/19 update</b> <i>To receive the report for comment</i>	Mr J Coulter, Deputy Chief Executive/ Finance Director	8.1
<b>9.0</b>	<b>Report from the Chief Operating Officer</b> <i>To receive the report for comment</i>	Mr R Harrison, Chief Operating Officer	9.0

<b>11.00am – 11.10am – Break</b>			
<b>11.10am – 12.15pm</b>			
<b>10.0</b>	<b>Clinical Workforce Strategy</b> <i>To <b>approve</b> the strategy</i>	Mr P Marshall, Director of Workforce and Organisational Development	10.0
<b>11.0</b>	<b>Report from the Chief Nurse (incl. the Trust's response to the Wood Report)</b> <i>To receive the report for comment</i>	Mrs J Foster, Chief Nurse	11.0
<b>11.1</b>	<b>Bi-annual Safe Staffing Acuity Tool</b> <i>To receive the report for comment</i>	Mrs J Foster, Chief Nurse	11.1
<b>12.0</b>	<b>Report from the Medical Director</b> <i>To be considered for comment</i>	Dr D Scullion, Medical Director	12.0
<b>13.0</b>	<b>Report by the Director of Workforce and Organisational Development</b> <i>To receive the report for comment and <b>approve</b> the NHS Improvement checklist for use of agency and locum staff</i>	Mr P Marshall, Director of Workforce & Organisational Development	13.0
<b>14.0</b>	<b>Oral Reports from Directorates</b> 14.1 Children's and County Wide Community Care 14.2 Long Term and Unscheduled Care 14.3 Planned and Surgical Care	Dr N Lyth, Clinical Director Mr A Alldred, Clinical Director Dr K Johnson, Clinical Director	- - -
<b>15.0</b>	<b>Committee Chair Reports</b> <i>To receive the report from the Quality Committee meeting held 2 November 2016</i>	Mrs L Webster, Non-Executive Director/ Quality Committee Chair	15.1
<b>16.0</b>	<b>Council of Governor meeting 3 August 2016</b> <i>To receive the minutes for information</i>	Mrs S Dodson, Chairman	16.0
<b>17.0</b>	<b>Other matters relating to compliance with the Trust's Licence or other exceptional items to report, including issues reported to the Regulators</b> <i>To receive an update on any matters of compliance:</i> 17.1 Well Led Review Action Plan Update	Mrs S Dodson, Chairman	17.1
<b>18.0</b>	<b>Any other relevant business not included on the agenda</b> <i>By permission of the Chairman</i>	Mrs S Dodson, Chairman	-
	<b>Board Evaluation</b>	Mrs S Dodson, Chairman	-
<b>Confidential Motion – the Chairman to move:</b> <i>Members of the public and representatives of the press to be excluded from the remainder of the meeting due to the confidential nature of business to be transacted, publicly on which would be prejudicial to the public interest.</i>			

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

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

The register is maintained by the Foundation Trust Office.

<b>Name</b>	<b>Position</b>	<b>Interests Declared</b>
Mrs Sandra Dodson	Chairman	<ol style="list-style-type: none"> <li>1. Partner in Oakgate Consultants</li> <li>2. Trustee of Masiphumelele Trust Ltd (a charity raising funds for a South African Township)</li> <li>3. Trustee of Yorkshire Cancer Research</li> <li>4. Chair of Red Kite Learning Trust – multi-academy Trust</li> </ol>
Dr Ros Tolcher	Chief Executive	<ol style="list-style-type: none"> <li>1. Specialist Adviser to the Care Quality Commission</li> <li>2. Member of NHS Employers Policy Board</li> </ol>
Mr Jonathan Coulter	Deputy Chief Executive/ Finance Director	None
Mrs Jill Foster	Chief Nurse	None
Mr Robert Harrison	Chief Operating Officer	<ol style="list-style-type: none"> <li>1. Appointed Voluntary Member of the Strategy and Resources Committee of the Methodist Church</li> <li>2. Charity Trustee of Acomb Methodist Church, York</li> </ol>
Mr Phillip Marshall	Director of Workforce and Organisational Development	<ol style="list-style-type: none"> <li>1. Member of the Local Education and Training Board (LETB) for the North</li> </ol>
Mr Neil McLean	Non-Executive Director	Director of: - Northern Consortium UK Limited (Chairman) - Ahead Partnership (Holdings) Limited - Ahead Partnership Limited - Swinsty Fold Management Company Limited - Acumen for Enterprise Limited - Yorkshire Campaign Board Chair Maggie's Cancer Caring Centres Limited
Professor Sue Proctor	Non-Executive Director	<ol style="list-style-type: none"> <li>1. Director and owner of SR Proctor Consulting Ltd</li> <li>2. Chair, Safeguarding Board, Diocese of York</li> <li>3. Member – Council of NHS Staff College (UCLH)</li> <li>4. Associate – Good Governance Institute</li> <li>5. Associate – Capsticks</li> </ol>
Dr David Scullion	Medical Director	<ol style="list-style-type: none"> <li>1. Member of the Yorkshire Radiology Group</li> </ol>

Mrs Maureen Taylor	Non-Executive Director	None
Mr Christopher Thompson	Non-Executive Director	1. Director – Neville Holt Opera 2. Member – Council of the University of York
Mr Ian Ward	Non-Executive Director	1. Vice Chairman and Senior Independent Director of Charter Court Financial Services Limited, Charter Court Financial Services Group Limited, Exact Mortgage Experts Limited, Broadlands Financial Limited and Charter Mortgages Limited 2. Chairman of the Board Risk Committee and a member of the Remuneration and Nominations Committee, the Audit Committee and the Funding Contingent Committee for the organisations shown at 1 above 3. Director of Newcastle Building Society, and of its wholly owned subsidiary IT company – Newcastle Systems Management Limited 4. Member, Leeds Kirkgate Market Management Board
Mrs Lesley Webster	Non-Executive Director	None
Mr Andrew Alldred	Clinical Director UCCC	None
Dr Kat Johnson	Clinical Director EC	None
Dr Natalie Lyth	Clinical Director IC	None
Dr David Earl	Deputy Medical Director	1. Private anaesthetic work at BMI Duchy hospital
Dr Claire Hall	Deputy Medical Director	1. Trustee, St Michael's Hospice Harrogate
Mrs Joanne Harrison	Deputy Director W & OD	None
Mr Jordan McKie	Deputy Director	1. Familial relationship with NMU Ltd, a company providing services to the NHS
Mrs Alison Mayfield	Deputy Chief Nurse	None
Mr Paul Nicholas	Deputy Director Performance and Infomatics	None

**November 2016**

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

Minutes of the Board of Directors meeting held in public on Wednesday 26 October 2016  
8.30am in the Boardroom, Trust Headquarters, Harrogate District Hospital

**Present:** Mrs Sandra Dodson, Chairman  
Dr Ros Tolcher, Chief Executive  
Mr Jonathan Coulter, Deputy Chief Executive/Finance Director  
Mr Rob Harrison, Chief Operating Officer  
Mrs Jill Foster, Chief Nurse  
Mr Phillip Marshall, Director of Workforce and Organisational Development  
Professor Sue Proctor, Non-Executive Director  
Mr Neil McLean, Non-Executive Director  
Mr Chris Thompson, Non-Executive Director  
Mr Ian Ward, Non-Executive Director  
Mrs Lesley Webster, Non-Executive Director  
Mrs Maureen Taylor, Non-Executive Director

**In attendance:** Ms Debbie Henderson, Company Secretary  
Mr Andrew Alldred, Clinical Director for Long Term and Unscheduled Care  
Dr Natalie Lyth, Clinical Director for Children's and County Wide Community Services  
Dr Claire Hall, Deputy Medical Director (*deputising for Dr Scullion*)  
Dr Chunda Sri-Chandana, Deputy Clinical Director for Planned and Surgical Care (*deputising for Dr Johnson, Clinical Director*)  
Mr Jordan McKie, Deputy Finance Director (*for Board briefing only*)  
Patient X – *Patient Story*

**Patient Story**

Patient X attended the Board in the private session to share his experience following treatment in Harrogate District Hospital. Patient X's recent complaint largely focused on lack of communication, the impact of the lack of continuity in terms of different people delivering his care and treatment, but more importantly, not being informed of any changes during his time as a patient, and issues of poor discharge planning.

On behalf of the Board, Mrs Dodson and Dr Tolcher had thanked the patient for sharing his experience and a range of actions were identified to address some of the issues raised.

**Board Briefing – Clinical Transformation Board**

Mr McKie delivered a presentation to the Board on progress of the Clinical Transformation Board, the purpose of which was to achieve the best care for people who receive care and treatment from the Trust, whilst realising financial savings through improved systems and controls.

Mr McKie referred to the Day Surgery Group and provided an overview of the benefits following the initiatives undertaken including: highest day case success rate in the region; increase in the total number of births and positive impact on fixed maternity costs; day case

Transurethral Resection of the Prostate length of stay reduced to 0; breast mastectomy length of stay reduced to 0; and savings resulting from pooling of theatre utilisation lists. The work of the Day Surgery Group had resulted in savings of approximately £140,000.

Mr Ward referred to the issues highlighted in the patient experience earlier in the meeting and asked if learning could be taken from the improvements in day case discharges for discharge planning in general. Mr Alldred stated that discharge planning for day case surgery was simpler due to advance planning, and referred to the challenges relating to unplanned care including implications of multiple partners, departments, and patient needs, but Dr Tolcher agreed that good practice should be explored further in terms of general discharge planning.

Mrs Webster referred to the reduction in length of stay for breast mastectomy and asked if there had been emotional and clinical benefits as well as financial. Dr Tolcher confirmed that the initiatives were underpinned by clinically led change programmes and were supported by a multi-disciplinary approach to support the patient.

Dr Lyth referred to priorities and focus moving forward and noted that although the Children's and County Wide Community Services Directorate did not have similar workstreams in place despite having similar demands in terms of cost improvement planning, Mr Richard Chillery, Operational Director, would be joining the Clinical Transformation Board to ensure opportunities for the Directorate could be explored moving forward.

Mr Thompson queried the benefits related to pooling of lists for theatres in the context of theatres not being fully utilised. Mr McKie confirmed that work had commenced to undertake activity and demand planning which included ensuring efficiency in terms of theatre activity. Mr Coulter referred to a Rapid Process Improvement Workshop undertaken to look at the patient pathway from arrival to discharge from theatre, and referred to other projects established to review theatre scheduling and utilising opportunities. Mr Harrison confirmed that pooling of lists would ensure last minute cancellations could be replaced by other patients on stand-by for treatment.

Mrs Taylor asked what initiatives were being utilised to increase the number of births. Mr McKie confirmed that a marketing strategy had been developed within the Directorate which included an increased focus in Leeds and raising awareness of the birthing pool.

The Board of Directors thanked Mr McKie for the presentation and update and noted a further update would be provided in January 2017.

## **1. Welcome and Apologies for Absence**

Apologies for absence had been received from Dr David Scullion (Medical Director) and Dr Kat Johnson (Clinical Director for Planned and Surgical Care Directorate).

Mrs Dodson welcomed to the meeting one Governor and a Healthwatch representative. Dr Claire Hall, Deputy Medical Director, deputising for Dr Scullion, and Dr Chunda Sri-Chandana, Deputy Clinical Director, deputising for Dr Johnson were also welcomed to the meeting

## **2. Declarations of Interest and Board Register of Interests**

There were no declarations of interest relevant to items on the agenda.

### **3. Minutes of the meetings of the Board of Directors on 28 September 2016**

The draft minutes of the meeting held 28 September 2016 were considered and it was noted that Mrs Taylor was present at the meeting.

#### **APPROVED:**

- **The Board of Directors approved the minutes of the meeting held 28 September 2016 as an accurate record of proceedings subject to the inclusion of Mrs Taylor being noted as present at the meeting**

### **4. Review of Action Log and Matters Arising**

Completed actions were noted. There were no further actions to note.

#### **Overview by the Chairman**

Mrs Dodson outlined two themes for the meeting, as identified by the Non-Executive Directors. She described these as two axis; long term planning (including sustainability and transformation planning, 2-year operational and contract planning and control totals); and ensuring business as usual whilst progressing through a significant period of change.

### **5. Strategic Key Performance Indicators Quarterly Report**

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

5.1 Mrs Dodson reminded members of the Board of the feedback received as part of the Well Led Review which suggested that further work was required to ensure the Board were focused on the Key Performance Indicators. Dr Tolcher noted that they would be critical to the success of mapping progress towards achievement of the Trust's strategic objectives.

5.2 Based on feedback from the Board of Directors and Executive Team away day, Dr Tolcher noted that the report provided detail on how success would be measured, and suggested that although a considerable amount of work had been undertaken, further work was required to refine a number of measures. Mr Coulter agreed that the next steps would be to articulate the Trust's vision through the regular quarterly reporting cycle.

5.3 Mrs Dodson asked the Board to confirm that the indicators and measures were appropriate, clear and measurable and acknowledge that the measures would be refined and reviewed over time.

#### **APPROVAL:**

- **The Board of Directors approved the content of the revised Strategic Key Performance Indicator Report and noted progress on strategic KPIs**

### **6. Report by the Chief Executive**

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

6.1 Dr Tolcher reflected on the two issues of focus highlighted by the Non-Executive Directors earlier in the meeting and took an opportunity to outline the priorities of the Executive Team over the next six months, following completion of mid-year reviews. Dr Tolcher referred

to three key priorities: keeping business as usual safe; delivering on plans; and optimising the Trust's position for the future.

6.2 In response to concerns raised by the Board at the September meeting, Dr Tolcher confirmed that an additional strategic risk had been included in the Board Assurance Framework to reflect the impact of Sustainability and Transformation planning on senior leadership capacity.

6.3 Dr Tolcher provided an update on progress towards achieving 90% compliance with appraisal rates and noted that a significant amount of work had been undertaken within both the Workforce and Organisational Development (OD) Team and individual Directorates. Dr Tolcher took an opportunity to congratulate the Wensleydale Ward which had achieved 100% compliance.

6.4 Following the extra-ordinary board meeting held on 19 October, Dr Tolcher confirmed that the feedback on the draft sustainability and transformation plan had been provided to the Project Management Office, and noted that the West Yorkshire and Harrogate Sustainability and Transformation Plan (WYHSTP) had been submitted on 21 October. The plan would be reviewed by Arm's Length Bodies (NHS Improvement and NHS England) with feedback being provided by mid-November. Dr Tolcher confirmed that the WYHSTP would be publicly available from week commencing 7 November, which would include a document regarding engagement and involvement and a short video.

6.5 With regard to the WYHSTP, Dr Tolcher emphasised the importance of recognising that the detailed figures within the plan did not reflect the newly apportioned control totals allocated to provider organisations, and confirmed that provider Boards were not required to commit to their control totals until after submission of the plan.

6.6 Dr Tolcher reiterated that although the plan had no statutory status in its own right, it was important to remember that individual provider two year Operational Plans and associated contracts would be required to reflect the content of STPs. Submission of two year Operational Plans and agreement of contract negotiations were required by 23 December 2016. Dr Tolcher also noted that regulators would use the STP as a reference document in the case of any contractual dispute.

6.7 Mr McLean referred to the engagement document and the Board's previous suggestion that the document required significant improvement. Dr Tolcher and Mrs Dodson agreed to feedback the view of the Board regarding the further work required prior to publication at the next meeting of the West Yorkshire Associate of Acute Trust's (WYAAT) Chairs and Chief Executive meeting.

6.8 Whilst acknowledging the WYHSTP was not statutorily binding, Mr McLean expressed concern that it would nevertheless guide the Trust's contract negotiations. Mr Coulter reminded members of the Board of the inclusion of the financial risk for Harrogate in the WYHSTP which would provide a reference in the event of any dispute, and advised that the Trust had not compromised its position, due to the caveats relating to financial risk within the STP. Dr Tolcher agreed that contractual negotiations would be challenging given the financial position of Harrogate and Rural District CCG (HaRD CCG).

6.9 Mrs Webster also suggested that the engagement and involvement document required further development and Dr Tolcher noted that an easy read document to describe the WYHSTP would also be available.



6.10 Professor Proctor advised that successful delivery of the WYHSTP would be predicated on supported and engaged staff and asked if plans had been developed to take staff engagement forward. Dr Tolcher confirmed that the continuous journey of sustainability and transformation planning had been subject to regular discussion within individual Directorates and had significant executive involvement in planning and workstreams.

6.11 Professor Proctor referred to the clear link between the operational planning, contractual agreement process and the WYHSTP, and noted that the nine themes detailed in the STP were not all encompassing of the services provided by the Trust. Professor Proctor asked for a measure of confidence of ensuring Local Authority commissioned services and long term conditions would not be disregarded. Dr Tolcher reassured members of the Board that specialty areas targeted at West Yorkshire level would not distract from managing business as usual and the range of other services within the Trust's portfolio. Mrs Dodson emphasised the importance of acknowledging that the content of the WYHSTP did not cover all services provided by the Trust. Mr Coulter also reminded Board members of the specific Harrogate and District STP which sat beneath the West Yorkshire and Harrogate level STP.

6.12 Mr Thompson noted that the significant area of challenge during the contract negotiations for 2016/17 with commissioners related to community services. In terms of the financial risks highlighted within the WYHSTP, Mr Thompson asked what level of assurance could be given that further reductions in the community contract would be avoided. Dr Tolcher acknowledged that although a robust level of assurance could not be provided at this stage, system partners remained committed to the vision to provide better health care for the local population via a focus on community care. Dr Tolcher advised that the commitment from the Trust to support the commissioners in delivering their financial recovery plan played an important role. As it currently stood, the Trust could not state with confidence that a further reduction of cost in one part of the system would impact positively on another.

6.13 Dr Tolcher provided an update on the Urgent and Emergency Care Acceleration Zone programme to achieve the ambition of delivering the Emergency Department (A&E) 95% 4-hour waiting time standard at West Yorkshire level by March 2017. The team had submitted a document outlining the support and resources required to deliver a realistic trajectory. A further update would be provided following feedback from NHS England and NHS Improvement.

6.14 Dr Tolcher briefed the Board on the request to NHS Providers to implement enhanced monitoring and reporting against use of agency and locum costs. This included a process for ensuring that Provider Boards were holding executive directors to account for taking all actions to reduce excess costs. The executive team would complete the checklist provided by NHS Improvement for circulation and approval at the November meeting of the Board of Directors.

6.15 Dr Tolcher confirmed receipt of notification of the Trust's control total for 2017/18 and 2018/19. The £1.8 billion Sustainability and Transformation (S&T) fund was conditional on the NHS provider sector delivering a minimum of break even in 2017/18 and 2018/19. To ensure this was the case, every provider would need to deliver an agreed financial control total in 2017/18 and 2018/19. Agreement to, and delivery of, the control total was a core part of NHS Improvement's new oversight regime.

6.16 Dr Tolcher stated that the Board were required to accept or decline the offer by 24 November. The Trust would receive £3.8m of S&T money in 2017/18 and 2018/19, contingent upon the Trust delivering a surplus of £2.4m in 2017/18 and £2.9m in 2018/19. The required control totals were therefore £6.2m in 2017/18 and £6.7m in 2018/19. These remain subject to adjustment depending upon the impact of HRG4+ and the NHS Litigation Authority premium for 2017/18.

6.17 Dr Tolcher referred to the in-year financial position of HaRD CCG and the associated financial recovery plan. Dr Tolcher reminded members of the Board of their commitment to amend the Trust's vision, mission and objectives to enhance the Trust's contribution and responsibilities relating to public health, and acknowledged the alignment to the CCG's strategy for health optimisation. This included the requirement for patients presenting to GPs for elective treatment (with certain exclusions) who are smokers and/or have a Body Mass Index of 30 to be offered the opportunity of support, without which, they would receive a six month deferral of treatment. The purpose of the strategy was to support patients undergoing elective care to have a better outcome due to being healthier at the point of treatment.

6.18 Dr Tolcher reiterated that the Trust would support CCGs to regain financial balance for the system. As a provider, the Trust was providing the right level of care within the tariff driven financial envelope but for commissioning colleagues, it had not been possible to contain the demand at an affordable level. Dr Tolcher advised that over time, referral rates and costs would need to be reduced and the Trust would contribute to these measures provided it did not compromise the Trust's control total and quality and safety of care.

6.19 Professor Proctor referred again to the importance of staff engagement and suggested that the actions to be delivered in support of commissioners would require a change in behaviour, in-year, and at rapid pace, particularly for clinicians, and asked for further information on the approach to be taken to mobilise the clinical workforce. Dr Tolcher confirmed that engagement with clinicians had commenced via the Clinical Board and would be supported by a more detailed piece of work including discussion via the Consultant Forum and team briefing. The Trust was also planning to host an evening event for clinicians and local GPs to facilitate a joined up discussion.

6.20 Dr Tolcher stated that clinicians had raised initial concerns regarding professional accountability, responsibilities, reputation and income. Mr Alldred also confirmed that discussions had taken place at the Clinical Leads meetings and Directorate Boards and supported the proposal for a detailed piece of work to identify how actions could be implemented.

6.21 Dr Sri-Chandana echoed the concerns regarding responsibilities of gatekeeping and income. Mr Coulter summarised the key principles as: the requirement to take cost out of the system; managing activity in a different way; whilst delivering on the constitutional standards and performance targets.

6.22 Mrs Webster referred to the proposals to reduce consultant to consultant referrals and reflected on the patient experience shared earlier in the meeting. Dr Tolcher confirmed that the patient experience issues related to non-elective work, and noted that the focus in terms of support for commissioners related to elective/planned pathways.

6.23 Should actions to support commissioners be delivered including a reduction in follow-up appointments and consultant to consultant referrals, Mr McLean asked what system would be used to holistically monitor the overall quality of care delivered to the patient to ensure standards are maintained. Dr Tolcher referred to various national programmes of collecting patient feedback including national surveys relating to patients, staff and GPs which would provide a year-on-year comparison. It was also acknowledged that the Trust had in place a quality governance system to monitor quality, experience and safety outcomes.

6.24 Dr Lyth provided the Board with insight to the advantages of reducing consultant-to-consultant referrals and noted the risks associated with making referrals outside of a given

speciality, which could be managed more effectively by GPs, and ensuring that only treatment which required secondary care input would be referred into the system.

6.25 With regard to the West Yorkshire Association of Acute Trusts (WYAAT), Dr Tolcher noted that work had progressed to establish a more formal governance arrangement in order to achieve the level of ambition describe in the STP. All Trusts had considered the options for collaboration and supported in principle the creation of a Committee in Common. A formal Memorandum of Understanding would be developed and this proposition would be discussed at the October meeting of Chairs and Chief Executives.

6.26 Dr Tolcher noted that NHS Improvement had completed the initial segmentation process for all NHS providers under the new Single Oversight Framework and HDFT had been placed in segment 2, as a result of the 'requires improvement' rating for a single domain within the CQC inspection framework. The Trust pushed back based on the CQC feedback that the Trust scored highly on the 'good' rating overall and did not require enhanced support. However, following due consideration, the Trust remained in segment 2.

6.27 Concern regarding continued high rates of Clostridium Difficile (C. Diff) had been raised and the Director of Infection Prevention and Control (DIPC) had provided an update at the October Senior Management Team meeting on organisational approach and testing methodology, but acknowledged the need for further investigation to understand the Trust's position further. Mrs Foster stated that an audit had been undertaken to review all samples, and an update would be provided to the November meeting of the Board of Directors.

6.28 Mrs Dodson stated that a request had been made to the DIPC to attend the November meeting of the Board of Directors to provide an update on the current position and actions to be taken to address infection control issues. For clarity, Mr Coulter confirmed that the Trust remained well within the threshold for the number of C. Diff cases as a result of a lapse in care and external scrutiny had been received from Public Health England in terms of the Trust's systems and processes. Mrs Webster also confirmed that C. Diff performance was also an area of focus for the Quality Committee and the regular report would be presented to the December meeting for consideration.

6.29 Dr Tolcher updated the Board with regard to a recent incident which had received significant media coverage. The incident related to an end of life care patient being moved to accommodate an emergency admission of a patient with an infection control risk. The end of life care patient passed away shortly after being moved. Dr Tolcher acknowledged the tragic circumstances of the incident and the distress caused to the family. Whilst not detracting from the distress of the family, Dr Tolcher reminded members of the Board of the extremely challenging decisions which face members of staff every day when caring for patients under intense pressure and sustaining compliance with safe practice. Dr Tolcher confirmed that a meeting had taken place with the family and the incident was under investigation by an independent investigation panel to understand and reflect on the decision making and policies involved. The investigation panel would be chaired by Dr Claire Hall, Deputy Medical Director with support from Professor Sue Proctor, Non-Executive Director.

6.30 Mr Marshall referred to risk number 9 in the Corporate Risk Register: withdrawal of trainees in medicine following the General Medical Council/Health Education Yorkshire and Humber visit, and noted that although the risk score had reduced, the Trust had also been given 28 days' notice to ensure adequate arrangements were in place to support Foundation Year 2 doctors. Actions were under consideration to provide a solution, however, Board members were asked to note that the risk score may require review.

**APPROVED:**

- The Board of Directors approved the inclusion of BAF risk 6 to reflect risks associated with the impact of sustainability and transformation planning on senior leadership capacity
- The Board of Directors approved acceptance of the offer of the Trust's control totals of £6.2m in 2017/18 and £6.7m in 2018/19, subject to confirmation from NHS Improvement following receipt of the NHS Litigation Authority premium and impact of HGR4+

**ACTION:**

- To circulate the checklist relating to use of agency and locum staff for approval at the November meeting of the Board of Directors
- An update to be provided to the November meeting of the Board on the Trust's current position relating to Clostridium Difficile and actions to be taken, including the outcome of the audit of samples taken

## **7. Integrated Board Report (IBR)**

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

7.1 Professor Proctor referred to delayed transfers of care (DToC) and the increasing trend during summer months, and requested assurance regarding winter plans as well as actions to be taken to reduce the number of DToCs going forward. Dr Tolcher noted that DToCs were a national issue and Mr Harrison advised that one third of the delays related to patient or family choice, with the second largest driver of delays relating to patients requiring further non-acute health care.

7.2 Mr Harrison confirmed that actions to reduce the number of DToCs included a request for support to all six acute trusts in the region in the use of the SAFER care bundle, and support in taking forward the discharge to assess model. This would result in the transfer of patients to a more appropriate setting to undertake assessments for long term care out-with the hospital setting. Mr Harrison emphasised that partner engagement via the A&E Delivery Board would be paramount in the success of reducing DToCs including engagement from Local Authority colleagues.

7.3 A further piece of work had commenced relating to longer stay patients to reduce the financial cost to the system, based on identifying appropriate, safe alternatives for out of hospital care. Mr Harrison stated that the A&E Delivery Board and winter plans would take account of the work and current position. Bed occupancy numbers had moderated and the Trust was operating with a lower bed compliment demonstrating that identifying DToCs had improved significantly, alongside reducing length of stay and reducing bed occupancy.

7.4 Mr Harrison also referred to the Trust's submission of a joint bid to develop an IT platform to support assessments and improved ways of sharing these and communication between partners, patients and relatives. Following a request from Mrs Dodson to provide an update on progress on the work to improve discharge planning, Dr Tolcher suggested a detailed discussion be undertaken at the next Board of Directors' Strategy Day.

7.5 Mr Thompson took an opportunity to congratulate colleagues on the consistent reduction of staff turnover, and asked if the Trust had a dedicated team in place to undertake root cause analysis when responding to cases of C. Diff and other outbreaks of infection. Mr Alldred confirmed that the Trust did not have a dedicated team, but cases were investigated by members of staff who were close to the incident.

7.6 Mr Thompson also noted that Children's Services had been within the Trust's portfolio for some time and asked when key performance indicators would be included in the Integrated Board Report (IBR). Mrs Dodson referred to the Board action log and confirmed that figures would be included from the November report.

7.7 Mr Ward referred to the RAG ratings applied to SIRS cases and asked that the executive team consider the inclusion of trends over time to add further value and intelligence for the Board.

**ACTION:**

- **Update on improvement work in delayed transfers of care and discharge processes to be delivered at January's Board Strategy Day.**
- **SIRS – review the RAG rating approach and include analysis of trend over time in future reports**
- **Update on progress of internal and system wide work to improve discharge planning to be submitted to the next Board Strategy Day**

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

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

8.1 Mr Coulter confirmed that the Trust reported a surplus of £627k to the end of September in line with the plan and noted that as a result, the second quarter of Sustainability and Transformation (S&T) funding would be received.

8.2 Mr Coulter acknowledged the work of Directorates following the focus on financial recovery at the August meeting of the Senior Management Team. It was acknowledged that further work was still required, but Directorate plans had embedded significant focus and commitment to ensuring strong financial performance. Mr Coulter also noted that the receipt of the S&T funding would be used to support the capital programme and incentivise Directorates by asking for ideas to use the funding to improve patient care.

8.3 The Trust had achieved a Financial Sustainability Risk Rating of 4 for quarter 2 under the auspices of the Monitor Risk Assessment Framework (RAF). Mr Coulter also confirmed that as of 1 October 2016, the RAF would be replaced by the NHS Improvement Single Oversight Framework, and noted that under the new assessment model, the Trust would have achieved a score of 1 on a scale of 1 (best) to 4 (worst). The Single Oversight Framework would also include compliance with the agency spend ceiling.

8.4 In terms of the approval process, NHS Improvement had revised the monthly submission timetable for submission of financial information. As a result, financial returns were submitted on 17th October. The Board were therefore asked to confirm and approve the financial return and associated risk rating of 4 for the quarter. Mrs Dodson raised concern regarding the request from NHS Improvement for mid-month submissions in terms of poor governance, and asked that this be considered and clarified at the November meeting of the Board of Directors.

8.5 Mr Coulter referred to HaRD CCG financial recovery plans and confirmed that there were no financial concerns regarding the impact on the Trust for 2016/17, however acknowledged the risk in terms of the impact of a reduction of activity on constitutional standards for 2017/18.

8.6 Mr Ward queried the potential financial impact should efficiencies relating to discharge planning come to fruition. Mr Coulter confirmed that the Trust would receive the same tariff/income for patients regardless of their length of stay, with the exception of a length of stay at 1 or 2 days, which would result in a lower tariff/income. Dr Tolcher emphasised the significance of the work of the Clinical Transformation Board in terms of gaining a better understanding of bed base, interventions and financial impact.

8.7 Mr McLean asked if the Trust was envisaging cash flow problems as a result of the pressures within the system. Mr Coulter stated that cash flow was not a significant issue of concern at the current time, but would ensure that this continued to be reviewed and considered as part of the future planning process.

8.8 In response to a query from Professor Proctor regarding forthcoming issues relating to contracting issues with HaRD CCG, Mr Coulter confirmed that there were no issues of concern relating to growth opportunities and relationships with Leeds CCG.

**ACTION:**

- **Clarify arrangements for seeking Board approval in light of the requirement for mid-month submissions to NHS Improvement on quarterly declarations under the new Single Oversight Framework**

**APPROVE:**

- **The Board of Directors approved the Quarter 2 Financial Sustainability Risk Rating of 4 for submission to NHS Improvement**

## **8.1 Operational Planning 2017/18 and 2018/19**

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

8.1.1 Mr Coulter briefed the Board following receipt of the Trust's control total for 2017/18 and 2018/19. Acceptance of the control total would, alongside delivering the relevant performance standards, allow the Trust to access £3.8m of S&T funding in each year. The Trust would be required to deliver a surplus of £2.4m in 2017/18 and £2.9m in 2018/19 in order to access the S&T funding available. The Board was required to confirm acceptance of the control total proposal.

8.1.2 Mr Coulter provided the Board with an overview of the key issues for discussion with HaRD CCG and advised that meetings were ongoing to discuss the issues and the impact of the financial recovery plan.

8.1.3 The timetable for development of the Trust's two year Operational Plan was received which required plans to be submitted, and associated contractual negotiations to be agreed by 23 December. Work would commence to achieve agreement with commissioners on actions, risks and gaps; however, it was acknowledged that a significant amount of work would be required to complete the process within the stringent timescales.

8.1.4 Mr McLean asked if the issues discussed earlier in the meeting relating to activity and demand would be taken into consideration as part of the planning process. Mr Coulter stated that commissioners had a surplus target to achieve, the equivalent of the Trust's control total. The Trust had started to develop internal process to consider cost improvement plans, delivery of the capital programme, and review of activity and capacity modelling. In terms of ensuring the Trust could develop a pragmatic plan, Mr Coulter advised that this would be predicated on assessment of the commissioner's financial recovery plan.

8.1.5 Dr Sri-Chandana referred to the challenges in maintaining financial performance at Directorate level in terms of the agency cap. Mr Coulter confirmed that rules regarding agency cap and ceilings were likely to be more robust in the future, particularly in light of the associated metric within the Single Oversight Framework. All providers were required to source alternatives to using agency.

**APPROVAL:**

- **The Board of Directors approved the recommendation to accept the NHS Improvement offer of a control total for Harrogate and District NHS Foundation Trust as: delivery of a surplus of £2.4m in 2017/18 and £2.9m in 2018/19, subject to confirmation from NHS Improvement following receipt of the NHS Litigation Authority premium and impact of HGR4+**

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

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

9.1 With regard to wheelchair services and the risk of the new provider disagreeing with the Trust's assessments and level of backlog, Mr Harrison confirmed that agreement had now been received from commissioners that the remainder of the backlog would transfer to the new provider as of 1 November, and would include the Trust's assessments undertaken from 1 September.

9.2 Professor Proctor referred to a recent patient safety visit to the community dental service and feedback from members of staff concerning waiting times for patients, and challenges in terms of space required for dental extractions. Professor Proctor also noted that a majority of the client group were adults with learning disabilities and asked for assurance regarding actions to address the issues raised.

9.3 Mr Harrison informed the Board of significant damage to one of the buildings and resulting challenges in terms of capacity to reinstate the service, limiting access for approximately 14 months. Throughout this time, staff had worked hard to relocate services, which had resulted in significant pressure on waiting lists. The building had since been re-opened and would address the issues regarding waiting times.

9.4 Mr Harrison also referred to dental access to general anaesthetics (GA) and theatres and noted that whilst the service had been reliant on partner organisations to access GA lists, they were rarely deemed a priority in terms of accessing the theatres of other provider organisations. Mr Harrison reassured members of the Board that the Trust would continue to work with other providers, but meeting GA activity would remain a challenge.

9.5 Dr Tolcher noted that she too had undertaken a recent visit and suggested that the level of angst within the team may have been as a result of the current tender process for the service. Dr Tolcher and Mr Harrison advised that the staff within the team were passionate and dedicated to the services they provided, and had demonstrated a high level of organisation and a robust system to ensure appropriate cover and high quality of care and treatment for patients. Dr Lyth also confirmed that investment had been made within the team in terms of leadership and support. Mrs Foster agreed and emphasised the need to ensure continued support for the service.

9.6 Following a query from Mrs Webster regarding bed closures, Mr Harrison confirmed that 22 elderly care beds had been closed since July to support the Vanguard work and assist

with staffing. In terms of winter planning, Mr Harrison confirmed that clear escalation plans were in place should the need to open additional beds arise. Dr Tolcher advised that the review of the Trust's bed base and nursing numbers was necessary to avoid inappropriate use of beds and to support provision of out of hospital care. Mrs Webster thanked Mr Harrison and Dr Tolcher for providing clarity regarding the closure of beds and suggested a review of the narrative within the report to reflect the clarity provided.

9.7 Mrs Dodson referred to the increase in the number of young patients with mental health comorbidities and asked if the issue related to training requirements. Mr Harrison stated that the issues related to training and support for staff in terms of response times to requests for assessment and support. Work had commenced to look at opportunities of support from Tees, Esk and Wear Valley NHS Trust and improving the Trust's offer of Children's and Adolescent Mental Health Services. Mrs Foster also highlighted the importance of ensuring safe space within the Emergency Department, Woodlands Ward and other areas to support these patients.

9.8 Mr McLean made reference to the recent media coverage regarding high levels of amputations in Scarborough and asked if this had been indicative that the level of service did not meet the needs the community, thereby requiring a review of the contract and associated value. Dr Lyth confirmed that the Podiatry team were working with vascular surgeons to conduct a detailed root cause analysis to identify the reasons for the increase in high morbidity. Dr Lyth also referred to media coverage regarding the impact of GPs encouraging early intervention on public health issues which was also under consideration by the team. Mr Thompson reflected on a visit to the podiatry team and expressed concern at the prospect of reducing the service due to the pressures observed. Dr Tolcher and Mr Coulter agreed that supporting public health was important and should be considered in terms of further reviewing the level of investment in the service.

9.9 The Board was asked to approve the Information Governance Toolkit Performance submission of 84% compliance for October.

9.10 Although the Board were not required to formally approve the Quarter 2 Governance section of the Risk Assessment Framework on this occasion due to the migration to the Single Oversight Framework as of 1 October 2016, Mr Harrison confirmed performance as 'Green' for the submission to NHS Improvement as detailed in the Integrated Board Report.

**APPROVAL:**

- **The Board approved the Information Governance Toolkit performance submission of 84% compliance for October**
- **Although not formally required, the Board of Directors approved the Quarter 2 Governance Risk Rating of 'Green' for submission to NHS Improvement**

## **10. Report from the Chief Nurse**

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

10.1 Mrs Foster referred to the outcome of the recent Directorate inspections and made particular reference to the red rated inspection on Pannal Ward due to cannula issues. Further feedback would be provided as part of the November report.

10.2 Mrs Foster noted that the report had omitted reference to a director inspection visit to Lascelles Rehabilitation Unit in August which had been red rated due to the lack of



identification of the person in charge. A follow-up visit would be arranged with feedback provided within the Chief Nurse report.

10.3 Mrs Foster invited Mr Coulter to comment on the patient safety visit undertaken on 25 October in County Durham Children's Services. Mr Coulter reflected on a positive and engaged group of staff, who had been complimentary regarding the mobilisation and transfer of services into the Trust.

10.4 With regard to actual versus planned staffing, Mrs Foster noted that the information provided an indication of where gaps had been identified and the areas of potentially increased risk to patient safety. Mrs Foster clarified that whilst the risk to patient safety had increased as a result of gaps in staffing, continual monitoring demonstrated that gaps in staffing had not translated into actual patient harm. As a result as Chief Nurse, Mrs Foster confirmed that Trust had provided safe and effective care during the period.

10.5 Mrs Foster noted concern regarding the lack of validation for category 2 Pressure Ulcers and emphasised the need to re-focus and address issues relating to leadership as well impact of vacancies.

10.6 Mrs Dodson requested that performance relating to falls, pressure ulcers and complaints continue to be monitored via the Quality Committee. Mrs Webster referred to a previous agreement to include figures for pressure ulcers in the community from 2015/16 in the IBR, to enable a comparison to be made.

10.7 Dr Sri-Chandana expressed his gratitude for supporting the increased nursing establishment in theatres and noted that the fill rates reflected a combination of substantive, agency and bank staff, which could result in increased pressure for substantive members of staff. Mrs Foster agreed and highlighted the importance of including the qualitative information reflecting the culture for nursing staff on the ground floor as well as quantitative metrics.

**ACTION:**

- **Include community pressure ulcer performance for 2015/16 in the Integrated Board Report to enable a year-on-year comparison to be made**

## **11. Report from the Medical Director**

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

11.1 Mrs Webster referred to the new arrangements for allegations of impropriety by Doctors in Training against Health Education England and Mr Marshall provided clarity by stating that previous arrangements prohibited allegations being made to the Deanery, as they were not classified as an employer. These arrangements now prevented providers being held to account for the actions of others.

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

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

12.1 Mr Marshall briefed the Board on the outcome of the Internal Audit on compliance with the Fit and Proper Persons Test (FPPT), which received an audit opinion of significant assurance. The Board acknowledged the audit recommendation for additional assurance to be provided to the Board and Council of Governors on the systems and process which underpin the regular review of compliance against the FPPT. The Trust currently undertakes

checks every three years, and whilst guidance from NHS Employers states checks should be undertaken on an annual basis, the advice to the Board by Mr Marshall and the senior management team was that this was disproportionate. Mr Marshall therefore requested approval to maintain the status quo and undertake checks every three years. Mr Thompson supported the proposal as a sensible and pragmatic approach.

12.2 Mr Marshall was pleased to announce that the Trust had signed the Charter for Employers who are Positive About Mental Health, accrediting the Trust as a 'Mindful Employer'.

12.3 With regard to the requirement to enhance systems and processes for agency and locum staff, Mr Marshall acknowledged the need to update the Trust's guidance regarding approval of agency use.

12.4 Mr Marshall provided a progress update on efforts to achieve 90% compliance with staff appraisals by December 2016. This included a meeting with the Children's and County Wide Community Services Directorate to discuss issues in areas with lower levels of appraisal uptake, integrity of data, and provision of support to enable achievement of the target.

12.5 The report included a summary of the Staff Friends and Family Test feedback for quarter 2. The information had been shared with Senior Management Team and Directorates to identify key themes and issues.

12.6 Mr Thompson referred to the Health Education England visit and was pleased to note the decision to remove the Trust from enhanced monitoring, due to satisfactorily meeting the requirements placed upon the Trust related to Doctors in Training. With regard to sickness absence levels for Children's Services, Mr Thompson asked whether the issues had been identified as part of the due diligence process during the transfer of services. Mr Marshall advised that the concern related to accuracy and timeliness of reporting, and data validation was ongoing to provide appropriate assurance.

12.7 Mrs Webster asked if there had been any feedback following the introduction of new contracts for Doctors in Training. Mr Marshall advised that a significant level of engagement had taken place to provide an opportunity to discuss new working patterns, and there had been no concerns raised regarding individual contracts. Mr Marshall also confirmed that the Trust had in place a Doctor in Training representative to provide additional support if required. Mr Alldred took an opportunity to congratulate and thank the Workforce and OD Team and Consultant body for their support.

12.8 Mrs Dodson cross referenced the work on Ocean's Blue to improve nurse rostering efficiency with concerns highlighted in the IBR, and the recent internal audit outcome. Mr Marshall noted that key performance indicators (KPIs) were under development and a significant amount of training had been undertaken with individual wards and departments. Mr Marshall confirmed that the 'Barnacles' work was a further solution to improve day to day rota management and had been used to address legacy issues regarding hours owing to the Trust.

**APPROVED:**

- **In response to the Internal Audit undertaken on the Fit and Proper Purpose Test, the Board of Directors approved the recommendation to under checks against compliance with the Fit and Proper Test every three years with an associated assurance report to be presented to the Board of Directors and Council of Governors, with an initial report in quarter 3 2017-18**

### **13. Oral Reports from Directorates**

#### **13.1 Long Term and Unscheduled Care Directorate**

13.1.1 With regard to the community contract, Mr Alldred confirmed that the consultation for New Care Models Team was complete with a planned roll out date on 16 November in relation to the response and overnight service. Recruitment continued to achieve full establishment and a GP engagement event had been held which resulted in positive feedback. Mr Alldred advised that an outstanding issue related to challenges of community care teams being established based on geography and discussions continued to rectify the issue.

13.1.2 Mr Alldred informed the Board of the roll-out of the SAFER care bundle on the combined Jervaulx and Byland ward.

13.1.3 The Board were informed of a change in leadership at Ripon Community Hospital which had contributed to the actions to address issues highlighted through ward visits and the CQC inspection including: leadership; space utilisation; and pace of decision making linking back to issues highlighted earlier in the meeting around discharge planning. Mr Alldred confirmed that there were no issues relating to patient harm or patient experience.

#### **13.2 Planned and Surgical Care Directorate**

13.2.1 Dr Sri-Chandana took an opportunity to acknowledge the hard work of the teams in their contribution to the achievement of the Trust's financial performance for the quarter. 80% of the cost improvement programme for the Directorate had been achieved to date.

13.2.2 Dr Sri-Chandana noted that a middle grade post had been recruited to provide cover for elderly care and recruitment would commence in November for a substantive post to support Orthogeriatrics. Dr Sri-Chandana expressed his gratitude to Claire Taylor, Respiratory Consultant, for providing support to develop job plans and cross cover.

13.2.3 Dr Sri-Chandana highlighted the high risks within the Directorate as: work towards reducing follow-ups; impact of the commissioners financial position; impact of the health optimisation programme; recruitment and retention issues; opening of new cosmetic surgery hospital in the region and impact on theatre staffing; predicted increase in births and impact on capacity; and the outcome of the Deanery visit.

#### **13.3 Children's and County Wide Community Services Directorate**

13.3.1 Dr Lyth noted the significant level of tendering and acknowledged the value and input from the Business Development team. It was noted that preparing for tender submissions required a high level of clinical and managerial input, which could impact on capacity within the Directorate.

13.3.2 Dr Lyth reminded members of the Board of staffing issues relating to Consultant Paediatrics with two clinicians on maternity leave. Interviews had been scheduled to take place on 1 December to recruit to the vacant position.

13.3.3 With regard to Community Adult Speech and Language Therapy, Dr Lyth highlighted an increased demand on services and work had commenced to explore this in further detail.

13.3.4 Two events had taken place which had both been well received: the Allied Health Professional Conference led by Robin Hull, Podiatrist; and Safeguarding Week.

## **14. Committee Chair Reports**

### 14.1 Report from the Quality Committee meeting held 5 October 2016

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

14.1.1 Mr McLean provided feedback as interim Chair of the Quality Committee meeting held 5 October and noted a broad discussion on nursing in its entirety. Members of the committee had commented on the value of engaging in a holistic discussion regarding nursing issues in general.

14.1.2 A lengthy discussion had taken place regarding complaints and committee members raised concern regarding poor performance in terms of complaints being responded to within the agreed timescale which currently stood at 34%. It was agreed that current performance was unacceptable and Mr McLean formally escalated the Committee's concerns to the Board. Mrs Dodson asked that the committee continue to closely monitor performance on behalf of the Board.

### 14.2 Report from the Finance Committee meeting held 19 October 2016

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

14.2.1 Mrs Taylor advised that the committee reviewed and discussed financial performance and the impact of the commissioner financial recovery plans in detail. Mrs Taylor took an opportunity, on behalf of the committee, to formally thank the Directorates for their commitment and focus on financial performance during the period.

14.2.2 With regard to cost improvement plans, the committee was advised that 25% of plans were non-recurrent and acknowledged the potential impact of this for 2017/18.

14.2.3 There remained an outstanding debtor issue relating to GP Out of Hours which had been escalated to senior management level to achieve a resolution.

14.2.4 Mrs Taylor advised the Board that activity following the opening of Alwoodley Medical Centre was behind plan due to an ongoing IT issue. Mr Harrison advised that a resolution had been planned for early November.

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

15.1 In line with the requirement for the Board of Directors to regular review and approve the Trust's Standing Financial Instructions and Standing Orders, Mrs Dodson referred to the documents, and noted that both had been subject to scrutiny and review at the meeting of the Audit Committee held 8 September. Mr Thompson confirmed that there had been no material changes and there were no significant issues to highlight to the Board.

15.2 The Board approved the Quarter 2 submission to NHS Improvement confirming the governance risk rating as 'Green' and financial sustainability risk rating as 4 under agenda items 8 and 9 above.

### **APPROVAL:**

- **The Board of Directors approved the Standing Financial Instructions and Standing Orders and acknowledged a minor amendment relating to business case limits and approvals to be taken to the next meeting**

## **16. Any other relevant business not included on the agenda**

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

## **17. Board Evaluation**

Mr Harrison reflected on a good, rounded discussion which triangulated well with the themes identified by the Non-Executive Directors and the patient experience feedback at the beginning of the meeting. He also noted a strong balance between operational issues and the Trust's long term strategic ambition, particularly in terms of future projects and initiatives.

Mrs Taylor valued the update on Sustainability and Transformation Planning and clinical transformation initiatives, including the discussion on quality and opportunities for the Trust.

Mr Alldred noted the benefit of the balance between strategic and operational issues and stated that as a Clinical Director, this gave him confidence to provide assurance to the Directorate that the Board remained focused on the issues important to staff on the ground floor, as well planning for the future of the Trust.

In terms of forward looking, Mrs Webster stated that having a sense of the quality impact as well as financial impact on the executive summary reports, may help avoid some of the repeated questioning asked at each meeting.

Dr Tolcher reflected on the patient experience feedback and felt a sense of frustration that the issues raised were known issues to the Trust, and suggested that it served as a reminder to the Board and senior leadership team of the importance of 'getting the basics right'.

Mr McLean stated that the plethora of issues discussed at the meeting highlighted the level of activity and work being undertaken and led by the executive team, and acknowledged the support required for the team to maintain business as usual safely.

## **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 12.35pm

**HDFT Board of Directors Actions Schedule as at November 2016**  
**Completed Actions**

This document logs actions completed since the previous Board of Director meeting. Completed items will remain on the schedule for three months and then be removed.

Item Description	Director/ Manager Responsible	Date of completion/ progress update	Confirm action Complete
Verbal update to be provided as part of the Quality Committee Chair's report on performance relating to completion of complaint action plans (Jun 16)	Mrs L Webster, Non-Executive Director/ Quality Committee Chair	September 2016	Complete
Further detail on metrics relating to health visiting for new born visits to be provided in the IBR (Jun 16)	Dr N Lyth, Clinical Director	September 2016	Complete – paper included for July meeting
An update on the NHS Improvement consultation and proposals for a Single Oversight Framework to be provided (Jul 16)	Dr R Tolcher, Chief Executive	September 2016	Complete – included in CEO Report. Consultation response uploaded to reading room
Provide confirmation of the Trust's current compliance with legionella water testing (July 16)	Mr R Harrison, Chief Operating Officer	September 2016	Included on Board Assurance Framework
Clarity to be sought to ensure that the current compliance rates for Information Governance Mandatory training support the requirements of the July Information Toolkit submission (July 16)	Mr R Harrison, Chief Operating Officer	September 2016	Complete – response circulated to Board members via e-mail 8/8/16
An update on the review of the Staff Friends and Family Test narrative outcome for Q1 to be provided to the Board (Jul 16)	Mr P Marshall, Director of Workforce and Organisational Development	September 2016	Complete – included within DWOD report
Assurance in relation to service activity and recovery plans (Jul 16)	Mr R Harrison, Chief Operating Officer	September 2016	Complete – within COO report
Assurance from the contracts team that no penalties associated with the contract due to the absence of a threshold target for new birth visits by Health Visiting team within 14 days of birth (Jul 16)	Mr J Coulter, Deputy Chief Executive/ Finance Director	September 2016	Complete
E-rostering implementation update to be included in the Chief Nurse report (Jul 16)	Mrs J Foster, Chief Nurse	September 2016	Complete – verbal update provided
Progress with regard to the appointment of Consultant Elderly Care post as part of the oral directorate report (May and Jun 16)	Dr K Johnson, Clinical Director	September 2016	Complete – provided under Directorate reports at September meeting

<b>Item Description</b>	<b>Director/ Manager Responsible</b>	<b>Date of completion/ progress update</b>	<b>Confirm action Complete</b>
Proposal for the appointment of the Trust's Freedom to Speak Up Guardian to be submitted to the Board of Directors (Jul 16)	Mr P Marshall, Director of Workforce and OD	October 2016	Complete – reported as part of DWOD report at the September meeting
The Board of Directors approved the revisions to the wording of the Trust's vision, mission and objectives subject to the amendment to change 'endeavour' to 'strive' (Sep 16)	Dr R Tolcher, Chief Executive	October 2016	Complete
Explore feasibility of recruitment opportunities for ODPs and Theatre Nurses via the GHEP and international recruitment (Sep 16)	Mr P Marshall, Director of Workforce and Organisational Development	October 2016	Complete
Undertake a review of the Strategic Key Performance Indicators and submit a proposal to the October meeting of the Board for approval, giving consideration to input from the Shadow Board (Jul 16)	Mr J Coulter, Deputy Chief Executive/Finance Director	October 2016	Complete – agenda item
Include a 6-month financial forecast within the October Finance Director report (Sept 16)	Mr J Coulter, Deputy Chief Executive/Finance Director	October 2016	Complete – include in Finance Directors Report
Write to Gill Morgan, Chair of NHS Providers to outline concerns regarding the impact of STPs on executive capacity (6.29)	Mrs S Dodson, Chairman	October 2016	Complete
IBR – narrative associated with GP out of hours to be improved to reflect the level of activity undertaken for future reports (Sept 16)	Mr A Alldred, Clinical Director	October 2016	Complete – included in IBR
Report on actions undertaken to support the increase required in appraisal compliance rates as part of the October DWOD report (Sep 16)	Mr P Marshall, Director of Workforce and OD	October 2016	Included in DoWOD report October meeting
Revisit the Board Assurance Framework to ensure adequate reflection of executive team capacity to delivery wider strategic initiatives (Sep 16)	Dr R Tolcher, Chief Executive	October 2016	Complete
Circulation of the checklist for enhanced monitoring for agency and locum use and submit for Board approval (Oct 16)	Mr P Marshall, Director of Workforce & OD	November 2016	Complete – agenda item for November meeting
Update to be provided on actions to be in response to concerns raised relating to C. Diff (including sample audit outcome) (Oct 16)	Dr J Child, Director of Infection Prevention and Control	November 2016	Complete – agenda item for November meeting
Include community pressure ulcer figures in the IBR for 2015/16 to allow a year-on-year comparison (Oct 16)	Mrs J Foster, Chief Nurse	November 2016	Complete

<b>Item Description</b>	<b>Director/ Manager Responsible</b>	<b>Date of completion/ progress update</b>	<b>Confirm action Complete</b>
Update on the action plan following the Alan Wood Report into Local Safeguarding Boards (Jun 16)	Mrs J Foster, Chief Nurse	November 2016	Included in the Chief Nurse report
Update on management of risks associated with the wheelchair service to be provided at a future meeting of the Board (Sep 16)	Mr J Culter, Deputy CHIEF Executive/ Finance Director	November 2016	Included in Business Development Report
Review and revise questions in annual Audit Committee survey (Jan 16)	Mr C Thompson, Non-Executive Director/ Audit Committee Chair	November 2016	Complete – verbal update provided at November meeting



## **HDFT Board of Directors Actions Schedule – Outstanding Actions as at November 2016**

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

Ref	Meeting Date	Item Description	Director/Manager Responsible	Completion date	Detail of progress
1	September 2016	Inclusion of KPIs on Children's Services and Community Services to be included in the IBR following a review of the new dashboard for the Directorate (4.1)	Dr N Lyth, Clinical Director	November 2016	<b>Agenda item 4.1</b>
2	October 2016	Review RAG rating approach to SIRIs and include analysis of trend over time (7.7)	Dr D Scullion, Medical Director	November 2016	<b>Verbal update to be provided under matters arising</b>
3	October 2016	Clarify arrangements for seeking Board approval in light of requirements for mid-month submissions to NHS I (8.4)	Mr J Coulter, Deputy Chief Executive/ Finance Director	November 2016	<b>Verbal update to be provided under matters arising</b>
4	June 2016 July 2016	Additional information to be included in the IBR relating to readmissions of older people / update on reducing readmissions in older people to be submitted to the September Board meeting (8.9)	Mr A Alldred, Clinical Director	November 2016	<b>Verbal update to be provided under matters arising</b>
5	May 2016	Further update on progress of the Care of Frail Older People Strategy and confirm an NED Lead (11.2.3)	Mr A Alldred, Clinical Director	November 2016	<b>Verbal update to be provided under matters arising</b>
6	June 2016	Update on the programme of work to reduce hospital admissions (9.3)	Mr A Alldred, Clinical Director	January 2017	N/A
7	January 2016	Update Board on progress with EDS2 action plan (11.10)	Mrs J Foster – Chief Nurse	January 2017	N/A
8	September 2016	Provide an update on progress with regard to actions associated with Corporate Risk Register CR8: risk of ophthalmology patients being lost to follow up (6.13)	Dr K Johnson, Clinical Director	January 2017	N/A
9	October 2016	Update on progress of internal and system wide work to improve discharge planning to <i>Board Strategy Day</i> (7.4)	Mr R Harrison, Chief Operating Officer	January 2017	N/A
10	March 2016	Submission of a Research and Development Strategy for Board comment	Dr A Layton - Associate Director for Research	January 2017	

11	March 2016	Additional information on learning from cases of C. Diff and associated action planning during 2015/16 to be included in the annual report (6.3)	Mrs J Foster, Chief Nurse	February 2017	N/A
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<b>Report to the Trust Board of Directors: 30 November 2016</b>	<b>Paper No: 4.1</b>
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<b>Title</b>	Briefing to update on progress regarding the development of a performance Dashboard for the Children's & Countywide Community Care Directorate
<b>Sponsoring Director</b>	Dr Natalie Lyth, Clinical Director
<b>Author(s)</b>	Richard Chillery, Operational Director
<b>Report Purpose</b>	To share the progress made so far and the complexity of the work that needs to be done.

## Key Issues for Board Focus:

- That progress has been made with a scoping process to determine more accurately what does or does not exist in terms of metrics for the Directorate and the position of each service in relation to the ability to report KPIs.
- To note the complexity of this piece of work which is a larger project than originally perceived due to its inter-dependencies with IT, SystemOne, Electronic Paper Records (EPR), diversity of services and the roll out of agile working.
- Next steps are proposed with timelines.

## Related Trust Objectives

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

<b>Risk and Assurance</b>	Once this work is complete, it will support HDFT Board to have assurance that the services in the CCCC Directorate are meeting their Key Performance Indicators, contracts and highlight any impact on quality and service delivery
<b>Legal implications/Regulatory Requirements</b>	None known.

## Action Required by the Board of Directors

To note this briefing and to support the direction of travel.

**Aim:**

A priority objective for the Children's & Countywide Community Care Directorate (CCCC) is to establish a robust performance dashboard within the Directorate and to then provide a sub set of key metrics for inclusion in the IBR for Board and the Senior Management Team.

The purpose of this briefing is to report on the progress regarding the development of this performance matrix for CCCC. This paper will outline what has occurred so far; the learning from this initial scoping stage; any issues identified and recommendations for the next stage.

The first part of the process has been to scope out what metrics currently exist within services and to identify data flows to support metric development.

**Scoping stage:**

A series of meetings have taken place with key leads within the performance team to agree a process regarding the development of the CCCC dashboard. Timelines have been agreed for the first stage, which was to understand within all the services the range of metrics that do and do not exist and report back by the end of November to the Operational Director (OD) and Clinical Director (CD).

All the services in CCCC have met with a member of the performance team, except Clinical Psychology and Adult Speech and Language Therapy (these meetings are scheduled to take place in the next two weeks) and a "wish list" developed with these services regarding what metrics they would want to see in a dashboard.

A rudimentary dashboard for CCCC has been developed from this wish list but is not being populated with data as yet, as this does not align with actual lines of reporting (see Appendix 1).

Feedback to the OD and CD from the performance leads, took place on 17 November concluding what the next stage of the process would be. A further review meeting has been set up for early January 2017.

**Learning from the initial scoping:**

- That the metrics appear to broadly fall into five key domains / areas: Children's Services (0-19); Safeguarding and Looked After; Community Services (Adults & Children's); Acute Services (Specialist Children's) and Dental (Software of Excellence).
- That there is a close relationship between the implementation of the Electronic Patient Record, use of SystmOne, ICS and agile working in the availability of metrics and so representatives from all these services will need to be included for future project work.
- Due to capacity constraints within the Performance and Information Service it is difficult for them to support the processing of data from services where information is being recorded locally in spreadsheets, word documents or on paper.
- That services are either:
  - On ICS but embedded in reporting systems within the old Directorate structure
  - On SystmOne (perhaps with little data validation process currently)
  - Waiting to go onto SystmOne; the roll out plan is critical
  - On other stand-alone patient systems (Dental)
  - That a number of services are not on any electronic reporting systems and therefore using individualised spreadsheets to record a range of varied information.

- That some of the data is not currently available in a reportable format. The Specialist Children's Services data is on a HDFT database for half of the service and contained in spreadsheets for the other and is not in a consistent format making reporting difficult.
- That the matter of developing metrics within CCCC is complex and constitutes a significant change project if this includes all services being on electronic systems and staff are trained in the use and recording on these systems with data validation process.
- A number of the services have more than one defined area that they support, and therefore work will need to be undertaken to identify the depth of analysis required and the level of detail to be presented.
- That priority should be given to Children's Service metrics to ensure robust reporting on these contracts which are under close scrutiny from commissioners and also the Safeguarding and Looked After metrics due to regular inspections regimes within Local Authorities.

### **Immediate Developments & Timelines:**

This section is to give an outline of what developments are proposed within the next three months ending in the period February 2017.

1. That a subset of the children's metrics will be developed based on the mandated indices for 0-19 Public Health Services, which will include Darlington, North Yorkshire and Durham. This may need to be manually reported for Middlesbrough due to recent changes in reporting. This will be shared with the CCCC Directorate Board and Trust Board in December 2016 for comments (Appendix 2 is a current report for North Yorkshire for Quarter 1)
2. That a gap analysis of the outstanding metrics for the four Children's Services contracts metrics will be written up and presented to the Directorate Board in December 2016.
3. That the draft dashboard will be finalised with all the services' "wish lists" and presented to the OD and CD in January 2017. Following this the team will seek to develop more detailed reports which can sit behind the Board report and support the managers with their performance panel meetings.
4. That a subset of Safeguarding and Looked After metrics will be shared with the CCCC Directorate Board and Trust Board in January 2017 for comments.
5. That a Safeguarding supervision tool, starting to be used by clinicians, will be moved from Excel to a Database which will increase the flexibility of the manipulation and reporting of the data, by January 2017.
6. That Podiatry will be prioritised for ensuring that the dashboard metrics will be produced (in line with contractual arrangements and requirements identified by the service) and then tested and validated during the period of January – March 2017, to then go live from 1<sup>st</sup> April 2017. These metrics will be broken down into the four CCGs.
7. A Children's Informatics and Performance Group is being established with representatives from the services and wider performance and IT services, which will be a subset of the IT Steering Group, most likely to start in January 2017. It is likely this group will be widened in April 2017 to be Directorate wide.

### **Next Steps:**

The next stage following scoping will be the planning stage to start to explore the programme of work regarding the desired objective. This programme will be developed by this working group to determine which services will be part of the programme, what work is required in developing and reporting on performance and in what order of priority.

This stage will also need to discuss and agree if those services that are not on any electronic systems are within scope or not and if they are in scope this will feed into wider transformation programmes regarding EPR and informatics development.

**Recommendations:**

1. That the Board of Directors recognise the complexities of this programme of work following the detailed work from the scoping stage.
2. That it is recognised that progress of this programme will be determined by availability of resources within the Performance and Information Team and the IT Department.
3. That the Board prioritise the CCCC Directorate within the SystemOne roll out programme to support progress on this project area.
4. That the Board of Directors and the Senior Management Team are able to provide feedback on the level of detail they want regarding a sub set of metrics during the development stage as they are produced.

**Children's and Countywide Community Care Directorate Report 2016-2017**  
**Pain and Chronic Fatigue**

Metrics	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Q1	Q2	Q3	Q4	YTD
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# Publicity and Marketing

Publicity and Marketing - please describe any activity carried out this quarter including strategic developments. Please provide detail of any additional comments or actions

We took part in a development day with NYCC and provided a workshop on school entry, which was well received.

We have had 2 development days where other agencies have been invited and delivered updates to staff, for example COMPASS Reach and Specialist Children's Service update on the SEND agenda. Sharon White, OBE, Professional Lead for School Nursing, attended the Selby Development Day and shared her vision of the service direction.

One of our SCPHNs has delivered a presentation on 'Making Men', which is a project to highlight the risks to young teenage boys as they mature. This was well received and the resources have been shared with all SCPHNs for them to use in their localities.

Our staff have taken part in the LGBT development and our champions are going out to youth groups to share good practice.

Our Teams have all attended many parents evenings across North Yorkshire and have tried to be pro-active in getting the health questionnaires out at this opportunity. This has been successful in some areas, and we would want to continue with this in the future.

Two of our SCPHNs have attended events in London on Leadership and the Future Vision, as part of this they are asked to work as change agents and cascade information with stakeholders.

HDFT are holding an Open Day and we have booked a stall to promote the 5-19 Service and staff will be present to speak to the public.

The Trust, through this quarter, was awaiting outcome of the CQC inspection which we are delighted to say we were categorised as good

Our ratings for Community Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for children, young people and families	Good	Good	Good	Good	Good	Good

We have also taken part in the OFSTED inspection of the Special Education Needs

We are awaiting the branding exercise to be completed - please see quotation specification attached for this area of work.



Report to the Trust Board of Directors: 30 November 2016		Paper No: 5.0
Title		Draft West Yorkshire and Harrogate Sustainability and Transformation Plan (WYHSTP)
Sponsoring Director		Dr Ros Tolcher, Chief Executive
Author(s)		Dr Ros Tolcher, Chief Executive
Report Purpose		To provide the Board of Directors with the final West Yorkshire and Harrogate Sustainability and Transformation Plan (WYHSTP)
Key Issues for Board Focus:		
<ul style="list-style-type: none"><li>• The Draft West Yorkshire and Harrogate STP covers eleven clinical commissioning groups (who buy care for local people), six local council boundaries, as well as services provided by a number of health and social care organisations.</li><li>• The STP is built from six local area place-based plans; Bradford District and Craven, Calderdale, Harrogate and Rural District, Kirklees, Leeds, and Wakefield. These are focused on the needs of local people.</li><li>• The plan will be delivered by local health and care organisations working together across the region to support changes needed to improve services by building on local plans that have been developed in each of the six local boroughs and they attempt to tackle long standing issues, improve care, and look at prevention, better coordinated services, preventing unnecessary hospital admissions and supporting people to stay well.</li></ul>		
Related Trust Objectives:		
1. To deliver high quality care	Yes – the report reflects a sustained organisational focus on providing high quality care through collaboration in line with the 5-year forward view.	
2. To work with partners to deliver integrated care	Yes – the report provides updates on the development of the Draft West Yorkshire STP reflecting partnership working across Harrogate and West Yorkshire.	
3. To ensure clinical and financial sustainability	Yes – the development and delivery of the WYHSTP will ensure ongoing clinical and financial sustainability within the sector at both local and regional level.	
Risk and Assurance	Strategic and operational risks are noted in section 6. Risks associated with this report are reflected in the Board Assurance Framework: BAF 14: risk to deliver of integrated models of care; BAF 4: lack of interoperable systems across New Care Models; BAF 15: misalignment of partner strategic plans; and BAF 9; failure to deliver the operational plan.	
Legal implications/Regulatory Requirements	There are no legal/regulatory implications highlighted within the report.	
Action Required by the Board of Directors		
The Board of Directors are asked to receive the Draft West Yorkshire and Harrogate Sustainability and Transformation Plan (WYHSTP) for comment		



# **West Yorkshire and Harrogate Sustainability and Transformation Plan (STP)**

**Draft proposals  
October 2016**

# Contents

## Foreword

- 1) Introduction and our approach
- 2) The triple aim
- 3) Place based proposals
- 4) West Yorkshire collaborative proposals
- 5) Enabling work streams
- 6) Creating an infrastructure for delivery
- 7) Conclusion

Annex A: Glossary of terms

# Foreword

The NHS and social care system in West Yorkshire and Harrogate provides care and treatment to 2.6 million people. Every day we work across the whole social spectrum, engaging people from birth to death, head to toe, inside and out. Our 113,000 staff are entrusted with a budget approaching £5bn.

Over the past decade we can be proud of how our health and care teams have made major improvements to services. The NHS is treating more people than ever before, providing services faster, more safely and in better environments. Research and innovation is delivering world leading new treatments at the forefront of technology. Our integration “pioneers” are joining up health and care. Our seven vanguards have been leading the way in developing new models of care that better meet people’s needs in care homes, hospitals and local communities.

This history of improvement and innovation in public services is supported by a thriving third sector, excellent universities and engaged businesses too. Increasingly, we have been working together to ensure we can make the biggest changes we can to the lives of local people. We have done this with a keen eye on local variation in populations, needs and service delivery.

In 2016, we face the most significant challenges for a generation. We know that we must keep innovating and improving if we are to meet the needs of our population in a tough financial climate. Demand for services is growing faster than resources. Services in some places are not configured to meet modern standards. And local people want things to be better, more joined up, and more aligned to their needs. This is clear from the continuous engagement we have with local people, as well as the changing world we live in.

Over the past six months, the leadership and staff of West Yorkshire and Harrogate health and care organisations have been working together on how we respond to these challenges. We have been combining existing plans and seeing how we deliver ambitious improvements for people in Bradford, Calderdale, Kirklees, Leeds, Harrogate and Wakefield. In doing so, we want to close the health gap that persists between communities; the care gap that leads to unwarranted variation; and the financial gap that we see opening up in future. In doing so we will deliver our contribution to the national “Five Year Forward View”.

This document sets out our high level proposals. These are built on the ongoing work that has been taking place locally through Health and Wellbeing Boards and local partnerships. They mean an emphasis on prevention, supported self care and joined up services in communities. They mean a genuine focus on people and their mental, physical and social care needs. They mean better cooperation between hospitals to deliver good care that is safe-sized. They mean changes to the commissioning of services, to be much more joined up so that we maximise the power of our finances. They mean a much better compact with local people and local third sector organisations – changing the deal with our communities to build on their assets. And they mean making West Yorkshire and Harrogate a place people want to work and innovate.

Over the next six months we will keep engaging with staff and the public, to further develop our plans and build on engagement activities to date, ensuring the involvement of everyone in future conversations around proposals for change.

**Rob Webster**

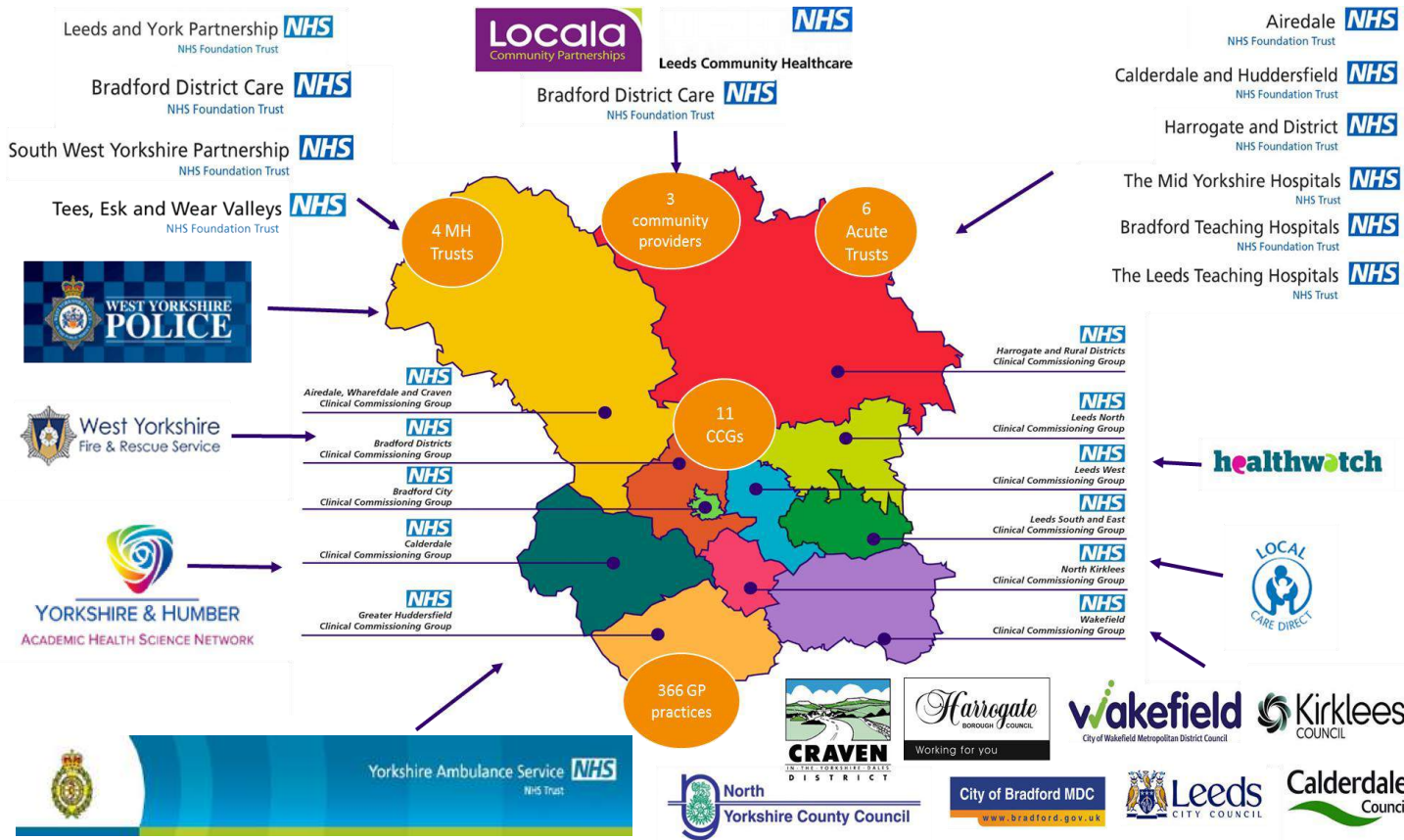
**On behalf of the leadership of West Yorkshire and Harrogate**



# Section 1: Introduction and our approach



# Our health and care economy



- Serving a population of 2.64m
- With a total allocation of £4.7bn across health by 20/21
- And 113,000 health and social care staff

Plus...

- 650 Care homes
- 319 Domiciliary care providers
- 10 hospices
- 8 large independent sector providers
- Thousands of Voluntary & Community Sector organisations

# A vision for health and care in West Yorkshire and Harrogate

We have worked together to develop a shared vision for health and care services across West Yorkshire and Harrogate. All of our proposals, both local and at STP level support the delivery of this vision:

- Every place will be a **healthy place**, focusing on **prevention, early intervention and inequalities**
- We will work with local communities to build **community assets** and resilience for health
- People will be **supported to self-care**, with **peer support** and technology supporting people in their communities
- Care will be **person centred**, simpler and easier to navigate
- There will be **joined-up community services across mental & physical health and social care** including close working with voluntary and community sector
- Acute needs will be met through services that are **“safe sized”** with an acute centre in every major urban area, connected to a **smaller number of centres of excellence providing specialist care**
- In some areas local services will evolve into **accountable care systems** that collaborate to keep people well
- We will move to a **single commissioning arrangement** between CCGs and local authorities and have a stronger West Yorkshire and Harrogate commissioning function
- We will **share back office functions and estate** where possible, to drive efficiencies to enable investment in services
- West Yorkshire & Harrogate will be **great places to work**
- We will always **actively engage people** in planning, design and delivery of care
- West Yorkshire and Harrogate will be an international destination for **health innovation**

# Leadership and guiding principles: a new way of working....

This STP has been created through our collective leadership. Our aim is to achieve the best possible outcomes for people through delivery of the Five Year Forward View

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

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

**These are critical common points of agreement that bind us together**



# Our approach is built on the principle that we do the work as close to local populations as possible...

West Yorkshire and Harrogate has significant pockets of deprivation and affluence. Populations with higher levels of deprivation continue to experience health inequalities and achieve worse outcomes. We have a large population of children and young people with 1 in 5 growing up in poverty and parts of the region such as Harrogate & Rural District and Craven have populations of older people growing faster than the national rate.

Our region has densely populated urban areas around the cities of Bradford, Leeds and Wakefield and large towns of Huddersfield and Halifax. Large rural areas cluster around the district of Craven.

Our different diversity of geography and communities makes West Yorkshire and Harrogate a diverse footprint and because of this it is important that we plan our health and care services to meet the needs of these different communities. The best way to do this is by planning and delivering services with and as close to these local populations as possible.

To support us in this process, we have strong local

relationships through our six Health and Wellbeing Boards and most of our transformation work is planned and delivered at this local level – based on people's needs and circumstances. This work is a collaboration of commissioning and provider organisations across physical and mental health, social care, voluntary and community sector and Healthwatch in these local areas of Bradford District and Craven, Calderdale, Harrogate and Rural District, Kirklees, Leeds and Wakefield.

There are some areas where we need to work on a bigger scale in order to be successful. We apply three tests to determine when to work at this level:

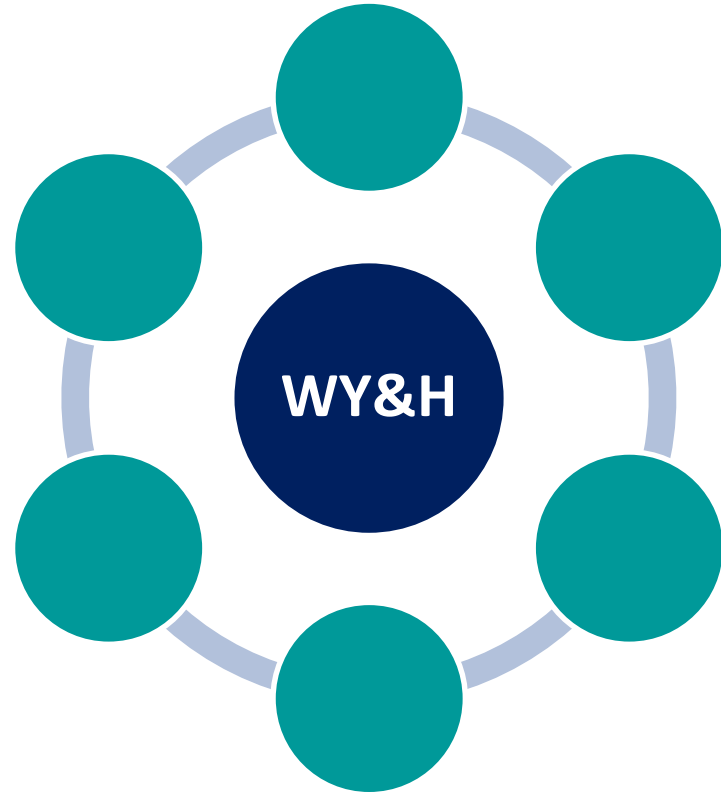
- To achieve a critical mass beyond local population level to achieve the best outcomes
- To share best practice and reduce variation
- To achieve better outcomes for people overall.

# Relationship between the West Yorkshire and Harrogate led work programmes and our six localities...

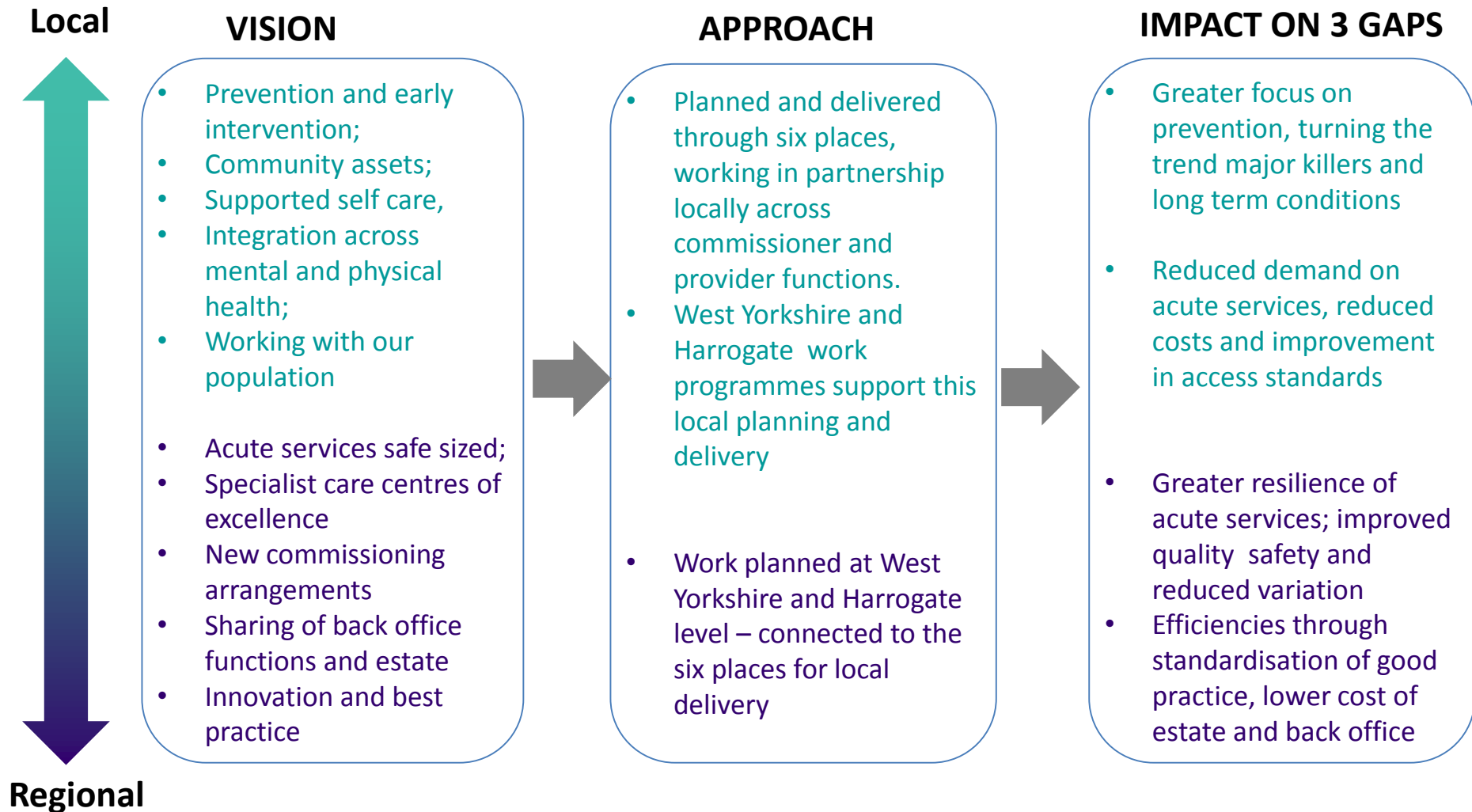
The connection between the West Yorkshire and Harrogate level work streams and the six 'places' is critical.

The planning, leadership and increasingly the decision making for these work programmes will be taken at a West Yorkshire and Harrogate level jointly through collaboration of statutory organisations.

Implementation is delivered through the six localities to an agreed set of principles and standards.



# From vision to impact



# There are a number of common actions to drive impact in our place based plans...

## Prevention and early intervention

- Programmes focused on locally relevant challenges with most areas prioritising areas such as obesity, smoking, cardiology, respiratory, mental wellbeing and frail elderly.

## Supported self care

- Evidence based, person-centred approaches, which support people to take greater control and management of long-term health conditions. Training of the workforce to facilitate this elevated level of independence.

## Primary and community care

- Increasing access to primary care in hours and out of hours through primary care at scale and new models of care in the community. A new compact with the voluntary and community sector. Commitment to implement the GP and Mental Health Forward Views. Managing demand for acute services.

## Joined up services

- A variety of models and options for integrating services to make them more efficient and better aligned to the delivery of people's health and wellbeing outcomes and person centred care.

# And we have identified the following priorities for working together at West Yorkshire & Harrogate level...

- Cancer services
- Urgent and emergency care
- Specialist services
- Stroke (hyper-acute and acute rehab)

We work together because of the need for critical mass

- Standardisation of commissioning policies
- Acute collaboration
- Primary and community services

We work together to reduce variation and share best practice

- Mental health
- Prevention at scale

We work together to achieve greater benefits

# The evolution of these plans is built on previous work and future planning processes...



The foundation of these proposals is the six place based health and wellbeing strategies.

These strategies are grounded in a clear understanding of local population needs and preferences.

The development of a West Yorkshire and Harrogate collaborative programme after application of the 'three tests'.

Nine programmes planned at West Yorkshire and Harrogate level and delivered locally.

As part of the current 2 year planning process , organisations will develop detailed plans for delivery in years 2 and 3 of the 5 year STP time line



## Section 2: The triple aim

# The triple aim: Closing the gaps

There are three gaps outlined in the Five Year Forward View these relate to health and wellbeing, care and quality of services and finance and efficiency.

Our approach is to ensure that we can improve outcomes in health and wellbeing and care and quality whilst delivering within the resources available.

**We consider all three gaps as equally important, with finance as a servant of the other two gaps.** All our plans are focused on closing these three gaps in West Yorkshire and Harrogate.



Health and  
Wellbeing

Care and quality

Finance and  
efficiency



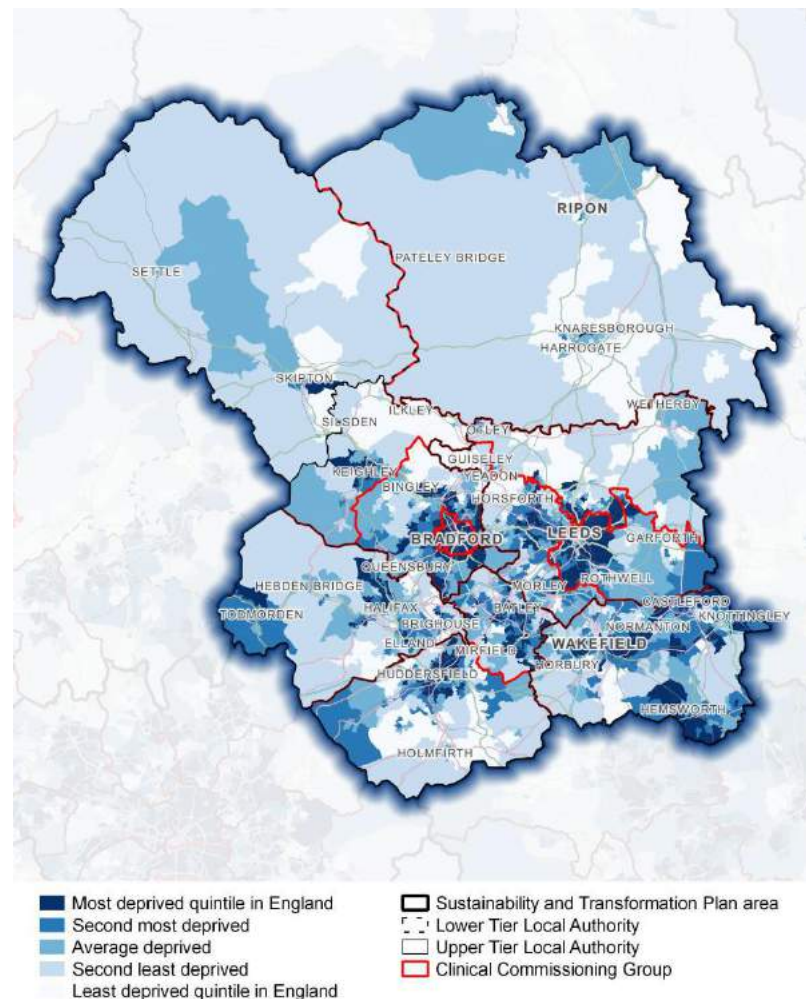
# Health and wellbeing gap: Our challenges

We have made significant progress on many health and wellbeing indicators of recent decades but there are still major challenges.

Where you live still has a significant impact on your life chances and health and care outcomes, for example:

- There is an 11 year variation in life expectancy for males across Leeds
- There is a 10.2 year variation in life expectancy for females across Calderdale
- We have higher than average rates of adult obesity
- We have higher than average rates of smoking, including maternal smoking at delivery.

## Deprivation across West Yorkshire and Harrogate STP footprint



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# Health and wellbeing gap: Our aspirations

THEME		ISSUE	ASPIRATION
Health and care inequalities	Smoking	18.6% of our population smoke. This is higher than average and is the main preventable cause of cancer.	To reduce smoking rates to 13% by 2020-21 - approximately 125,000 fewer smokers compared to 2015-16.
	Obesity	8 of 11 CCGs have significantly higher than average childhood obesity levels. 1.3 million people (50% of population) are overweight.	There are 226,000 people at risk of diabetes in West Yorkshire and Harrogate. Our aspiration is that 50% of these are offered diabetes prevention support, with a 50% success by 2021.
	Alcohol	There are around 455,000 binge drinkers in West Yorkshire and Harrogate. This has major health consequences and adds significant burden on services.	To reduce alcohol related hospital admissions by 500 a year and achieve a 3% reduction in alcohol related non-elective admissions.
	Cancer	Only around half of all cancers are diagnosed at a curable stage. Significant inequalities in outcomes across ethnic groups.	Increase in survival rate to 75% by 2020-21, with the potential to save 700 lives each year.
	Mental Health	We have a higher prevalence of anxiety disorders and depression and a higher than average suicide rate.	A zero suicide approach to prevention, aspiring to a 75% reduction in numbers by 2020-21
	CVD & Stroke	All West Yorkshire Authorities have significantly worse rates for CVD mortality in under 75s when compared to England.	Reduce cardiovascular events by 10% by 2020-21 e.g. in Bradford District & Craven this will mean a reduction in cardiovascular events for 600 people

# Care and quality gap: Our challenges

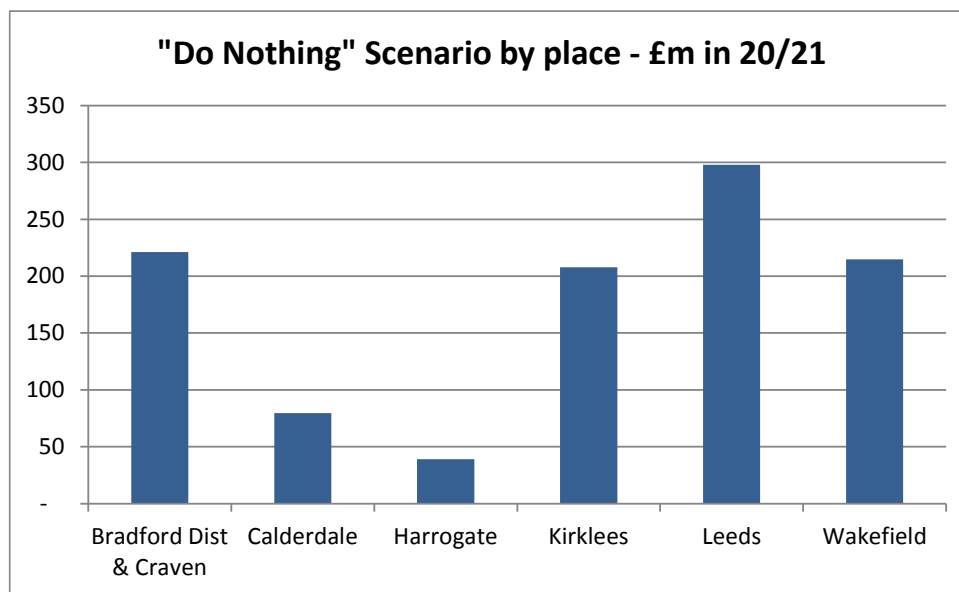
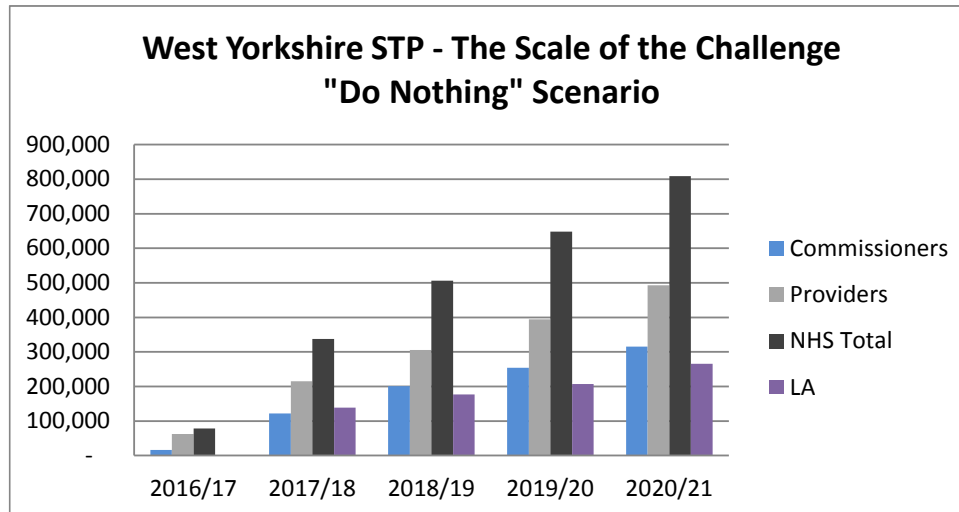
- The significant majority of services are high quality, timely and offer a good experience for service users.
- Performance against key standards has dipped in recent times and patient experience for some services remains below average, for example:
  - Performance against the accident and emergency 4 hour waiting standard and the 18 week referral to treat standard have been deteriorating over time across most of the STP area.
  - Delayed transfers of care are a problem for patients and the system. They are one of the biggest challenges for acute providers in terms of performance and quality. Without action this position will deteriorate further.
  - There still differential experiences and worse outcomes for those people with mental health issues when compared to others
  - People's experience of health and care services varies considerably by service and community.
  - Half of people over 65 are not satisfied with the level of social contact they have

# Care and quality gap: Our aspirations

THEME	ISSUE	ASPIRATION
Urgent and Emergency care	The urgent and emergency care system is complex and difficult to navigate. A&E performance is deteriorating. Pathways are often unnecessarily complicated.	To deliver the 95% 4 hour A&E standard in March 2017, and consistently thereafter. 30% all calls to 111 transferred to a clinical advisor in March 2017.
Planned care	The increasing demand for planned care is placing an unsustainable burden on the acute system leading to a deterioration in the referral to treatment standard.	To deliver the 92% 18 week referral to treatment standard consistently.
Patient experience	There are significant variations in patient experience across services, population groups and local geographies	To deliver an aggregate improvement in patient experience for all major services by 2020/21
Cancer services	There are currently a number of access standards for cancer services depending on pathway. Performance against these standards are variable.	Deliver a new 28 days to diagnosis standard for 95% of people investigated for cancer symptoms
Mental Health	People with mental health concerns are better served in the community rather than through A&E – yet A&E use is still relatively high. People needing acute mental health care are still too often placed many miles away from home.	A 40% reduction in A&E attendances for people with mental health issues by 2020-21 Elimination of out of area placements by end 2017

# Finance and efficiency gap: The financial challenge

- Resources across the health sector grow from £4.2bn to £4.7bn by 2020-21. This is lower than the national average, and is far outstripped by the demand for services over the same period
- Demand for and cost of services, if unmanaged will drive a gap of £1.07bn by 2021 for health and social care – based on a bottom up analysis built up and owned by the individual organisations.
- This has captured the “Do Nothing” challenge for 2016/17 to 2020/21 which equates to £809m for the NHS plus a further £265m for social care and public health.



# Finance and efficiency gap: Our solutions by 2020/21

Our solutions are developed as part of the place based planning - with West Yorkshire and Harrogate programmes supporting local delivery. The high level position for 2020-21 is as follows:

- The total value of our solutions is £983m across health and social care by 2020-21 each of which requires some further development to strengthen confidence. We are factoring in £78m of STF monies in 2020-21 towards closing the gap, and £94m for the cost of change.
- Our overall position is a deficit of £91m, made up of an NHS surplus of £43m, and a gap of £135m in social care.
- Local authorities are statutorily required to break even and we are working together to understand how this pressure can be mitigated.

		£m
<b>Do Nothing</b>		<b>(1,075)</b>
<b>Solutions</b>		
<b>1. Operational Efficiencies:</b>		
Provider efficiencies: Carter programme - Estates		8
Provider efficiencies: Carter programme - All other		93
Provider efficiencies: Non-Carter		329
Primary medical care (GP)		7
CCG other efficiencies (e.g. CHC, prescribing, admin, other)		102
<b>2. Activity Moderation Efficiencies:</b>		
Specialised commissioning QIPP		30
Urgent and Emergency Care (UEC)		10
New Care Models (NCM)		34
RightCare		36
Self Care		1
Prevention		31
Low value interventions		1
<b>3. Social Care</b>		131
<b>4. West Yorkshire Programmes &amp; Opportunities</b>		93
<b>Gross Solution Total</b>		<b>906</b>
<b>less STF used to deliver change</b>		<b>(95)</b>
<b>Net Solution Total (as visible in the template)</b>		<b>811</b>
<b>STF Monies</b>		172
<b>Total</b>		<b>983</b>
<b>Residual Do Something Surplus / (Deficit)</b>		
NHS		43
LA		(135)
<b>Total</b>		<b>(91)</b>

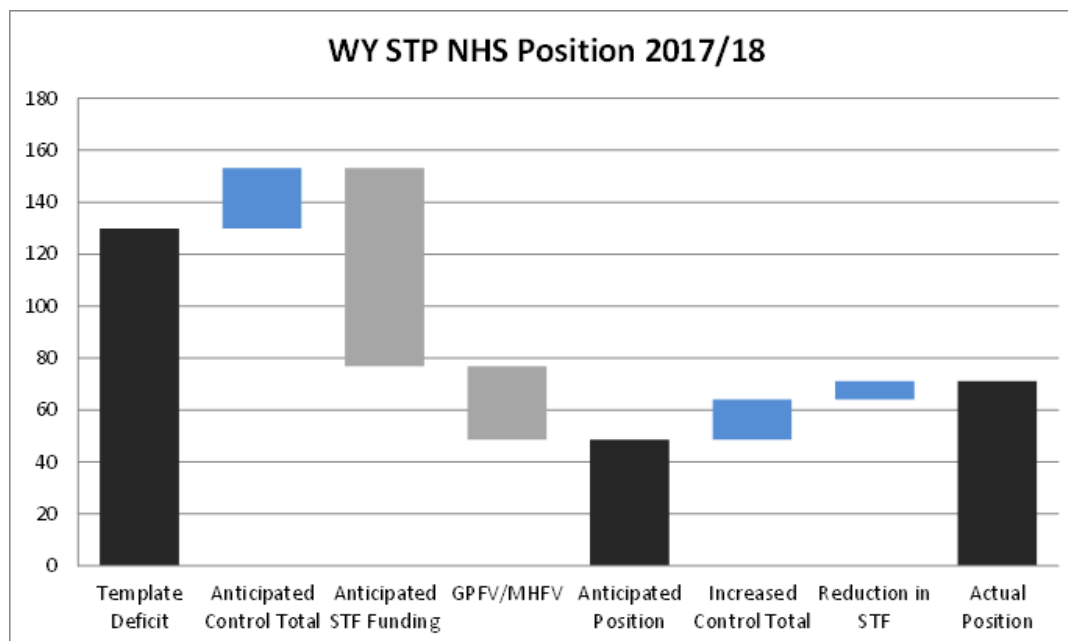
# Finance and efficiency gap: Our approach

- We recognise the need to work collaboratively towards a West Yorkshire and Harrogate control total and are exploring how best to do so and manage our collective opportunities and risks.
- Due to our growth and the underlying financial position of some of our organisations, the scale and scope of our transformation needs to be early and radical, and requires significant revenue and capital investment in the early years.
- There is an assumption that organisations collectively will deliver their control totals in 2016/17, which would bring significant risk to the outer years if these are not achieved.
- Transformational capital is required to enable the service reconfiguration and back office efficiency gains of our provider sector, to deliver financial sustainability and tackle the long term structural challenges.
- Release of Transformation Funds in the early years will enable an faster implementation of our solutions and bring them forward from the later to the earlier years of our STP plan.

**In order to deliver the proposals in this document, our preferred approach is that the available transformation resources for our footprint are devolved for management at a West Yorkshire and Harrogate level. This would give us the ability to plan ahead collectively, deploy transformation funds towards our greatest opportunities and enable rapid change.**

# Our NHS Position in 2017/18

- The challenge facing West Yorkshire and Harrogate in 2017/18 is significant. The ability to deliver the financial position in 2016/17 will have a material impact on our plans heading in to 2017/18.
- The current STP plan forecasts a £4m surplus for CCGs, before any investment in the GP 5YFV and the MH 5YFV. This is broadly in line with national expectations.
- The provider position is currently £36m from breakeven (prior to any transformation funds being received). This means a further £39m would be required to achieve the control totals that have been set by NHS Improvement.
- We believe this position will improve as the discussions around control totals continue and through receipt of transformation funding.







## Section 3: Place based proposals

# Place based plans: Our approach

The foundation of our proposals is the six place based health and wellbeing strategies.

West Yorkshire and Harrogate has a diverse population with a range of health and social care needs. We believe that for the majority of care and services, these needs can be best met by developing and delivering plans locally through local partnership working – rather than a top-down approach.

The following slides provide an overview of each place based plan. These plans have strong local buy-in and have been approved by the relevant Health and Wellbeing Board.

## Our six 'places'



Bradford District and  
Craven

Calderdale

Harrogate and Rural  
District

Kirklees

Leeds

Wakefield

# Bradford District & Craven: Overview of place and plans

**Bradford District and Craven has a large geographic footprint incorporating significant deprivation, some affluence, urban, rural and city living. Our population is one of the most diverse nationally and significant health inequalities still exist across the different areas of the district. People, especially women, live a significant proportion of their lives in poor health and more than 33,000 children live in relative poverty. The District is known nationally for its work in digital healthcare in particular providing 24/7 face to face video consultation.**

## High level overview of plans

- Prevention and early intervention at the first point of contact with a specific focus on children, obesity, type 2 diabetes, CVD, cancer, respiratory and mental wellbeing
- Creating sustainable, high impact primary care through our primary medical care commissioning strategies and commissioning social prescribing interventions
- Supported self-care and prevention by maximising our community assets to support individuals and train our workforce to empower and facilitate independence
- Provision of high quality specialist mental health services for all ages and early intervention mental wellbeing support services.
- Delivering population health outcomes and person centred care through new contracting, payment and incentives in line with accountable care models elsewhere. This includes specific interventions that transform services to address the physical, psychological and social needs of our population, reducing inequalities and addressing the wider determinants of health.
- Developing a sustainable model for 24/7 urgent and emergency care services and planned care.

# Bradford District & Craven: The triple aim

## Health and Wellbeing

By 2020/21 we will:

- Reduce childhood obesity by 5%
- Reduce smoking prevalence by 5%
- Train 10% of the workforce to support people to better self-care
- Prevent cardiovascular events for 600 people
- Screen an additional 5500 women for breast cancer
- Screen an additional 1500 people for bowel cancer
- Screen an additional 500 women for cervical cancer
- Recognise and value peoples mental wellbeing and take an early action to maintain their mental health (indicators as per the mental wellbeing strategy 2016-2021).

## Care and Quality

By 2020/21 we will:

- Save 150 lives by reducing variation in care
- Reduce non-elective admissions by 4%
- Develop a sustainable care market and create a sustainable model of planned and emergency/urgent care that meets clinical and constitutional standards including seven day services in the 4 priority areas as a minimum.
- Commission primary medical care that ensures seven day access achieved for 100% of population
- Have all-age MH liaison teams in place in all acute providers and meet the “Core 24” standards
- 90% of people who access Psychological Therapies will engage through direct self-referral.
- Ensure 70% of people with diabetes experience the 8 care processes

## Finance and efficiency

By 2020/21 we will have implemented plans to close the £221m gap as follows:

- £106.7m of provider and commissioner efficiencies, transforming care programmes in acute and community service areas
- Utilising £18.1m of Sustainability and Transformation Funding (STF)
- Creating the opportunity to shift additional resources into primary care (£1.8m by 2018/19)
- £46.1m of efficiencies through further work on clinical thresholds, procedures of limited clinical value, reducing unwarranted variation and further West Yorkshire and Harrogate opportunities

Through our transforming care programmes we will seek to mitigate the £50m pressure in social care.

# Bradford District & Craven: Progress and next steps

## Progress so far

- In 2016/17 we established provider alliances, including primary medical care at scale, and together with the commissioner alliance are progressing to our ambition of improving population health outcomes and person centred care.
- Addressing the holistic needs of patients with multiple comorbidities through complex care models across the patch. AWC is a pioneer site and has seen a 2% reduction in non-elective admissions. We are a Vanguard site (Enhancing Health in Care Homes) and are evaluating video consultation in care homes and the Gold Line service for patients at the end of life.
- Developing our first population health outcomes type of contract for Bradford ; accountable care accelerator programme in AWC designing new contracting models .
- Aligned our three CCGs under single accountable officer and chief finance officer with further shared arrangements over the next twelve months.
- Ensured the shift of secondary to primary care activity over the last ten years have been mainstreamed through the PMS review alongside improvements in primary care access .
- Our crisis care concordat and first response services have received national recognition and we have had no mental health out of area placements in over a year.
- We have a nationally recognised digital shared care record across health and social care.
- We have a big lottery funded programme Better Start Bradford aimed at improving life chances for children through a comprehensive programme of interventions and activities which will improve outcomes.

## Next steps

- Building on the transformation of complex and enhanced primary care programme, AWC will move to a shadow accountable care system in April 2017 with a 'go live' aim of April 2018.
- Structured collaboration for Bradford out of hospital clinical and social care model commenced in September 2016 with intention to create a new contracting model in 2017.
- Procurement of a new model of care for diabetes awarding one outcomes-based accountable care contract in April 2017.
- We aim for a total population coverage of accountable care by 2021.
- Sign off of our mental wellbeing strategy including the Children and Young People's Mental Health Transformation Plans implementation 2016/17 & 2017/18.
- Develop a sustainable care market and a sustainable model of planned and emergency/urgent care that meets clinical and constitutional standards including seven day services in the four priority areas as a minimum for Bradford and Craven that takes account of the West Yorkshire and Harrogate acute collaboration work, workforce challenges and quality standards. Programme scope agreed by Autumn 2017.
- Review investment in Public Health expenditure by December 2016 for implementation with effect from March 2017
- Workforce strategy for the health and care system by December 2016.
- As part of the one public estate programme we will have an estates strategy for the health and care system by March 2017.
- Digital technology strategy for the health and care system by June 2017.

# Calderdale: Overview of place and plans

**Calderdale has a plan to improve the health of local people, and the quality and efficiency of local services. We are reimagining a new health and wellbeing system which promotes personalisation, supports healthy decisions, enables physical activity and encourages responsibility by focusing on preventative services, self-care and early intervention, and providing interventions in the community, and using community assets, we can reduce the public need to visit hospitals**

## High-level overview of plans

- Our system is over-reliant on emergency unplanned hospital activity compared to the rest of the country with high levels of 'avoidable' admissions - £9m avoidable admissions per annum.
- Local people tell us they would prefer to receive care closer to home, with good access to appointments and continuity of care
- Our workforce is getting older and we have difficulty retaining and recruiting in some professions.
- By focusing on preventative services, self-care and early intervention, and providing interventions in the community, and using community assets, we can reduce the public need to visit hospitals and contribute to the triple aim
- By pursuing our dual aim of changes to hospital based care and changes to primary and community based care we aim to improve care and quality of services for the people of Calderdale

# Calderdale: The triple aim

## Health and wellbeing

- 10% fall in mortality from causes considered preventable by 2020
- Increase number of physically active adults by 10% by 2020, equal to >9000 people
- Reduce health inequalities by focussing action with vulnerable communities. Right Care data suggests we can save 43 lives by working together on this. National benchmarks suggest we can add 10-15 years to the lives of people with long term mental health needs.

## Care and quality

- Increase proportion of people satisfied with access to care and continuity of care in the GP Patient Survey and Friends and Family tests.
- Reduce number of people admitted to hospital with a treatable or preventable condition within the community by 70% to 1,695 admissions by 2021.
- In 4 years we will achieve a 75% reduction in suicides, with an ambition to reach zero
- Halving the number of patients who have extended LOS in hospital of between 11-100+ days (reduction from current 157 to 79 per quarter from Q1 16/17 baseline)

## Finance and efficiency

- Deliver the Calderdale STP solutions to reduce the financial gap for Calderdale in 2020/21 from £79m to £56m.
- Council would review medium term financial strategy to mitigate the deficit across the Council, including application of BCF, then work together as a system to mitigate the remaining Local Authority gap for example through integrated commissioning arrangements, reducing the financial gap currently forecast to be around £29m by 2020/21. This reduces the total Calderdale gap to £27m.
- Subject to CCG decision making on 20 October Right Care Right Place programme will further reduce the gap by £11m in 21/22 to £16m
- Work with partners across West Yorkshire and Harrogate to create a balanced financial plan for West Yorkshire and Harrogate

# Calderdale: Progress so far and next steps

## Progress so far

- We have engaged and consulted on large scale hospital change
- Community and primary care with other partners developing a fully integrated locality approach
- Created Calderdale Vanguard new care model
- We have a full value assessment/logic model of the care closer to home model including prevention and self care management
- Through the Better Care Fund we have an integrated Gateway to Health and Social Care, an integrated team managing transfer of care from hospital, an agreed approach to transforming care for people with learning difficulties, use of the NHS number as a single identifier across our system, an agreed approach to integrating our monitoring and performance management.

## Next steps

- Strengthening our primary care delivery plan for Calderdale in the light of development of the General Practice FV – Ongoing
- Consultation on future provision hospital and community healthcare - CCG decision to progress October 2016
- The first point of contact for health and social care will be delivered by Spring 2017
- Roll out of integrated community services through the implementation of 5 localities by Spring 2017
- Full implementation of new care model in community and primary care by 2018.



# Harrogate & Rural District: Overview of place and plan

Within the district there are pockets of deprivation and issues relating to rural isolation. We have an aging population – 10 years ahead of the national aging curve with 1 in 5 people aged over 65. There is likely to be an increase in the number of people who have a limiting long-term illness and the number living with dementia by 2020. Our population use more elective and non elective services than peer CCGs and have a positive experience of care.

## High-level overview of plans

- Self care, prevention and early intervention, specific focus on evidence based lifestyle prevention services, falls prevention, stroke prevention and mental health and wellbeing.
- Supporting individual and community resilience through our Stronger Communities and My Neighbourhood programmes, and social prescribing interventions.
- Integrated, expanded community-based teams capable of supporting the person's needs holistically, including physical, mental health and social needs. Person-centred and led care, optimised through proactive management, with people supported to manage their conditions in the way that suits them and are enabled to self-care.
- Redesigning out of hospital care - primary care and community services, with enhanced access and primary care working at scale.
- System approach to reducing demand and variation in elective care.
- Developing a sustainable 24/7 urgent care system.
- Stabilising the care market, improving availability and quality.
- Developing new approaches to personal care at home to address challenges facing us now, including an ageing workforce, increase in demand for care and the complexity of this care, and a shortage of people joining the profession.
- Redesigning the way care is commissioned.

# Harrogate & Rural District: The triple aim

## Health and wellbeing

- 95% of patients supported by a locality Integrated Team have a single care plan by March 2017.
- 72.2% of people with a long-term condition feel supported to manage their condition in 2016/17.
- Increase in the number of people with diabetes diagnosed less than a year who attend a structured course (national av. currently 5.7%).
- Increasing the proportion of people using social care who receive self-directed support and those using direct payments.
- Increasing the number of people using personal health budgets, focusing initially on learning disabilities, mental health and children and young people with long-term healthcare conditions.
- Reduce % of children aged 10 or 11 (Year 6) who have excess weight.

## Care and quality

- Develop affordable model for planned care that supports delivery of NHS constitutional standards
- 60% of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral by 2021.
- 75% people referred to IAPT begin treatment within six weeks, and 95% within 18 weeks, with a 55% recovery rate from treatment
- Long term support needs met by admission to residential and nursing care per 100,000 population aged 65+ reduces year on year.
- Increase % of new cases of cancer diagnosed at stage 1 and 2.
- Increase % of people whose blood pressure is controlled to 150/90.

## Finance and efficiency

- Delivery of all organisational control totals in the local systems' organisations in 16/17 is expected
- There are recognised pressures in the system at a local level. There is currently £3.1m unmitigated risk
- Delivery required of £38.9m efficiencies against 'do nothing' trajectory (assumes no in year in risks materialise) to contribute towards delivery of financial balance across the wider system by 2020/21.
- Current local 'do something' plan identifies £17.6m 20/21 gap
- Reduction in A&E attendances by 11% by 2018/19
- Reduction in emergency admissions by 16% by 2020/21.

# Harrogate & Rural District: Progress so far and next steps

## Progress so far

- Implementation of our New Care Model: 'What Matters to Us'. By November 2016 we will have 4 community care teams, covering the whole district, aligned to clusters of GP practices, linked to adult social care services, ten additional community beds to support discharges from hospital and to prevent avoidable admissions and an Acute Response and Overnight Service
- Use of Calderdale framework to assess skills needed within the new care model. A clinical skills trainer is enabling staff to bring new skills into their repertoire and provide more holistic and coordinated care.
- We have engaged with our population on the design and delivery of the model.
- We are using Right Care methodology, the Elective Care Rapid Testing Programme (100 day challenge) and work on clinical thresholds to reduce elective demand and variation.
- We are working with our GP Federation and 17 practices on the GP Forward View Transformation Plan to deliver extended access and primary care at scale.
- We have discussed and agreed our local plan within our Harrogate Health Transformation Board and agreed a Memorandum of Understanding.
- We are exploring organisational forms and contractual options and having early discussions on integrated health and social care commissioning and delivery models.

## Next steps

- Referral Management Service with clinical review in place (January 2017).
- Roll-out of diabetes prevention programme (during 2017/18)
- Evaluation of our New Care Model during 2017/18 to ensure it is delivering the right place-based solution of integrated care.
- Agreement on scope of Integrated Health and Social Care Commissioning arrangements (Q4 2016/17).
- Development of Out Of Hospital Strategy – to include Primary and community estate strategy to meet changes in demography and demand for healthcare services (2017/18).
- Evaluation and decision on organisational form and affordability of new care model.
- Local Digital Roadmap implementation.

# Kirklees: Overview of place and plan

Kirklees has a diverse population that includes both urban and rural areas. The population is ethnically diverse, with some areas experiencing high levels of deprivation. There is variation in healthcare outcomes. The two Kirklees clinical commissioning groups: North Kirklees and Greater Huddersfield are within a single local authority footprint. Each CCG shares a main acute provider with another CCG in a different local authority; this adds complexity to the system. Some people in Kirklees wait too long to be seen for diagnosis and treatment, stay in hospital for too long and many of our patients don't have a good experience in our hospitals.. Whilst we face many challenges locally we are a forward thinking and innovative area. Our focus has been on driving integration across health and social care services and our first big step change in this was through the commissioning of an integrated model for community services across Kirklees providing a care closer to home model.

## High-level overview of plans

- Early Intervention and Prevention Programme including the development of a thriving voluntary and community sector;
- Implement and build on the Healthy Child Programme;
- Development of an adult wellness model in Kirklees;
- Improving the capacity and quality of primary care (including GP Forward View);
- Making social care provision more sustainable and more effective, including the development of vibrant and diverse independent sector;
- Development of business models to encourage providers to maximise independence;
- Change the configuration of acute services to improve quality and create efficiencies through the implementation of RCRTRP, Meeting the Challenge and Healthy Futures plans (UEC, Cancer, Specialist MH, acute stroke etc.);
- New approach/model for how to support people with continuing healthcare needs;
- Implementation of the Transforming Care Programme for people with learning disabilities;
- Changes to the commissioner landscape, including more integrated approaches; and
- Changes to the provider landscape to move towards adopting new models of care across health and social care and developing alliances.

# Kirklees: The triple aim

## Health and wellbeing

- Improve independence of vulnerable adults and year-on-year gains in self reported QOL for adults and carers in receipt of adult social care
- Childhood Immunisations – continue to achieve the 0-5years childhood Immunisation target of 95%.
- NCMP – 86.2% Reception children measured.
- Maximising Independence: 86% reported confidence in managing own condition on exit from our therapy services which exceeds the commissioner's target of 80%.

## Care and quality

- 19% reduction in hospital admissions.
- 95% of patients demonstrate a maintained or improved level of functioning on exit from therapy services
- 98% of patients report a positive outcome on conclusion of care episode from Community Nursing, Specialist Nursing and Intermediate Care.
- 91% of patients clinically appropriate to remain at home are still at home following assessment and intervention at 24 hours
- Work with partners across the system to Reduce NEA back to 2014/15 levels (focus on care homes, frailty and LTC)
- Increase the number of people who die in their preferred place
- Increase screening rates across all cancers to national average
- Reduce number of emergency presentations for cancer

## Finance and efficiency

- 'Do nothing' gap of £208m.
- Programmes in place to close that gap include the re-configuration of acute service delivery (Right Care Time Place), second stage development of community services (Care Closer to Home) and implementation of the primary care strategy.
- The outstanding 'do something' NHS gap by 20/21 is £40m. Subject to CCG decision we expect implementation of Right Care Time Place in 21/22 would significantly reduce that gap. NHS and LA are working on the 'Kirklees plan' to close the remaining social care gap.

# Kirklees: Progress so far and next steps

## Progress so far

- Early Intervention & Prevention model agreed, based on complex, targeted and community plus levels, and programme entering Year 2, critical part of shift to 'New Council'.
- Healthy Child Programme in procurement phase.
- Model for an adult wellness model across Kirklees has been developed. Links to diabetes prevention.
- Both CCGs have co-produced primary care strategies. Plans are in development to produce local GPFV delivery plans.
- Models developed to deliver primary care at scale through a hub and spoke approach.
- CCG resources are being targeted at supporting practices to collaborate and be stronger together through federations.
- Kirklees Vision for Social Care agreed. Commitment to single approach to supporting the independent care sector.
- Strengths based social care practice training underway.
- Public consultation around changes to acute services at CHFT undertaken. Decision regarding next steps taken in Oct 2016.
- Partners across the MYHT health economy are mobilising the final year of the planned changes to acute services. Some changes are already in place to rationalise/centralise.
- Number of workstreams identified to manage demand, promote recovery and longer term sustainability at MYHT.
- Joint Chief Officer post is being piloted across NKCCG and Kirklees Council. A similar arrangement is also being piloted across the acute interface in North Kirklees.
- Procurement and mobilisation of an integrated community model across Kirklees

## Next steps

- Decision to proceed to Full Business Case on CHFT acute changes taken in October 2016
- Local delivery plans for the GPFV in place by December 2016
- Meeting the Challenge Year 3 changes to be made by April 2017 (pending further evaluation of system risk)
- Implementation of new Early Help Model for Children and families (2017/18)
- Models to deliver primary care at scale to be worked up (2017/18)
- Implementation of Healthy Child Programme (April 2017)
- New domiciliary care contract in place (April 2017)
- Roll out of new Frailty Model in North Kirklees (2017/18)

# Leeds: Overview of place and plan

Leeds is ambitious: we want to be the Best City in the UK by 2030. Our vision is that 'Leeds will be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest'. We have the people, partnerships and placed-based values to succeed.

We will be the place of choice in the UK to live, to study, for businesses to invest, for people to come and work, and as the regional hub for specialist health care.

Our services will provide a minimum 'universal offer' but will tailor specific provision to the areas that need it the most. These are bold statements, in one of the most challenging environments for health and care in living memory. We need to do more to change the way we have conversations across the city and develop our infrastructure and workforce to be able to respond to the challenges ahead. Much will depend on changing the relationship between the public, workforce and services, and ensuring that we work 'with' and not 'doing to'. We need to encourage greater resilience in communities so that more people are able to do more themselves. This will reduce the demands on public services and help us prioritise our resources to help those most at need. We recognise that we will have to continue to change the way we work, becoming more enterprising, bringing in new service delivery models and working more closely with public, partners and workforce in Leeds, and across the region, to deliver shared priorities.

## High-level overview of plans

- Investing more in prevention, targeting those areas that will reap the greatest reward.
- Building on our 13 integrated neighbourhood teams, we will develop new models of working, increasing and integrating our primary and community offer for out-of-hospital health and social care, providing proactive care and rapid response in a time of crisis: Self Management and Proactive Care, Efficient and Effective Secondary Care, Urgent Care / Response.
- Increasing sustainability and transformation of general practice as the cornerstone for New Models of Care (NMC) designed around GP registered lists.
- Using existing estate more effectively, ensuring it is fit for purpose, and disposing of surplus estate.
- Reviewing our procurement practices and top 100 supplier organisation spend to ensure that we get best value in spending for the Leeds £, and are benefitting from economies of scale.
- Engaging 'One Workforce' to work collaboratively and promote a 'working with' approach across all partners within the Health and Social Care system to provide high quality seamless services to support the delivery of new models of care to meet the population needs.
- Work collaboratively across the system to attract recruit, retain, develop the workforce through leading edge innovation and education and optimise the use of new roles, apprentice and skills mix.
- Having nationally pioneering integrated digital capabilities being used by a 'digitally literate' workforce.
- Digital capabilities and consistent information to support effective discharges, referrals, transfers etc. self and assisted care and integrated intelligence to inform better whole-system operational and strategic decisions.
- Use our high quality education, innovation and research to strengthen service delivery and its outcomes.
- Creating a citywide culture of shared responsibility between citizens and services; working with' people at every stage of change through clear communications and engagement.

# Leeds: The triple aim

## Health and wellbeing

- Progress the twelve priorities in the Leeds Health and Wellbeing Strategy to reduce premature morbidity and mortality and help narrow the health inequalities gap
- Reduce smoking rates from 21% to 13% by 2020/21 (for adults aged 16 years +)
- Breast cancer screening: increase uptake to England average of 75% by 2020
- Bowel cancer screening: increase uptake by 3% by 2020
- Bring the Leeds suicide rate down below the national average by 2020/21
- Support 2880 people who have been identified to be at risk of developing diabetes to attend the NHS National Diabetes Prevention Programme by 2019/20

## Care and quality

- Ensure 60% on Severe Mental Illness (SMI) registers undergo a physical health check each year
- Eliminate acute mental health out-of-area placements by 2020/21
- Deliver of the Emergency Care Standard
- Reduce the numbers of patients admitted as emergency cases for bed-based care
- Reduce bed days lost due to delayed discharges to 2.5% of the acute bed base by 2020/21
- Reduce the numbers of learning disability inpatient placements to 40 per million population by 2019/20
- Reduce the staff capacity gap by building multi-disciplinary teams and ensuring wider skills base for specific functions (e.g. care home worker)
- Ensure that 80% of people with a diagnosis of dementia will have been offered information and support to live with the condition, and a named contact with a 'care navigator' role, by 2020

## Finance and efficiency

- Our forecast for 2020/21 across Health and Social Care is a 'do-something' deficit of c£46m.
- The partners in the city are investing resources in the continued development and implementation of our local improvement plans. Our assumption is that we will receive our 'fair share' of national Sustainability and Transformation Funds and that our gap will be bridged through a combination of this funding, further local developments and the Leeds share of benefits delivered through the West Yorkshire and Harrogate workstreams.



# Leeds: Progress so far and next steps

## Progress so far

- A number of New Models of Care testbed sites across the city; 13 Integrated Neighbourhood Teams and Discharge teams launched.
- 'Choose Leeds' pan-sector recruitment campaign ongoing with events supported collaboratively across the seven Leeds partners; 'Citywide Workforce Database' established. Health and Care Academy plans initiated.
- Identified opportunities to pilot a One Workforce approach across the Health and Social Care system.
- Leeds Care Record in place, with ongoing developments to link to other health and social care record systems
- Plans underway to align workforce engagement with the wider culture change ambition.
- Phased estates review underway and early recommendations for site re-configurations being taken forward.
- Citywide Procurement review covering transport, utilities, agency staffing, stationery, catering and security underway.
- National Diabetes Prevention Programme (NDPP) pilot commenced July 2016 with 66 practices recruited so far and referrals commenced.
- Significant progress on the informatics agenda through the national Pioneer informatics network, led by Leeds
- Successful bid for innovation monies for projects such as digital literacy in the workforce, health coaching, development of provider governance tools and evaluation of the proactive telecare pilot (approx. £200k).
- Digital discovery workshops held on Prevention and House of Care; and Rapid response at time of crisis (0-4hrs) set in the context of the Urgent Care strategy, with findings validated with Leeds citizens.

## Next steps

- National Diabetes Prevention Programme pilot: GP practices have access to referrals process – October 2016.
- Integrated discharge service live from January 2017.
- Expand Leeds role as a centre of excellence for precision medicine during 2016-17 including the launch of the Centre for Personalised Medicine and Health in February 2017.
- New models of care pilot: Interim evaluation report and recommendations – September 2017.
- Phased Communications plan completed and enacted by December 2017.
- Early Implementer of 7 day services (LTH site) 2017-18 and roll out of extended access to Primary Care in 2018/19 and 2019-20.
- Further development of integrated out of hospital care based on NMC work to date exploring potential new community contract models.
- Leeds General Infirmary, significant site re-development planned to support major trauma and consolidation of children's hospital as part of development of the Leeds innovation district.

# Wakefield: Overview of place and plan

Our aspiration for 2020/21 is that we want people in Wakefield to have healthier, happier and longer lives with less inequality. Wakefield continues to have significant health issues despite much progress being made. Our JSNA reaffirms to us that our Health and Wellbeing Board priorities of early years (with a focus on childhood obesity, and maternal smoking at delivery), long term conditions (including diabetes, respiratory and circulatory diseases), Mental Health (including dementia and self harm) and older people (including reducing social isolation and falls) will address the health and wellbeing gap for Wakefield. We need to continue to tackle variation in care and to reduce health inequalities across the district. Constitutional indicators such as Referral to Treatment and A&E waiting times also will have a significant focus over the next five years to ensure we provide the best quality of care to our patients.

## High-level overview of plans

- Continue to implement our reconfiguration of hospital services across the Mid-Yorkshire Hospital footprint through the Meeting the Challenge programme, working towards delivery of seven day services for all acute care.
- Building on Meeting the Challenge, further transforming the provision of acute care at the regional or sub regional level.
- Develop a local network of urgent Health and Social Care Provision including out of hours provision, walk in and minor injuries, emergency departments, ambulance services, hyper acute centres and effective utilisation of 111 services.
- Further collaborative working with Mid-Yorkshire Hospital to develop a demand management approach to our planned care cohort.
- Collaborate with practices and Health and Social Care providers to develop and deliver high quality, evidence based, out of hospital services including advanced diagnostic testing, maternity care, specialists doctors, nurses and therapists and viable smaller hospitals
- Deliver a collaborative approach to working across the health and social care sector to ensure integrated care across primary and community providers.
- Prevention and early intervention with a specific focus on obesity, smoking prevalence, cardiology, respiratory, mental health and frail elderly working towards a collective prevention resource across the health and social care system.
- Implement a new Multi-Speciality Community Provider led Accountable Care System in Wakefield.
- Develop an ambitious co-owned strategy for ensuring safe and healthy futures for children and young people.
- Develop a new business model for the provision of corporate functions and corporate services across Wakefield, including estates, workforce and digital.
- Ensure person-centred primary care through our deliver of the the GP Forward View.
- Deliver a collaborative approach to self care.

# Wakefield: The triple aim

## Health and wellbeing

- Reduce Smoking prevalence by 2.4% by 20/21 bringing it lower than the current West Yorkshire and Harrogate average.
- Reduction of physical inactivity in adults from a baseline of 29.8% (2015) by 4.8% by 20/21 bringing it below the current England average.
- Reduce premature mortality from CHD to 42 per 100,000 by 20/21.
- Reduce premature mortality from COPD to 19.5 per 100,000.
- By April 2017 to achieve access standards for Early Intervention Psychosis service of >50% of people with a first episode of psychosis receiving treatment within 2 weeks, 75% referred to IAPT being treated within 6 weeks and 95% within 12 weeks.
- By 2020/21 to have reduce Injuries from falls in people aged 65 and over to 1827 per 100,000 population.
- By 2017 we will reduce our percentage of young people who are Not in Education, Employment or Training (NEET) to 4.5%.
- As part of the Integrated Pioneer programme, roll out a workplace wellness check service for 1,000 Wakefield System employees per year from January 2017.

## Care and quality

- Working collaboratively across MYHT, the LA and the CCG to reduce DToc by 3.5%.
- Increase and maintain dementia diagnosis to 67% by 2020.
- Increase the number of GP practices signed up to carrying out health checks on adults with learning disabilities from 37 to 40.
- Maintain our performance around diabetes, sharing learning and taking part in the diabetes prevention programme.
- By April 2017, reduce maternal smoking at delivery to 18%.
- Agreed with MYHT, non face-to-face telephone appointments as the default booking approach for follow-up appointments, with defined exceptions to this, with effect from 1st October 2016.
- From 1st October 2016 agreement with MYHT for e-consultation to be the default option for GPs to access outpatient care, via specialist advice and opinion, in Cardiology, and then Gastroenterology; Ear, Nose and Throat, and Pain Management.

## Finance and efficiency

- Delivery of £229m efficiencies against the 'do nothing' trajectory to deliver financial balance across the Wakefield system by 2020/21. Local contribution estimated as £185m and with additional measures at West Yorkshire & Harrogate level.
- Delivering a fully integrated model of accountable care of which a financial business case in development.
- An optimised back office for Wakefield, including workforce, IT and estates.
- Collaboration between acute care providers both on a regional and sub regional level.
- Fulfilling our statutory duties locally to achieve constitutional targets, in particular A&E 4 hour wait, 18 week Referral to Treatment and working towards our 28 day diagnosis standard.
- In addition, delivery of financial opportunities including RightCare, partnerships with public health making savings through better health and wellbeing outcomes, care home vanguard, Urgent and Emergency care redesign and planned care reform through a collaborative approach to demand management.

# Wakefield: Progress so far and next steps

## Progress so far

- We have centralised surgery and paediatrics as part of the ongoing Meeting the Challenge programme of service reconfiguration in Mid-Yorkshire Hospital Trust.
- We have developed the Wakefield Connecting Care Integrated Workforce Framework to support our transformation work.
- We have successful care home and MCP vanguards that have brought both commissioners and providers together to support and agree a joint committee for our MCP.
- Our new model of integrated care has been comprehensively evaluated and has highlighted that 96% of our patients felt that they were treated with kindness and compassion.
- Our five GP Federations are working in partnership with us to execute the Five Year Forward View and are fully aligned to development of an Accountable Care System.
- We have developed strong governance and accountability through our Health and Wellbeing Board supported by our STP which has clear lines of accountability
- We are better at meeting the needs of some of our most vulnerable patients having commissioned Mental Health workers in each of the Connecting Care Hubs.
- We have commissioned Mental Health Navigators in collaboration with Wakefield District Housing to support their tenants with a wide variety of mental health needs.
- Working with West Yorkshire Police we have been successful in securing £140k funding to implement a Street Triage scheme which will provide better support both to patients and police and lead to less patients inappropriately being held in s136 or custody suites and getting timely support.
- We have maintained a focus on our children and young people through our Children and Young People IAPT programme and our Future in Mind programme.

## Next steps

- By January 2017 we will have an operational plan which is aligned to activity and interventions with clear lines of accountability.
- Development of a Joint Committee in across commissioners and providers for our MCP by January 2017 to support the development of an Accountable Care System.
- Final business case approval for the MCP October 16.
- Engagement process for MCP starting Oct 16 and market engagement Dec 16.
- Develop Accountable Care Organisation by 2020/2021 bringing provision and integrated commissioning together to improve quality of delivery for community care.
- Business case for integrated support services through Local Services Board 2017.
- Full implementation of the Meeting the Challenge reconfiguration of services to deliver 7 day services for all acute care by 2019



## **Section 4: West Yorkshire & Harrogate proposals**

# Prevention at Scale

379,836  
smokers

## Smoking

- Reduce smoking related admissions and demand on services
- Systematic implementation of NICE guidelines in acute and MH services
- Effective communications across multiple media to support quit attempts

455,000  
binge  
drinkers

## Alcohol

- Reduce alcohol related admissions of those placing disproportionate demand on A&E and hospital beds
- Systematic implementation of hospital based alcohol liaison services, in-reach by community alcohol services and assertive outreach

1.3 m  
overweight

## Obesity

- Reduce the number of people currently at high risk of diabetes from going on to develop diabetes and reduce future demand on services
- Systematic early identification and intervention
- Annual review and access to healthy living services including intensive lifestyle behaviour change programmes

### Workforce and prevention

**To enhance the health and social care workforce contribution to place based preventative care and lifestyle behavioural change**

- Embedding 'Making Every Contact Count' into everyday practice
- Embed the principles and standards of Health Promoting Hospitals

# Prevention at Scale

## Key milestones and decisions

- **Nov 2016** Workforce workshop to work up priorities & plan
- **Nov 2016** Leeds NDPP all practices to have access to referral process
- **Nov 2016** Calderdale, Wakefield, Kirklees NDPP bid submitted
- **March 2017** Follow up on Alcohol Care team Review with partners to identify next steps
- **March 2017** Review alcohol related A&E data to understand barriers to implementing Cardiff model
- **Summer 2017** Workforce regional conference with 3<sup>rd</sup> sector, emergency services
- **Summer 2017** New e-learning resource to support MECC
- **2017** Harrogate to be 3<sup>rd</sup> wave NDPP
- NICE guidance on smoking:
- **Mid 2017** Communications and marketing
- **End 2017** implementation community /MH Trusts
- **End 2018** Implementation Hospital Trusts

## Impact

### Health and wellbeing

- ↓ Alcohol related mortality reduced
- ↓ Reduce smoking prevalence from 18.6% to 13% by 2020 (or by 105,000 smokers)
- ↓ Reduce cardiovascular mortality
- ↓ Reduce cancer mortality
- ↓ Reduce numbers of high risk of developing diabetes by 30-60% by 2020

### Care and quality

- ↓ Reduce alcohol related hospital admissions (narrow & broad measure) by 3%
- ↓ Reduce smoking attributable admissions in people over 35yrs
- ↑ Increase successful quit rates at 4 weeks per 100,000 smokers
- ↑ Increase numbers of identified at high risk of diabetes by 20% from baseline
- ↑ Numbers of attending NDPP programme and number of referred to Health Living Services
- ✓ Progress on meeting Health Promoting Hospitals standards
- ✓ Increased numbers of staff trained in Making every contact count

### Finance and efficiency

- ↓ An investment of £825k for five Alcohol Care Teams would lead to a reduction of 500 alcohol related admissions a year, resulting in a £3.17m ROI per year (Note: does not account for current services – that is variable)
- ↓ An investment of £450k would lead to a reduction of 50,000 smokers over 5 years at a saving to the NHS of £9m. Maintenance of current investment is required to continue a similar decline and savings over the same time period.
- ↓ Diabetes cost between £1107 – £2836 per year. West Yorkshire and Harrogate has an estimated 226,000 people at high risk of diabetes, if 50% attend and 50% do not go on to diabetes the savings are £62.5m - £160m over 5 years.

# Primary and community services

It is fundamental that primary care is locally planned and delivered to best meet the needs of local populations and deliver the commitments of the GP and MH Forward View documents (as set out in our six place-based plans). By working at a West Yorkshire and Harrogate level we can add value through:

- Sharing best practice and innovation
- Collectively determining what good care looks like
- Agreeing shared principles and operating to these.

In West Yorkshire and Harrogate we consider primary care to encompass a wide range of services supporting the health and wellbeing of the population, this includes general practice, community provision to meet physical health, mental health and social care. Many services delivered by Councils and the third sector sit firmly within our definition of primary care.

We have defined these principles with representatives from general practice, community services, mental health services, social care, voluntary and community services with Healthwatch.

Leadership for this work is provided through two Chief Executives of community provider organisations, our RCGP Ambassador for West Yorkshire and Harrogate STP and Medical Advisor (Primary Care Strategy, NHS England Yorkshire & Humber) chairing the primary and community workforce group for West Yorkshire & Harrogate.

## Next steps

The transformation of hospital care is predicated on the ability for all of primary care to work differently and collaboratively with patients' needs at its heart.

We must focus our energy in the right places and this means defining a few areas of focus in collaboration with our acute providers. These areas will be defined by:

- a) good quantitative evidence at West Yorkshire and Harrogate level that this is a material issue and can deliver benefit.
- b) evidence on a West Yorkshire level that the population's healthcare needs can be addressed in the community both effectively and sustainably.



# Primary and community services

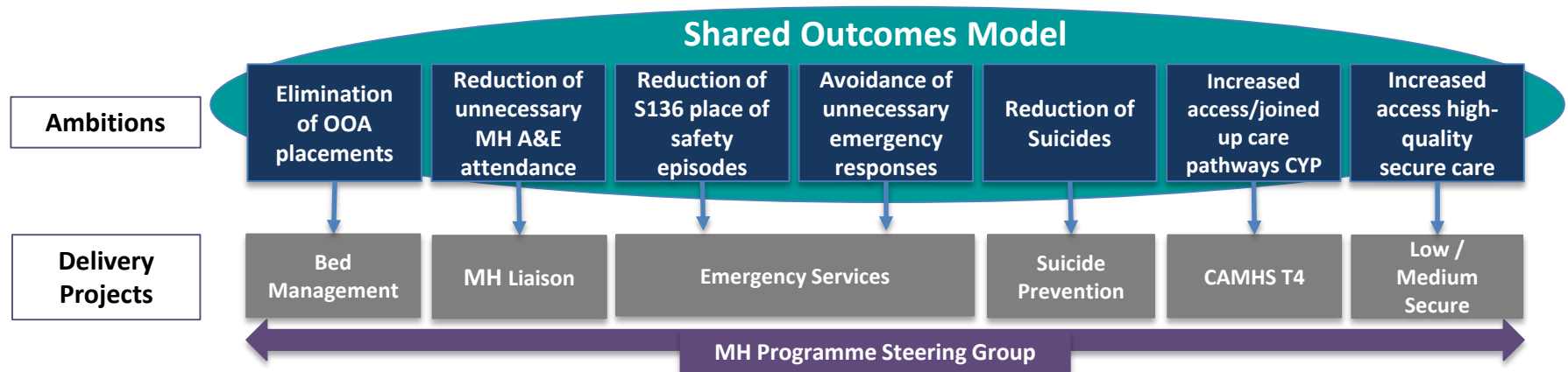
## Our principles for high quality primary care in West Yorkshire and Harrogate:

- We will deliver good quality integrated primary care to local populations, with 24/7 services that meet the needs of that local population, ensuring that services are organised around peoples' needs. This will be planned around a population size of c.30,000 – 50,000 (locally determined) with all resources focused on the holistic and community oriented care of that population.
- We will be bold in the adoption of the prevention at scale transformation to create a system-wide 'left shift' as a central philosophy, which will mean a fundamental move to enabling people to self-care and stay well for longer
- We will embrace new and existing technology to support people using services, their carers (paid and unpaid) in their care
- People will be partners in their care and engaged and involved at every level – this could mean the scaling of health coaching and or asset based approaches to care
- We will breakdown the culture of organisational silos and barriers to give the best care to our populations, focusing on the values of those people who work in primary care
- We will stop medicalising issues and ensure people get the right support from the right professional. We will look outside the clinical model to deliver a more holistic service to our local populations and achieve better outcomes; prescribing will not be the default position.
- We will ensure that we have the right workforce, in the right place, to deliver services. The people who make up the workforce will be energised, happy and fulfilled in their work and not limited in their ability to care
- We will create the space for primary care thought leadership which will allow innovation to flourish for the benefit of our patients. We will recognise and better share the real examples of transformation, best practice and new ways of working. In West Yorkshire and Harrogate we have great people doing great things, we will harness and share this, learning from one another.
- We must be bold in rationalising our estate where this mutually agreed and evidence shows that this in the interests of patient care and integrated working, ensuring that more public sector estate is utilised cohesively and to best value.

# Mental health

The providers of mental health services, working with commissioners and partners, are developing a **Shared Outcomes Model** to reduce variation in quality, improve outcomes and drive efficiency to ensure the sustainability of services.

Collective system ambitions and outcomes include: delivery of 7-day services, reducing out of area placements, ensuring people in crisis get the multiagency care they need, more care delivered in the community and full system pathway integration. Also key to achieving this ambition will be shared models for support services e.g. workforce planning and IT. Additional clinical areas have been identified as areas to be planned and developed at a West Yorkshire and Harrogate level these are; ADHD, Autism, eating disorders and perinatal services. The delivery of the Five Year Forward View for Mental Health is through interconnecting plans of the West Yorkshire and Harrogate level programmes and the six place-based plans. The focus of this programme is the delivery of acute/in patient services, specialist services that can be delivered over a larger footprint or where the pathway requires a full system approach.



## Progress so far...

- ✓ A new Safe Haven has been established in Bradford for people experiencing mental health crisis, with work underway to evaluate and inform roll out of similar models in other parts of West Yorkshire and Harrogate.
- ✓ Safer Spaces pilot for children and young people which will be rolled out to other parts of West Yorkshire and Harrogate, ensuring that young people requiring crisis care do not end up in police cells or A&E
- ✓ Introducing a model that places mental health nurses in police control rooms to establish effective ways of ensuring people in crisis receive the appropriate mental health support they need.
- ✓ Mental health screening tool and approach to mental health training across acute wards as an in-reach approach to driving a coherent, integrated and comprehensive mental health assessment for all patients is in development
- ✓ A system-wide multi-agency suicide prevention strategy is in development

# Mental health

## Key milestones and decisions

### Quarter 4 2016/17:

- Business case for control room MH nurses
- MH Liaison service proposal developed
- Suicide strategy and plan developed
- Business case for safer community spaces for adults and children
- Target operating model developed for provider trust support services

### Quarter 1 2017/18:

- Plan developed CYP in patient units (integrated with local pathways) eliminating inappropriate placements
- Plan developed for Low/medium secure services and associated pathways

### Quarter 2-4 2017/18:

- Bed management proposal developed to support reduction in out of area placements
- Proposal developed for standard approach to commissioning acute mental health services across West Yorkshire & Harrogate
- Provider alliance governance to be formalised

## Impact

### Health and wellbeing

- ↓ Reduction in mortality rates for mental illness
- ↓ A zero suicide approach to prevention, aspiring to a 75% reduction in numbers by 2020-21

### Care and quality

- ↓ Reduction in local variation of quality in services
- ↓ Elimination of out of area placements for non specialist acute care within 12 months
- ↓ 50% reduction of S136 PoS episodes both police and health based places of safety
- ↓ 40% reduction in unnecessary A&E attendance
- ✓ Deliver waiting time standard for CYP eating disorder service
- ✓ Deliver EIP target across West Yorkshire and Harrogate
- ↑ Increased access rates to IAPT services
- ↑ Increased access to 24/7 urgent and emergency mental health services for CYP
- ↑ Increased access to specialist perinatal mental health healthcare

### Finance and efficiency

- ✓ Delivery of the 5YFV for MH will require investment in services.
- ✓ This programme will support the delivery of system and provider cost improvement programmes reinvested in mental health care

# Cancer

The focus of the Cancer programme is to deliver the national cancer strategy in a way that makes sense in our region, ensuring that we deliver the best outcomes and experience. This includes:

Define **the characteristics of high quality primary care services** in support of the cancer ambitions

**Understand the gap in diagnostic capacity** required to deliver our ambition in relation to shift in stage of diagnosis.

**Develop and deliver pathways** for 95% of patients referred with suspicious symptoms to have a **diagnosis within 28 days**

Develop approaches to **using feedback from people affected by cancer & engaging them directly in service improvement**, e.g. pilot real-time interactive patient portal

Delivering the pledge to on **recovery package interventions and risk stratified follow-up** by 2020

**Improvement in treatment services driving out variation in practice and outcome**, based on best available evidence, focused on chemotherapy in first instance.

**Agree protocols for MDT working to release clinical resource** without compromising quality.

Develop and pilot more **strategic approaches to commissioning and provision of cancer care**.

## Progress so far...

- ✓ Re-establishment of local system leadership, securing stakeholder agreement for a chief executive-led Alliance Board reflecting multi-disciplinary and geographic diversity at a senior level & supporting programme infrastructure with strong executive buy-in.
- ✓ Secured agreement for the Alliance Board to develop a single delivery plan for cancer for West Yorkshire and Harrogate with a dual emphasis on delivery of the clinical priorities in the national cancer strategy and the system behaviours and requirements to facilitate this through more collective, strategic approaches to provision and commissioning.
- ✓ Successful in bidding to host two pilot sites for multidisciplinary diagnostic centres and a 28 day standard test site.
- ✓ Cross system deep dive to agree local priorities April 2016, baseline inventory of activity against the 96 Cancer Taskforce recommendations.

# Cancer

## Key milestones & Decisions

### 2016/2017

- Agree headline diagnostic growth and cancer content for 2 year operational plans

### 2017/2018

- Sign off Alliance Delivery Plan (April) including 5 year diagnostic capacity building plan.
- Commit to local action plans to deliver Recovery Package & risk stratified post-treatment pathways by 2020
- Produce option appraisal for service model for strategic diagnostic growth. Agree preferred model.
- Develop and agree to pilot new strategic approaches to commissioning and provision of cancer care.

### 2018/19

- Implementation planning for new diagnostic models including consultation as necessary.
- Roll out new protocols for MDT working.
- Agree implementation plans for delivery of 28 day Faster Diagnosis Standard.
- Begin implementation of commissioning policy to address variation in chemotherapy prescribing.

### 2019/20

- All cancer patients to have tailored support to live well and as independently as possible beyond diagnosis.

### 2020/21

- 95% of people referred for investigation of cancer symptoms to have diagnosis within 28 days.

## Impact

Focus of the Cancer Programme is on spending the West Yorkshire and Harrogate pound as cost effectively as possible to deliver the highest possible outcomes and experience.

### Health and wellbeing

- ↓ Reduce adult smoking rates from 18.6% to 13% resulting in c105,000 fewer smokers and c11,250 averted admissions.
- ↑ Increase 1 year survival from 69.7% to 75% equating to c700 lives per year.
- ↑ Increase stage 1&2 diagnoses from 40% to 62% offering 3,000 extra people the chance of curative or life extending treatment.

### Care and quality

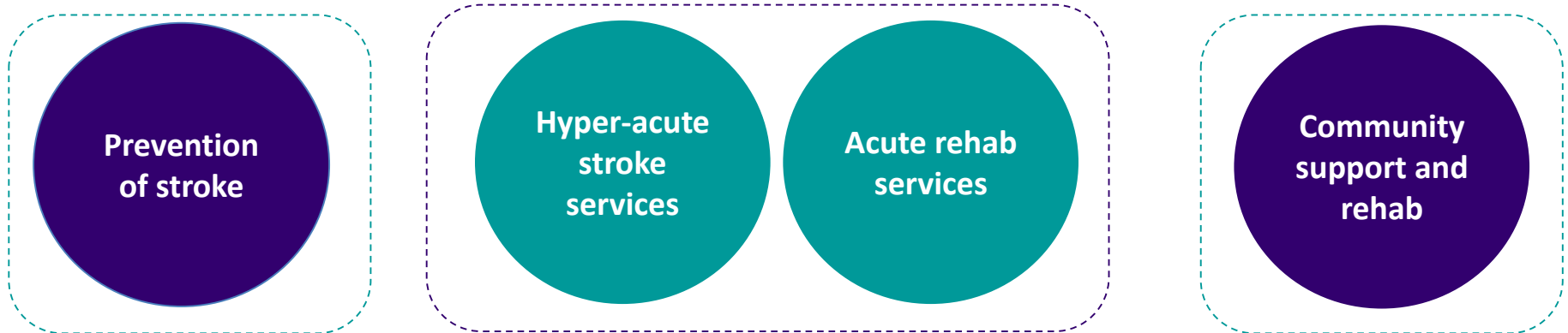
- ↑ Increased % of patients formally invited to feedback to improve services over and above CPES (target TBC)
- ✓ Deliver the 28 days to diagnosis standard for 95% of people investigated for cancer symptoms to deliver faster diagnosis for c5,000 people currently diagnosed with cancer through RTT pathways.

### Finance and efficiency

- ↓ Estimated savings of up to £12million over 5 years based on lower treatment costs associated with earlier stage diagnosis for many forms of cancer.
- ↑ Delivering this efficiency will require growth in diagnostic capacity of c2-3% additional to that in local baseline trajectories.

# Stroke

Considerable progress has been made to improve outcomes for stroke patients across West Yorkshire and Harrogate. Variation continues to exist in outcomes and quality of services. Our work focuses on the whole stroke pathway with stroke prevention and community rehabilitation and support delivered in local places to meet the needs of the specific populations; these elements will be locally planned with a consistent approach determined by clinicians and stakeholders across West Yorkshire and Harrogate to reduce variation. We've already worked together on preventative measures to detect and treat atrial fibrillation. In West Yorkshire and Harrogate, future sustainability and patient flow requires that we focus on hyper-acute stroke services and acute rehabilitation together on a regional basis to deliver the best possible outcomes for those people affected by stroke.



## West Yorkshire and Harrogate planning of services

We currently have five hyper-acute stroke units in West Yorkshire and we know that this is not sustainable for the future. The Strategic Clinical Network has produced an in-depth blueprint which details service models to ensure delivery of the best clinical outcomes for patients who need hyper-acute stroke care. This indicates that we will need to reduce the number of hyper-acute stroke units across West Yorkshire and Harrogate, so that our services are safe and resilient. In doing so, we will save more lives, reduce ongoing disability and ensure better care and quality of service for patients, including provision of a consistent service over seven days.

### Our plan:

- Work with key stakeholders to understand the options for delivering stroke services – we've started this process.
- Formal consultation with our population on the configuration of hyper-acute and acute rehabilitation of services
- Because of our geography, we'll be working closely with our colleagues across the wider Yorkshire and Humber footprint to ensure high quality, sustainable hyper-acute stroke services for all.

# Stroke

## Key milestones & Decisions

**End December 2016** - Stage 1 NHSE Assurance - Strategic Case for Change (SCfC) assurance and sign off

**End January 2017** - Stage 1 NHSE Assurance - SCfC sign off by NHSE

**End April 2017** - Stage 2 NHSE Assurance – Outline Business Case sign off (subject to Stage 1 NHSE approval to proceed)

**End May 2017** - Stage 2 NHSE Assurance – OBC sign off by NHSE and approval to proceed to Formal Consultation

**End September 2017** - Stage 3 Assurance – Formal Consultation completed (Subject to NHSE Stage 2 approval)

**End December 2017** - Stage 3 Assurance – Consultation outcome and recommendation considered by HF Collaborative Forum (Subject to NHSE Stage 1 and 2 approvals)

**End February 2018** - Stage 4 Assurance – Delivery Plan prepared and signed off

**2018/19** Mobilisation to commence subject to completion of all of above & dependent on procurement approach.

## Impact

Improving access to high quality, safe, sustainable and resilient emergency & urgent stroke care for patients across the West Yorkshire and Harrogate footprint in line with agreed vision for stroke:

***To reduce the incidence of stroke and avoidable deaths due to stroke, across the West Yorkshire and Harrogate health economy, minimising the long term effects and improving the quality of life for survivors. This will be achieved by providing consistently high quality care that is responsive to individual needs and through encouraging healthier lifestyles and reducing inequalities in risk factors of stroke.***

## Health and wellbeing

- ↓ Under 75 mortality rate from CVD NUMBERS
- ↓ Reduce hypertension QOF prevalence all ages national / West Yorkshire and Harrogate / CCG
- ↓ Reduce premature mortality from stroke
- ↓ Reduce incidence of stroke (e.g. anticoagulant treatment – for every 25 patients with AF receiving an anticoagulant, we can avoid one stroke every 18 months)

## Care and quality

- ↓ Reduce median time between clock start and thrombolysis
- ↑ Increase proportion of stroke patients assessed by a stroke specialist consultant physician and nurse trained in stroke management within 24 hours of clock start
- ↑ Increase proportion of patients given swallow screen within 24 hours of clock start
- ↑ Increase proportion of patients scanned within 12 hours
- ✓ Implementation of 7 Day Standards (2, 5, 6 and 8) for stroke services

\*Increase from Blueprint SSNAP performance data (Oct – Dec 2015)

# Urgent and emergency care

## Our vision for Urgent and Emergency Care is for:

- adults and children with **urgent care needs**, we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients, carers and families
- those people with **more serious or life-threatening emergency care needs**, we should ensure they are treated in centres with the right expertise, processes and facilities to maximise the prospects of survival and a good recovery

## Our work is focused on:

- **Hear, See and Treat** – delivery of a Clinical Advice Service (CAS), integration of 111 and out of hours services, working on a Yorkshire and Humber basis to integrate 999 with 111 services, developing the ambulance service to provide a treatment service rather than conveyance function only by March 2017. So that people get the right access to the right people at the right time
- **Primary Care** – building on the local development and delivery of primary and community new care models to manage the urgent needs of patients in community settings - the delivery of direct booking from 111 extending from out of hours to extended and in-hours services. Delivery of a Pharmacy Urgent Repeat Medication service (PURMs) across West Yorkshire and Harrogate in partnership with community pharmacies.
- **Designation** – develop and deliver plans for configuration of services across West Yorkshire and Harrogate
- **7 day services** - work collaboratively to deliver sustainable 7 day services across the clinical priority areas (Vascular, Stroke, Acute Paediatrics and Cardiology)
- **Technology/inter-operability** – improved access to a patient's summary care record with an increasing amount of information available. Remote working facility for CAS clinicians. Delivery of a care record for 999 staff. Direct booking technology.

## Progress so far...

- ✓ Out of hours booking facility improved. In-hours booking tested with EMIS. Remote access tested. SCR access improved for 111 staff.
- ✓ Pilot in hours booking of appointments from NHS 111 to GPs due to go live imminently with further roll-out in Quarter 4 2016/17.
- ✓ Pharmacy Urgent Repeat Medications enabling NHS 111 to direct callers to local pharmacy live
- ✓ Strong engagement in the Hear, See & Treat programme with face to face sessions in hospital and GP practice waiting rooms; meetings with voluntary and community groups and attendance at sports days, colleges and care homes. We received 2,585 completed surveys either via face to face engagement activities or social media advertising. The results show us that the majority of people that responded support the proposals. The engagement work reached over 300,000 people in West Yorkshire and Harrogate.



# Urgent and emergency care – Acceleration Zone

West Yorkshire and Harrogate has been identified as the only urgent and emergency care ‘acceleration zone’ nationally in September 2016. We have developed some proposals (awaiting approval) which build on our existing work with the target to achieve 95% 4 hour A&E target and 30% 111 calls transferred to a clinical advisor in March 2017. The trajectory will be dependent on resources available which are yet to be confirmed.

Programmes	Main Projects
<b>Pre-hospital Care</b> Increase availability of primary care, 111 and other alternatives to avoid A&E attendances	<b>Primary care :</b> Increase access to primary care out of hours <b>111 :</b> Mobilisation of enhanced clinical advisory (mental health, palliative care, pharmacy and generic advice) and home-working; direct booking proof of concept to 20 GP practices; West Yorkshire and Harrogate marketing campaign to promote 111 <b>999:</b> Continuation of Ambulance Response Programme pilot; call centre access to A&E consultant <b>Care homes (major 999 users):</b> 111 and telemedicine in care homes <b>Mental health:</b> Pilot high volume service user team in Leeds
<b>Streaming and Ambulatory Care</b> Increase access to alternatives to A&E and access to ambulatory care once patients attend the emergency department	<b>Streaming:</b> Pilot NHS Pathways Reception Point (“Blackpool model”) at Dewsbury and Bradford EDs; implement trust schemes to deliver primary care streaming at EDs without 111RP; pilot online NHS Pathways app at EDs without 111RP <b>Ambulatory Care:</b> Implement trust schemes to increase access to ambulatory care pathways (aiming for 12 hours 7days) <b>Mental health:</b> Increase access to mental health liaison as part of MH Vanguard
<b>Flow and Discharge</b> Improve flow through hospital and discharge from hospital to reduce length of stay	<b>SAFER wards:</b> Implement SAFER bundle across all trusts: early senior review; red/green day and afternoon huddle <b>Discharge:</b> Implement trust schemes to deliver Discharge to Assess and Trusted Assessor; rollout pharmacy discharge and re-admission avoidance <b>Care homes:</b> Purple bag scheme in care homes and trusts; end of life care plans; daily bed state

# Urgent and emergency care

## Key milestones & Decisions

**October 2016:** Defining and delivery of the WY UEC Acceleration Zone in the four key areas

**January 2017:** Agree outline approach to designation

### March 2017

- 30% of calls transferred to a clinical advisor through NHS 111 by March 2017
- System delivery of the 95% A&E 4 hour standard across Acute providers
- Meet the four priority standards for 7 day services
- Pilot direct booking from 111 in 22 GP practices in-hours and further roll-out

### Ongoing work: 2016/17 and 2017/18

- Significant improvements in the development of the clinical advice service which supports NHS 111, 999 and out-of-hours calls
- Reconfiguration of services, priority pathways and wider STP work
- Ongoing benefits realisation work & ROI working with YHEC and the AHSN

## Impact

### Health and wellbeing

- ↓ Reducing mortality rates

### Care and quality

- ✓ Improve patient experiences substantially, including patient choice
- ✓ Provision of high quality and safe care across all seven days of the week
- ↓ Reduce ambulance conveyances to ED by 12% by 2021 (23,033)
- ↓ Reduce avoidable emergency admissions by 3% by 2021 (1,693)
- ↓ Management of demand and expected growth of ED attendances - reduce ED attendances by 4% by 2021
- ↓ Reduction in average length of stay
- ↓ Reduction in avoidable readmissions

### Finance and efficiency – including planned savings and planned investment required

- ✓ The Vanguard ROI is expected to be £12m by 2020/21 (excluding the Imaging Collaborative) focused on the eight elements of integrated urgent care (IUC)
- ✓ Integrated urgent and emergency care services that manage demand more effectively have the potential to be significantly more cost-effective than existing arrangements

# Specialised commissioning



Prevention  
/ managing  
demand for  
specialist  
care

Consistent local  
prevention strategies

Specialist  
treatment

West Yorkshire and Harrogate  
planning of services

Our approach to specialised commissioning and provision of specialist services is two-fold. Firstly to manage the demand for specialist services e.g. reduce the increasing demand for bariatric surgery through consistent preventative approaches to tackle obesity and implementation of consistent weight management services across West Yorkshire and Harrogate. This is primarily being planned and delivered by local places in line with the needs of their local population. The second element is the provision of specialist services and how this is planned and delivered to ensure services are sustainable and fit for the future. This will mean services will be provided through a networked approach. To do this we must plan collaboratively at a West Yorkshire and Yorkshire and Humber level.

## Impact

A West Yorkshire and Harrogate Specialised Services Steering Group (CCGs, Cancer Alliance Board reps, Providers and NHSE Specialised Commissioners) has been established to take forward collaborative approaches to planning and transforming services and work in 2016/17 has already commenced on:

- **CAMHS Tier 4 Beds** – aim to improve outcomes for CAMHS patients and reduce out of area placements - West Yorkshire and Harrogate Review to commence early 2017
- **Vascular** – implement the optimum model of service provision across Yorkshire & Humber that best meets the needs of patients and improves patient outcomes, addresses inequality of access and ensures quality of service provision in line with the national specification - Clinical Senate Review Nov 2016
- **Complex Neuro-rehab** – develop and agree a Yorkshire & Humber wide collaborative strategy for specialised rehabilitation for adults with acquired brain injury (ABI) which is intended to address under-provision of level 1 or 2a facilities. This will improve patient experience and reduce delays. Service review completed Q3 2016/17
- **HIV** – review arrangements to ensure future resilience and sustainability of HIV provision and improve patient access.
- **Specialist weight management** - identification and implementation of transformational opportunities for services and pathways prior to entry to tier 4 services set in the context of place-based obesity strategies.

# Acute Collaboration

## Clinical standardisation for efficiency

- 'Centres of excellence' approach to higher acuity specialties eliminating avoidable cost of duplication and driving standardisation
- WY standardised operating procedures and pathways. Building on current best practice and using GIRFT to drive out variation in quality as well as operational efficiency.
- Elective centres to increase quality, maximise efficiency and reduce cost
- Operational clinical networks and alliances as a vehicle for sustainable services (e.g. HAS, head and neck cancer, vascular, pathology and radiology)
- Workforce planning at scale and managing workforce risk at system level supporting free movement of bank and agency staff under single shared Bank arrangements.
- Deliver economies of scale in corporate services e.g. procurement, pathology services, estates & facilities management, informatics and other infrastructure

## WY Pathology Strategy

Including specialist services and integrated IT platform

## Workforce planning at scale

Focused on securing the pipeline of 'fit for purpose' staff and improved productivity

## WY Strategy Corporate Services

Inclusive of:

- Procurement
- Estates & facilities management
- Finance
- HR
- Informatics

The default position for these services is collaboration. This is being explored with other providers in order to increase scale / economies of scale.

### Progress to date:

- ✓ Consultation on CHFT strategy completed
- ✓ Phase 2 of MYHT reconfiguration implemented
- ✓ Diagnostic and case for collaboration jointly commissioned by WYAAT
- ✓ Established working groups for Estates & Facilities, Finance Procurement, HR & Workforce
- ✓ WYAAT Radiology Collaborative established
- ✓ Collaborative strategy and supporting programme infrastructure in development
- ✓ Proposed operating model for WYAAT alternative service delivery models in development
- ✓ Establishing Committee in Common

# Acute Collaboration

## Key milestones and decisions

### October 2016

- Commence development of Case for change for Pathology & Corporate Services
- CHFT reconfiguration

### December 2016

- Business Case for Acute Collaboration programme

### December 2016

- Acute collaboration decision making Framework

### March 2017

- Establish programme infrastructure
- Pathology and Corporate Service plan agreed

### May 2017

- Final phase of MYHT implementation

### June 2017

- Clinical standardisation plan and Timescales developed
- LGI masterplan for specialist services
- ASDM for corporate services established

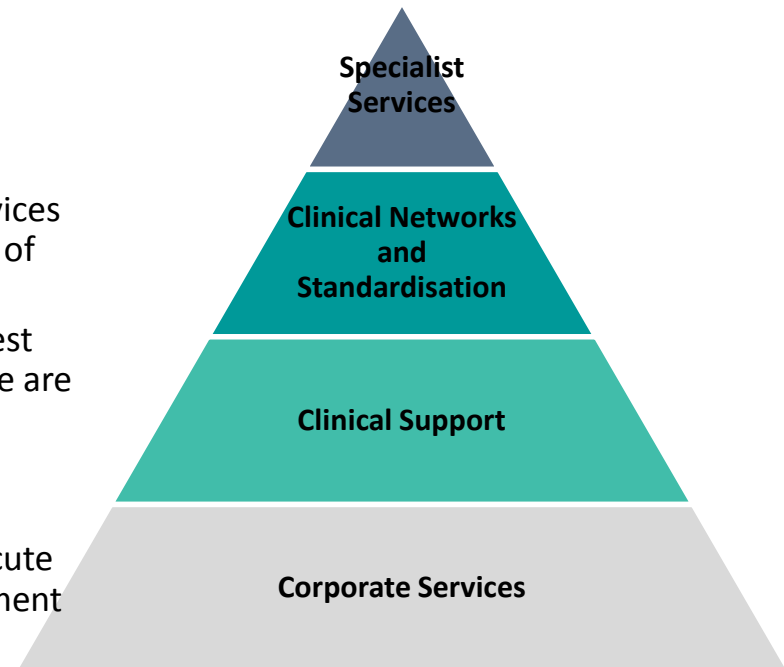
### 2017-2021

- 3 year programme for clinical and non-clinical transformation with milestones agreed to 2021

## Impact

There are significant challenges in the acute sector and through collaborative working, standardisation and operational networks acute providers will reduce variation and improve resilience. Delivering efficiencies will require standardisation in the wider system of out of hospital care focusing on an integrated approach to demand and patient flow (Delayed Transfers of Care). The impact of the acute collaborative strategy and wider system alignment will be to fundamentally underpin our ambitions to close the three gaps in West Yorkshire and Harrogate, including:

- Consistent delivery of constitutional targets
- Improved patient experience
- Improved safety in services by consistent adoption of good practice
- Ensuring services in West Yorkshire and Harrogate are more resilient
- Reduce reference cost variation
- Underpin delivery of acute provider cost improvement programmes



# Standardisation of commissioning policies

This work supports our ambition to reduced unwarranted variation and standardise clinical practice across West Yorkshire and Harrogate. We will utilise RightCare methodology, commissioning for value data and evidenced-based clinical thresholds which will enable us to commission to ensure:

- Maximum health gain from each intervention
- Consistency of access and outcomes
- Delivery of the constitutional Referral to Treatment Time (RTT) standard

This work will allow us to ensure our elective capacity is 'right-sized' and sustainable across our acute provider network. This supports the acute collaboration approach to clinical standardisation. The programme is divided into four key workstreams covering elective hospital based care, follow-ups and prescribing. The prescribing workstream is focused on reduced both costs in relation to waste medicines and prescribing. It will cover over the counter medicines, primary care and hospital based prescribing costs.

## Health and wellbeing thresholds

## Clinical thresholds and policies

## Follow-up management

## Prescribing

### Progress so far...

- ✓ Agreed collective approach at a West Yorkshire and Harrogate footprint
- ✓ Local 'Place' and CCGs progressing earlier (e.g. 'Linking Prevention and Better Health to elective care' in Harrogate & Rural District CCG)
- ✓ Agreement of consistent implementation across West Yorkshire and Harrogate by 2020/21
- ✓ Provider and commissioner chief executive SROs in place
- ✓ Commenced discussion with Healthwatch and in some local communities
- ✓ Approach to health optimisation and reduction in variation supported by NHS England
- ✓ Identified resources to support programme work plan development and delivery

# Standardisation of commissioning policies

## Key milestones and decisions

**Dec 2016:** 'First wave' procedures signed-off by Healthy Futures Collaborative Forum

**Jan 2017:** Final agreement of future phasing of roll-out and scope of interventions

**2017 – 2021:** Quarterly rolling process of development, agreement and implementation of commissioning policies

**2021:** Standardisation of commissioning policies in place across West Yorkshire and Harrogate footprint

## Impact

- ✓ Support delivery of the West Yorkshire and Harrogate targets in relation to smoking and obesity
- ✓ Support delivery of Referral to Treatment Time (RTT) standards
- ✓ Dovetail with the development of acute, mental health and provider collaborations to secure improvements in service delivery
- ↑ Clarity for patients and the public
- ↑ Improved cost effectiveness in prescribing
- ↓ Reduced variation in eligibility
- ↓ Planned savings of £50m delivered through consistent reduction in low value clinical procedures and interventions and ensuring patients are optimised for surgery



# Section 5: Enabling workstreams



# Context

All of our proposals are about improvement and change. To do this we must:

- Create the right workforce, in the right place with the right skills, to deliver services at the right time, ensuring the wellbeing of our staff
- Engage our communities meaningfully in co-producing services and making difficult decisions
- Using technology to drive change and create a 21<sup>st</sup> century NHS
- Place innovation and best practice at the heart of our collaboration ensuring that our learning benefits the whole population
- Ensure we have effective commissioning structures to push through the change.

# Workforce

## Challenges

70-80% of the West Yorkshire & Harrogate resource is spent on workforce. Every one of our STP workstreams has workforce implications

90% of the workforce we will have in 5 years' time already work for us

Longstanding shortages of clinical and support staff

Development of new skills to deliver new ways of working

Affordability of current pay bill – high locum and agency spend

Variation in team productivity

Insufficient integration across sectors

Concerns for staff wellbeing

## Actions

**Establishment of West Yorkshire and Harrogate STP Local Workforce Action Board**

**Chair:** Dr Ros Tolcher (Chief Executive, Harrogate and District NHS Foundation Trust)

**Co-chair:** Mike Curtis (Health Education England)

**Vision:** West Yorkshire and Harrogate will have an affordable, skilled and resilient workforce providing sustainable health and care

**Mission:** To ensure that the workforce is a positive enabler and not a constraint to achieving the ambitions of the West Yorkshire and Harrogate STP

Primary and community care, and public health  
**Dr Andrew Sixsmith**

Registered workforce initiatives  
**Philip Marshall**

Non-registered workforce initiatives  
**Sandra Knight**

Prevention at Scale  
**Dr Ian Cameron**

Workforce flexibility and enablers  
**Jo Carr**

# Workforce

Programme outlines	Primary Care, Community Care and Public Health	Registered Workforce Initiatives	Non-registered workforce initiatives	Prevention at scale	Workforce flexibility and resilience enablers
<b>Vision</b>	Plan and secure a transformed workforce for Primary and Community care. Make Every Contact Count. <i>Working with the Primary Care &amp; Community Services Group</i>	Plan for foreseeable demand for registered workforce capacity. Transform existing roles and influence new training programmes and supply for advanced practice and new roles.	Plan for foreseeable demand for non-registered workforce capacity. Transform existing roles and ensure supply of new training programmes	All sections of the health and care workforce contribute to the prevention agenda as a priority for future	Optimise the efficiency of HR processes through standardisation; reduce the cost of workforce gaps
<b>Core outputs</b>	<ul style="list-style-type: none"> <li>A Primary and Community care workforce strategy</li> <li>Quantify demand for future workforce &amp; investment required</li> <li>Specify adaptation requirements for primary and community care to deliver new ways of working</li> </ul>	<ul style="list-style-type: none"> <li>Quantify demand for registered nursing and ACPs and secure right capacity of training to achieve a pipeline of ACPs for all sectors</li> <li>Quantify and address gaps in OPD workforce</li> <li>Strategy for medical specialty shortages</li> </ul>	<ul style="list-style-type: none"> <li>Proposal for career escalator</li> <li>Development of a WY Excellence Centre</li> <li>Optimise use of apprenticeship levy</li> </ul>	<ul style="list-style-type: none"> <li>Making Every Contact Count Framework and Plan for WY&amp;H.</li> <li>Health Promoting Trusts proposal (TBC)</li> <li>Workforce development strategy for prevention priorities.</li> </ul>	<ul style="list-style-type: none"> <li>Savings from internal agency</li> <li>Savings from standardisation</li> </ul>
<b>Workstreams to be developed</b>	<p>Primary Care Workforce working in General Practice - workforce analysis</p> <p>Investment plan – for wider roles in primary care (adaptation and innovative roles) nurses, pharmacists, advanced practitioners, physicians associates, clinical support workers, care navigators</p> <p>New Care Models, new ways of working</p> <p>Support for self care, expert patients &amp; volunteers</p>	<p>ACP supply</p> <ul style="list-style-type: none"> <li>ODP function supply</li> <li>Endoscopists</li> <li>Physicians Associates</li> <li>Social workers</li> </ul> <p>Nurse recruitment strategies at WY&amp;H level</p>	<p>Development of the West Yorkshire Excellence Centre</p> <ul style="list-style-type: none"> <li>Pathway for B1-4</li> <li>Support to the primary care workstream</li> <li>Working with Advanced Training Practices</li> </ul>	<p>Development of an STP Prevention at Scale plan</p> <ul style="list-style-type: none"> <li>Priorities TBC (Nov 16)</li> <li>Workforce development of all prevention priorities.</li> <li>MECC</li> <li>Health Promoting Hospitals/Health and Care (TBC)</li> <li>Support and links to primary care</li> </ul>	<p>Development of Internal Agency</p> <p>Workforce passports</p> <p>Improve quality and value for money of GP locum market</p> <p>Standardisation of HR processes &amp; streamlining</p> <p>Adoption of digital &amp; technology solutions</p>

# Digital and interoperability

Building on the six Local Digital Roadmaps, there are some key themes where we know digital solutions can drive change across our health and social care economy and support our overarching aims, including:



Development **Record Sharing technology across West Yorkshire and Harrogate** to ensure **access to individuals' health and care information across all care settings** improving safety, experience and clinical effectiveness



Technology to support **knowledge, education and self-care** to ensure **people are empowered to manage their own health and wellbeing**



Technology implementation to support **clinical models e.g. clinical advice hub, direct booking, telehealth / telecare**

In addition, the digital support is fundamental to delivery of our transformation plans in local places and to our collaborative workstreams. Some of this work has already started and further priorities will be identified as the draft proposals for our workstreams are further developed.

## Progress to date

- ✓ **CIOs Group** – Establishing a group of Chief Information Officers across CCGs, local authorities and NHS providers and expanding to form a network of Clinical Chief Information Officers (CCIOs)
- ✓ **Established digital leadership** with director leadership from commissioner and provider organisations and GP sponsor
- ✓ **Designing a data sharing architecture** this as a priority workstream with sign-up from all our acute providers. We have also formally secured the input from NHS Digital to this at a senior level. This work underpins anything that we will need to do around integrated and shared records, capabilities such as cross-organisational appointment booking etc.
- ✓ Themes across 6 **Local Digital Roadmaps** under review to identify consolidated opportunities to use technology to support STP delivery
- ✓ **UEC Vanguard** - A full technology work programme is in place and opportunities reviewed as part of the Acceleration Zone
- ✓ Technology to **assist the implementation of Carter efficiencies**

# Harnessing the power of communities

We will establish a new relationship with our communities built around good work on the co-production of services and care. Our proposals to support people to self-care, prevent ill-health, implement the GP 5YFV and join up community services require a new relationship that sees people as assets not issues. They are fundamentally linked to building resilience through community assets, local populations and the large numbers of thriving voluntary and community sector organisations across West Yorkshire and Harrogate.

We are already seeing this in the digital space with the development of the mHealthhabitat programme out of mental health, sponsorship of the #YHDigitalcitizen programme and the People Driven Digital movement. These are also reflected in local vanguards and the AHSN is sponsoring a developing social movement through our Digital Health & Wellbeing Ecosystem. This is a platform for health and social care, academic, industry, the voluntary sector and patient organisations, to collaborate to increase the uptake of digital health technology. This will enhance patient care and participate in shared learning across the ECHAlliance International Permanent Network of Ecosystems.

We already rely on the involvement of the wider VCS in strategy development, leadership, engagement and service delivery. We will form new relationships, support innovative ways of working, and the development of community capacity building. This will be supported by new compact with the 3<sup>rd</sup> sector.



# Harnessing the power of communities

## Principles

- We will work together on a **'no surprises'** basis and set out a realistic case for change at both a local and regional level.
- Our emerging plan draws on existing **insight** and local **intelligence**. We want to build on the engagement and consultation work already underway and consider what we have already been told.
- Starting **conversation with the public** about their role in managing their own care
- Secure **political and public buy-in through a compelling case for change**
- **Nurture** our partner, stakeholder relationships and develop new to achieve our ambition together.
- Engaging our **health and social care workforce** is critical if we are to reach realistic improved outcomes
- We will **formally consult** where there is a proposal for significant service change

## Progress to date

- ✓ Every local place-based plan has been built up from a wealth of information which local people have told us about local services
- ✓ Local plans have been developed and approved by local Health and Wellbeing Boards (or equivalent structures)
- ✓ Healthwatch is a key partner in our STP and provide leadership, assurance and challenge acting as the voice of the patient and has supported our Vanguard engagement e.g. reaching over 300,000 on our Hear, See and Treat proposals
- ✓ We will always fulfil our legal duties to consult and we are already consulting formally with our populations on some of our proposals e.g. reconfiguration of hospital and community services in Calderdale and Huddersfield
- ✓ A strategic communications and engagement lead has been employed to support engagement and communication with all our stakeholders across the STP. This role is embedded within the STP Programme Management Office and works closely with the STP Lead
- ✓ This role is supported by an established multi-agency communications and engagement regional network to ensure the approach is embedded in all organisations and existing communication channels are used to full effect.

## Sharing our proposals

- Local place-based plans have been designed and approved by all local Health and Wellbeing Boards (HWB) or equivalent and are in the public domain. Council leaders and Chairs of the HWB meet on a regional level
- We are fully committed to sharing all proposals with our population and will publish our plan and public summary during the week commencing 31 October 2016
- Sharing our proposals will start a series of public engagement activities.

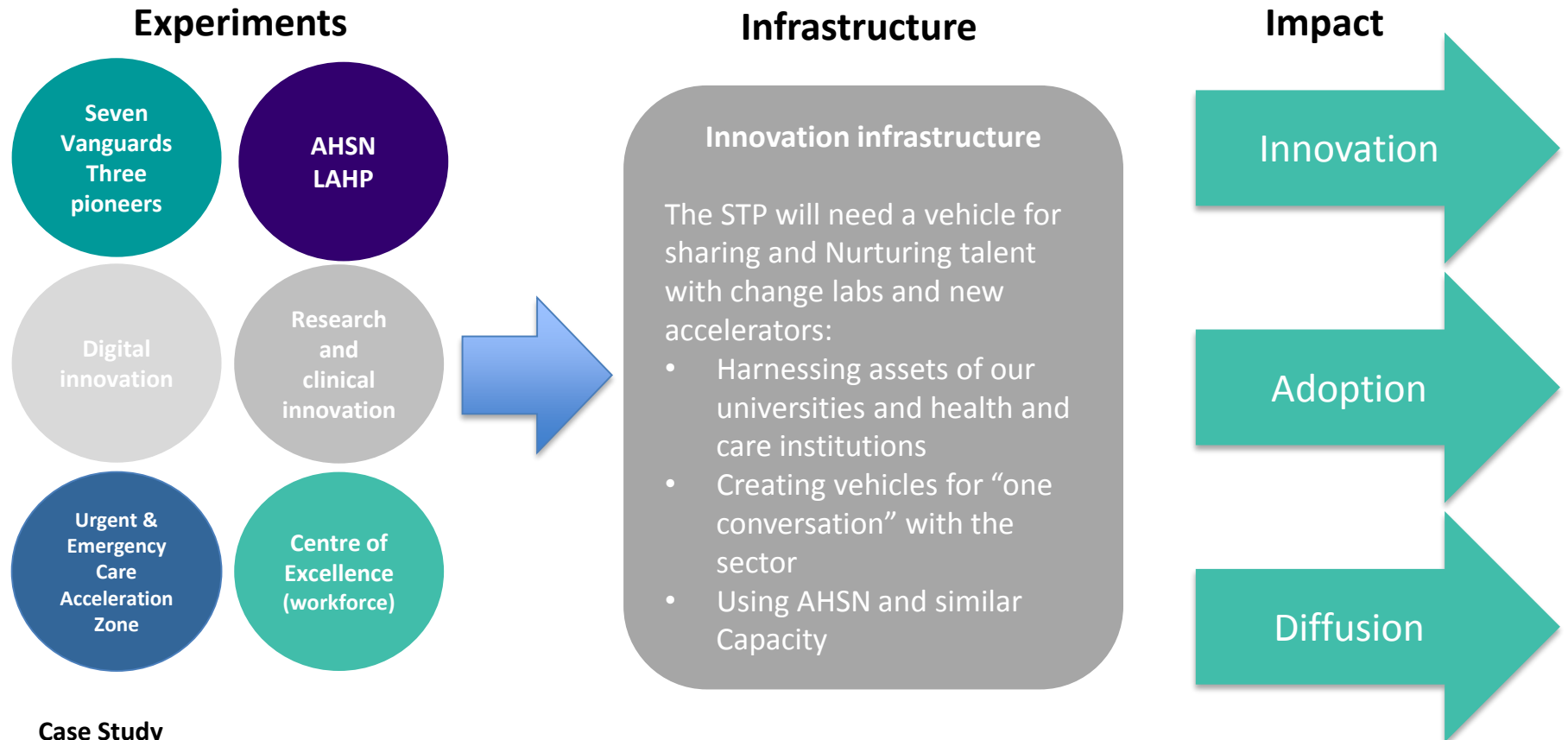
# Harnessing the power of our communities

In line with our principles, we have reviewed our recent engagement activity across our CCG footprints which is identified below. This information has informed the development of our plans to date and will support us in identifying where further engagement work is required with populations on some of our proposals. This will be a fundamental part of our developing proposals further.

	Airedale, Wharfedale, Craven	Bradford City	Bradford District	Calderdale	Greater Huddersfield	Harrogate and Rural District	Leeds North	Leeds South and East	Leeds west	North Kirklees	Wakefield	Key themes
Prevention		E	E	E	E	E C	E	E	E	E	E C	Care Closer to Home, Vanguard, Bowel Cancer, Smoking, Personal Health Budgets, Long Term Conditions Care Planning, Self-Care, Early Intervention and Prevention, Winter Health Strategy Consultation, Autism Strategy for North Yorkshire, Learning Disabilities Strategy Consultation, Healthy Weight, Healthy Lives Strategy Consultation, Shared Decision Making
Primary and community services	E	E C	E C	E C	E C	E	E	E	E	E	E	Care Closer to Home, Right Care, Right Time, Right Place, Our Street, Unplanned Care, Walk in Centres, GP services - extended hours/changes/closures and access (including enhanced access), NHS Dentist, Care Homes, Winter Campaigns, What Matters to us, Integrated Care, Community Equipment Services, Enhanced Care, Access to primary care for people with a learning disability, Scribble live, Anti-coagulation, Closure of GP practice, Endoscopy and Gynaecology services, PMS and PBSR, ENT, Ophthalmology, Discharge, Connecting Care, IAPT, Primary Strategies, APMS, Adult Hearing Services, Gynaecology, ENT, Year of Care, Single point of access
Mental Health	E	E C	E C	E	E	E	E	E	E	E	E	Children and Young people (CAMHS), Crisis Intervention, Section 136, SWYFHT Transformation, Mental Health strategies, The Future in Mind, Autism, bereavement services
Stroke	E	E	E C			E					E	Improvements to Stroke Services, Reconfiguration of Services, patient surveys
Cancer				E	E	E	E	E	E			Breast, Gynaecological, Prostate, Colorectal, Childhood and Young Adults services, Cancer Services CHFT, living with and beyond cancer project, surviving cancer
Urgent & Emergency care	E	E	E	E C	E C	E	E	E	E	E C	E C	Urgent and Emergency Care Strategy, Right Care, Right Time, Right Place, Meeting the Challenge, What Matters to us, Urgent Care Transformation Programme
Specialised commissioning		E	E									Eating disorders, Specialised Mental Health
Acute reconfiguration		E	E	E C	E C					E C	E C	Meeting the Challenge, Right Care, Right time, Right Place, Accountable Care
Standardisation		E C	E C	E	E		E	E	E	E	E	Patient Transport, Talk Health, IVF, Stop Before your OP, Medicines Management, Gluten Free, OTC medicines, cows' milk intolerance

# Innovation and best practice

Our ambition is to become an international destination for health innovation



## Case Study

Airedale has been working successfully for several years across health and social care to develop an integrated health record which enables more seamless care for the population. This provides an integrated workflow across providers and improves the experiences of people accessing services ensuring information is collected from people only once. This also supports reduced duplication as set out in the Getting It Right First Time (GIRFT) programme and Carter Review. We are talking to Connected Yorkshire (Leeds University) to see how we can use our data to understand our population health and bring the biggest benefit through health and care interventions.





# Section 6: Creating the infrastructure for delivery

# Creating an infrastructure to deliver

These proposals require a different way of working across organisations in West Yorkshire and Harrogate.

There are a number of components to this:

- Establishing appropriate governance arrangements to allow us to work more closely and take decisions collectively across commissioners, providers, health and social care
- Evolving our current commissioning arrangements so that there is a great emphasis on place and a stronger infrastructure at a West Yorkshire and Harrogate level
- Rapidly expanding capacity and resources to do the work through realignment of existing roles and functions, both at local organisation and Arms Length Body (ALB) level

The following section sets out our proposals for taking this forward.

# Strategic commissioning

**A West Yorkshire & Harrogate wide commissioning / contractor function dealing with acute and some specialist services**

- Design of evidence based pathways and service standards
- System wide outcomes and payment incentives
- Extension / formalisation of the CCG joint committee arrangements
- Identification of services that need to be commissioned on a WY basis

**and...**

**A place based commissioner bringing together the functions of LAs CCGs and NHS England (primary care) commissioning**

- Organisations collaborate on a defined geographic footprint – collective accountability
- Essential that we maintain 'connection' between West Yorkshire and Harrogate and place based commissioning

**And / or...**

**A local 'commissioning' function embedded within ACO models**

- ACOs working to a capitated budget will need to make decisions about how resources are used to best meet population needs.
- Therefore some 'commissioning' competencies required aligned to strategic function of organisation.

## Example services

### **WEST YORKSHIRE & HARROGATE**

- Low volume, high cost, high risk planned care
- Emergency centres and co-dependencies
- Specialised & tertiary services
- Inpatient mental health services
- 'Hard Pressed' specialties
- Specialised diagnostics
- High volume, low cost, low risk planned care

**Shared view of strategic intent and planning**

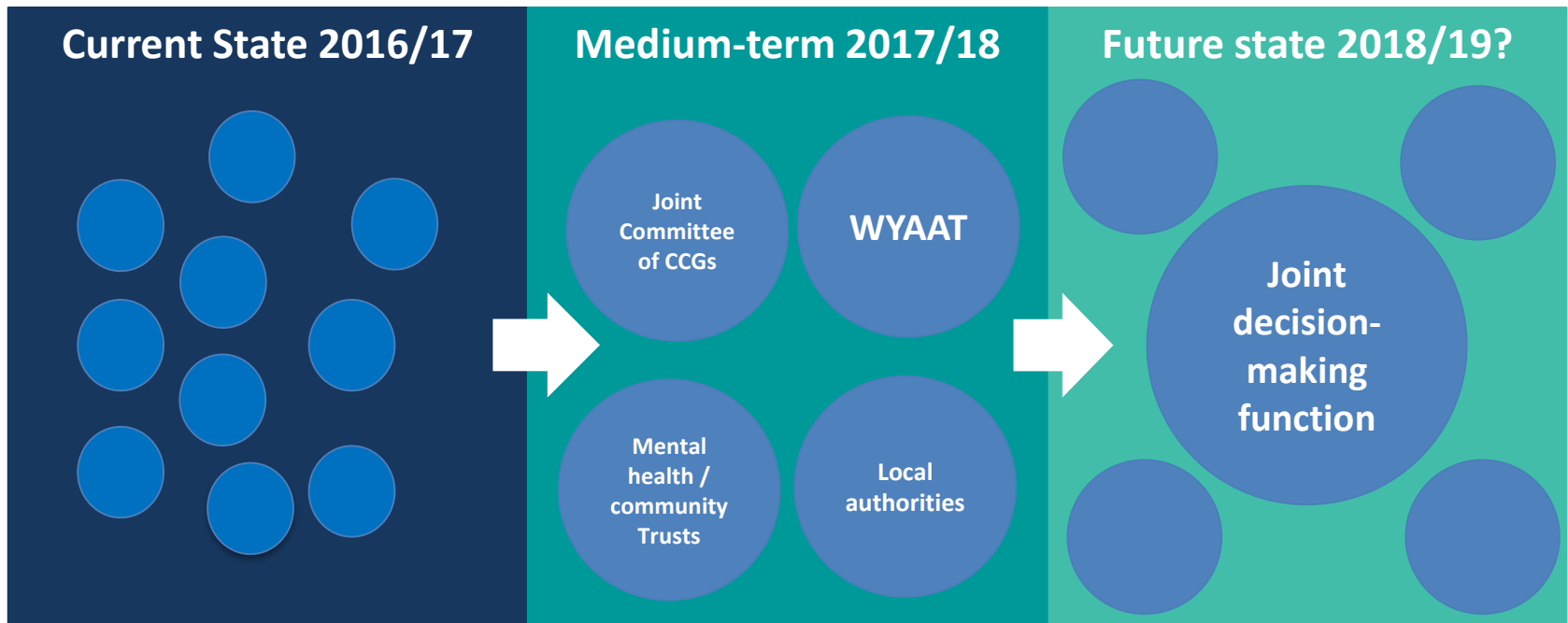
### **LOCAL**

- Diagnostics
- Primary and community care
- Social care
- Long term conditions management
- Frailty services
- Community Mental Health

# Governance and decision-making

- Health and Wellbeing Boards are the key mechanism for taking decisions on place based proposals at local level. Alongside our partnership with Local Authorities, this will continue to be an important way of ensuring our proposals represent the views and interests of local people.
- We have developed an approach based on collaboration and partnership – leadership group, steering group, CCG forum and clinical forum. These have been important vehicles to move the STP forward – but they have not been tested in terms of challenging decisions and they do not go far enough given the expectations placed on the STP as a planning area.
- The arrangements are therefore changing in line with the increased responsibilities placed on STP areas. Over the course of the next 12 months we will move to more formal joint decision making arrangements within sector in order to support collective decision making.
- Beyond that, we recognise that closer working and decision making across traditional sector boundaries will become increasingly important as we take decisions that put place over organisation. As a leadership group we are considering mechanisms to facilitate place based governance and decision making.
- The following slide illustrates this journey.

# Moving forward we intend to formalise the current arrangements and move towards joint decision making



- Single statutory organisations
- Some groupings / informal collaboration of providers and of commissioners
- Formalised collaborative structures of commissioners and providers to support collective decision-making
- Run new commissioning model in shadow form
- Joint decision-making function where appropriate, or in the best interests to do so representing commissioners and providers joint-decision making function
- Supported by formal collaborative structures established in 2017/18



# Section 7: Conclusion

# Conclusion

We are committed to delivering the vision set out in this document. The STP sets out the strategic context in West Yorkshire and Harrogate and high-level proposals for how we might get there.

Our focus now shifts to building on conversations we have already had with our communities to developing meaningful coproduction for turning these high-level proposals into more detailed implementable plans.

Our next important milestone is the two-year operational NHS planning process through which we will translate into delivery.



# Annex



# Annex A: Glossary 1

Item	Description
ABI	Acquired Brain Injury
ACO (also ACS)	Accountable Care Organisation / System. ACOs are an approach to population-based commissioning for outcomes as opposed to activity.
ACP	Advanced Clinical Practitioner
ADHD	Attention Deficit Hyperactivity Disorder
AF	Atrial Fibrillation
AHSN	Academic Health Science Network. AHSNs are organisations which link different parts of the health system to ensure that health improvement initiatives are considered and evaluated using proven methodology.
ASDM	Alternative Service Delivery Model
AWC	Airedale, Wharfedale and Craven
A&E	Accident and Emergency [department]
BD&C	Bradford District and Craven

Item	Description
CAMHS	Child and Adolescent Mental Health Service
CAS	Clinical Advice Service
CCG	Clinical Commissioning Group. CCGs are organisations that commission most of the hospital and community NHS services in the local areas for which they are responsible.
CCIO	Chief Clinical Information Officer
CHD	Coronary Heart Disease
CHFT	Calderdale and Huddersfield NHS Foundation Trust
COPD	Chronic Obstructive Pulmonary Disease
CPES	Cancer Patient Experience Survey
CVD	Cardiovascular Disease
CYP	Children and Young People
DToC	Delayed Transfer of Care

## Glossary 2

Item	Description
ED	Emergency Department
EMIS	A supplier providing electronic patient record systems to primary care
ENT	Ear, Nose and Throat
FYFV	Five Year Forward View. This national document, published in October 2014, sets out a new shared vision for the future of the NHS based around new models of care.
GP	General Practice / Practitioner
GPFV	General Practice Forward View. This national document, published in April 2016, setting out intentions to improve general practice.
GIRFT	Getting it Right First Time
HAS	Hyper-acute Stroke
HFCF	Healthy Futures Collaborative Forum. A collaborative meeting of all the 11 CCGs across the West Yorkshire and Harrogate STP.

Item	Description
HIV	Human Immunodeficiency Virus
HWBB	Health and Wellbeing Board. Hosted by local authorities, these boards bring together the NHS, public health, adult social care and children's services, including elected representatives and Local Healthwatch, to plan how best to meet the needs of the population.
IAPT	Improving Access to Psychological Therapies
IUC	Integrated Urgent Care
IVF	In Vitro Fertilisation
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LTC	Long Term Condition
LTHT	Leeds Teaching Hospitals NHS Trust
LOS	Length of Stay

# Glossary 3

Item	Description
MCP	Multispecialty Community Provider. This is a new model of care focusing on bringing together services operating in the community.
MDT	Multi-disciplinary Team
MYHT	Mid Yorkshire Hospitals NHS Trust
MECC	Making Every Contact Count
MH	Mental Health
MHFV	Five Year Forward View for Mental Health. This national document, published in February 2016, sets out 59 recommendations of the Mental Health Taskforce aiming to improve Mental Health service provision.
NCMP	National Child Measurement Programme
NEET	Young people who are “Not in Education, Employment of Training”
NHS	National Health Service

Item	Description
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
OBC	Outline Business Case
ODP	Operating Department Practitioner
OP	Outpatient
OTC	Over the Counter
PBSR	Practice Based Services Review
PMS	Personal Medical Services [contract]
PoS	Place of Safety
PURMs	Pharmacy Urgent Repeat Medication service
QOF	Quality and Outcomes Framework
QOL	Quality of Life

# Glossary 4

Item	Description
ROI	Return on Investment
RTT	Referral to Treatment Time (a national legal right to start non-emergency NHS consultant-led treatment within a maximum of 18 weeks from referral, unless a patient chooses to wait longer or it is clinically appropriate that they wait longer.)
SCfC	Strategic Case for Change
SCR	Summary Care Record
SSNAP	Sentinel Stroke National Audit Programme
STF	Sustainability and Transformation Fund
STP	Sustainability and Transformation Plan. Every health and care system in England will produce a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years.

Item	Description
SWYPFT	Also; SWYFT / SWYFHT – South West Yorkshire Partnership NHS Foundation Trust
UEC	Urgent and Emergency Care
Vanguard	Vanguards are a group of organisations and partnerships which will take a lead on the development of new care models which will act as the blueprints for the NHS moving forward, piloting new models of care identified in the Five Year Forward View.
WYAAT	West Yorkshire Association of Acute Trusts
WY&H	West Yorkshire and Harrogate
YAS	Yorkshire Ambulance Service
YHEC	York Health Economics Consortium

# West Yorkshire & Harrogate STP



A partnership between, health services, clinical commissioning groups, care providers, local councils, and Healthwatch

[westyorkshirestp@nhs.net](mailto:westyorkshirestp@nhs.net)

Report to the Trust Board of Directors: 30 November 2016		Paper No: 6.0
Title		Report from Chief Executive
Sponsoring Director		Dr Ros Tolcher, Chief Executive
Author(s)		Dr Ros Tolcher, Chief Executive
Report Purpose		To update the Board of Directors on significant strategic, operational and performance matters
Key Issues for Board Focus:		
The Board of Directors are asked to note: <ul style="list-style-type: none"><li>• The publication of the draft West Yorkshire and Harrogate Sustainability and Transformation Plan.</li><li>• Ongoing development of the Trust's 2 year Operational Plan for 2017/18 and 2018/19.</li><li>• Significant progress to improve the governance arrangements for the West Yorkshire Association of Acute Trusts (WYAAT) to improve partnership working.</li><li>• The financial position at the end of month 7 has deteriorated and further action is being taken to mitigate risks.</li><li>• The New Care Model is now fully rolled out.</li><li>• There have been no amendments to the Board Assurance Framework for the period.</li></ul>		
Related Trust Objectives:		
1. To deliver high quality care	Yes – the report reflects a sustained organisational focus on providing high quality care and ensuring robust controls and assurances on care quality.	
2. To work with partners to deliver integrated care	Yes – the report provides updates on the work of the HHTB and West Yorkshire reflect partnership working in Harrogate and West Yorkshire areas.	
3. To ensure clinical and financial sustainability	Yes – the report notes from the SMT meeting demonstrate a particular focus on financial performance	
Risk and Assurance	Strategic and operational risks are noted in section 6. Risks associated with this report are reflected in the Board Assurance Framework: BAF 14: risk to deliver of integrated models of care; BAF 4: lack of interoperable systems across New Care Models; BAF 15: misalignment of partner strategic plans; and BAF 9; failure to deliver the operational plan.	
Legal implications/Regulatory Requirements	There are no legal/regulatory implications highlighted within the report.	
Action Required by the Board of Directors		
<ul style="list-style-type: none"><li>• The Board is requested to <b>note</b> the strategic and operational updates</li><li>• The Board is asked to <b>note</b> progress on risks recorded in the BAF and Corporate Risk Register and confirm that progress reflects the current risk appetite.</li></ul>		

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

### **1.1 2017/18 – 2018/19 Operating Plan development**

NHS Foundation Trusts and Trusts are required to submit draft 2-year Operating Plans by the end of November and final 2-year plans by 23 December 2016. NHS Improvement has also set an expectation that contracts for the 2-year period will have been agreed by the end of December. The Trust continues to develop its Operational Plan and the draft plan will be discussed in the confidential session of the Board at the meeting on 30 November 2016. The final Operational Plan will be submitted for approval at the extraordinary meeting of the Board of Directors on 21 December 2016.

Further information of the development of the Trust's Operational Plan can be found in the Operational Planning Update.

### **1.2 New Care Models (NCM) update**

The new care model is now live across the whole district for the first time and we are hoping to start seeing a big impact on supporting more people at home and improving bed utilisation. Partners across the system have worked hard to reach this point and I would like to pay tribute to our community colleagues who have remained dedicated to providing safe and responsive services to patients throughout a prolonged period of change. The final step in implementing the new model had to take place on one day because of several inter-related dependencies as staff transitioned to their new roles. There are now fully operational Community Care Teams (CCTs) working extended hours and an Acute Response and Overnight Service (AROS) reaching into the Emergency Department and CATT at the hospital on a daily basis to support bringing patients home as quickly as possible.

The NCM Quarter 2 Review took place on 10 November and was attended by the Deputy Chief Executive/Finance Director. Verbal feedback on progress was positive.

A national set of metrics for monitoring the impact of New Care Models has been developed. This will enable trends to be monitored and some direct comparisons between similar sites (including non-Vanguard sites). Harrogate has a lower number of GPs per 1,000 weighted population than most other Primary and Acute Care Systems (PACs) sites and a lower emergency admission rate overall. The Harrogate system has the lowest bed utilisation rate of all the PACs areas at 677 per 1,000 (range 677-954 per 1,000). Emergency admission activity has shown a very marginal downturn since the start of the project although this masks some changes in admission rates for under 65s. Interpretation of the data remains complex and it would be premature to draw any conclusions based on this data.

A further Value Proposition is due to be submitted by 24 November. This is the last of three years for which national transitional funding will be made available. From 2018/19, the New Care Model will be self-funded, from savings it creates elsewhere in the system and particularly by reducing bed utilisation.

## **2.0 STRATEGIC UPDATE**

### **2.1 West Yorkshire and Harrogate Sustainability and Transformation Plan (WYHSTP)**

The draft West Yorkshire and Harrogate Sustainability and Transformation Plan (WYHSTP) was submitted to NHS Improvement on 21 October 2016 and has now been published. The public summary, full plan and other supporting information is available at <http://bit.ly/WestYorkshireSTP>.

The plan will be delivered by local health and care organisations, including Harrogate and District NHS Foundation Trust, working together across the region to support changes needed to improve services for the 2.6 million people who live in the area. It builds on local plans that have been developed in each of the six localities and is designed to tackle long standing issues, improve care, and look at prevention, better coordinated services, preventing unnecessary hospital admissions and supporting people to stay well. Nine priority areas have been identified which will be worked on across the region:

- Prevention
- Primary and community services
- Mental health
- Stroke
- Cancer
- Urgent and emergency care
- Specialised services
- Hospitals working together
- Standardisation of commissioning policies

STP partners will continue to work with staff, stakeholders and the public to build the plan, ensuring the involvement of everyone in future conversations around the draft proposals.

The full plan will be discussed as a separate agenda item at the Board of Directors meeting on 30 November 2016.

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

Following the work of Chief Operating Officer's across the region to agree what actions would be required in order to achieve the ambition of delivering the Emergency Department (A&E) 95% 4-hour waiting time standard at West Yorkshire level by March 2017, capital and revenue funding has now been agreed. Although the value of the funding was less than required, plans to implement the work has been accelerated.

A further update will be provided in the Chief Operating Officer's report.

## **3.0 NATIONAL COMMUNICATIONS RECEIVED AND ACTED UPON**

### **3.1 2-year tariff consultation**

NHS Improvement have recently issued a 2-year tariff for consultation with the service. This tariff builds on the engagement tariff used for earlier planning and organisations are asked for any comments by mid-December. We are currently modelling the impact on HDFT of the proposed tariff and any changes from the initial engagement tariff used for planning purposes. The tariff uses 'HRG4+' which is a more granular tariff than previous, and the assumption is that HDFT will see an income reduction for similar activity. This has been reflected in our draft Operational Plan and the CCG's allocation has also been reduced on this basis.

As part of our final plan submission, we will be incorporating the modelling work we are currently undertaking.



## **4.0 WORKING IN PARTNERSHIP**

### **4.1 Harrogate Health Transformation Board (HHTB)**

The next meeting of the Harrogate Health Transformation Board is on Thursday 24 November 2016. A verbal update following the meeting will be provided to the Board of Directors meeting on 30 November.

The Key Messages from the meeting will be placed in the Reading Room in due course.

### **4.2 West Yorkshire Association of Acute Trusts (WYAAT)**

Chairs and Chief Executives (CEs) from the six WYAAT partners met on 27 October to discuss collaboration and future ways of working. Work to date has confirmed a high level case for change in terms of clinical services and some clinical and non-clinical support services. The scale of opportunity will be subject to further work which now needs resourcing. The Chairs and CEs agreed that funding should be agreed to enable this and that the first call on savings generated through implementation of collaborative work streams will be the resourcing of the Project Management Office.

There is broad support for the development of a Committee in Common. This is in line with the paper on Acute Care Collaborations published by NHS Improvement in October and will enable collective decision making within an agreed governance framework. Draft terms of reference are being drawn up for review at a further meeting in December.

The Board of Directors is asked to confirm support for this direction of travel. The draft Memorandum of Understanding and Terms of Reference will be discussed by the Board of Directors in confidential session on 30 November 2016 with the final copies being submitted to the Board of Directors on 21 December 2016.

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

## **5.0 FINANCIAL POSITION**

The reported position at the end of Month 7 (October) is a year to date operational surplus before Sustainability and Transformation (S&T) funding of £144k, a deterioration from Quarter 2 of £483k and £761k behind plan. Given the in-month performance, no S&T funding has been assumed for October. The main reason for the deterioration relates to activity and income shortfalls, and whilst activity recovery plans are being reviewed we will be taking action to more tightly control expenditure as a result. This was a subject of significant discussion at Senior Management Team and all supported the necessary measures such as a more stringent approach to vacancy management, focus on agency medical staffing and stopping further 'discretionary' spend.

The Use of Resources rating remains as a 1 for the year to October.

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

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

The SMT met on 23 November and key issues discussed and for noting by the Board of Directors are as follows:

- The total number of Clostridium Difficile (C. Diff) cases in 2016/17 will exceed the number of cases in 2015/16 if the current trend continues. Underlying issues were discussed. Environmental factors are seen as increasingly significant and an enhanced approach to

environmental controls will be developed. The Infection Prevention and Control (IPC) team are also considering a further third party review.

- The number of hospital acquired grade 3 pressure ulcers is lower than in the prior year but total number of grade 2 and 3 hospital acquired pressure ulcer numbers exceeds the internally set stretch target. Root Cause Analysis suggests that attention to turning the patient is the most important influenceable factor. The local target for reducing community acquired grade 2, 3 and 4 pressure ulcers will also be exceeded.
- Falls are down 23% year to date. An internal audit of Falls Prevention has been given a Limited Assurance rating.
- The adverse trend in incident reporting ratios (high:low harm) was discussed. The Datix tool is seen as a barrier to encouraging reporting of low risk incidents. This is to be reviewed by the Risk Management Team and the Medical Director.
- The Month 7 finance position has deteriorated significantly. The biggest change is a fall in activity and income against plan, despite significant effort by Directorate teams. Following discussion further measures to reduce discretionary spend and manage vacancies will be enacted with immediate effect.
- Consultant job plans were discussed, including apportionment of Supporting Professional Activities (SPA) time. Increasing the proportion of time spent on Direct Clinical Care (DCC) will be further explored.
- The draft Clinical Workforce Strategy was approved and had been submitted to the Board of Directors for approval at the 30 November Board meeting.
- The Apprenticeship strategy and business case was approved.
- A consultation on future delivery of GP Out of Hours services from Northallerton Hospital, led by the Hambleton, Richmond and Whitby CCG was noted.
- Dr Will Peat, Clinical Lead for Simulation and Consultant Anaesthetist briefed SMT on service pressures and opportunities.
- The CQC action plan was discussed.

Despite the considerable pressures operational performance remains strong and I would like to record my thanks to colleagues across the Trust for their continued hard work to sustain this position.

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

## **7.0 BOARD ASSURANCE AND CORPORATE RISK**

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

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

The BAF was reviewed by the Executive Directors during week commencing 17 October. Although no risks have been removed, all BAF entries have action plans to address the gaps in controls and all action plans have progress scores of 1 or 2, providing assurance that actions to mitigate existing gaps in controls are being progressed. A review of key controls has been undertaken as a result of the completion of actions, and additional actions have been added to mitigate increased levels of risk, where appropriate.

### **Changes to the Board Assurance Framework since October**

There are no new risks to note during the period. There have been no changes to the residual risk scores since the October report.

## Summary

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

Ref	Description	Risk score	Progress score
BAF 1	Risk of a lack of medical, nursing and clinical staff	Red 12 ↔	Unchanged at 1
BAF 2	Risk of a high level of frailty in the local population	Amber 8 ↔	Unchanged at 2
BAF 3	Risk of a failure to learn from feedback and Incidents	Amber 9 ↔	Unchanged at 2
BAF 4	Risk of a lack of integrated IT structure	Red 12 ↔	Unchanged at 1
BAF 5	Risk of maintaining service sustainability	Amber 8 ↔	Unchanged at 2
BAF 6	Risk to senior leadership capacity	Amber 9	1 – new risk
BAF 9	Risk of a failure to deliver the Operational Plan	Red 12 ↔	Unchanged at 2
BAF 10	Risk of breaching the terms of the Trust's Licence to operate	Amber 10 ↔	Unchanged at 2
BAF 12	Risk of external funding constraints	Red 12 ↔	Unchanged at 2
BAF 13	Risk of a reduced focus on quality	Yellow 4 ↔	Unchanged at 1
BAF 14	Risk of delivery of integrated models of care	Red 12 ↔	Unchanged at 2
BAF 15	Risk of misalignment of strategic plans	Red 12 ↔	Unchanged at 1
BAF 16	Risk that the Trust's critical infrastructure is not fit for purpose	Amber 8 ↔	Unchanged at 1

Key to progress score on actions:

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

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

The CRR was reviewed at the monthly meetings of the Corporate Risk Review Group on 11 November 2016. The Corporate Risk Register contains fourteen risks. Changes to the CRR since the October meeting of the Board of Directors are:

### **Risks removed**

The risk score for C49c – risk to business objectives due to non-delivery of integrated Electronic Patient Record and Digital Roadmap requirements was reduced from Red 12 to Amber 8. The reduction in the risk score was as a result of progress relating to the project plan. Risk C49c was removed from the Corporate Risk Register.

The risk score for CR15 – risk to reputation due to wheelchair service user perception of poor service due to delays in securing equipment was reduced from Red 12 to Amber 8. The reduction in the risk score was as a result of completion of all mitigating actions. Risk CR15 was removed from the Corporate Risk Register.

### **Changes to the Corporate Risk Register**

The risk score for CR9 – risk to sustainability of service delivery and acute rotas due to withdrawal of trainees by GMC/HEEYH, was increased from Red 12 to Red 16. The increase in risk score was as a result of notification from HEEYH that the Trust would remain on a probationary period for enhanced monitoring for a further three months, contrary to earlier indications.

The risk score for CR11 – financial risk due to reduced activity due to shortages of Theatre staff as a result of the impact of the agency cap rules; and CR9 – risk to sustainability of service delivery

and acute rotas due to withdrawal of trainees by GMC/HEEYH, remained the top scoring risks at Red 16. Risks CR12 and CR17 have reported actions behind plan with the progress score of 3.

There were no new risks added to the Corporate Risk Register during the period. The corporate risks are as follows:

Ref	Description	Risk score	Progress score
<b>CR2</b>	Risk to the quality of service delivery due to reduction in trainee numbers	Red 12 ↔	2
<b>CR5</b>	Risk of patient harm due to national shortage of registered qualified nurses	Red 12 ↔	2
<b>CR7</b>	Risk of failure to meet the 4-hour A&E waiting time national standard and poor patient experience	Red 12 ↔	2
<b>CR9</b>	Risk to sustainability of service delivery and acute rotas due to withdrawal of trainees by GMC/HEEYH	Red 16 ↑	2
<b>CR11</b>	Financial risk due to reduced activity due to shortages of Theatre staff as a result of the impact of the agency cap rules	Red 16 ↔	2
<b>CR12</b>	Risk to financial sustainability from failure to deliver the Clinical Transformation Programme at pace and scale	Red 12 ↔	3
<b>CR8</b>	Risk of harm to ophthalmology patients as a result of being lost to follow-up	Red 12 ↔	2
<b>CR13</b>	Risk to quality of service as a result of the changes to the community contract	Red 12 ↔	2
<b>CR14</b>	Risk to delivery of the Trust's Operational Plan	Red 12 ↔	2
<b>CR16</b>	Risk of patient harm due to clinical risk or deteriorating conditions due to delays in ordering equipment	Red 12 ↔	2
<b>CR17</b>	Risk of patient harm as a result of being lost to follow-up	Red 12 ↔	3

Dr Ros Tolcher  
Chief Executive  
November 2016

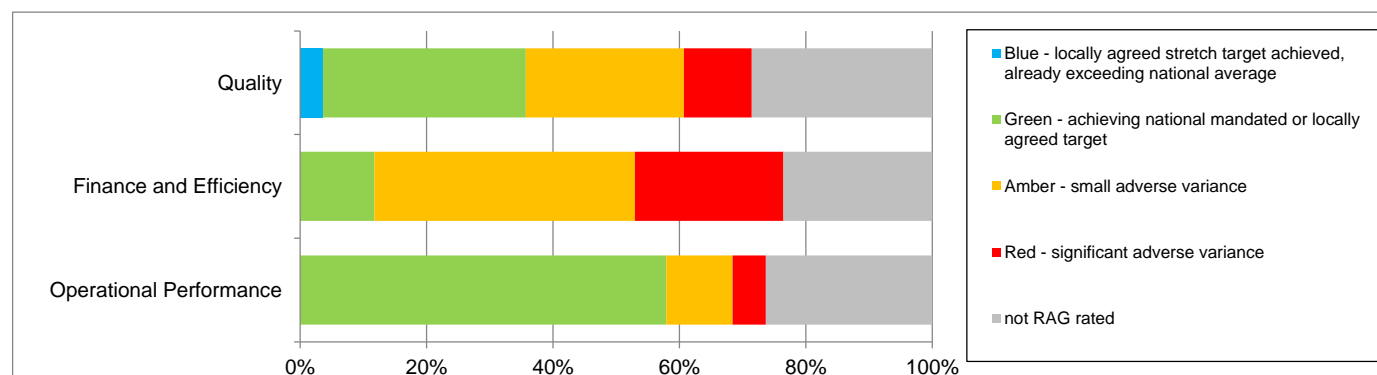
<b>Report to the Trust Board of Directors: 30 November 2016</b>	<b>Paper No: 7.0</b>
<b>Title</b>	<b>Integrated Board Report</b>
<b>Sponsoring Director</b>	Dr Ros Tolcher, Chief Executive
<b>Author(s)</b>	Ms Rachel McDonald, Head of Performance & Analysis
<b>Report Purpose</b>	To provide the Board with an update on performance relating to: operational performance; quality; and finance and efficiency.
<b>Key Issues for Board Focus:</b>	
<p>The Trust is required to report its operational performance to NHS Improvement and to routinely submit performance data to NHS England and Harrogate and Rural District CCG. The Board of Directors are asked to note that:</p> <ul style="list-style-type: none"> <li>In October, HDFT was above the required level for each of the 4 key operational performance metrics in the newly introduced NHS Improvement Single Oversight Framework and also reported a rating of 1 (where 1 is best) for the "Use of Resource Metric", although the 1 rating was not as strong as expected.</li> <li>HDFT's Summary Hospital Mortality Index decreased to 93.03, compared to 95.23 last month. This remains below the national average and is now below expected levels.</li> <li>HDFT's standardised readmission rate for the most recently published 12 month period has increased and is above the national average and above expected levels.</li> <li>Despite being below the agency ceiling, agency expenditure was at the highest level seen in 2016/17 at 3.9% for October.</li> <li>In October, 96% of babies in Darlington, 91% of babies in Co. Durham, 99% of babies in Middlesbrough and 86% of babies in North Yorkshire were recorded on Systmone as having had a new birth visit within 14 days of birth - this is an improvement on last month in all four localities, with overall performance now above 90% for the first time.</li> </ul>	
<b>Related Trust Objectives</b>	
To deliver high quality care	Yes – 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 in the delivery of high quality care.
To work with partners to deliver integrated care	Yes – key performance metrics allow the Board to receive assurance in terms of the delivery of high quality care, often underpinned by collaboration and partnership working, particularly when developing new care models.
To ensure clinical and financial sustainability	Yes – the report provides the Board with assurance on progress of work across the region to ensure clinical and financial sustainability.
<b>Risk and Assurance</b>	Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF# 1: risk of a lack of medical, nursing and clinical staff; BAF# 2: risk of a high level of frailty in local population; BAF# 9: risk of failure to deliver the operational plan; and BAF# 12: external funding constraints.
<b>Legal/regulatory implications</b>	The report does not highlight any legal/regulatory implications for the period.
<b>Action Required by the Board of Directors</b>	
The Board of Directors are asked to receive and note the content of the report.	

## Integrated board report - October 2016

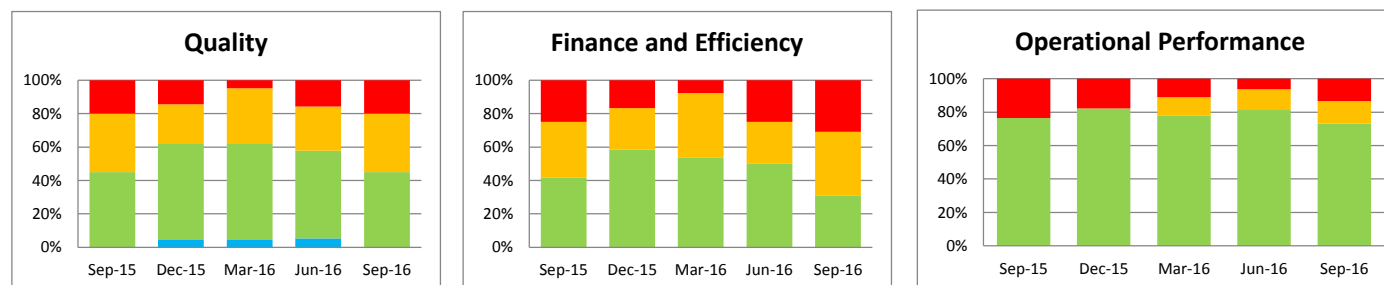
### Key points this month

1. In October, HDFT was above the required level for each of the 4 key operational performance metrics in the newly introduced NHS Improvement Single Oversight Framework and also reported a rating of 1 (where 1 is best) for the "Use of Resource Metric", although the 1 rating was not as strong as expected.
2. HDFT's Summary Hospital Mortality Index decreased to 93.03, compared to 95.23 last month. This remains below the national average and is now below expected levels.
3. HDFT's standardised readmission rate for the most recently published 12 month period has increased and is above the national average and above expected levels.
4. Despite being below the agency ceiling, agency expenditure was at the highest level seen in 2016/17 at 3.9% for October.
5. In October, 96% of babies in Darlington, 91% of babies in Co. Durham, 99% of babies in Middlesbrough and 86% of babies in North Yorkshire were recorded on Systmone as having had a new birth visit within 14 days of birth - this is an improvement on last month in all four localities, with overall performance now above 90% for the first time.

### Summary of indicators - current month




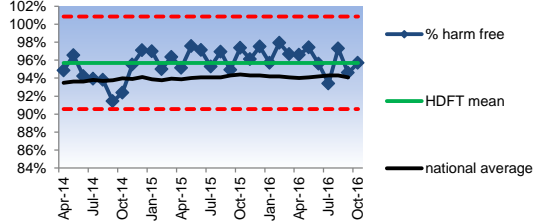

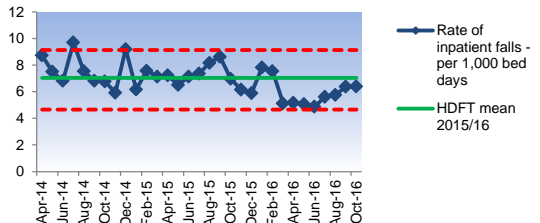

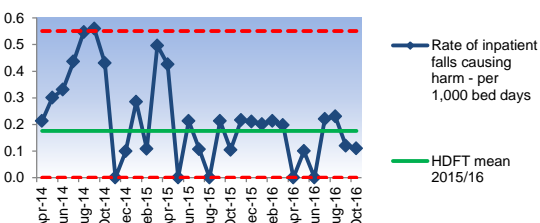

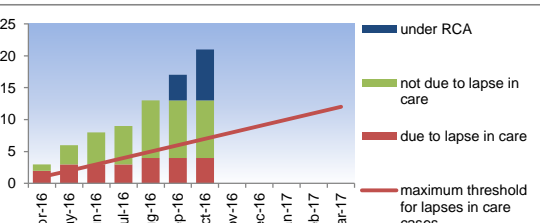
### Summary of indicators - recent trends



## Quality - October 2016


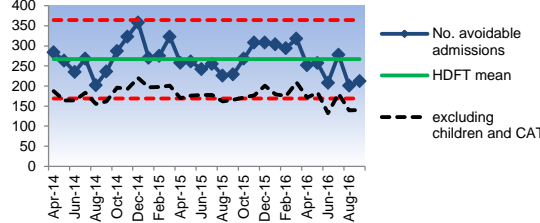

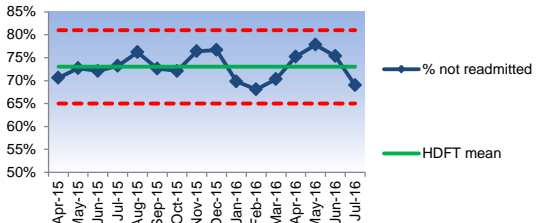

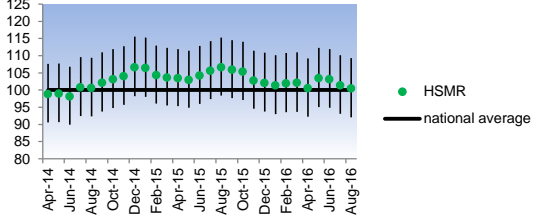

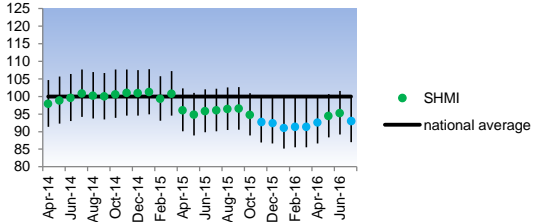
Indicator name / data quality assessment	Description	Trend chart	Interpretation
<div>✓</div> <b>Pressure ulcers - hospital acquired</b>	The chart shows the cumulative number of category 3 or category 4 hospital acquired pressure ulcers in 2016/17. The data includes hospital teams only.		<p>There were 2 hospital acquired category 3 pressure ulcer reported in October. In the year to date, 18 hospital acquired category 3 or category 4 pressure ulcers have been reported. Of these, 7 were deemed to be avoidable, 6 unavoidable and 5 cases are still under root cause analysis (RCA).</p> <p>The Trust has set a local trajectory for 2016/17 of zero avoidable hospital acquired category 3 or category 4 pressure ulcers.</p>
	The chart includes category 2, 3 and 4 hospital acquired pressure ulcers. The data includes hospital teams only.		<p>The number of hospital acquired category 2-4 pressure ulcers reported in 2016/17 to date is 107. This compares to 97 in the same period last year.</p> <p>A maximum trajectory for 2016/17 of 155 cases of category 2-4 hospital acquired pressure ulcers has been agreed via the Quality Committee.</p>
<div>✓</div> <b>Pressure ulcers - community acquired</b>	The chart shows the cumulative number of category 3 or category 4 community acquired pressure ulcers in 2016/17. This metric includes all pressure ulcers identified by community teams including pressure ulcers already present at the first point of contact.		<p>There were 8 community acquired category 3 pressure ulcers reported in September. In the year to date, 53 community acquired category 3 or category 4 pressure ulcers have been reported. Of these, 21 were deemed to be avoidable, 12 unavoidable and 20 cases are still under root cause analysis (RCA).</p>
	<div>⚠</div> <p>This additional chart has been added this month showing the trend in category 2, 3 and 4 community acquired pressure ulcers. The data includes community teams only.</p>		<p>A maximum trajectory for the number of category 2-4 community acquired pressure ulcers was agreed at the Quality Committee and is based on a 20% reduction against the number of cases reported in 2015/16.</p> <p>In 2016/17 to date, 157 cases have been reported, compared to 88 in the same period in 2015/16. The observed increase in reported cases may be partly due to improvements in incident reporting during the period.</p>

## Quality - October 2016


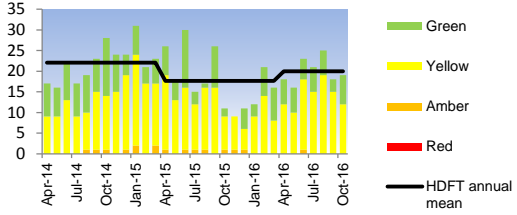

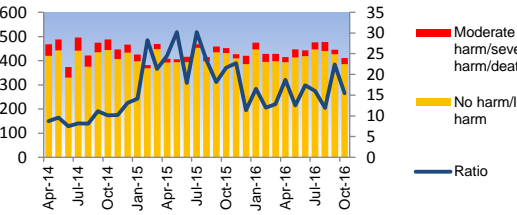

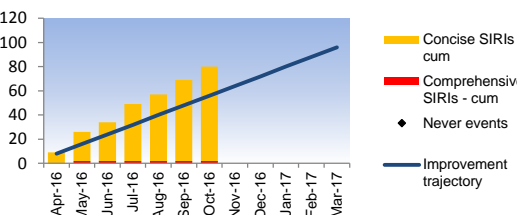

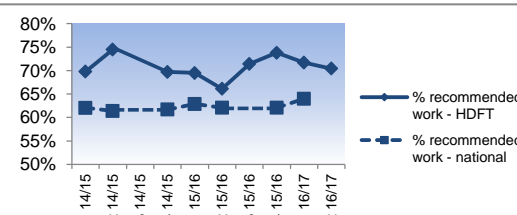
Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Safety thermometer - harm free care</b> 	Measures the percentage of patients receiving harm free care (defined as the absence of pressure ulcers, harm from a fall, urine infection in patients with a catheter and new VTE) in the Safety Thermometer audits conducted once a month. The data includes hospital and community teams. 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 October was 95.7%, an increase on last month and remaining above the latest national average.
<b>Falls</b> 	The number of inpatient falls expressed as a rate per 1,000 bed days. The data includes falls causing harm and those not causing harm. A low rate is good.		The rate of inpatient falls was 6.4 per 1,000 bed days in October, no change on last month and remaining below the HDFT 2015/16 average rate.  The falls sensors are now in place on Byland, Jervaulx, Farndale and Trinity wards and there is a plan to roll out to the other ward areas.
<b>Falls causing harm</b> 	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 moderate harm, severe harm or death was 0.11 per 1,000 bed days in October, a decrease on the previous month and below the average HDFT rate for 2015/16.  There have been 7 inpatient falls causing moderate or severe harm in 2016/17 to date, all of which resulted in a fracture. This compares to 10 moderate or severe harm falls in the same period last year.
<b>Infection control</b> 	The chart shows the cumulative number of hospital apportioned C. difficile cases during 2016/17. HDFT's C. difficile trajectory for 2016/17 is 12 cases, no change on last year's trajectory. Cases where a lapse in care has been deemed to have occurred would count towards the Monitor risk assessment framework. Hospital acquired MRSA cases will be reported on an exception basis. HDFT has a trajectory of 0 MRSA cases for 2016/17. The last reported case of hospital acquired MRSA at HDFT was in Oct-12.		There were 4 cases of hospital apportioned C. difficile reported in October, bringing the year to date total to 21 cases. 17 cases have now have root cause analysis (RCA) completed by HDFT and 13 of the RCAs have been discussed and agreed with HARD CCG. Of the 13 cases discussed and agreed, 4 have been determined to be due to a lapse in care and 9 were determined to not be due to a lapse in care. No cases of hospital acquired MRSA have been reported in 2016/17 to date.




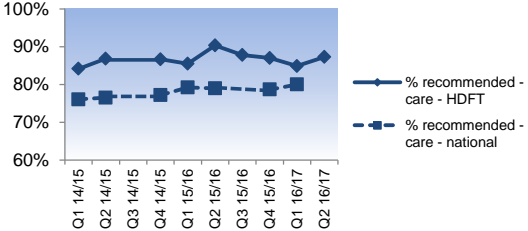

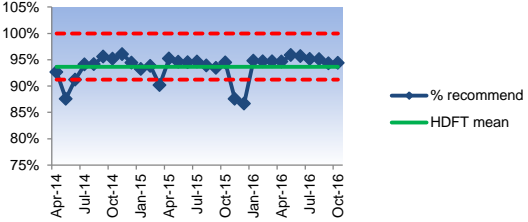

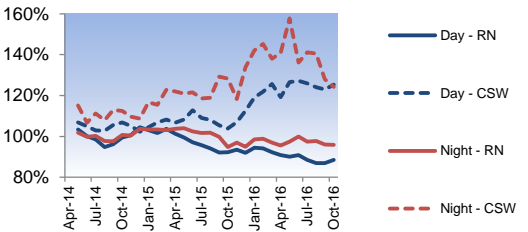

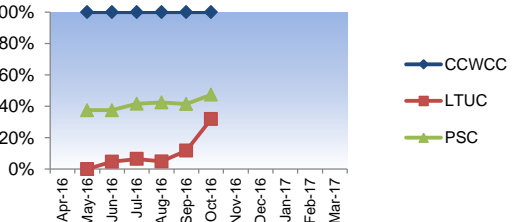
## Quality - October 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Avoidable admissions</b> 	<p>The chart shows the number of avoidable emergency admissions to HDFT as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require admission. Conditions include pneumonia and urinary tract infections in adults and respiratory conditions in children.</p>		<p>There were 212 avoidable admissions in September, an increase on last month but below the HDFT average. There is some seasonality in this metric so a reduction during the summer months is expected. However this is lower than the level in the same period last year.</p> <p>An extra line has been added to the chart to show the number of avoidable admissions excluding CAT (Clinical Assessment Team) attendances and admissions aged 0-17 years. This allows us to isolate and track the adult emergency admissions that may be avoided by the New Care Model.</p>
<b>Reducing hospital admissions in older people</b> 	<p>The chart shows the proportion of older people aged 65+ who were still at home 91 days after discharge from rehabilitation or reablement services. A high figure is good.  <i>This indicator is in development.</i></p>		<p>For patients discharged from rehabilitation or reablement services in July, 69% were still in their own home at the end of October, a decrease on the previous month.</p> <p>A case note audit of a sample of patients is being carried out to understand any themes and actions required and the results will be reported by Long Term and Unscheduled Care Directorate in the Autumn.</p>
<b>Mortality - HSMR</b> 	<p>The Hospital Standardised Mortality Ratio (HSMR) looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care. A low figure is good.</p>		<p>HDFT's HSMR decreased to 100.43 in July and remains within expected levels. At specialty level, 2 specialties (Geriatric medicine and Gastroenterology) have a standardised mortality rate above expected levels.</p>
<b>Mortality - SHMI</b> 	<p>The Summary Hospital Mortality Index (SHMI) looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care. A low figure is good.</p>		<p>HDFT's SHMI decreased to 93.03, compared to 95.23 last month. This remains below the national average and is also below expected levels.</p> <p>At specialty level, 2 specialties (Geriatric Medicine and Gastroenterology) have a standardised mortality rate above expected levels.</p>


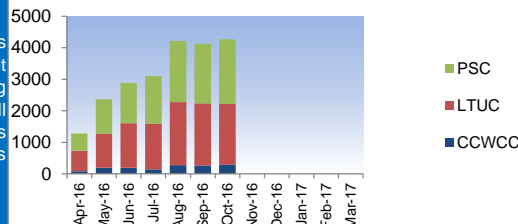

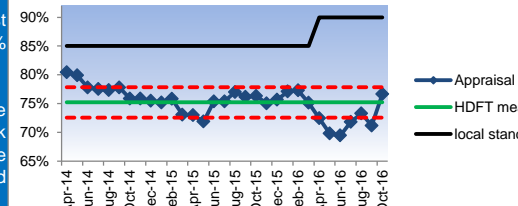


## Quality - October 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Complaints</b> 	<p>The number of complaints received by the Trust, shown by month of receipt of complaint. The criteria define the severity/grading of the complaint with green and yellow signifying less serious issues, amber signifying potentially significant issues and red for complaints related to serious adverse incidents.</p> <p>The data includes complaints relating to both hospital and community services.</p>		<p>19 complaints were received in October compared to 18 last month, with none classified as amber or red. This is just above the 2015/16 average.</p>
<b>Incidents - all</b> 	<p>The chart shows the number of incidents reported within the Trust each month. It includes all categories of incidents, including those that were categorised as "no harm". The data includes hospital and community services.</p> <p>A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture</p>		<p>The latest published national data (for the period Sep 15 to Mar 16) shows that Acute Trusts reported an average ratio of 34 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 the same period was 18 which places the Trust in the bottom 25% nationally. The focus going forward is to improve our incident reporting rate particularly encouraging staff to report no harm/ near miss incidents. Work is progressing to review the datix system to simplify the incident reporting process.</p>
<b>Incidents - SIRIs and never events</b> 	<p>The chart shows the number of Serious Incidents Requiring Investigation (SIRIs) and Never Events reported within the Trust each month. The data includes hospital and community services.</p> <p>We have changed this indicator to now include both comprehensive and concise SIRIs and have amended the presentation to show a cumulative position.</p>		<p>There were no comprehensive SIRIs and no never events reported in October.</p> <p>There have been 78 concise SIRIs and 2 comprehensive SIRIs reported in the year to date. In 2015/16, HDFT reported an average of 9.6 SIRIs per month.</p>
<b>Friends &amp; Family Test (FFT) - Staff - % recommend as a place to work</b> 	<p>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.</p> <p>The chart shows the percentage of staff that would recommend the Trust as a place to work. A high percentage is good. The Trust's aim is to feature in the top 20% of Trusts nationally which would typically mean that 71% of staff would recommend the Trust as a place to work.</p>		<p><i>There is no update of this data this month.</i></p> <p>In Quarter 2, 70.4% of HDFT staff surveyed would recommend HDFT as a place to work, this remains above the most recently published national average of 64%.</p> <p>The Staff Friends and Family Test is now surveying the whole Trust rather than by Directorate. This will allow us to benchmark our response rate. During 2015/16, the whole Trust was only surveyed during Quarter 3.</p>


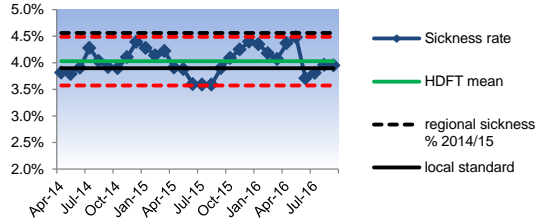

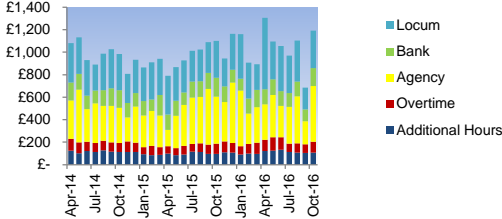

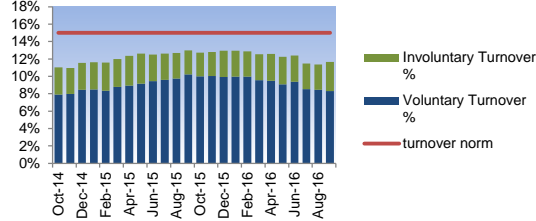

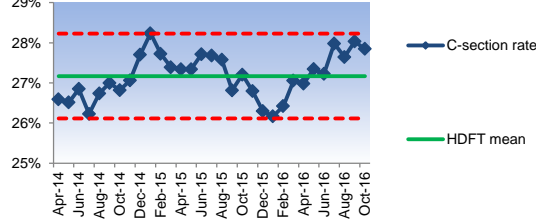
## Quality - October 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Friends &amp; Family Test (FFT) - Staff - % recommend as a place to receive care</b> 	<p>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.</p> <p>The chart shows the percentage of staff that would recommend the Trust as a place to receive care. A high percentage is good. The Trust's aim is to feature in the top 20% of Trusts nationally which would typically mean that 88% of staff would recommend the Trust as a place to work.</p>		<p><i>There is no update of this data this month.</i></p> <p>In Quarter 2, 87.3% of HDFT staff surveyed would recommend HDFT as a place to receive care. This is an increase on Q1 and above the most recently published national average of 80%.</p> <p>The Staff, Friends and Family Test is now surveying the whole Trust rather than by Directorate. This will allow us to benchmark our response rate. During 2015/16, the whole Trust was only surveyed during Quarter 3.</p>
<b>Friends &amp; Family Test (FFT) - Patients</b> 	<p>The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of hospital and community services including inpatients, day cases, outpatients, maternity services, the emergency department, some therapy services, district nursing, community podiatry and GP OOH. A high percentage is good.</p>		<p>94.4% of patients surveyed in October would recommend our services, remaining in line with recent months and above the latest published national average.</p>
<b>Safer staffing levels</b> 	<p>Trusts are required to publish information about staffing levels for registered nurses/midwives (RN) and care support workers (CSW) for each inpatient ward. The chart shows the overall fill rate at HDFT for RN and CSW for day and night shifts. The fill rate is calculated by comparing planned staffing with actual levels achieved. A ward level breakdown of this data is published on the Trust website.</p>		<p>Overall staffing compared to planned was at 102% in October. Care Support Worker staffing remains high compared to plan - this is reflective of the increased need for 1-1 care and the number of newly qualified nurses working before they have received full registration.</p> <p>A significant focus is being placed on Registered Nurse recruitment and as a result, the Trust welcomed 24 newly qualified and 11 experienced Registered Nurses during September and October.</p>
<b>Electronic rostering timeliness</b> 	<p>The chart shows the proportion of rosters that were published on time on Rosterpro (at least 4 weeks before the roster start date). It includes data for 20 specific clinical areas (mostly inpatient wards) involved in the pilot phase. Data presented is for a rolling 12 months period and is split by Clinical Directorate. A high percentage is good.</p>		<p>Overall, 45% of rosters were published on time during the period May to October 2016. The presentation of this data has been amended to show rosters based on roster start date, instead of roster end date, to provide more up to date information. All three Clinical Directorates are now showing improvements in recent when the data is presented this way.</p> <p>Publishing electronic rosters in a timely manner improves staff morale, increases bank fill rates and reduces bank/agency costs.</p>


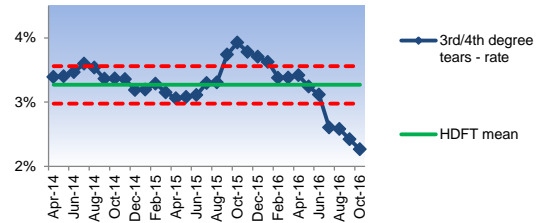

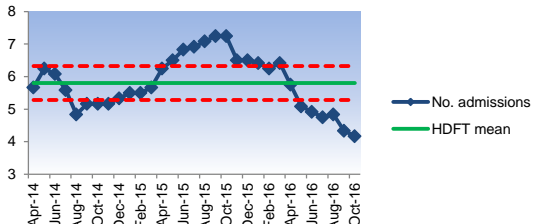
## Quality - October 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation																		
<div>Electronic rostering hours owed</div> <div></div>	<p>This metric shows the sum of unused hours for staff as a running balance from the Trust's predefined audit start date. To allow for some flexibility in assigning hours over rosters (ie. for Night workers), an alert will be triggered when staff owe 30 hours or more. Data is split by Clinical Directorate for 20 specific clinical areas (mostly inpatient wards) involved in the pilot phase. A low number is good.</p>		<p>The chart shows the cumulative position. The number of unused hours has been reducing since July. There have been significant improvements in data quality within the Rosterpro system during this period.</p> <p>Properly managed balances increase available clinical hours, improves staff morale and management decision making.</p>																		
<div>Staff appraisal rates</div> <div></div>	<p>The chart shows the staff appraisal rate over the most recent rolling 12 months. The Trusts aims to have 90% of staff appraised. A high percentage is good.</p> <p>The figures from May 2016 onwards exclude employees currently on maternity leave, career break or suspension and staff who TUPE transferred into the organisation from Darlington, Durham and Middlesbrough from 1st April 2016.</p>		<p>The appraisal rate for the 12 months to end October is 76.6%, an increase of 5.5% from September. The data cleansing is ongoing for the Durham, Darlington and Middlesbrough (DDM) teams who transferred on 1 April 2016. As at end October, 75.6% of TUPE transferred DDM staff had recorded appraisals. Following meetings with Directorates, changes have been made to the appraisals for multi-post holders to ensure that if an appraisal is undertaken in a primary assignment, it is reflected in other assignments.</p>																		
<div>Mandatory training rates</div> <div></div>	<p>The table shows the most recent training rates for all mandatory elements for substantive staff. The table excludes staff who TUPE transferred into the organisation on 1st April 2016. A high percentage is good.</p>	<table><tr><th>Competence Name</th><th>% Completed</th></tr><tr><td>Equality, Diversity and Human Rights - Level 1</td><td>93</td></tr><tr><td>Fire Safety Awareness</td><td>86</td></tr><tr><td>Infection Prevention &amp; Control 1</td><td>99</td></tr><tr><td>Infection Prevention &amp; Control 2</td><td>84</td></tr><tr><td>Information Governance: Introduction</td><td>87</td></tr><tr><td>Information Governance: The Beginners Guide</td><td>79</td></tr><tr><td>Prevent Basic Awareness (December 2015)</td><td>99</td></tr><tr><td>Safeguarding Children &amp; Young People Level 1 - Introduction</td><td>94</td></tr></table>	Competence Name	% Completed	Equality, Diversity and Human Rights - Level 1	93	Fire Safety Awareness	86	Infection Prevention & Control 1	99	Infection Prevention & Control 2	84	Information Governance: Introduction	87	Information Governance: The Beginners Guide	79	Prevent Basic Awareness (December 2015)	99	Safeguarding Children & Young People Level 1 - Introduction	94	<p>The data shown is for the end of October and excludes the staff who were TUPE transferred into the organisation on the 1st April 2016. The overall training rate for mandatory elements for substantive staff in this group is 91 %.</p> <p>The new follow up procedure is now in place for Directorates to use and we hope to see a positive impact on compliance going forward.</p>
Competence Name	% Completed																				
Equality, Diversity and Human Rights - Level 1	93																				
Fire Safety Awareness	86																				
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<div>Mandatory training rates</div> <div></div>	<p>The table shows the most recent training rates for all mandatory elements for substantive staff. The table only includes staff who TUPE transferred into the organisation on 1st April 2016. A high percentage is good.</p>	<table><tr><th>Competence Name</th><th>% Completed</th></tr><tr><td>Equality, Diversity and Human Rights - Level 1</td><td>54</td></tr><tr><td>Fire Safety Awareness</td><td>66</td></tr><tr><td>Infection Prevention &amp; Control 1</td><td>100</td></tr><tr><td>Infection Prevention &amp; Control 2</td><td>45</td></tr><tr><td>Information Governance: Introduction</td><td>56</td></tr><tr><td>Information Governance: The Beginners Guide</td><td>0</td></tr><tr><td>Prevent Basic Awareness (December 2015)</td><td>55</td></tr><tr><td>Safeguarding Children &amp; Young People Level 1 - Introduction</td><td>96</td></tr></table>	Competence Name	% Completed	Equality, Diversity and Human Rights - Level 1	54	Fire Safety Awareness	66	Infection Prevention & Control 1	100	Infection Prevention & Control 2	45	Information Governance: Introduction	56	Information Governance: The Beginners Guide	0	Prevent Basic Awareness (December 2015)	55	Safeguarding Children & Young People Level 1 - Introduction	96	<p>The data shown is for the end of October and shows the statistics for the TUPE staff that transferred into the organisation on the 1st April 2016 from Middlesbrough, Durham and Darlington. The overall training rate for mandatory elements for substantive staff in this group is 57%. This is an increase on 1% since the 1st October 2016. The TUPE staff compliance figures will be reported separately until January 2017 at which point we plan to amalgamate the figures into one table of data. This allows the newly transferred staff time to establish systems and processes to access their mandatory training, complete data validation and increase their overall compliance to the level we have achieved across the Trust prior to their transfer.</p>
Competence Name	% Completed																				
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## Quality - October 2016


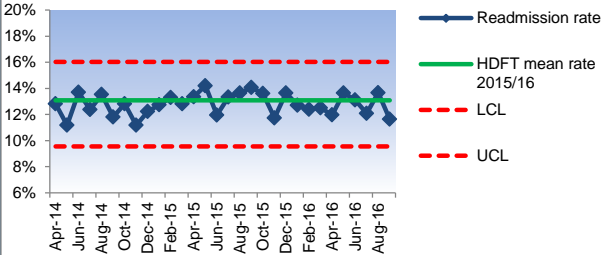

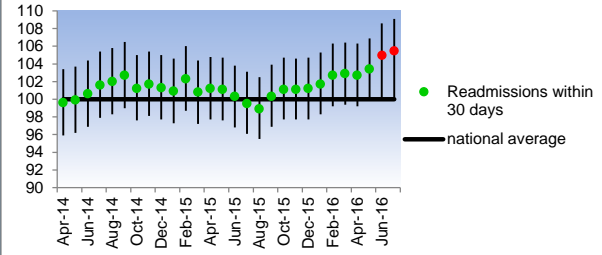

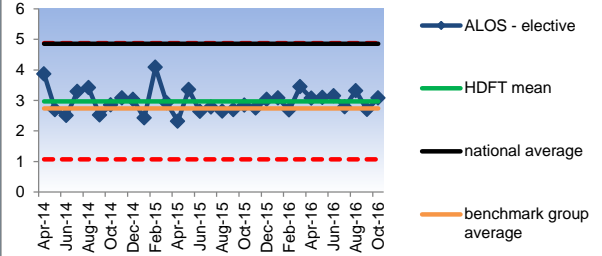

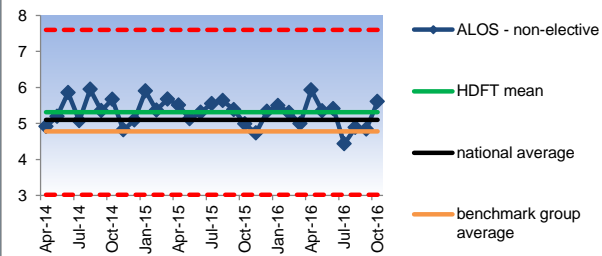
Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Sickness rates</b> 	<p>Staff sickness rate - includes short and long term sickness.</p> <p>The Trust has set a threshold of 3.9%. A low percentage is good.</p>		<p>The sickness rate for September was 3.95%. Stress, anxiety and depression remains the leading cause for sickness absence. This month, we see the launch of the Schwartz Rounds, designed to support staff in their roles and reduce stress and isolation.</p> <p>The HR team remains focused on attendance management across the Trust, particularly in relation to the resolution of long term sickness cases. Flu jabs are currently being administered across the Trust with the aim of combating cough, cold and flu related absences which peak during the winter months.</p>
<b>Temporary staffing expenditure - medical/nursing /other</b> 	<p>The chart shows staff expenditure per month, split into contracted staff, overtime and additional hours and temporary staff. Lower figures are preferable.</p> <p><i>The traffic light criteria applied to this indicator is currently under review.</i></p>		<p>The proportion of spend on temporary staff during September was 8.6%, an increase on last month and above the average level (7.6%) during 2015/16.</p>
<b>Staff turnover rate</b> 	<p>The chart shows the staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. The turnover figures include both voluntary and involuntary turnover. Voluntary turnover is when an employee chooses to leave the Trust and involuntary turnover is when the employee unwillingly leaves the Trust.</p> <p>Data from the Times Top 100 Employers indicated a turnover rate norm of 15%, i.e. the level at which organisations should be concerned.</p>		<p>Voluntary turnover comprised 8.29% of the overall figure of 11.67%, this continues the trend of decreasing voluntary turnover. A retention group has been established to develop a retention strategy for staff groups with higher levels of turnover.</p>
<b>Maternity - Caesarean section rate</b> 	<p>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.</p> <p>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.</p>		<p>HDFT's C-section rate for the 12 months ending October 2016 was 28.0% of deliveries, a decrease on last month but remaining higher than average.</p> <p>The major contributing factor to the recent upward trend appears to be a significant increase in elective caesarean sections during 2016/17, with the emergency caesarean section rate remaining static and within expected parameters.</p>

## Quality - October 2016


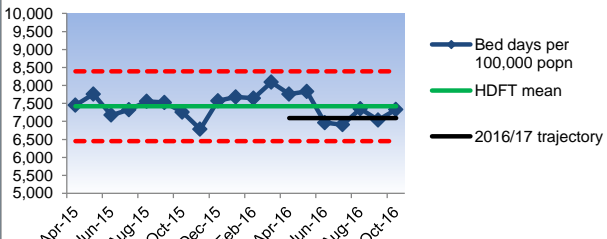

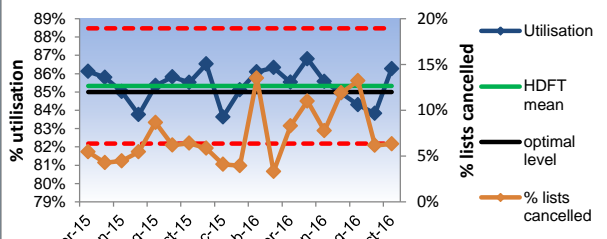

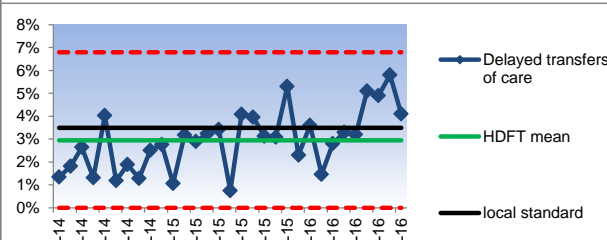

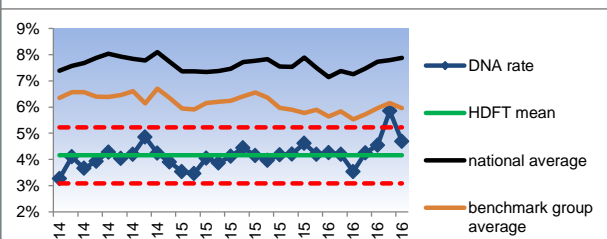
Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Maternity - Rate of third and fourth degree tears</b> 	<p>Third and fourth degree tears are a source of short term and long term morbidity. A previous third degree tear can increase the likelihood of a woman choosing a caesarean section in a subsequent pregnancy. 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.</p>		<p>The rate of third or fourth degree tears was 2.3% of deliveries in the 12 month period ending October 2016, remaining well below previous months.</p> <p>The rolling 12 months rate is at its lowest point since the dashboard was created. This may reflect the significant amount of quality improvement work aimed at reducing the incidence of third degree tears.</p>
<b>Maternity - Unexpected term admissions to SCBU</b> 	<p>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.</p> <p>We have amended the presentation of this indicator this month to show a 12 month rolling average position.</p>		<p>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.</p> <p>There were 4 term admissions to SCBU in October. The average number per month over the last 12 months is 4.2.</p>



## Finance and Efficiency - October 2016


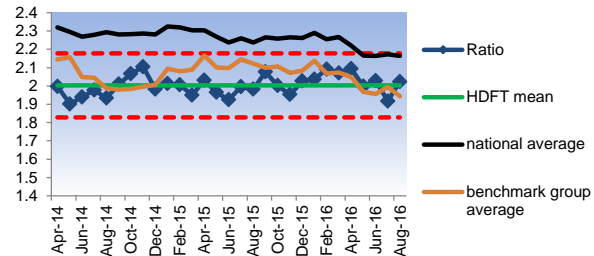

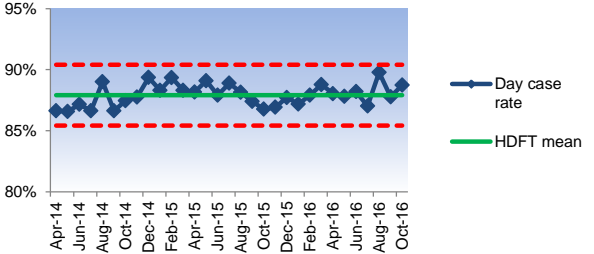

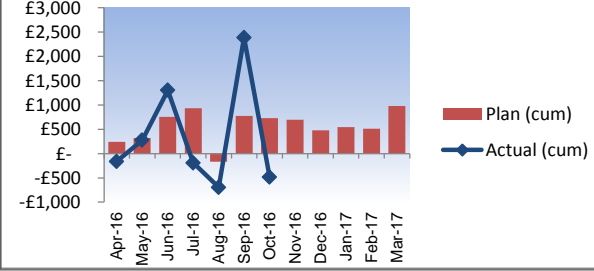

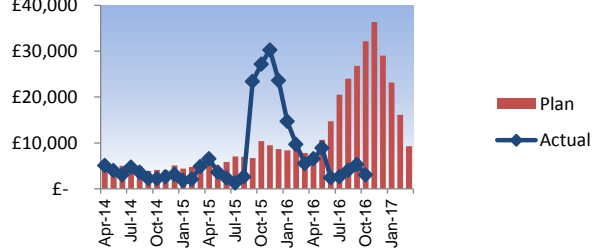
Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Readmissions</b> 	<p>% of patients readmitted to hospital as an emergency within 30 days of discharge (PbR exclusions applied). To ensure that we are not discharging patients inappropriately early and to assess our overall surgical success rates, we monitor the numbers of patients readmitted. A low number is good performance. This data is reported a month behind so that any recent readmissions are captured in the data.</p>		<p>The number of readmissions decreased in September, when expressed as a percentage of all emergency admissions. The rate is now below the average rate for 2015/16.</p> <p>HDFT and HARD CCG will be undertaking an audit of readmissions in Quarter 3 to determine the proportion of readmissions which were avoidable.</p>
<b>Readmissions - standardised</b> 	<p>This indicator looks at the standardised readmission rate within 30 days. The data is standardised against various criteria including age, sex, diagnosis, comorbidities 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.</p>		<p>Two months' worth of data has been published in HED since last month's report. Both months show an increase in HDFT's standardised readmission rate - for the rolling 12 month period ending July 2016, the figure rate was 105.5, above the national average and above expected levels.</p> <p>At specialty level, Clinical Haematology, ENT, Paediatrics, Medical Oncology and Well Babies all have standardised emergency readmission rates above expected.</p>
<b>Length of stay - elective</b> 	<p>Average length of stay in days for elective (waiting list) patients. The data excludes day case patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.</p>		<p>The average elective length of stay for October was 3.1 days, an 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.</p>
<b>Length of stay - non-elective</b> 	<p>Average length of stay in days for non-elective (emergency) patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.</p>		<p>The average non-elective length of stay for October was 5.6 days, an increase on the previous month and above the HDFT average.</p>

## Finance and Efficiency - October 2016



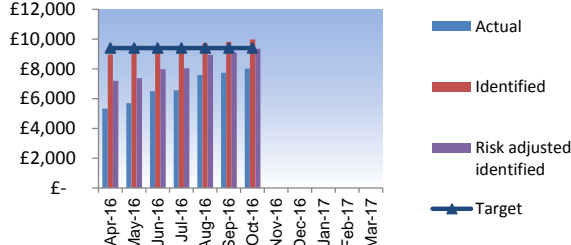

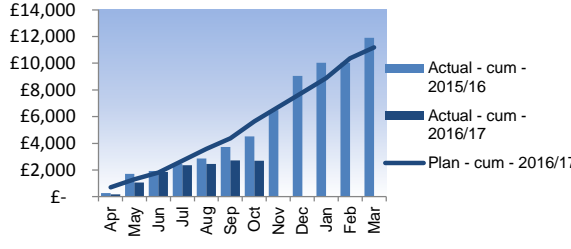

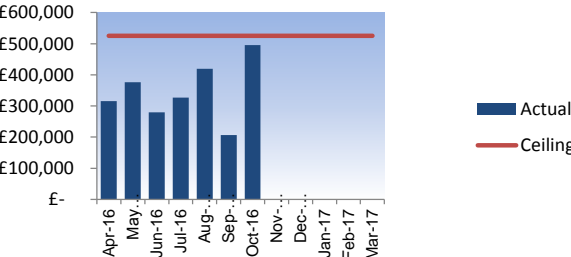
Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Non-elective bed days</b> 	<p>The charts shows the number of non-elective (emergency) bed days at HDFT for patients aged 18+, per 100,000 population. The chart only includes the local HARD CCG area. The 2016/17 trajectory is based on allowing for demographic growth and reducing by the non-elective reductions identified in the Value Proposition. A lower figure is preferable.</p>		<p>Non-elective bed days for patients aged 18+ have been lower over the last few months. In October, there was a slight increase but levels remain below average.</p>
<b>Theatre utilisation</b> 	<p>The percentage of time utilised during elective theatre sessions (i.e. those planned in advance for waiting list patients). The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. An extra line has been added to the chart to allow monitoring of this.</p> <p>A higher utilisation rate is good as it demonstrates effective use of resources. A utilisation rate of around 85% is often viewed as optimal.</p>		<p>Theatre utilisation increased to 86.3% in October. The number of cancelled sessions was 6.3%, no change on last month.</p> <p>The agency cap is still impacting on theatre staffing and hence on utilisation.</p>
<b>Delayed transfers of care</b> 	<p>The proportion of patients in acute hospital beds who are medically fit for discharge but are still in hospital. A low rate is preferable.</p> <p>A snapshot position is taken at midnight on the last Thursday of each month. The maximum threshold shown on the chart (3.5%) has been agreed with the CCG.</p>		<p>Delayed transfers of care decreased to 4.1% when the snapshot was taken in October, but remain above the maximum threshold of 3.5% set out in the contract.</p> <p>Further work to understand the reasons for this continued increase is being carried out by the Discharge Steering Group.</p>
<b>Outpatient DNA rate</b> 	<p>Percentage of new outpatient attendances where the patient does not attend their appointment, without notifying the trust in advance.</p> <p>A low percentage is good. Patient DNAs will usually result in an unused clinic slot.</p>		<p>HDFT's DNA rate decreased to 4.7% in August but is now back within expected levels.</p> <p>HDFT's DNA rate remains below that of both the benchmarked group of Trusts and the national average.</p>




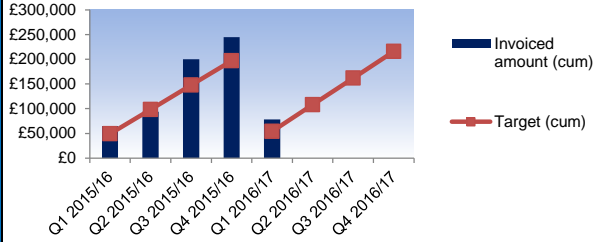
## Finance and Efficiency - October 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Outpatient new to follow up ratio</b> 	The number of follow-up appointments per new appointment. A lower ratio is preferable. A high ratio could indicate that unnecessary follow ups are taking place.		<p>Reducing the number of follow ups is a major part of HARD CCG's financial recovery plan. HDFT's new to follow up ratio increased in August - it is below the national average but above the benchmark group average.</p> <p>The Trust worked closely with HARD CCG on the Elective Care Rapid Testing Programme as part of the work of the Joint Clinical Board. The three specialties running the rapid testing programme all have reducing face to face follow ups as part of their ambition.</p>
<b>Day case rate</b> 	The proportion of elective (waiting list) procedures carried out as a day case procedure, i.e. the patient did not stay overnight. A higher day case rate is preferable.		The day case rate increased to 88.7% in October and remains within expected levels.
<b>Surplus / deficit and variance to plan</b> 	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's underlying position to date, following the removal of S&T funding, is a deficit of £144k, £761k behind plan. The Trust has therefore not assumed S&T funding in October, increasing the variance to £1,144k to date. A deficit of £483k was reported in October, significantly behind plan. Acute income was £593k behind plan with recovery plans not having the impact expected to date. There was also an increase in pay expenditure, resulting in an adverse variance of £194k in month.
<b>Cash balance</b> 	Monthly cash balance (£'000s)		The Trust reported a cash position of £3,046k. This is £4,934k behind the reprofiled plan. This is a significant area of focus for the finance team at present. £1,150k of this variance is a result of the timing of S&T payments.



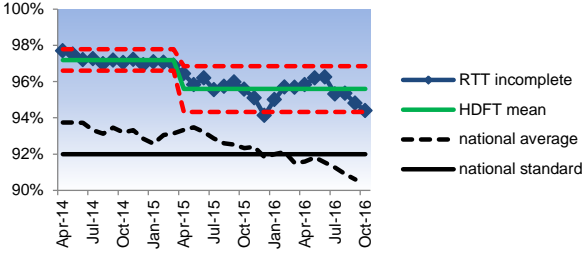

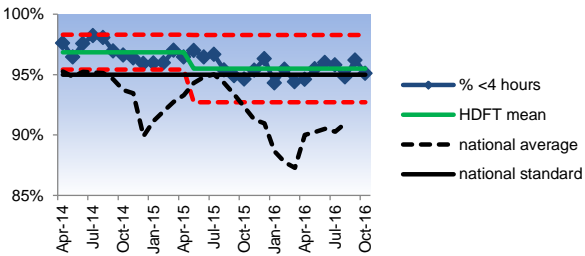

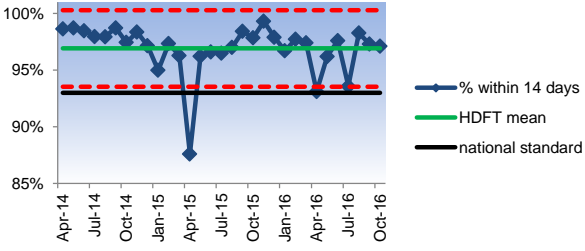
## Finance and Efficiency - October 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation																					
NHS Improvement Single Oversight Framework - Use of Resource Metric 	From 1st October 2016, NHS Improvement introduced the Single Oversight Framework. As part of this this, Use of Resource Metric was introduced to replace the previous Financial Sustainability Risk Rating. This is the product of five elements which are rated between 1 (best) to 4.	<table><thead><tr><th>Element</th><th>Plan</th><th>Actual</th></tr></thead><tbody><tr><td>Capital Service Cover</td><td>1</td><td>1</td></tr><tr><td>Liquidity</td><td>1</td><td>1</td></tr><tr><td>I&amp;E Margin</td><td>1</td><td>1</td></tr><tr><td>I&amp;E Variance From Plan</td><td></td><td>2</td></tr><tr><td>Agency</td><td>1</td><td>1</td></tr><tr><td><b>Financial Sustainability Risk Rating</b></td><td><b>1</b></td><td><b>1</b></td></tr></tbody></table>	Element	Plan	Actual	Capital Service Cover	1	1	Liquidity	1	1	I&E Margin	1	1	I&E Variance From Plan		2	Agency	1	1	<b>Financial Sustainability Risk Rating</b>	<b>1</b>	<b>1</b>	The Trust reported a rating of 1 for October. However, this is not as strong a 1 as planned due to the current variance from plan.
Element	Plan	Actual																						
Capital Service Cover	1	1																						
Liquidity	1	1																						
I&E Margin	1	1																						
I&E Variance From Plan		2																						
Agency	1	1																						
<b>Financial Sustainability Risk Rating</b>	<b>1</b>	<b>1</b>																						
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.		85% of CIP schemes have been actioned to date. Plans are in place for 106% of the efficiency requirement, the risk adjusted total reducing to 100%.																					
Capital spend 	Cumulative Capital Expenditure by month (£'000s)		Cumulative capital expenditure reduced in month as a result of a benefit in relation to VAT.																					
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.		Despite being below the agency ceiling, agency expenditure was at the highest level seen in 2016/17 at 3.9% in October.																					


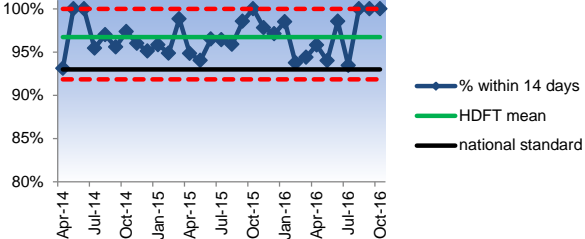

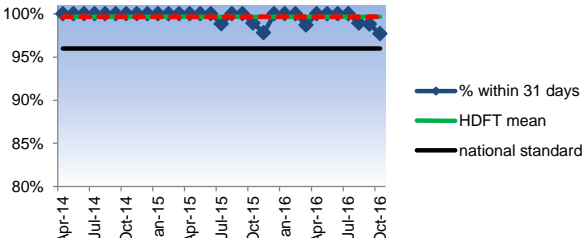

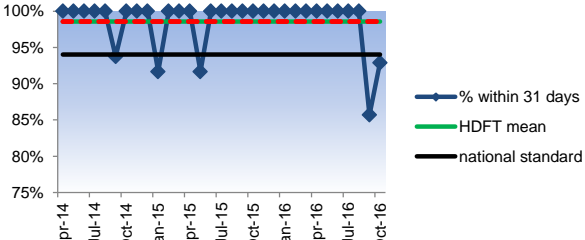

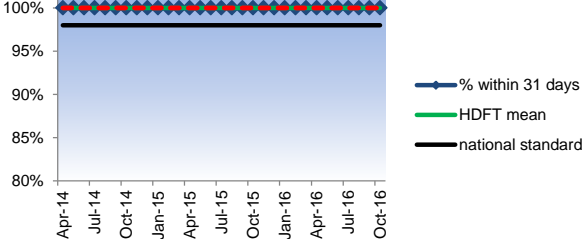
## Finance and Efficiency - October 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Research - Invoiced research activity</b> 	Aspects of research studies are paid for by the study sponsor or funder.	 <p>£300,000 £250,000 £200,000 £150,000 £100,000 £50,000 £0</p> <p>Q1 2015/16 Q2 2015/16 Q3 2015/16 Q4 2015/16 Q1 2016/17 Q2 2016/17 Q3 2016/17 Q4 2016/17</p> <p>■ Invoiced amount (cum) ■ Target (cum)</p>	<p><i>There is no update of this data this month.</i></p> <p>As set out in the Research &amp; 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.</p>


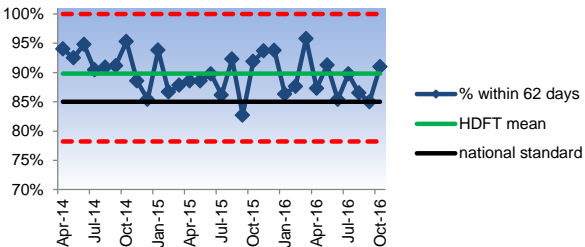

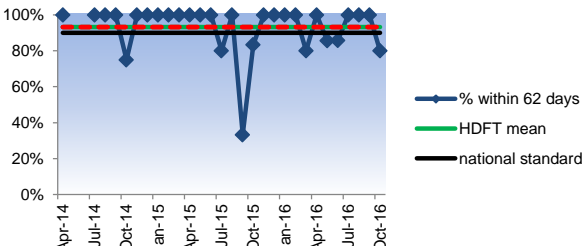

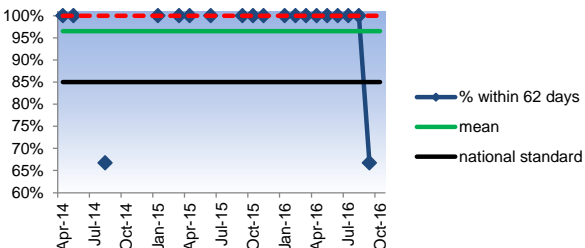

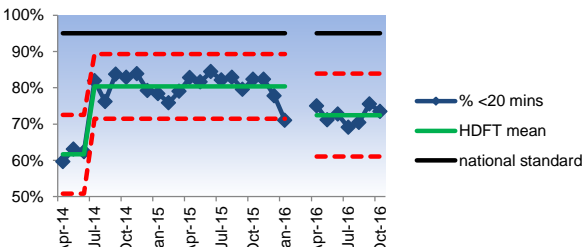
## Operational Performance - October 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation																																								
<b>NHS Improvement Single Oversight Framework</b> 	<p>From October 2016, NHS Improvement will 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 "operational performance metrics" section.</p>	<table border="1"> <thead> <tr> <th>Standard</th><th>Oct-16</th><th>Nov-16</th><th>Dec-16</th></tr> </thead> <tbody> <tr> <td>RTT incomplete pathways</td><td>94.4%</td><td></td><td></td></tr> <tr> <td>A&amp;E 4-hour standard</td><td>95.1%</td><td></td><td></td></tr> <tr> <td>Cancer - 62 days</td><td>91.0%</td><td></td><td></td></tr> <tr> <td>Diagnostic waits</td><td>99.9%</td><td></td><td></td></tr> </tbody> </table> <table border="1"> <thead> <tr> <th>Standard</th><th>Jan-17</th><th>Feb-17</th><th>Mar-17</th></tr> </thead> <tbody> <tr> <td>RTT incomplete pathways</td><td></td><td></td><td></td></tr> <tr> <td>A&amp;E 4-hour standard</td><td></td><td></td><td></td></tr> <tr> <td>Cancer - 62 days</td><td></td><td></td><td></td></tr> <tr> <td>Diagnostic waits</td><td></td><td></td><td></td></tr> </tbody> </table>	Standard	Oct-16	Nov-16	Dec-16	RTT incomplete pathways	94.4%			A&E 4-hour standard	95.1%			Cancer - 62 days	91.0%			Diagnostic waits	99.9%			Standard	Jan-17	Feb-17	Mar-17	RTT incomplete pathways				A&E 4-hour standard				Cancer - 62 days				Diagnostic waits				<p>In October, HDFT was above the required level for each of the 4 key operational performance metrics.</p>
Standard	Oct-16	Nov-16	Dec-16																																								
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<b>RTT Incomplete pathways performance</b> 	<p>Percentage of incomplete pathways waiting less than 18 weeks. The national standard is that 92% of incomplete pathways should be waiting less than 18 weeks. A high percentage is good.</p>		<p>94.4% of patients were waiting 18 weeks or less at the end of October, a decrease on last month but remaining above the required national standard of 92%.</p> <p>At specialty level, Trauma &amp; Orthopaedics and General Surgery were below the 92% standard in October.</p>																																								
<b>A&amp;E 4 hour standard</b> 	<p>Percentage of patients spending less than 4 hours in Accident &amp; Emergency (A&amp;E). The operational standard is 95%. The data includes all A&amp;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.</p>		<p>HDFT's Trust level performance for October 2016 was 95.1%, a decrease on last month but remaining above the required 95% standard. This includes data for the Emergency Department at Harrogate and Ripon MIU.</p> <p>Performance for Harrogate ED was below the standard in October at 94.0%.</p>																																								
<b>Cancer - 14 days maximum wait from urgent GP referral for suspected cancer referrals</b> 	<p>Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%. A high percentage is good.</p>		<p>Delivery at expected levels.</p>																																								


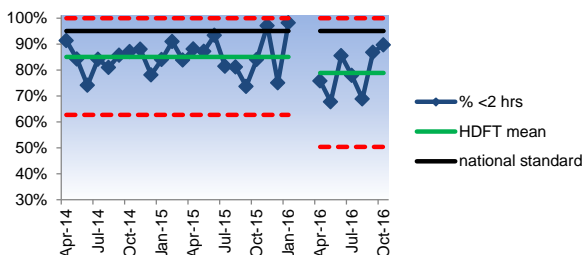

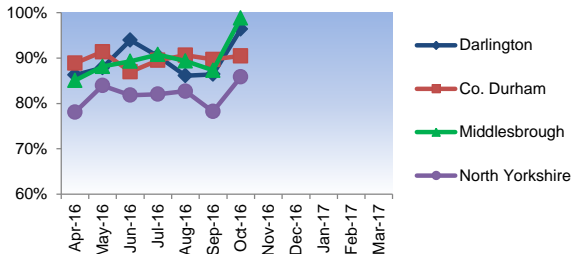

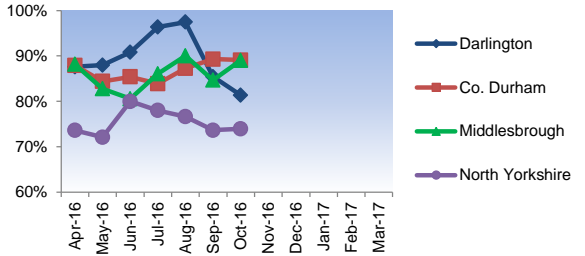

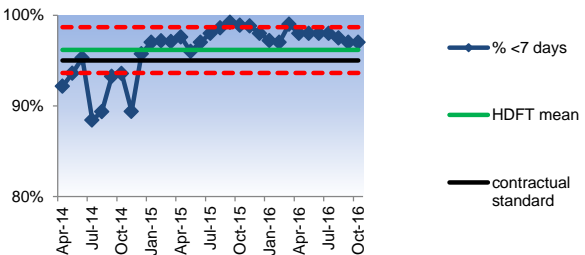
## Operational Performance - October 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Cancer - 14 days maximum wait from GP referral for symptomatic breast patients</b> 	Percentage of GP referrals for breast symptomatic patients seen within 14 days. The operational standard is 93%. A high percentage is good.		Delivery at expected levels.
<b>Cancer - 31 days maximum wait from diagnosis to treatment for all cancers</b> 	Percentage of cancer patients starting first treatment within 31 days of diagnosis. The operational standard is 96%. A high percentage is good.		Delivery at expected levels.
<b>Cancer - 31 day wait for second or subsequent treatment: Surgery</b> 	Percentage of cancer patients starting subsequent surgical treatment within 31 days. The operational standard is 94%. A high percentage is good.		Provisional performance is below the required 94% standard in October with 1 breach of the 31 day standard. The main reason for the breach was due to capacity issues within the service. However the patient was not harmed as a result of the delay.
<b>Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug</b> 	Percentage of cancer patients starting subsequent drug treatment within 31 days. The operational standard is 98%. A high percentage is good.		Delivery at expected levels.


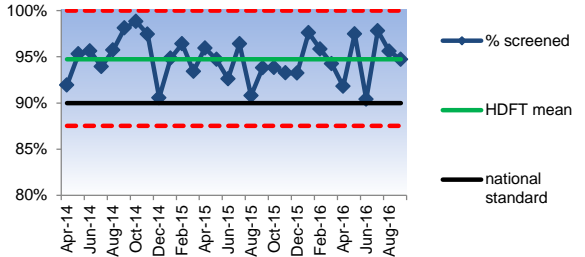

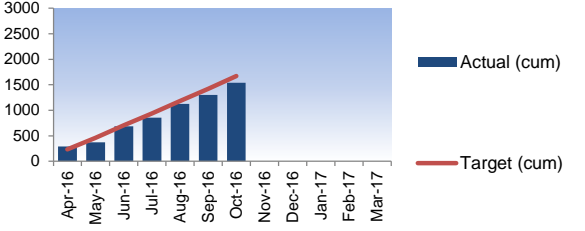

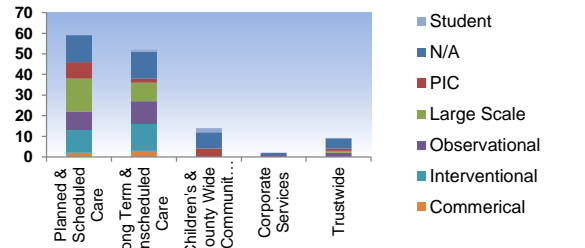
## Operational Performance - October 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>Cancer - 62 day wait for first treatment from urgent GP referral to treatment</b> 	Percentage of cancer patients starting first treatment within 62 days of urgent GP referral. The operational standard is 85%. A high percentage is good.		<p>Trust total delivery at expected levels.</p> <p>Of the 11 cancer sites treated at HDFT, 6 had performance below 85% in October - colorectal (1 breach), gynaecological (0.5 breach), haematological (1 breach), head and neck (0.5 breach), lung (1 breach) and sarcoma (0.5 breach).</p> <p>2 patients waited over 104 days for treatment in October. The main reasons for the delays were complex diagnostics, capacity delays and an administrative error when the patient was transferred between providers.</p>
<b>Cancer - 62 day wait for first treatment from consultant screening service referral</b> 	Percentage of cancer patients starting first treatment within 62 days of referral from a consultant screening service. The operational standard is 90%. A high percentage is good.		<p>There was 1 breach and 5 pathways in October giving a performance of 80% for the month. However this is not currently reportable as it is at the de minimis level of 5 pathways.</p>
<b>Cancer - 62 day wait for first treatment from consultant upgrade</b> 	Percentage of cancer patients starting first treatment within 62 days of consultant upgrade. The operational standard is 85%. A high percentage is good.		<p>There were no applicable pathways in October.</p>
<b>GP OOH - NQR 9</b> 	<p>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.</p> <p>A high percentage is good.</p>		<p>Performance remains below the required 95% for this metric and was at 74% in October.</p> <p>Work continues with the Information Team to implement new, meaningful performance metrics and assure the quality of the data and reports from the Adastra system. The service is also undertaking a GP performance review which will provide further assurance as to the quality of the service provision.</p>

## Operational Performance - October 2016











Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>GP OOH - NQR 12</b> 	<p>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.</p> <p>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.</p>		<p>Performance remains below the required 95% for this metric but has improved to 90% in October.</p> <p>Work continues with the Information Team to implement new, meaningful performance metrics and assure the quality of the data and reports from the Adastra system. The service is also undertaking a GP performance review which will provide further assurance as to the quality of the service provision.</p>
<b>Children's Services - 10-14 day new birth visit</b> 	<p>The percentage of babies who had a new birth visit by the Health Visiting team within 14 days of birth. A high percentage is good.</p> <p>Data shown is for the 0-5 Health Visiting Service in North Yorkshire and the Healthy Child Programme in Darlington, Co. Durham and Middlesbrough. A high percentage is good. The contract does not specify a required level.</p>		<p>In October, 96% of babies in Darlington, 91% of babies in Co. Durham, 99% of babies in Middlesbrough and 86% of babies in North Yorkshire were recorded on Systmone as having had a new birth visit within 14 days of birth. This is an improvement on last month in all four localities with overall performance now at 90%.</p>
<b>Children's Services - 2.5 year review</b> 	<p>The percentage of children who had a 2.5 year review. A high percentage is good.</p> <p>Data shown is for the 0-5 Health Visiting Service in North Yorkshire and the Healthy Child Programme in Darlington, Co. Durham and Middlesbrough. A high percentage is good. The contract does not specify a required level.</p>		<p>In October, 81% of children in Darlington, 89% of children in Co. Durham, 89% of children in Middlesbrough and 74% of children in North Yorkshire were recorded on Systmone as having had a 2.5 year review.</p> <p>Overall performance is at 83%, compared to 82% last month.</p>
<b>Community equipment - deliveries within 7 days</b> 	<p>The number of standard items delivered within 7 days by the community equipment service. A high percentage is good.</p>		<p>Performance remains above expected levels.</p>

## Operational Performance - October 2016

Indicator name / data quality assessment	Description	Trend chart	Interpretation
<b>CQUIN - dementia screening</b> 	<p>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.</p>		<p>Delivery at expected levels.</p>
<b>Recruitment to NIHR adopted research studies</b> 	<p>The Trust has a recruitment target of 2,800 for 2016/17 for studies on the NIHR portfolio. This equates to 234 per month. Over recruitment is encouraged.</p>		<p>The year to date position on recruitment to research studies is 8% below plan, an improvement on the position reported last month. There are a number of issues that have impacted recruitment year to date including availability of suitable studies, changes in types of studies and also capacity within the research team. An increase in the availability of studies suitable for our population and additional capacity within the research team means that we are confident that we will be back on target by the end of the financial year.</p>
<b>Directorate research activity</b> 	<p>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.</p>		<p>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.</p>



## Data Quality - Exception Report




Report section	Indicator	Data quality rating	Further information
Quality	Pressure ulcers - community acquired - grades 2, 3 or 4	Amber 	This is the first time that the data has been presented in this way. The observed increase in reported cases may be partly due to improvements in incident reporting during the period.
Quality	Mandatory training rates - Darlington, Durham & Middlesbrough staff	Amber 	This indicator includes training data for TUPE staff that transferred into the organisation on 1st April 2016 from Middlesbrough, Durham and Darlington. There are some concerns about the quality and completeness of this information.
Operational Performance	GP Out of Hours - National Quality Requirement 9	Amber 	Following patient pathway changes in late 2015, reports from the Adastra system no longer calculate the correct start time for these patients and as a result, the performance reported for NQR9 was incorrect. Significant work from has been carried out by information staff at HDFT and we are now able to report performance again for this metric again, based on calculations from raw data extracts from the Adastra system. The new calculations have been shared with HARD CCG.
Operational Performance	GP Out of Hours - National Quality Requirement 12	Amber 	
Quality	Reducing readmissions in older people	Amber 	This indicator is under development. We have recently amended the calculation of this indicator so that it correctly handles patients who had multiple admissions and multiple contacts with community services.
Finance and efficiency	Theatre utilisation	Amber 	The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. An extra line has been added to the chart to allow monitoring of cancelled sessions.
Operational Performance	Children's Services - 10-14 day new birth visit	Amber 	Caution should be exercised as further work is required to understand the completeness and quality of this data.
Operational Performance	Children's Services - 2.5 year review	Amber 	Caution should be exercised as further work is required to understand the completeness and quality of this data.
Quality	Electronic rostering timeliness	Amber 	Caution should be exercised as further work is required to understand the completeness and quality of this data.
Quality	Electronic rostering hours owed	Amber 	Caution should be exercised as further work is required to understand the completeness and quality of this data.

Indicator traffic light criteria

Section	Indicator	Further detail	Traffic light criteria	Rationale/source of traffic light criteria
Quality	Pressure ulcers - hospital acquired	No. category 3 and category 4 avoidable hospital acquired pressure ulcers	tbc	tbc
Quality	Pressure ulcers - community acquired	No. category 3 and category 4 community acquired pressure ulcers	tbc	tbc
Quality	Safety thermometer - harm free care	% harm free	Blue if latest month $\geq 97\%$ , Green if $\geq 95\%$ 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	Falls	IP falls per 1,000 bed days	Blue if YTD position is a reduction of $\geq 50\%$ of HDFT average for 2015/16, Green if YTD position is a reduction of between 20% and 50% of HDFT average for 2015/16, Amber if YTD position is a reduction of up to 20% of HDFT average for 2015/16, Red if YTD position is on or above HDFT average for 2015/16.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Quality	Falls causing harm	IP falls causing moderate harm, severe harm or death, per 1,000 bed days	Green if below trajectory YTD, Amber if above trajectory YTD, Red if above trajectory at end year or more than 10% above trajectory in year.	NHS England, NHS Improvement and contractual requirement
Quality	Infection control	No. hospital acquired C.diff cases	tbc	tbc
Quality	Avoidable admissions	The number of avoidable emergency admissions to HDFT as per the national definition.	tbc	tbc
Quality	Reducing hospital admissions in older people	The proportion of older people 65+ who were still at home 91 days after discharge from 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).	Comparison with national average performance.
Quality	Mortality - SHMI	Summary Hospital Mortality Index (SHMI)	Blue if no. complaints in latest month is below LCL, Green if below HDFT average for 2015/16, Amber if on or above HDFT average for 2015/16, 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	Complaints	No. complaints, split by criteria	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 - all	Incidents split by grade (hosp and community)	Green if less than 8 SIRIs reported per month in the year to date and no never events reported in the current month; Amber if 8 or 9 SIRIs and reported per month in the year to date and no never events reported in the month; Red if 1 or more never event reported in the current month and/or 10 or more SIRIs reported per month in the year to date.	
Quality	Incidents - SIRIs (comprehensive and concise) and never events	The cumulative number of SIRIs (comprehensive and concise) and the number of never events reported in the year to date. The indicator includes hospital and community data.		
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 and/or the % staff recommending the Trust is above 95%, Green if in top 25% of acute trusts nationally, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
Quality	Friends & Family Test (FFT) - Staff	% staff who would recommend HDFT as a place to receive care	Green if latest month $\geq$ latest published national average, Red if $<$ latest published national average.	Comparison with national average performance.
Quality	Friends & Family Test (FFT) - Patients	% recommend, % not recommend - combined score for all services currently doing patient FFT	Green if latest month overall staffing $\geq 100\%$ , amber if between 95% and 100%, red if below 95%.	The Trusts aims for 100% staffing overall.
Quality	Safer staffing levels	RN and CSW - day and night overall fill rates at trust level	Annual rolling total - 90% green. Amber between 70% and 90%, red $< 70\%$ .	Locally agreed target level based on historic local and NHS performance
Quality	Staff appraisal rate	Latest position on no. staff who had an appraisal within the last 12 months	Blue if latest month $\geq 95\%$ , 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	Mandatory training rate	Latest position on the % staff trained for each mandatory training requirement	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	Staff sickness rate	Staff sickness rate	tbc	tbc
Quality	Temporary staffing expenditure - medical/nursing/other	Expenditure per month on staff types.	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	Staff turnover	Staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts.	Green if $< 25\%$ of deliveries, amber if between 25% and 30%, red if above 30%.	tbc
Quality	Maternity - Caesarean section rate	Caesarean section rate as a % of all deliveries	Green if $< 3\%$ of deliveries, amber if between 3% and 6%, red if above 6%.	tbc
Quality	Maternity - Rate of third and fourth degree tears	No. third or fourth degree tears as a % of all deliveries.	tbc	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.	Blue if latest month rate $<$ LCL, Green if latest month rate $<$ HDFT average for 2015/16, Amber if latest month rate $>$ HDFT average for 2015/16 but below UCL, red if latest month rate $>$ UCL.	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	Blue = better than expected (95% confidence interval), Green = as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval).	Comparison with national average performance.
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%.	Comparison with performance of other acute trusts.
Finance and efficiency	Length of stay - non-elective	Average LOS for non-elective patients		

Section	Indicator	Further detail	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	Green if latest month < 2016/17 trajectory, amber if latest month below 2015/16 level plus 0.5% demographic growth but above 2016/17 trajectory, red if above 2015/16 level plus 0.5% demographic growth.	A 2016/17 trajectory has been added this month - this is based on allowing for demographic growth and reducing by the non-elective reductions identified in the Value Proposition.
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		
Finance and efficiency	Outpatient new to follow up ratio	No. follow up appointments per new appointment.	Blue if latest month score places HDFT in the top 10% of acute trusts nationally. Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
Finance and efficiency	Day case rate	% elective admissions that are day case	Green if on plan, amber <1% behind plan, red >1% behind plan	Locally agreed targets.
Finance and efficiency	Surplus / deficit and variance to plan	Monthly Surplus/Deficit (£'000s)	Green if on plan, amber <10% behind plan, red >10% behind plan	Locally agreed targets.
Finance and efficiency	Cash balance	Monthly cash balance (£'000s)	Green if rating =4 or 3 and in line with our planned rating, amber if rating = 3, 2 or 1 and not in line with our planned rating.	as defined by NHS Improvement
Finance and efficiency	NHS Improvement Financial Performance Assessment	An overall rating is calculated ranging from 4 (no concerns) to 1 (significant concerns). This indicator monitors our position against plan.	Green if achieving stretch CIP target, amber if achieving standard CIP target, red if not achieving standard CIP target.	Locally agreed targets.
Finance and efficiency	CIP achievement	Cost Improvement Programme performance	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	Capital spend	Cumulative capital expenditure	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	Agency spend in relation to pay spend	Expenditure in relation to Agency staff on a monthly basis (£'s).	to be agreed	
Finance and efficiency	Research - invoiced research activity	Trust performance on Monitor's risk assessment framework.	As per defined governance rating	as defined by NHS Improvement
Operational Performance	NHS Improvement governance rating			
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, NHS Improvement 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, NHS Improvement 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, NHS Improvement 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, NHS Improvement 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, NHS Improvement 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, NHS Improvement 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, NHS Improvement 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, NHS Improvement 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, NHS Improvement 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	Children's Services - 10-14 day new birth visit	% new born visit within 14 days of birth	Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%.	Contractual requirement
Operational Performance	Children's Services - 2.5 year review	% children who had a 2 and a half year review	Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%.	Contractual requirement
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	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	

#### Data quality assessment

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

<b>Report to the Trust Board of Directors: 30 November 2016</b>	<b>Paper No: 8.0</b>
<b>Title</b>	<b>Financial Report</b>
<b>Sponsoring Director</b>	Mr J Coulter, Deputy Chief Executive/Finance Director
<b>Author(s)</b>	Mr J Coulter, Deputy Chief Executive/Finance Director
<b>Report Purpose</b>	Review of the Trusts financial position
<b>Key Issues for Board Focus:</b>	
<p>The Board are as to note:</p> <ol style="list-style-type: none"> <li>1. The Trust reported a surplus of £2,444k for the year to the end of October, £1.1m behind plan. This position includes Q1 and Q2 S&amp;T funding. The Trusts underlying position is a surplus of £144k, £761k behind plan.</li> <li>2. Plans are in place for 106% of the £9.4m Cost Improvement target, reducing to 100% following risk adjustment. 85% of plans have been actioned to date.</li> <li>3. The Trust cash balance at the end of October was £3,046k.</li> <li>4. There is a risk to delivery of the 2016/17 financial plan if budgetary control is not improved. Mitigation is in place through regular monthly monitoring, and discussions on improving this process are ongoing.</li> </ol>	
<b>Related Trust Objectives</b>	
To deliver high quality care	Yes – the report provides assurance that high quality care is not compromised by the Trust's financial performance.
To work with partners to deliver integrated care	Yes – the report provides assurance that it continues to work with partners to understand the financial challenges across the sector, and that the Trust continues to address the challenges within the system which may impact on the Trust's performance.
To ensure clinical and financial sustainability	Yes – the report provides the Board with a detailed update on the Trust's financial performance and actions taken to ensure ongoing financial sustainability.
<b>Risk and Assurance</b>	Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF 9: risk of a failure to deliver the operating plan; BAF 10: risk of a breach of the terms of the NHS Provider Licence; BAF 12: risk of external funding constraints; BAF 14: risk to delivery of integrated models of care; and BAF 15: risk of misalignment of commissioner/partner strategic plans.
<b>Legal implications/Regulatory Requirements</b>	The report does not highlight any legal/regulatory implications for the period.
<b>Action Required by the Board of Directors</b>	
The Board is asked to <b>note</b> and <b>comment</b> , where appropriate, on the information in this report	

# October 2016 Financial Position

## Financial Performance

- The Trust reported a surplus of £2,444k for the year to the end of October, £1.1m behind of plan. This position includes S&T funding and is outlined below:

Description	YTD Plan	YTD Actual
Operating income	£125,394k	£123,193k
Operating expenditure	£119,953k	£118,784k
<b>EBITDA</b>	<b>£5,441k</b>	<b>£4,409k</b>
Non operating expenses	£4,536k	£4,265k
<b>Net surplus</b>	<b>£905k</b>	<b>£144k</b>
S&T funding	£2,683k	£2,300k
<b>Trust financial position</b>	<b>£3,588k</b>	<b>£2,444k</b>

- Page 3 outlines the Trusts underlying position to date in more detail. Following the removal of S&T funding, there is a surplus of £144k, £761k behind plan. The Trust has therefore not assumed S&T funding in October, increasing the variance to £1,144k to date.
- A deficit of £483k was reported in October, significantly behind plan. Acute income was £593k behind plan with recovery plans not having the impact expected to date. There was also an increase in pay expenditure, resulting in an adverse variance of £194k in month.
- Discussion at SMT focused on financial recovery plans, both at a directorate level and further Trustwide actions. Although there is a significant number of plans which would improve performance to above the control total requirement, there are a number of risks related to each.
- Given the risks related to recovery plans, a number of further actions were agreed Trustwide. These include –
  - Strengthening the Vacancy Control Process.

# October 2016 Financial Position

- Restricting discretionary spend. This includes expenditure in relation to IT hardware, furniture and fittings, hospitality, office equipment, training and materials linked to training. In relation to training, a criteria is under development to ensure a consistent approach is applied.
  - Develop an action plan for areas of high medical agency spend. As outlined on page 7 and in the IBR, agency is at its highest level this year and the increase in October is predominantly as a result of medical staffing agency usage.
  - Linked to the point above, there was a discussion about the potential to increase clinical capacity by reviewing current non clinical commitments.
- Actions at directorate level are being further reviewed and challenged at finance and activity meetings. The majority of the Trustwide actions have commenced with immediate affect.

## NHS Improvement Use of Resource Metric

- From 1st October 2016, NHS Improvement introduced the Single Oversight Framework. As part of this this Use of Resource Metric was introduced to replace the previous Financial Sustainability Risk Rating. This is the product of five elements which are rated between 1 (best) to 4. The Trust position for October is outlined below.

Element	Plan	Actual
Capital Service Cover	1	1
Liquidity	1	1
I&E Margin	1	1
I&E Variance From Plan		2
Agency	1	1
<b>UoR Rating</b>	<b>1</b>	<b>1</b>

# October 2016 Financial Position

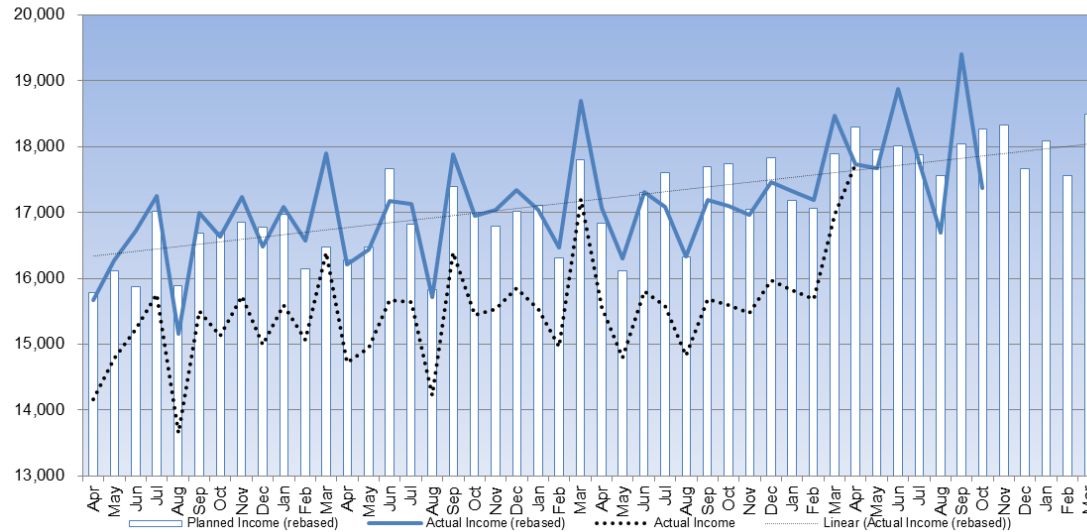
Summary Income & Expenditure 2016/17  
For the month ending 31st October 2016

	Budget		Actual To Date	Cumulative Variance	Change in Variance	October Actuals
	Annual Budget £000	Proportion To Date £000				
	£000	£000	£000	£000	£'000	£'000
<b>INCOME</b>						
<b>NHS Clinical Income (Commissioners)</b>						
NHS Clinical Income - Acute	142,657	82,691	81,280	(1,411)	(593)	11,432
NHS Clinical Income - Community	55,837	32,760	32,340	(421)	114	4,536
System Resilience & Better Care Funding	561	328	327	(0)	(0)	47
<b>Non NHS Clinical Income</b>						
Private Patient & Amenity Bed Income	1,909	1,128	719	(409)	(76)	84
Other Non-Protected Clinical Income (RTA)	523	305	276	(29)	(5)	38
<b>Other Income</b>						
Non Clinical Income	13,541	7,999	8,068	68	51	1,189
Hosted Services	403	183	183	(0)	8	51
<b>TOTAL INCOME</b>	<b>215,431</b>	<b>125,394</b>	<b>123,193</b>	<b>(2,201)</b>	<b>(502)</b>	<b>17,376</b>
<b>EXPENSES</b>						
<b>Pay</b>						
Pay Expenditure	(149,161)	(88,964)	(87,751)	1,213	(194)	(12,801)
<b>Non Pay</b>						
Drugs	(9,296)	(8,034)	(8,021)	14	10	(1,047)
Clinical Services & Supplies	(17,418)	(10,665)	(10,526)	139	79	(1,453)
Other Costs	(18,693)	(10,955)	(11,866)	(911)	(106)	(1,852)
					0	
					0	
<b>Reserves :</b>						
Pay	237	(3)	0	3	1	0
Pay savings targets	0	0	0	0	0	0
Other Reserves	(6,470)	(745)	0	745	(143)	0
High Cost Drugs	(3,364)	0	0	0	0	0
Non Pay savings targets	(169)	0	0	0	0	0
<b>Other Finance Costs</b>	(18)	(10)	(8)	3	1	0
<b>Hosted Services</b>	(1,104)	(578)	(613)	(35)	(10)	(123)
<b>TOTAL COSTS</b>	<b>(205,455)</b>	<b>(119,953)</b>	<b>(118,784)</b>	<b>1,169</b>	<b>(362)</b>	<b>(17,276)</b>
<b>EBITDA</b>	<b>9,976</b>	<b>5,441</b>	<b>4,409</b>	<b>(1,032)</b>	<b>(863)</b>	<b>101</b>
Profit / (Loss) on disposal of assets	0	0	0	0	0	0
Depreciation	(5,081)	(2,964)	(2,620)	344	90	(334)
Interest Payable	(90)	(53)	(116)	(64)	(9)	(17)
Interest Receivable	41	24	11	(12)	(2)	1
Dividend Payable	(2,646)	(1,544)	(1,633)	(90)	(13)	(233)
<b>Net Surplus/(Deficit) before donations and impairment</b>	<b>2,200</b>	<b>905</b>	<b>51</b>	<b>(854)</b>	<b>(797)</b>	<b>(481)</b>
Donated Asset Income	0	0	93	93	(1)	(1)
Impairments re Donated assets	0	0	0	0	0	0
Impairments re PCT assets	0	0	0	0	0	0
<b>Net Surplus/(Deficit)</b>	<b>2,200</b>	<b>905</b>	<b>144</b>	<b>(761)</b>	<b>(799)</b>	<b>(483)</b>
Consolidation of Charitable Fund Accounts	0	0	0	0	0	0
Sustainability and Transformation Fund	4,600	2,683	2,300	(383)	(383)	0
<b>Total and Consolidated Net Surplus/(Deficit)</b>	<b>6,800</b>	<b>3,588</b>	<b>2,444</b>	<b>(1,144)</b>	<b>(1,182)</b>	<b>(483)</b>

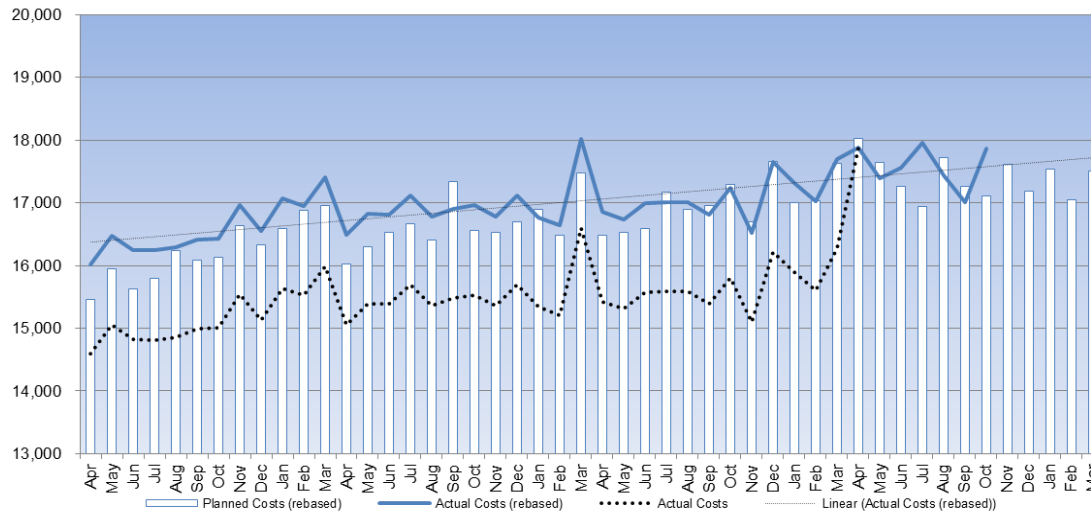
You matter most

# October 2016 Financial Position

**Planned and Actual Income Apr 2013 - Mar 2017 (rebased for new contracts)**



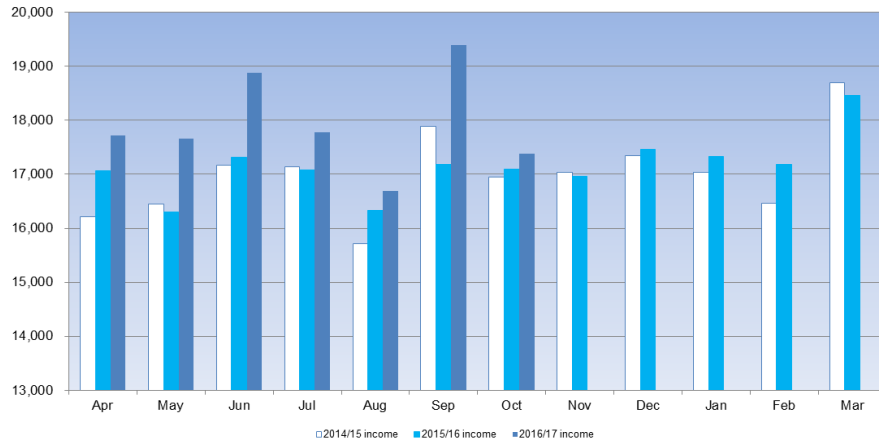
**Planned and Actual Costs Apr 2013 - Mar 2017 (rebased for new contracts)**



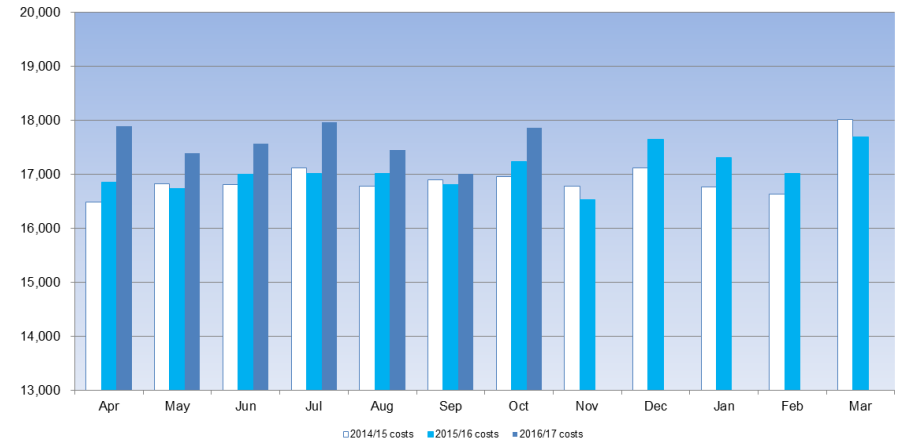


# October 2016 Financial Position

**Actual Income (rebased) 2014/15, 2015/16 & 2016/17**



**Actual costs (rebased) 2014/15, 2015/16 & 2016/17**

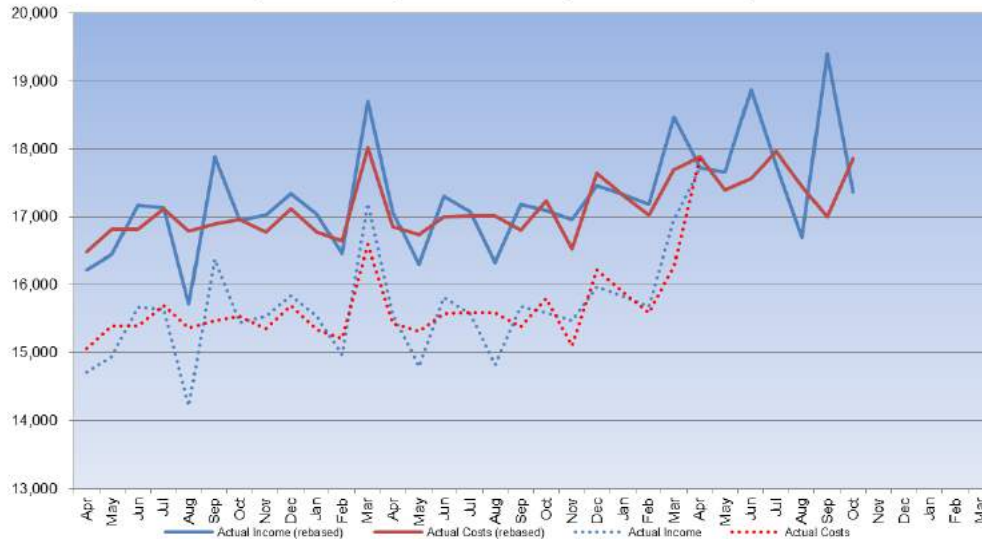


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15 income plan	14,779	14,981	16,165	15,325	14,332	15,901	15,506	15,293	15,523	15,606	14,809	16,305
2014/15 income actual	14,717	14,945	15,674	15,637	14,221	16,388	15,451	15,533	15,845	15,539	14,967	17,201
<b>2014/15 variance</b>	<b>-62</b>	<b>-36</b>	<b>-491</b>	<b>312</b>	<b>-111</b>	<b>487</b>	<b>-55</b>	<b>240</b>	<b>322</b>	<b>-67</b>	<b>158</b>	<b>896</b>
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	15,560	16,385
2015/16 income actual	15,564	14,802	15,810	15,578	14,826	15,689	15,595	15,467	15,968	15,828	15,686	16,967
<b>2015/16 variance</b>	<b>229</b>	<b>192</b>	<b>11</b>	<b>-527</b>	<b>-4</b>	<b>-513</b>	<b>-650</b>	<b>-87</b>	<b>-361</b>	<b>151</b>	<b>126</b>	<b>582</b>
2015/16 % variance	1.5%	1.3%	0.1%	-3.3%	0.0%	-3.2%	-4.0%	-0.6%	-2.2%	1.0%	0.8%	3.6%
2016/17 income plan	18,293	17,958	18,013	17,877	17,555	18,035	18,009	18,319	17,664	18,084	17,561	18,489
2016/17 income actual	17,725	17,665	18,876	17,771	16,693	19,398	17,376					
<b>2016/17 variance</b>	<b>-568</b>	<b>-293</b>	<b>863</b>	<b>-106</b>	<b>-861</b>	<b>1,363</b>	<b>-633</b>					
2016/17 % variance	-3.1%	-1.6%	4.8%	-0.6%	-4.9%	7.6%	-3.5%					

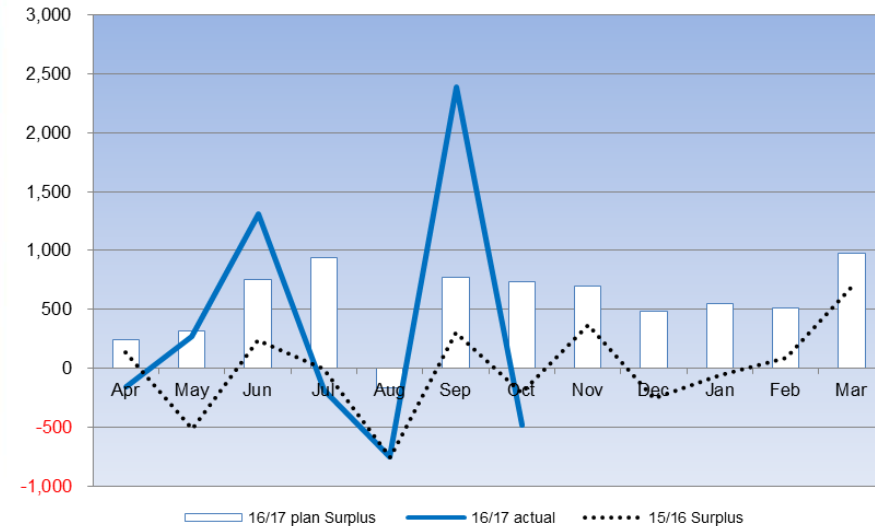
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15 expenditure plan	14,602	14,875	15,107	15,236	14,983	15,912	15,128	15,105	15,268	15,465	15,052	16,051
2014/15 expenditure actual	15,058	15,394	15,387	15,695	15,362	15,476	15,533	15,358	15,695	15,346	15,214	16,591
<b>2014/15 variance</b>	<b>456</b>	<b>519</b>	<b>280</b>	<b>459</b>	<b>379</b>	<b>-436</b>	<b>405</b>	<b>253</b>	<b>427</b>	<b>-119</b>	<b>162</b>	<b>540</b>
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	15,874	15,267	16,229	15,581	15,615	16,204
2015/16 expenditure actual	15,427	15,314	15,572	15,584	15,584	15,384	15,807	15,099	16,222	15,890	15,597	16,275
<b>2015/16 variance</b>	<b>375</b>	<b>205</b>	<b>408</b>	<b>-155</b>	<b>118</b>	<b>-152</b>	<b>-67</b>	<b>-168</b>	<b>-7</b>	<b>309</b>	<b>-18</b>	<b>70</b>
2015/16 % variance	2.5%	1.4%	2.7%	-1.0%	0.8%	-1.0%	-0.4%	-1.1%	0.0%	2.0%	-0.1%	0.4%
2016/17 expenditure plan	18,021	17,640	17,258	16,941	17,721	17,262	17,278	17,620	17,184	17,539	17,052	17,509
2016/17 expenditure actual	17,887	17,392	17,567	17,961	17,444	17,007	17,859					
<b>2016/17 variance</b>	<b>-134</b>	<b>-248</b>	<b>309</b>	<b>1,020</b>	<b>-277</b>	<b>-255</b>	<b>581</b>					
2016/17 % variance	-0.7%	-1.4%	1.8%	6.0%	-1.6%	-1.5%	3.4%					

# October 2016 Financial Position

Actual Income against Actual Cost April 2014 - March 2017



Comparison of monthly Surplus/(Deficit) - April 15 to March 17

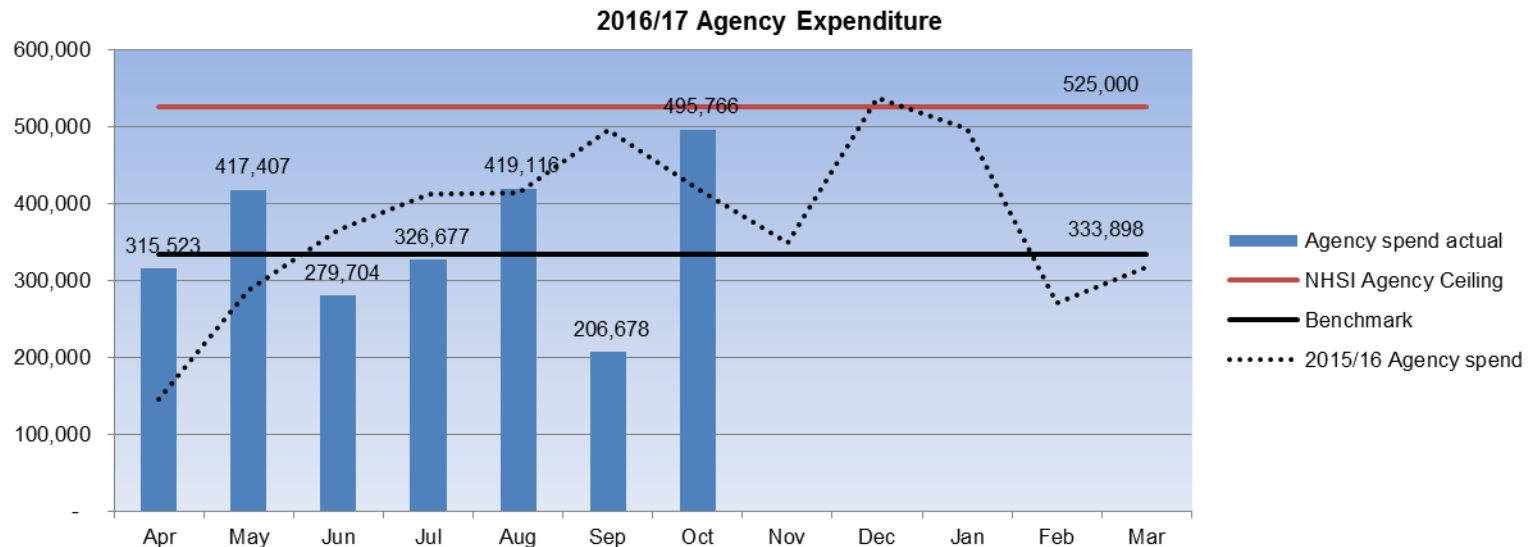


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15 income	14,717	14,945	15,674	15,637	14,221	16,388	15,451	15,533	15,845	15,539	14,967	17,201
2015/16 income	15,564	14,802	15,810	15,578	14,826	15,689	15,595	15,467	15,968	15,828	15,686	16,967
2016/17 income	17,725	17,665	18,876	17,771	16,693	19,398	19,398					
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	15,807	15,099	16,222	15,890	15,597	16,275
2016/17 costs	17,887	17,392	17,567	17,961	17,444	17,007	17,007					
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	-212	368	-254	-62	90	693
16/17 Surplus	-162	273	1,309	-190	-751	2,391	2,391					

# October 2016 Financial Position

## Agency Expenditure

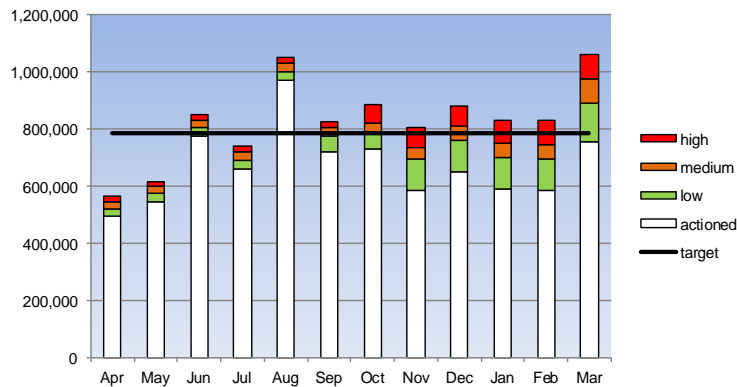
- Agency expenditure remains a key area of focus. The graph below outlines the Trust performance against the Agency ceiling. This expenditure ceiling was set by NHSI using information which included internal locum expenditure. The black line outlines a benchmark when internal locums are removed from the ceiling calculation.



# 2016/17 Efficiency Update

## Trustwide Cost Improvement Programme

2016/17



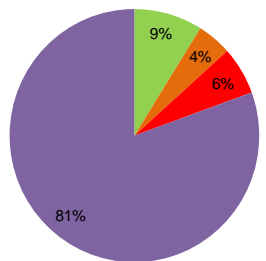
Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Trustwide	9,400,000	8,035,372	884,015	446,567	610,700	9,976,654	106%	9,354,580	100%
%age of target			9%	5%	6%				

### Top 10 unactioned schemes

Top 10 as % of schemes - 7%

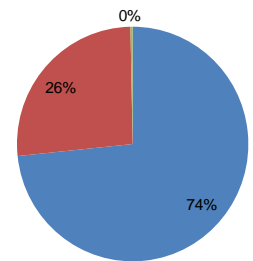
No.	Scheme	Value	Risk
1	Income Activity and Transformation - Additional Income from new business (Podiatry to staff services, Pathology, etc)	125,500	Low
2	ED Clinical Coding Higher Tariff	100,000	Low
3	Estates Rationalisation	90,000	High
4	Reduction in overspend on Middle Grades	75,000	Medium
5	ECG OP procedures captured in pre assessment - no more activity just a higher tariff (£200k less 20%)	66,700	Low
6	Straight to daycases (400 days) Assumed £150 per bed day to just reflect nursing costs	60,000	High
7	Radiology Clinical Coding Higher Tariff	57,000	High
8	Repatriation of hand trauma	55,000	High
9	Staffing Review s/Skill Mix Savings/Reduce GP Spend/Med Staff retirement savings REC	54,100	Low
10	Transformation 6 - Urgent Care Transformation - skill mix reception/drivers, job role, ED and GPOOH joint re	50,000	Medium

CIP schemes by Risk



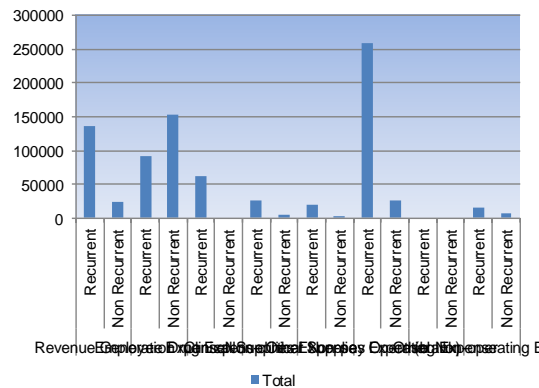
Low Medium High Actioned

Recurrent V Non Recurrent Plans

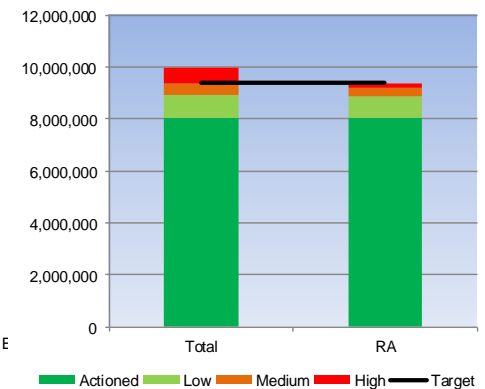


Recurrent Non Recurrent (blank)

Efficiency Category



Risk Profile



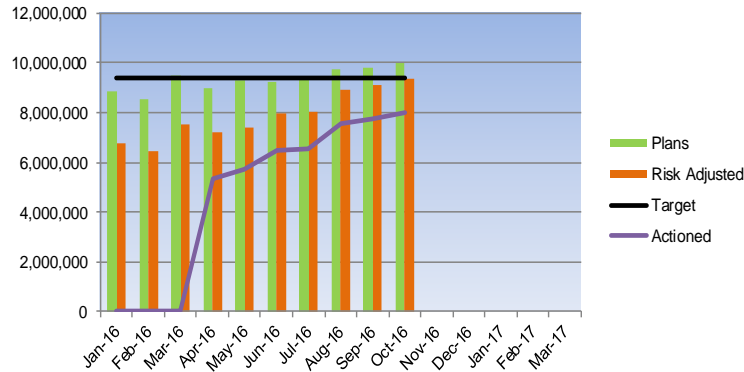
- As outlined above, £8m full year effect of cost improvement schemes have been actioned to date. This equates to 85% of the target.
- 26% of plans are currently non recurrent savings. This is being reviewed as will present a risk for 2017/18.

# 2016/17 Efficiency Update

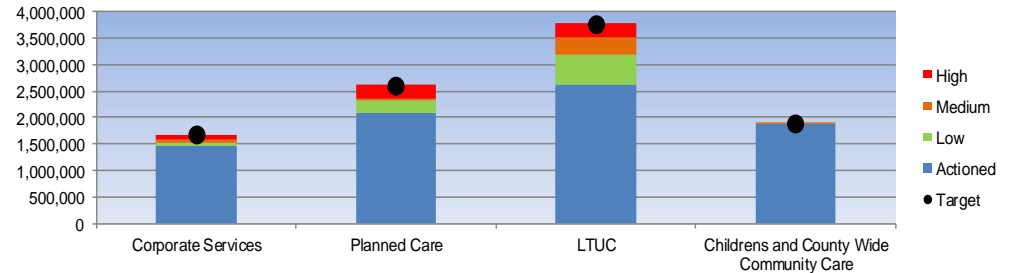
## Trustwide Cost Improvement Programme

2016/17

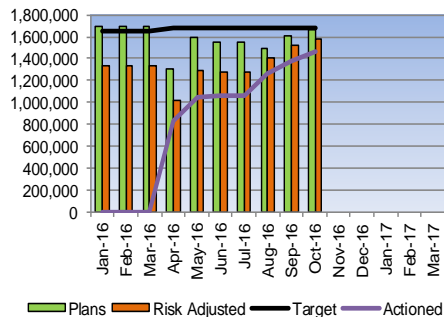
Trustwide Monthly Progress against Target (Full Year Effect)



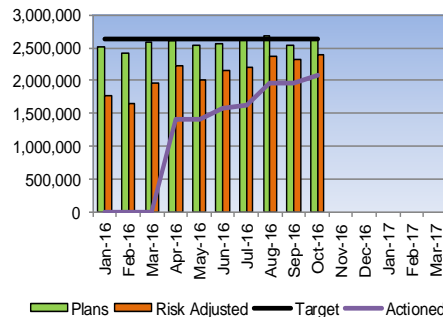
Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Corporate Services	1,675,100	1,464,800	55,800	52,000	90,000	1,662,600	99%	1,577,410	94%
Planned Care	2,620,400	2,079,072	247,635	33,267	262,900	2,622,874	100%	2,393,519	91%
LTUC	3,761,800	2,616,200	580,580	329,700	257,800	3,784,280	101%	3,483,071	93%
Childrens and County	1,906,900	1,875,300	0	31,600	0	1,906,900	100%	1,900,580	100%



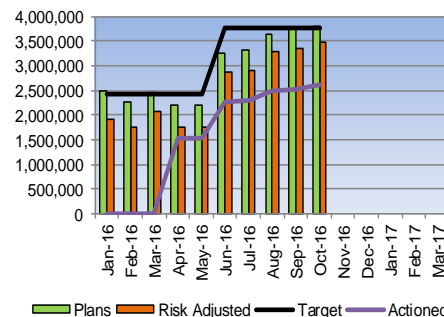
Corporate Monthly Progress against Target (Full Year Effect)



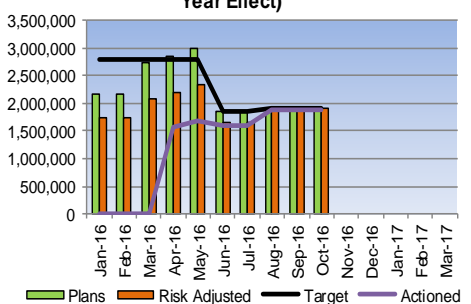
Planned Care Monthly Progress against Target (Full Year Effect)



Unplanned Care Monthly Progress against Target (Full Year Effect)



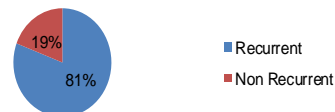
Childrens and County Wide Community Care Monthly Progress against Target (Full Year Effect)



Corporate R - NR Split



Planned Care R - NR Split



Unplanned Care R - NR Split



Childrens and County Wide Community Care R - NR Split

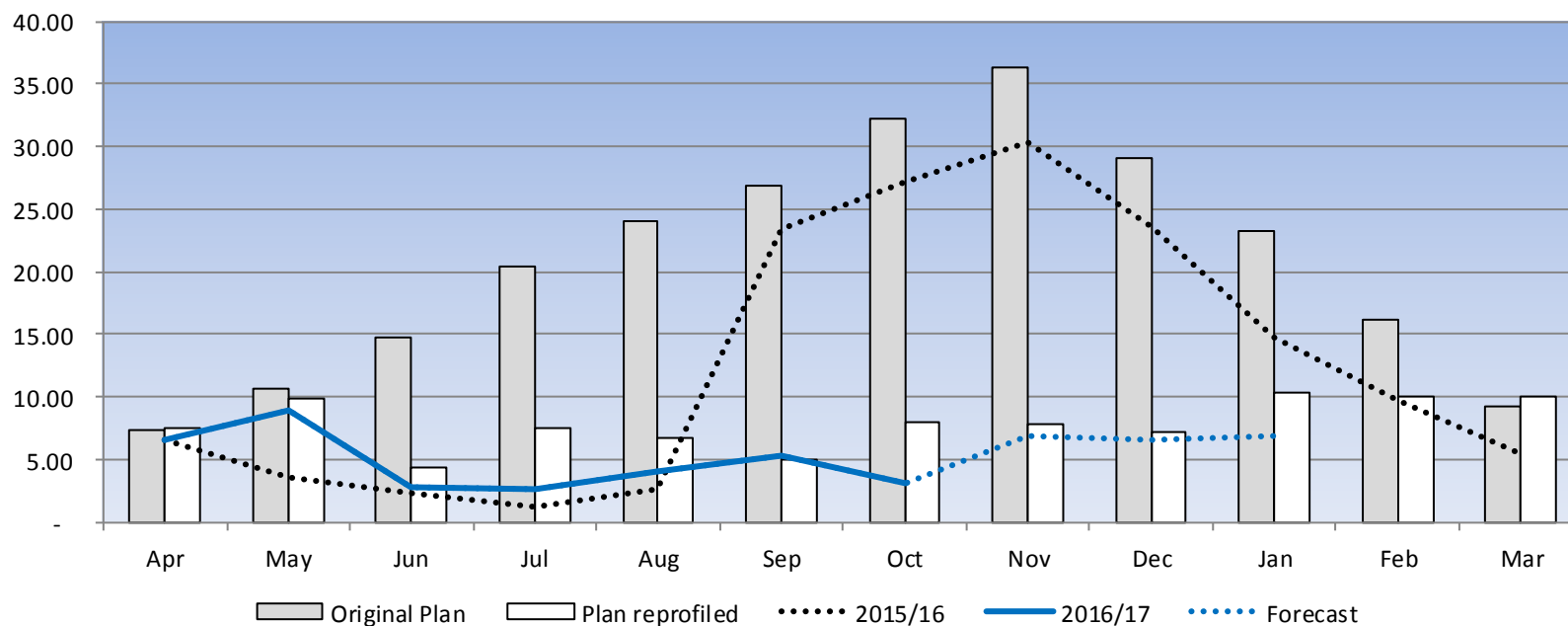


# Cash Management

The Trust reported a cash position of £3.046m at the end of October

£'m	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	6.56	3.60	2.38	1.25	2.63	23.42	27.18	30.27	23.59	14.71	9.70	5.53
2016/17	6.54	8.89	2.77	2.61	4.04	5.28	3.05					
Original Plan	7.34	10.67	14.74	20.48	23.98	26.81	32.15	36.33	29.02	23.19	16.11	9.27
Plan reprofiled	7.48	9.86	4.33	7.57	6.66	5.06	7.98	7.75	7.27	10.27	10.02	10.01

## Cashflow Monitoring 2016/17



<b>Report to the Trust Board of Directors: 30 November 2016</b>	<b>Paper No: 8.1</b>
<b>Title</b>	<b>Operational Planning 2017/18 and 2018/19 update</b>
<b>Sponsoring Director</b>	Mr J Coulter, Deputy Chief Executive/Finance Director
<b>Author(s)</b>	Mr J Coulter, Deputy Chief Executive/Finance Director
<b>Report Purpose</b>	To provide the Board with an update on the business of the Operational Plan 2017/18 – 2018/19
<b>Key Issues for Board Focus:</b>	
The Board of Directors are asked to note the:  Progress on the development of the Operational Plan 17/18-18/19.	
<b>Related Trust Objectives</b>	
To deliver high quality care	Yes – the Operational Plan sets out the plans for the organisation supports the Trust's ability to continue to provide high quality services in a financially challenged environment via new and innovative approaches to how we operate.
To work with partners to deliver integrated care	Yes –work closely with other providers and commissioning colleagues to explore opportunities for partnership working to deliver new care models.
To ensure clinical and financial sustainability	Yes – the report provides assurance on the Trust's approach to ensure sustainability of services and improvements to core services.
<b>Risk and Assurance</b>	Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF# 5: risk to service sustainability; BAF #9: risk of failure to deliver the Operational Plan; BAF #12: risk of external funding constraints
<b>Legal implications/Regulatory Requirements</b>	The report does not highlight any legal/regulatory implications for the period.
<b>Action Required by the Board of Directors</b>	
The Board is asked to <b>note</b> and <b>comment</b> , where appropriate, on the information in this report	

**Board of Directors 30 November 2016**

**Operational Plan 2017/18 – 2018/19**

**Report from:** Jonathan Coulter Deputy Chief Executive / Finance Director

**Report Purpose:** For Information / Discussion

## **1. Introduction**

- 1.1 The Board of Directors considered a paper outlining progress on the development of the Operational Plan 17/18–18/19 at the last Board of Directors meeting. The purpose of this paper is to update the Board of Directors on progress to date.

## **2. Current Position**

- 2.1 The Trust submitted the first draft of the Operational Plan on the 23<sup>rd</sup> November 2016, as requested by NHS Improvement. The draft followed the template requested by NHSI and included the following:-
- Strategic Context
  - Activity Planning
  - Quality Planning
  - Workforce Planning
  - Financial Planning
  - Capital Plans
  - Membership and Elections
- 2.2 Detailed financial, workforce and activity information was also submitted as a draft.
- 2.3 In addition to this work, discussions are continuing with regard to the agreement of our Acute and Community contracts with our main commissioners. An update on the current position will be given at the meeting.

## **3. Conclusion**

- 3.1 The contents of the draft are outlined here but will be discussed in detail in the latter part of the meeting.
- 3.2 The Board of Directors is asked to note the submission of the first draft of the Operational Plan for 2017/18-18/19 to NHS Improvement and the further work to finalise the Plan for final submission on 23<sup>rd</sup> December 2016.

JC/AG  
24/11/16



<b>Report to the Trust Board of Directors: 30 November 2016</b>	<b>Paper No: 9.0</b>
<b>Title</b>	<b>Chief Operating Officer's Report</b>
<b>Sponsoring Director</b>	Mr R Harrison, Chief Operating Officer
<b>Author(s)</b>	Ms Rachel McDonald, Head of Performance & Analysis Mr Jonathan Green, Information Analyst Specialist
<b>Report Purpose</b>	To provide the Board with an update on operational issues during the period for information
<b>Key Issues for Board Focus:</b>	
<p>The Board of Directors are asked to note that:</p> <ul style="list-style-type: none"> <li>The latest publication of Sentinel Stroke National Audit Programme (SSNAP) data shows that the Trust has improved its overall rating from a D to a C, with improvements seen in 5 out of 10 domains within the audit.</li> <li>The Trust is participating in the West Yorkshire Accelerator Zone initiative to support providers in West Yorkshire in delivery of an aggregated performance for the A&amp;E 4-hour standard of 95% for the month of March 2017 and has been provided with funding from NHS England to enable delivery of a number of schemes to support this.</li> <li>Activity remains below plan in a number of areas. The Clinical Directorates are continuing to work to address this with recovery plans.</li> </ul>	
<b>Related Trust Objectives</b>	
To deliver high quality care	Yes – the report provides updates to the Board on progress with regard to work to improve the efficiency and effectiveness of high quality care deliver within the Trust. The report provides detail on operational issues and delivery against national performance standards.
To work with partners to deliver integrated care	Yes – the report provides updates on the collaborative work with partners across the region and our commissioners to improve delivery of care and treatment to patients.
To ensure clinical and financial sustainability	Yes – the report provides the Board with assurance on progress of work across the region to ensure sustainable delivery of clinical models across the system.
<b>Risk and Assurance</b>	Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF 4: risk of a lack of interoperable systems across New Care Models partners; BAF 9: risk of a failure to deliver the operational plan; BAF 10: risk of a breach of the terms of the NHS Provider licence; BAF 16: risk to delivery of integrated care models.
<b>Legal/regulatory implications</b>	The report does not highlight any legal/regulatory implications for the period.
<b>Action Required by the Board of Directors</b>	
The Board of Directors are asked to receive and note the content of the report.	

## **CHIEF OPERATING OFFICER'S REPORT**

### **Board of Directors' meeting 30 November 2016**

#### **1.0 WEST YORKSHIRE ACCELERATION ZONE**

West Yorkshire was chosen by the Secretary of State for Health as an Accelerator Zone for Emergency Care performance. The purpose of the initiative is for the collective Urgent Care system across West Yorkshire to deliver an aggregated performance of 95% for March 2017. In order to deliver this improved performance, each Trust submitted a list of schemes with associated funding that would be required to deliver this step-change in performance, this work was coordinated by Robert Harrison on behalf of the WYAAT Trusts.

WYAAT have now received notification from NHS Improvement and NHS England that funding will be made available for these schemes. For Harrogate this is as follows:

##### Revenue

£35,000 to support the streaming of patients from ED to Primary Care (or GP OOH)

£73,000 to support increased provision of ambulatory care on weekend

£340,000 discharge / transfer to assess models and additional discharge transport

##### Capital

£885,000 to increase capacity in ED by creating additional assessment cubicles and co-location of the GP OOH service with the ED.

Work is now underway to progress these schemes to allow us to support the delivery of the performance improvement, with an aim that Harrogate delivers over 96% in March 2017.

#### **2.0 WINTER DELIVERY**

In line with the Winter Plan, six beds on Nidderdale and seven beds on Farndale were closed in October. However, week commencing 14<sup>th</sup> November the beds were opened due to additional demand. In addition, eight additional Elderly Care beds opened during this period. This has placed additional demands on nurse staffing and therefore teams are working to de-escalate these areas as soon as possible. This increased demand and occupancy has also had an impact on A&E performance in November to date.

#### **3.0 UNSCHEDULED CARE CLINICAL TRANSFORMATION**

As part of the Unscheduled Care Transformation work stream, the Long Term and Unscheduled Care Directorate (LTUC) has started the roll out of 'SAFER' across the medical wards starting with the Elderly Care wards. SAFER is a nationally defined and evidenced set of simple rules for adult inpatient wards to improve patient flow and prevent unnecessary waiting for patients. The implementation managers will be working with clinicians and nurses on the wards for a three week period to embed the change.

The program will be completed on the medical wards by the end of January 2017. The LTUC Directorate are coordinating an event on 30 November for the national Emergency Care Improvement Programme to run a half day workshop for clinicians, support services and ward managers on the SAFER bundle and how we can use it to support better patient flow through the hospital.

#### **4.0 NEW CARE MODEL**

The new Locality Community Care Teams and Acute Overnight and Responsive Service were launched on 14 November and the management team in LTUC will now be working with the new

teams to maximise the benefits of the new ways of working to reduce admission and support earlier discharge from hospital.

The New Care Models 2<sup>nd</sup> Quarter review by NHS England took place on 10 November with initial positive feedback received. The team are now making the case to continue funding for 2017/18 to allow the new models time to be embedded and demonstrate real impact on lengths of stay and non-elective admissions.

## **5.0 SERVICE TENDERS**

The Children's and County Wide Care Directorate is currently focussed on a significant amount of work relating to tenders. This includes the submission of the Podiatry bid to retain Podiatry services across North Yorkshire and York. Feedback at this stage suggests that our effective engagement has produced a strong bid. The organisation will be informed of the outcome in January 2017.

The Directorate was successful in its bid for the Vaccinations and Immunisations tender in Darlington and Durham.

The team are supporting staff through the decommissioning and transition of Wheelchair and Equipment Services to their new providers on 1 December 2016.

The Community Dental Service has identified some significant work streams as part of their preliminary work for a tender. This will take place over the next six months.

## **6.0 CHILDRENS SERVICES INSPECTION**

County Durham received notification last week of an unannounced CQC inspection of services for Looked After Children and Safeguarding. Feedback is expected imminently.

## **7.0 SURGICAL ON SITE COVER**

Following the recent Deanery visit, a new requirement to provide overnight on site support for F2s in surgery was identified. A short term measure has been put in place to provide Locum Middle Grade cover on site. This is not a long term solution and therefore following a number of meetings with the Directorate team and Clinical Leads, the Senior Management Team approved the approach to moving the General Surgical Middle Grades from an offsite on-call rota to an on-site full shift rota, with the recruitment of two further Middle Grade doctors. This will provide further benefits for patients by enabling a senior surgical doctor to be present on site 24/7.

## **8.0 COMMISSIONER FINANCIAL RECOVERY PLAN**

The Planned and Surgical Care Directorate is working closely with the HaRD CCG in supporting the changes related to the Health Optimisation Programme as part of the CCG's financial recovery plan. The impact of this has not yet materialised due to the delay in referrals being processed by RSS. Information has gone out to all clinicians and will be followed up with further information this week.

## **9.0 SENTINEL STROKE NATIONAL AUDIT PROGRAMME (SSNAP) UPDATE**

The latest SSNAP results for the period April to July 2016 were published recently. These reports are now published every four months, instead of quarterly.

HDFT has been rated a C overall, compared to a D in Q4 2015/16. The overall score is 62, compared to 54 last quarter. The SSNAP data set has 10 domains, five of these have seen an improvement since the last report:

- Stroke unit (C to B)
- Specialist assessments (C to B) – timely access to Stroke Consultant and Stroke Nurse specialists has contributed to this improvement
- Occupational therapy (B to A)
- Physiotherapy (D to B)
- MDT working (C to B)

One domain has seen a deterioration this quarter after improving last quarter:

- Thrombolysis (D to E) – six out of seven eligible patients were thrombolysed, but none within one hour. The average (median) time to thrombolysis was one hr 20 mins. This measure is currently the focus of work by the Long Term and Unscheduled Care Directorate.

The other four domains stayed at the same score.

## **10.0 SEVEN-DAY SERVICES**

NHS Digital recently published three hospital trust indicators to aid research into seven-day NHS provision. The experimental statistics presented in 'Seven-day Services, England, April 2015 – March 2016' will provide a starting point for discussions on how to effectively measure improvement and variation in care provision across the week. The publication, which is accompanied by trust level data, includes the following indicators for the 2015/16 period:

- Mortality within 30 days of admission by week-part of admission to hospital.
- Emergency re-admissions within seven days of discharge from hospital by day of discharge.
- Length of stay following an emergency admission to hospital by day of admission.

The overall national conclusions are:

- Patients who are admitted at the weekend have an increased likelihood of mortality within 30 days of admission compared to those who are admitted midweek.
- Patients who are discharged on Friday, Saturday and Sunday have an increased likelihood of an emergency re-admission within seven days of discharge compared to those who are discharged on a Wednesday.
- Patients who are admitted in an emergency stay slightly longer in hospital if they are admitted between Friday and Sunday inclusive.

A significant amount of data is also published for individual trusts showing mortality, length of stay and re-admission rates by day of week of admission. However, the data is not RAG rated or ordered in anyway. In terms of HDFT performance, we appear not to have any indicators where we are significant difference to the national picture.

This work will contribute to the development of the Trust's Seven Day Service Strategy, which will support the continuing focus on the quality of care provided by the Trust across seven days.

## **11.0 CARBON AND ENERGY FUND**

Over the course of November, the system changeovers from steam to medium temperature hot water have commenced. During this work a number of challenges have arisen with respect to the automatic control of the systems that ensure correct temperatures are maintained in accordance with the contract. These matters have taken time to investigate and resolve which has delayed the commencement of the 10 day proving period for each system. Imtech are currently reviewing the programme to establish the impact of this on the completion date.

A visit was made to the project from the Estates Team at Sheffield Children's Hospital who are going to undertake a CEF project with Imtech on their site. They were impressed with the project and also gained some valuable feedback on lessons learnt from the HDFT project.

## **12.0 SERVICE ACTIVITY**

Variances above or below 3% are as follows – At the end of October, new outpatient activity was 4.9% below plan, follow-up outpatient activity was 3.1% below plan, elective admissions were 10.2% below plan, and ED attendances were 3.0% above plan.

For Leeds North CCG, new outpatient appointments were 14.9% above plan, follow-up outpatient activity was 4.3% above plan, elective admissions were 3.8% below plan, and ED attendances were 3.4% below plan.

Work is ongoing with regards to delivery of activity recovery plans. Challenges include main theatre staffing and filling premium rate lists. Outpatient clinic utilisation is also being reviewed. Focus is also on services that may be able to over-deliver in order to support the financial position of those under-delivering.

Work is being received from Leeds for Gynaecology, Ophthalmology and Plastic Surgery. Patients continue to be received for Wharfedale Endoscopy and we are working with Leeds to increase the number of lists provided at Wharfedale Hospital. There will be a Time-out session in December in order to review alliance working with Leeds.

Day Surgery Unit (DSU) staffing has improved, and as a result the ability to staff weekend lists has improved and will assist with the activity recovery plan. DSU staff will also continue to be used to cover gaps in Main theatre where turnover remains higher.

There are significant recruitment challenges in the Scarborough Podiatry team and the service is looking to develop "apprenticeship" roles to support activity.

Waiting times for Paediatric Autism Assessments have increased, due to increases in referrals above commissioned levels, discussions are ongoing with commissioners.

The waiting times in Speech and Language Therapy services are above the expected levels and therefore a Locum is being recruited for a three month period to work specifically on the Dysphasia waiting times.

## **13.0 FOR APPROVAL**

There are no items for approval this month.

<b>Report to the Trust Board of Directors: 30 November 2016</b>	<b>Paper No: 10.0</b>
<b>Title</b>	<b>Clinical Workforce Strategy</b>
<b>Sponsoring Director</b>	Mr Phillip Marshall, Director of Workforce and Organisational Development Mr Robert Harrison, Chief Operating Officer
<b>Author(s)</b>	Mrs Shirley Silvester, Head of Learning and Development Mrs Joanne Harrison, Deputy Director of Workforce and Organisational Development
<b>Report Purpose</b>	To approve the clinical workforce strategy
<b>Key Issues for Board Focus:</b>	
<p>The Board are asked to note:</p> <ol style="list-style-type: none"> <li>1. The vision for the Workforce of the Future – the vision for the future clinical workforce</li> <li>2. the model for Workforce Sustainability – how to create workforce sustainability; and</li> <li>3. the Key Performance Indicators – how the implementation of the strategy is to be measured</li> </ol>	
<b>Related Trust Objectives</b>	
To deliver high quality care	Yes – Through an efficient, productive, skilled and resilient workforce.
To work with partners to deliver integrated care	Yes – Working with external organisations including; educational institutions, Health Education England and the Local Workforce Action Board, to provide a qualified and professional workforce fit to deliver services.
To ensure clinical and financial sustainability	Yes – By seeking to recruit and retain our workforce to full establishment and minimise the use of agency staff.
<b>Risk and Assurance</b>	Any identified risks are included in the Directorate and Corporate Risk Registers and the Board Assurance Framework.
<b>Legal/regulatory implications</b>	Health Education England and the Local Education and Training Board have access to the Trust's workforce data via the Electronic Staff Records system. Providing access to this data for these organisations is a mandatory requirement for the Trust.
<b>Action Required by the Board of Directors</b>	
The Board is invited to comment on and <b>approve</b> the Trust's Clinical Workforce Strategy.	



## Clinical Workforce Strategy

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

**2016-2021**



*Joanne Harrison, Deputy Director of Workforce & Organisational Development  
Shirley Silvester, Head of Learning & Organisational Development*

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## **Foreword by: Professor Sue Proctor, Vice Chair and Non-Executive Director**

*Harrogate and District NHS Foundation Trust employs a substantive workforce of 4244 members of staff, of which 2932 are employed in clinical roles. The Trust's vision for its services is to provide "Excellence every time" and we know that staff across the organisation are committed to this vision.*

*Reports by the Care Quality Commission, Robert Francis and Don Berwick tell us that the best health care organisations are those where staff feel motivated, engaged, valued, are given opportunities to learn and develop, and to progress in their careers. There is also a clear correlation between these factors and the quality and outcomes of care for patients and their families. Our workforce is therefore paramount to delivering high quality care for our patients, whether in hospital, in community clinics or at home.*

*This Clinical Workforce Strategy sets out our ambitions, opportunities and also our key challenges during the next five years. We have developed this strategy by engaging with our staff and stakeholders, and by listening to their views. It is important to us that this strategy reflects current opportunities and challenges, and is flexible enough to respond to such matters in the future. We will continue to involve staff in the implementation of this strategy and look forward, through them, to making our vision for excellence a reality, for every patient in our care.*

## 1. Introduction

Harrogate and District NHS Foundation Trust (HDFT/the Trust) has a vision to provide Excellence Every Time, across our acute and community services. Having the right number of appropriately skilled staff is a critical determinant of the quality and efficiency of the delivery of health care.

*"The single most powerful determinant of care quality is the collective knowledge, skills and behaviours of the people providing care. Our clinical workforce strategy will ensure that we have a workforce equipped to deliver sustainable and resilient services in a transformed NHS"*

Dr Ros Tolcher, CE, HDFT

We have an obligation to ensure services are clinically and financially sustainable for the long term in order to assure delivery of high quality care to the people who use our services.

Staffing costs account for 75% of the Trust's spend every year, the aim of this strategy is to ensure that the Trust has the right number of appropriately skilled staff, working at the most appropriate clinical level for their role, to support the Trust in the achievement of its strategic aims and to ensure that we are making the best use of finite NHS resources. To achieve this, Doctors should be providing the care that only Doctors can provide, Nurses should be providing the care that only Nurses can provide, and Support workers should be working to the highest level of clinical skill a non-registered worker can, in order to deliver excellence every time for our patients, in a sustainable way.

In developing the vision and mission for this strategy we have considered the wider strategic direction of the West Yorkshire and Harrogate, Sustainability and Transformation Plan (STP) as well as the Local Workforce Action Board (LWAB).

### 1.1.1 Scope of the Clinical Workforce Strategy:

1. Medical Staff; including Consultants, SAS Doctors and Doctors in Training
2. Registered Workforce; including Nursing and Midwifery, Healthcare Scientists and Allied Health Professionals
3. Support workers; including all clinical Band 1-4 roles across Nursing and Midwifery, Healthcare Sciences and Allied Health Professional

- 1.1.2 This document outlines the mission, vision and strategic objectives of the clinical workforce strategy over the next five years and then leads into a strategic overview of the national and local context for change. Sections three to six describe how this strategy has been developed through a process of engagement and analysis of key workforce data and metrics and is summarised in a strengths, weaknesses, opportunities and threats (SWOT) analysis that determines organisational readiness. Section seven describes the vision for the workforce of the future and leads into the model through which this will be created together with



the identification of the Key Performance Indicators describing how progress will be measured. Finally the conclusion brings together the key elements of this strategy.

## 2. Strategic Overview

### 2.1. National Context for Change

Traditional workforce planning has focused on the training pipeline. However, with only around 8,000 doctors graduating from medical school each year, and only 30,000 nurses and allied health professionals graduating each year, there is an urgent need to reshape the NHS workforce, to equip it to meet the changing demand from the population it serves and deliver the vision set out in the Five Year Forward View. This is not just around changing medical or nursing school curricula, but developing the current workforce at all grades. (Source: *Reshaping the Workforce to Deliver the Care Patients Need, Nuffield Trust in association with NHS Employers, May 2016*)

*We can have a vision of excellence every time, but it simply will not remain a reality unless we have a workforce with the right numbers, skills, values and behaviours to deliver it.*  
(adapted from NHS England 2014)

#### 2.1.1 Growing workforce gaps

Across health and social care, organisations are facing difficulties with recruitment and retention, resulting in a growing use of expensive agency and locum staff. There are particular problems in some areas of nursing and medicine. Turnover rates among newly qualified nurses are particularly high in the NHS, at up to 34%. There are forecast gaps in the senior medical workforce in primary care, emergency care, elderly care and psychiatry, all specialties where the needs are high and growing. The Doctors in Training workforce is also declining in numbers as the recent expansion in the consultant workforce comes to an end. As a system we must plan for levels of training that address gaps created by leavers and changes in patient needs. Health Education England (HEE) allocated 4% of their total annual budget for new and extended role development in 2015/16.

There are currently national shortages of Registered Nurses and the impact of the removal of the nursing bursary is an emerging picture. There are contradicting views about whether the removal of the bursary will discourage students from studying for a nursing degree or open up more places for those interested in a nursing career and result in a surplus nursing workforce.

#### 2.1.2 An NHS Budget that is Failing to Keep Pace with the Health Care Needs of a Growing Population

The NHS faces a £22 billion gap in its finances by 2020. Demand for NHS services, from a growing and ageing population, is projected to rise by 6.6% by 2020. In many areas, the remaining front-line staff are left to absorb the rising demand for care into their day-to-day workload. Staff burnout is becoming a significant risk in many settings.

#### 2.1.3. The Changing Workforce

Research from the Chartered Institute of Personnel and Development (CIPD) finds that although the UK's policy framework for supporting older workers and creating fuller working lives is well-developed in comparison to many other European countries, there is a crucial need to turn this thinking into practical action, to avoid losing the skills and experience of employees who could choose to work beyond retirement. With around 30% of the UK workforce currently over 50, compared to 20% in the 1990s, the CIPD is urging employers to put the tools and culture in place now, to support older workers as they represent an increasingly significant proportion of the labour market. The majority of the staff working in the NHS today will still be in it in 10 years' time, so flexible working policies as well as the development and extension of skills and roles within the current workforce needs to be a central part of any workforce strategy.

The diagram below sets out the routes to workforce change.

2.1.4 Routes to workforce change *(Source: Reshaping the Workforce to Deliver the Care Patients Need, Nuffield Trust in association with NHS Employers, May 2016)*



## 2.2 Local Context for Change

The local context for the Trust mirrors the National context:

### 2.2.1 There are Long Standing Shortages of Clinical Staff in some Areas

The temporary agency staffing bill year to date is 2.5% of the Trust's pay expenditure. Whilst this remains below the agency ceiling set by NHS Improvement of 3%, the proportion of spend on temporary staffing (Bank, Agency and Locum) year to date is 6.5%. In 2015/16 the proportion of spend on temporary staffing was 7.5% of total pay expenditure equating to £9.7million. Vacancy rates across clinical roles especially within medical and nursing roles, leads to increased pressure in the system and raises concerns regarding staff wellbeing.

Like many NHS organisations, the Trust has a highly committed workforce, but it currently lacks the integration across health and social care sectors to drive further efficiencies.

### 2.2.2. The Local Budget is Failing to Keep Pace with the Local Patient Needs

We have an NHS and social care system in West Yorkshire and Harrogate that employs 113,000 staff who provide care and treatment to 2.6 million people. We are entrusted with a budget approaching £5 billion. Resources across the health sector will grow from £4.2 billion to £4.7 billion by 2020-21, however this is lower than the national average, and is far outstripped by the demand for services over the same period. Demand for and cost of services, if unmanaged, will drive a gap of £1.07 billion by 2021 for health and social care. It is predicted that if we were to continue on our current trajectory the Harrogate system gap would be £39 million across health and social care.

Protecting the quality of care we are able to provide for people using our services is critically dependent on restoring financial balance across our local system. Clinical Commissioning Groups will continue to tender services in a competitive environment with the key driver being balancing high quality care with affordability and value for money.

### 2.2.3 The Changing Workforce


Currently, only 8% of the Clinical workforce is over the age of 55, evidencing the fact that the majority of staff do retire when they are eligible to do so. In five years' time another 10% of our clinical workforce will be over the age of 55 and therefore, 20% will be eligible to retire. It is crucial that we consider our working longer priorities to ensure that we are able to retain the skills and experience of this significant part of our workforce as part of this strategy. Within the clinical workforce profile we have identified four key staff groups particularly at risk: Health Visitors, Schools Nurses, Midwives and District Nurses.

The Trust is already developing new approaches to accessing the future workforce that is currently in the training pipeline to reflect the changing educational commissioning landscape, by commissioning programmes directly with Education Providers. To support the development of skills and new roles we are training our first cohort of Advanced Clinical Practitioners (ACPs) and have commenced training staff for a new Band 4 role within the Outpatients Department. This work will need to continue at pace and scale in order to address the challenges we face.

### **3. Development of the Clinical Workforce Strategy – Engagement**

#### **3.1 Patient, Family and Carers Engagement**

At the heart of our organisation and our services is the patient, their families and carers. Their vision for how they want their care to be delivered was elicited through a patient consultation process in May 2015 as part of the Vanguard initiative. The output from the consultation is shown in Appendix 1 and has informed the development of this strategy.



*“The world café events were very well received and the contributions that staff gave have been critical in the development of this strategy.”*

**Shirley Silvester, Head of Learning and OD, HDFT**

It is important as we establish the work streams to take forward the implementation of the clinical workforce strategy that the patient remains central to the development of this work at speciality level. This will be taken forward by each work stream as appropriate, utilising the patient forums that already exist within the Trust.

#### **3.2 Workforce Engagement**

This strategy has been sponsored by Robert Harrison, Chief Operating Officer and Professor Sue Proctor, Vice Chair and Non-Executive Director and has been developed with input from across the Trust. This has included; the Trust Board including Executives and Non-Executives, senior leadership, clinical professional leads, Clinical Directorates, Trade Union colleagues, and most importantly representatives of our clinical workforce.

In addition to meeting with key stakeholders, workforce engagement took the form of a series of World Café events and provided the context and aims of this work. It posed two questions to attendees:

1. What does the clinical workforce of the future need to look like?
2. What are the resources required to deliver this?

We had over 60 clinical representatives from across both the acute and community setting including; Medical Staff, Registered Nurses, Allied Health Professionals, Health Care Scientists and support staff. There was also external representation from some of our key stakeholders. The output from the World Café Events is summarised in Appendix 2.

### **4. Development of the Clinical Workforce Strategy- Workforce Profile Analysis**

#### **4.1 Current Staff Mix**

The current clinical workforce profile is detailed in Appendix 3. It is important to understand where we are now so that we can set a clear direction for the future. In conducting the analysis the Trust has, where possible, benchmarked its performance against private sector, public sector and other NHS organisations.



## 4.2 Distribution of Workforce Across Clinical Roles

The distribution of our current clinical workforce is shown in Appendix 3 – Figure 4.1 – Clinical Staff mix, which highlights the opportunity for the Trust to review the balance between the Registered and Non-Registered workforce to address the challenges that the national labour market shortages present.









## 4.3 Clinical Workforce Age Profile

As part of the workforce data analysis the Trust has identified some clinical staff groups of concern when reviewing the age profile. A consideration of this strategy will need to include the delivery of a future workforce pipeline, the development of new roles and a working longer initiative, to support the following professions; Midwifery, District Nursing, Health Visiting and School Nursing the analysis is shown in Appendix 3 – Figure 4.2 – Age Profiles. Currently only 8% of our clinical workforce is over the age of 55.

## 4.4 Labour Turnover

According to the Xpert HR benchmarking survey 2015 (Appendix 3 – Figure 4.3 – Total Labour Turnover Rates), when reviewing the average voluntary turnover rate, we find that around one in six (16.1%) employees resigned from their job in 2015. Labour turnover rates have been steadily increasing since 2012. While this is a reflection of the growing confidence in both the UK's economic performance and employers' optimism in recruitment, increasing voluntary labour turnover certainly needs to be monitored. (**Source: XpertHR**)

Overall the NHS and HDFT specifically are bucking this trend (Appendix 3 – Figure 4.4 – Trust Wide Labour Turnover), which is predominantly being driven by the private sector. However there are key staff groups with high levels of turnover (shown in Appendix 3 - Figure 4.5 – Clinical Workforce Labour Turnover):

-  Pharmacy Technicians – 21%
-  Pharmacists – 23%
-  Inpatient Nurses Band 5 – 18%
-  Inpatients Nurses 6/7 – 15%
-  Unregistered AHP Staff Band 2 – 17%
-  Unregistered AHP Staff Band 3 – 13%
-  Unregistered AHP Staff Band 4 – 20%
-  Unregistered Health Care Assistants – 16%

## 4.5 Ethnicity Profile and Post Brexit Impact

Appendix 3 – Figure 4.6 shows the ethnicity profile of the clinical workforce, revealing this is significantly dominated by white British employees. The development of this clinic workforce strategy provides an opportunity for the Trust to begin to address one of the findings of the 2016 round of the Workforce Race Equality Standard (WRES). This shows us that whilst overall the percentage of Black and Minority Ethnic (BME) employees in our workforce is broadly representative of the communities we serve, there are pockets of significant under representation, particularly in more senior clinical positions (see Appendix 3 - Figure 4.7).

The Trust recognises that a diverse workforce delivers more inclusive services and improves patient care. Therefore, we will actively encourage and support the development of existing BME members of

the workforce and ensure our recruitment processes are always equitable, fair and that they value diversity. Our overarching aim is to ensure that the Trust develops a reputation as an employer that provides equality of opportunity and career progression for people from all backgrounds.

Approximately 144,000 European Union (EU) nationals work in health and social care in England. In the NHS, around 10 per cent of doctors and 5 per cent of nurses are from the EU. However as shown in Appendix 3- figure 4.8 Clinical Workforce Post Brexit EU Nationals, at HDFT, only 3% of our clinical workforce will be, post Brexit, EU Nationals. The majority of our EU Nationals are within the Medical and Dental Workforce with limited numbers in the other staff groups (shown in Appendix 3 - Figure 4.9 – Post Brexit EU Nationals by Clinical Staff Group).

Until the UK extracts itself from its obligations under EU treaties (anticipated 2019), the policy on freedom of movement remains unchanged; however, given the current shortfalls being experienced in the health sector, the government must clarify its intentions on the ability of EU nationals to work in health roles in the UK, not least to avoid EU staff who are currently working in the NHS deciding to leave to work in other countries.

It is anticipated that providers of NHS services should retain the ability to recruit staff from the EU when there are not enough resident workers to fill vacancies.

#### 4.6 Temporary Staffing Spend

The proportion of spend on temporary staffing (Bank, Agency and Locum) for 2016/17 up to September 6.5% of the total pay expenditure equating to £4.9 million. For the financial year 2015/16 the proportion of spend on temporary staffing was 7.5% of total pay expenditure equating to £9.7 million. The agency bill for the Trust year to date is 2.5% of Trust pay expenditure which remains below the agency ceiling set by NHS Improvement of 3% for the Trust, (Appendix 3 – Figure 4.10 – Summary of the spend on Agency and Locums).

The key clinical specialities that are driving this spend within the Consultant staff group are Elderly Medicine and Cardiology. Within the SAS Doctor workforce Emergency Medicine is more than double the spend of other specialities within this workforce group. Gaps within the Doctors in Training rotas in General Medicine are the highest cost within this staff group. Within Theatres the Registered workforce is an area of concern. Registered Nurses and Operating Department Practitioner staffing levels are driving the temporary spend and this has more than doubled over the last three years. The Clinical non-registered workforce spend is being driven by inpatient wards and theatres.

**Note: Analysis is on-going to determine the proportion of temporary staffing spend for the reasons of vacancies and absence. This will be incorporated into this section of the report to support the measurement of the key performance indicators.**

#### 4.7 Doctors in Training Rotas 2014 – 2016

Appendix 3 – Figures 4.11 and 4.12 Gaps in Training Rotas shows the training gaps for Doctors in Training from the Health Education England Yorkshire and the Humber, Learning and Development Agreement (LDA). Gaps can increase or decrease throughout the year as trainees do or do not rotate into posts for a number of reasons; resigning from schemes, maternity leave, and out of programme experience.

The Foundation gaps tend to occur at Foundation Year 2 when either a Foundation Year 1 doctor needs to extend their training or does not complete their first year. The Trust is allocated trainees at Core Trainee years 1-3, Speciality Trainee years 1-3 or Specialty Trainee year 3+. When gaps appear on rotas due to posts not being filled by Health Education England this causes significant operational and financial difficulties for the Trust.

## 5. Workforce Metrics

Appendix 4 shows the Trust current performance against workforce metrics and where possible benchmarks the Trust against Private, Public and NHS organisations. This analysis demonstrates where the key opportunities lie in the employee life-cycle for the Trust to drive further improvements in workforce engagement and competence as well as support recruitment and retention.

The metrics reviewed include:

- ▲ Staff Friends and Family Test (Figure 5.1)
- ▲ Staff appraisals (Figure 5.2)
- ▲ Sickness absence (Figure 5.3)
- ▲ Mandatory and essential skills training (Figure 5.4)

## 6. Organisational Readiness

A summary of current organisational readiness to meet the national and local challenges is drawn out in the Strengths, Opportunities, Weaknesses and Threats (SWOT) analysis shown on the next page:

Figure 6.1 SWOT Analysis

<b>Strengths</b> <ul style="list-style-type: none"> <li>Care Quality Commission report – overall good rating with ambition to move to outstanding (3 services already rated as outstanding)</li> <li>Links with Health Education England working across Yorkshire &amp; the Humber and Education Providers</li> <li>Clinically led organisation with Clinical Leadership embedded through the Directorate structures</li> <li>Levels of staff engagement (National NHS Staff Survey) ranked 3<sup>rd</sup> in Group</li> <li>Service Improvement methodology and clinical engagement in delivery</li> <li>Mandatory and Essential Skills Training compliance</li> <li>Trust wide labour turnover</li> <li>Values &amp; Behaviours embedded</li> <li>Staff Friends and Family Test results</li> <li>Advanced Clinical Practitioner Development Programme</li> <li>Established Health &amp; Wellbeing programme</li> <li>Calderdale Framework Expertise</li> <li>Harrogate is an attractive place to live and work</li> <li>Partnership working with Trade Unions</li> </ul>	<b>Opportunities</b> <ul style="list-style-type: none"> <li>Leadership of the Local Workforce Action Board</li> <li>Partnership working across the STP/West Yorkshire and Harrogate Association of Acute Trusts (WYAAT)</li> <li>Apprenticeship Levy from April 2017</li> <li>Changing educational commissioning landscape</li> <li>International recruitment</li> <li>Foundation Trust status “to do things differently”</li> <li>Local Jobs, for Local people</li> <li>Business Development</li> <li>Widening participation agenda</li> <li>Vanguard and Acute Medical Model site</li> <li>Marketing the Trust as employer of choice</li> <li>Accessibility of flexible working arrangements</li> <li>Largest provider of Children’s services</li> <li>Sickness absence performance</li> <li>Working Longer Initiatives</li> <li>Expenditure on temporary staff</li> <li>Development of Collaborative Internal Bank model</li> </ul>
<b>Weaknesses</b> <ul style="list-style-type: none"> <li>Conversion from students into substantive staff</li> <li>High cost of living in Harrogate</li> <li>Investment in building workforce clinical and leadership competence</li> <li>Labour turnover within the Registered Nurses, Pharmacists, Pharmacy Technicians and the support workforce</li> <li>Lack of competency framework for job roles</li> <li>Lack of career pathways</li> <li>Appraisal compliance</li> <li>Impact of workforce shortages on workforce resilience</li> <li>Workforce spend on temporary staff; Emergency Department, General Medicine, General Surgery and Theatres</li> </ul>	<b>Threats</b> <ul style="list-style-type: none"> <li>Brexit and potential impact on flow of European Union workforce</li> <li>Ageing profile of Midwives, Health Visitors, District Nurses and School Nurses</li> <li>Reduction in Health Education England funding</li> <li>Removal of the nursing bursary</li> <li>Patient and staff resistance to change and new ways of working</li> <li>Training pipeline insufficient to meet current/future demand i.e. Doctors in Training, Registered Nurses and Operating Department Practitioners</li> <li>Clinical Commissioning Group (CCG) funding pressures</li> <li>Reducing national NHS funding and increasing patient demand for services</li> <li>CCG tendering of current HDFT provided services</li> </ul>



## 7. A Vision for the Workforce of the Future

Figure 7.0.1 Vision for the Clinical Workforce of the Future

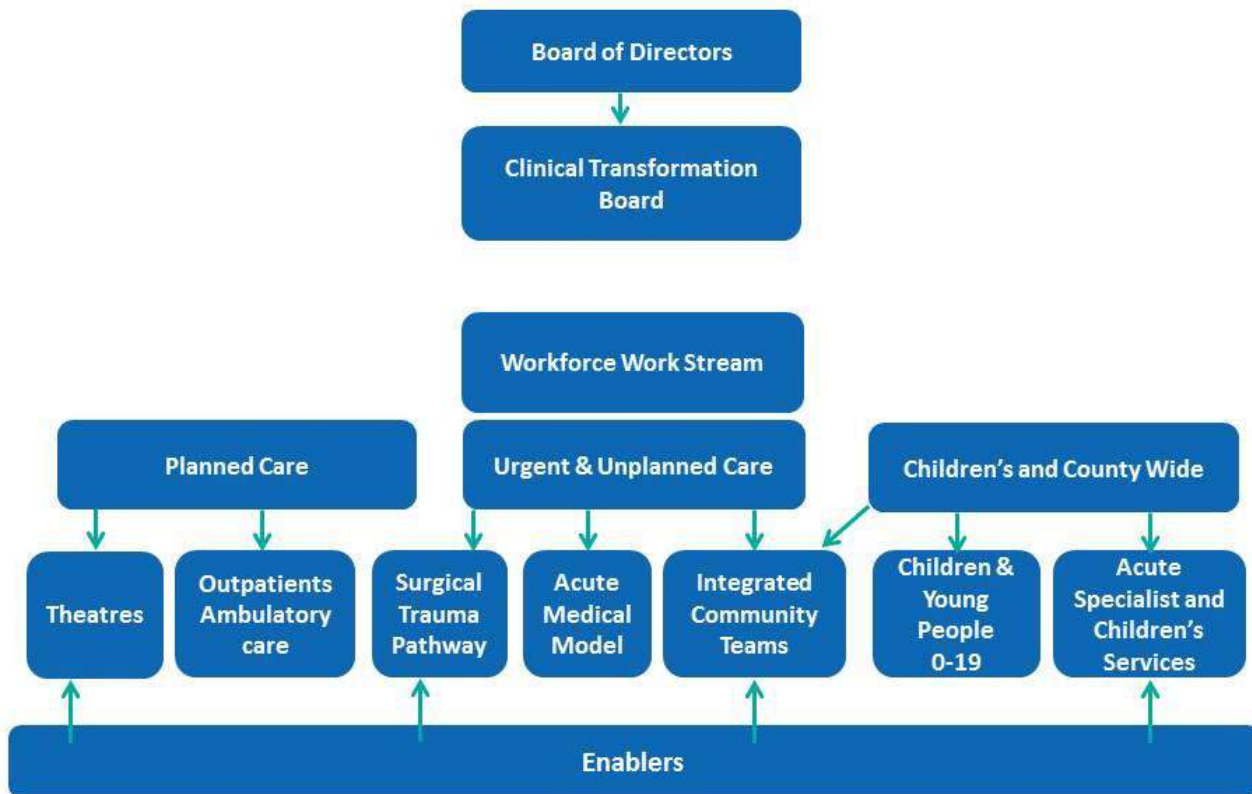


### 7.1 Creating the Clinical Workforce of the Future

Creating the clinical workforce of the future will be clinically led through organising the work streams by clinical pathway to ensure that clinical buy in is secured early on and that a multi-disciplinary approach is taken to workforce transformation and service sustainability. The clinical workforce strategy will be aligned to the Clinical Transformation Board and the Workforce work stream supported by the Project Management Office. Clinical Professional Leads will be identified for each work stream and will be clinically led at service level and accountable through the Directorate Management Structures.

*Organising the workforce transformation by clinical pathway will secure the clinical buy in needed and a multi-disciplinary approach to how we deliver care.*  
Robert Harrison, Chief Operating Officer, HDFT

Figure 7.1.2 Clinical Workforce Strategy Governance Structure

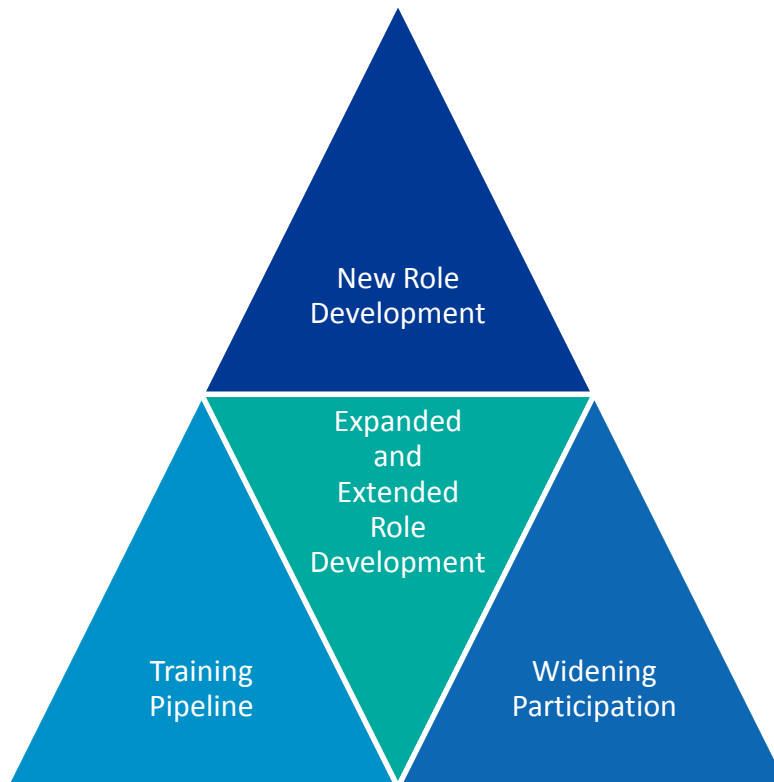


## 7.2 Key Themes of this Work Stream will include

- ▲ New roles for the Registered workforce creating new career pathways i.e. Advanced Clinical Practitioners, Physician Associates and Nurse Consultant roles
- ▲ New roles for the Non-Registered workforce to create new career pathways i.e. Assistant Practitioner and Associate Nurse roles
- ▲ Extending skills in both the Registered and Non-Registered workforce to ensure that each role is undertaking the tasks that only they can do
- ▲ Working longer initiatives to improve the retention of our ageing workforce

*"Our ACPs are the first exciting step in addressing the unprecedented workforce challenge to meet the growing needs of our patients – in developing this skilled alternative clinical workforce we gain the advantage of their previous experience and look forward to being able to build, year on year, on their clinical skills".*  
 Dr Matt Shepherd, Consultant and Lead Clinician, Emergency Medicine, HDFT

Figure 7.2.1 Model for Workforce Sustainability (Adapted from: *Reshaping the Workforce to Deliver the Care Patients Need*, Nuffield Trust in association with NHS Employers. May 2016)



### 7.3 Risks Associated with Workforce Transformation

New and extended roles may not always achieve the desired outcomes. There is strong evidence that without careful role and service redesign, new and extended roles can:

- ▲ Increase demand and service costs - where new or extended roles are used to provide an enhanced service, rather than manage the existing workload, demand may increase
- ▲ Supplement rather than substitute other staff - new roles are often expected to substitute for existing staff, thereby reducing demand on existing resources. This will only happen if staff stop performing the tasks that have been delegated to others
- ▲ Cost rather than save - substituting senior staff for cheaper alternatives has historically been used to reduce costs, however those in new or extended roles may take longer to complete tasks, spend more time with patients, recall them at higher rates and carry out more investigations than their senior counterparts. Long-term cost evaluations are needed.
- ▲ Threaten the quality of care - higher numbers of senior staff are often associated with better patient outcomes i.e. reduced hospital-related mortality, length of stay. Therefore configuration needs to be considered carefully and tested through small, local pilots.

### 7.4. Workforce Programme Underpinned by Quality

To mitigate against the risks of clinical workforce transformation stated above, the clinical workforce strategy will be underpinned by quality. The following enablers will be the building blocks that will support the delivery across the clinically led work streams as appropriate. The delivery of these enablers will be led corporately and will require some investment, redirection of existing resources and collaboration at system level.

Clinical Competencies	Workforce Transformation Tool	Health Coaching	Leadership Development	Team Working
Practice Education and Clinical/Simulation Skills Training	Clinical Supervision	Apprenticeships	Digital and IT Skills	NHSI Cultural Tool
Investors in People	Preceptorship	Educational Placements	Values and Behaviours	Collaboration across STP/LWAB
Appraisal/Talent Management	Partnerships with Education Providers	Staff Passports across STP	Workforce Planning	Health and Wellbeing

### 7.5. Key Performance Indicators - Measures of Success

The Key Performance Indicators (KPI's) have been developed in line with the review of the current workforce profile, current workforce metrics and the SWOT analysis, to deliver the strategic objectives of the clinical workforce strategy which includes the triple aims of:

- ▲ Growing our capability
- ▲ Increasing staff engagement
- ▲ Driving productivity and efficiency

These will be developed and agreed by the Clinical Transformation Board, incorporating a base line assessment, trajectory and milestones for achievement and an overall target over the five years. These KPI's will be reviewed within the first two years of this strategy to ensure that they remain appropriate, due to the significant unknowns at the time the strategy has been developed i.e. impact of Brexit and the impact of the removal of the Student Bursary. This will enable sensible adaptations to be made during the lifetime of this strategy.

The Trust Board will receive annual reports on progress against the vision, mission and strategic objectives of the Clinical Workforce Strategy. This will include status up-dates from each work stream and will detail; the key deliverables and milestones in the previous 12 months and the planned deliverables and milestones for the next 12 month period. Progress against the strategy will be measured by tracking progress made against each of the KPI's.

#### 7.5.1 Growing our Capability



Delivering a sustainable workforce by:

- Increasing the number of non-trainees on the medical staffing rotas by 30 (ACP's Medical Training Initiative (MTIs), Clinical Fellows, SAS doctors)
- The development of 30 new roles in the Registered workforce (ACPs, Physician Associates and Nurse/Allied Health Professional Consultant)
- The development of 50 new Band 4 roles in the Non-Registered workforce (Assistant Practitioner and Associate Nurse roles)
- The development of 200 Apprenticeships



Delivering a high quality, competent workforce by:

- Achieving 95% mandatory training compliance
- Increasing the competencies of the Registered Workforce in: nasogastric tube insertion, diagnostics, capability assessments, non-medical prescribers
- Increase the competencies of the Non-Registered Workforce in: cannulation, diagnostics, observations, urinary catheters, administration of medicines, discharge planning and process, phlebotomy



## 7.5.2 Staff Engagement



To create an engaged, motivated workforce where everyone can contribute to their fullest by:

1. Being within the top 10% of Acute and Community Providers for overall Staff Engagement, including 3 sub dimensions:
  - a. Staff recommendation of the Trust as a place to work or receive treatment
  - b. Staff motivation at work
  - c. Staff ability to contribute towards improvement at work



To be an employer and provider of choice by:

1. Achieving 90% of staff who would recommend the Trust as a place to work
2. Achieving 90% of staff who would recommend the Trust as a place to receive care



To deliver a performance improvement culture by:

1. Achieving 90% appraisals for all staff over a 12 month period

## 7.5.3 Productivity and Efficiency



To create a sustainable workforce by reducing spend on temporary (Bank/Agency/Locum) staff by £2 million which is 20% of the total temporary staffing spend (based on 2015/16) for the following groups

- Foundation Doctors in Training
- Registered Workforce
- Unregistered Workforce



To improve retention and reduce costs of recruitment in key staff groups by reducing voluntary labour turnover to remain in line with the NHS average of 9.9% across:

- Registered Workforce (Bands 5-8B)
- Unregistered Workforce (Bands 2-4)
- Increase the retention of our over 55 workforce to 15% of the total clinical workforce



To improve workforce resilience by reduce overall sickness absence across the Trust

- To achieve 3.25% absence across the Trust
- To reduce absences related to stress, anxiety and depression to 10% of overall sickness absence

## 8. Conclusion

There is an urgent need to reshape the NHS workforce and equip it to meet the changing and growing demands from the population it serves. Change is not easy, it takes skill, resources and persistence. However, with careful attention to role design, team working and effective change management, the potential benefits are significant.





Reshaping the NHS workforce can deliver benefits for patients through more patient focused care and improved health outcomes. It can deliver benefits for staff through more rewarding roles and enhanced career pathways. It can deliver benefits for NHS organisations through greater efficiencies and helping to address potential workforce gaps. The financial context in which organisations are currently operating makes this agenda particularly challenging. There is little headspace in terms of time and resources, yet this is exactly what is needed. National and local training budgets are being cut at the point that they require expansion. This agenda is not a 'nice to do'. It is essential if we are to find a sustainable balance between available funding, patient needs and staff needs. (Source: *Reshaping the Workforce to Deliver the Care Patients Need*, Nuffield Trust in association with NHS Employers, May 2016)

Having the right number of appropriately skilled staff is a critical determinate of the quality and efficiency of healthcare. At this challenging time for the NHS the Trust remains absolutely focused on clinical and financial sustainability in the longer term in order to continue to deliver high quality care to the patients who use our services.

In developing the Clinical Workforce Strategy we have considered the national and local drivers for change, specifically; growing workforce gaps, an NHS budget that is failing to keep pace with the healthcare needs of a growing population and a changing workforce. These pressures are creating a burning platform for change and innovation, however we must not lose sight of the more fundamental requirement to adapt the workforce to better support our patient and population needs.

To address these challenges, the Trust has developed a compelling Vision and Mission for its clinical workforce of the future, to ensure we provide Excellent Care Every Time, delivered by an Excellent Workforce, where Every Contact Counts.

Through extensive consultation and engagement with our clinical workforce, we have an in-depth understanding of both:

1. The Trust's current Clinical Workforce profile
2. The opportunities for:
  -  New roles for the Registered workforce creating new careers
  -  New roles for the Non-Registered workforce to create new career pathways
  -  Extending skills in both the Registered and Non-Registered workforce to ensure that each role is undertaking the tasks that only they can do
  -  Working longer initiatives to improve the retention of our ageing workforce

By focusing on these key priorities, the Trust can not only meet these challenges, the expectations of our patients, their relatives and carers, but also create innovative career pathways that attract the very best clinicians and provide local jobs for local people.

## 9. Acknowledgements

This document has been produced through the wide consultation with and support from the following people:

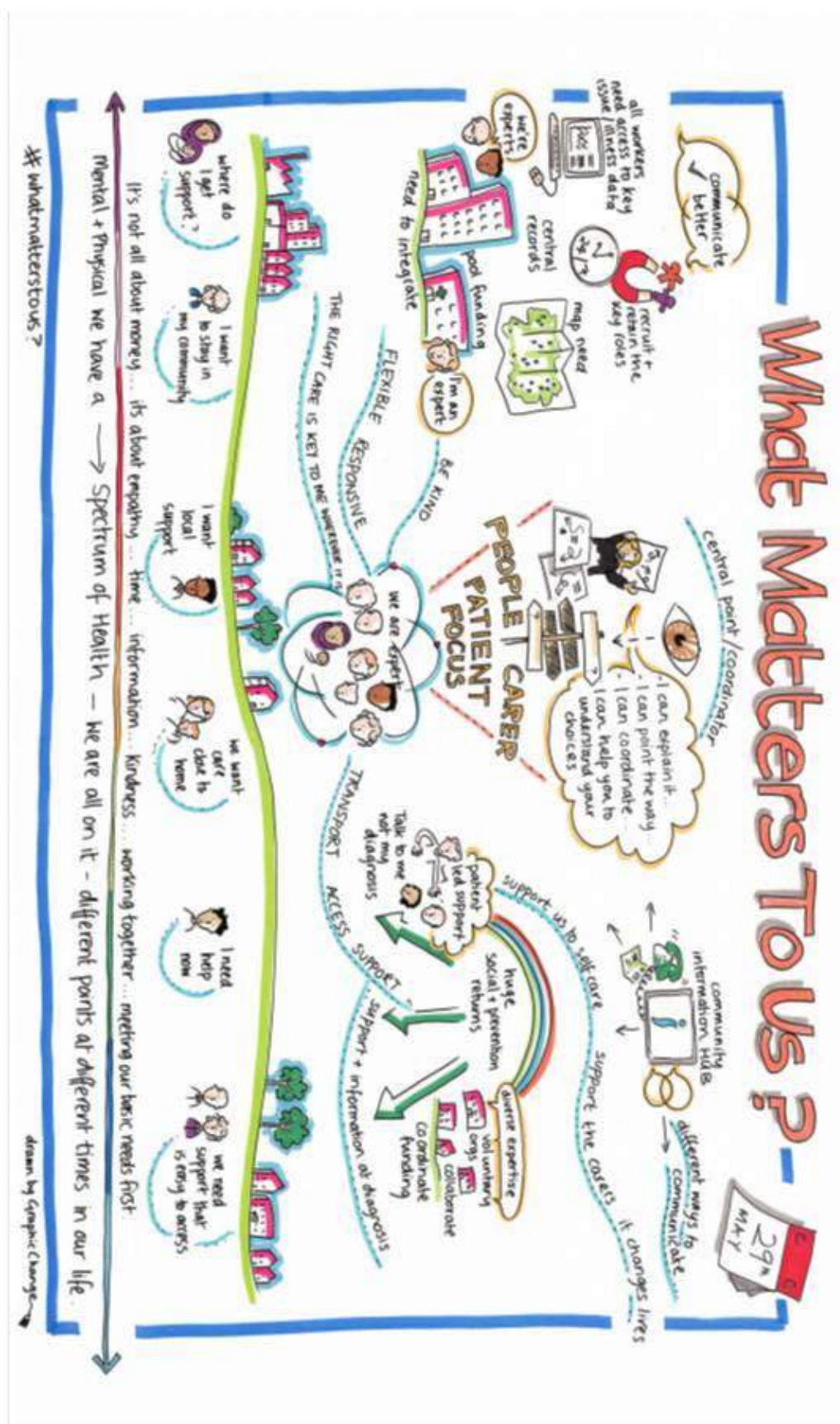
-  Professor Sue Proctor, Vice Chair and Non-Executive Director
-  Robert Harrison, Chief Operating Officer
-  Liz Pugh, HR Business Partner
-  Sharon Wilkes, Workforce Transformation Lead
-  Jake Wise, Workforce Information Analyst
-  Katie Laurence, Finance Manager
-  Kim Donkersley, Finance Manager

- Dr David Scullion, Medical Director
- Dr Simon Holbrook, Director of Post Graduate Medical Education
- Diane Fisher, Medical Education Manager
- Dr Ros Tolcher, Chief Executive
- Jill Foster, Chief Nurse
- Phillip Marshall, Director of Workforce and OD
- Dr Matt Shepherd, Consultant and Clinical Lead, Emergency Medicine Clinical Directorates
- World Café Attendee's

## 10. References

- HDFT Strategic Plan 2014-2019
- HDFT Operational Plan – 2015-2016
- Clinical Directorate Business Plans – 2015 - 2016
- HDFT Business Development Strategy 2013 - 2018
- HDFT Nursing and Midwifery Strategy 2016 -2017
- HDFT Workforce and Organisational Development Strategy 2015-2020
- HDFT Strategy for Simulation – 2016-2019
- Healthy Futures, West Yorkshire STP
- The Five Year Forward View – NHS England, October 2014
- Reshaping the workforce to deliver the care patients need – The Nuffield Trust in association with NHS Employers, May 2016
- Supporting integration through new roles - Kings Fund
- 5 Big Issues for Health & Social Care After the Brexit vote – The Kings Fund
- The World Café Community Foundation 2015.
- Crunch time for Britain's workforce, CIPD Editorial, May 2016
- HR Benchmarking Data - Xpert HR







Appendix 2 – World Café event output - Word Cloud



## Appendix 3 – Clinical Workforce Profile

Figure 4.1 – Clinical Staff Mix (source: Flu Denominator)

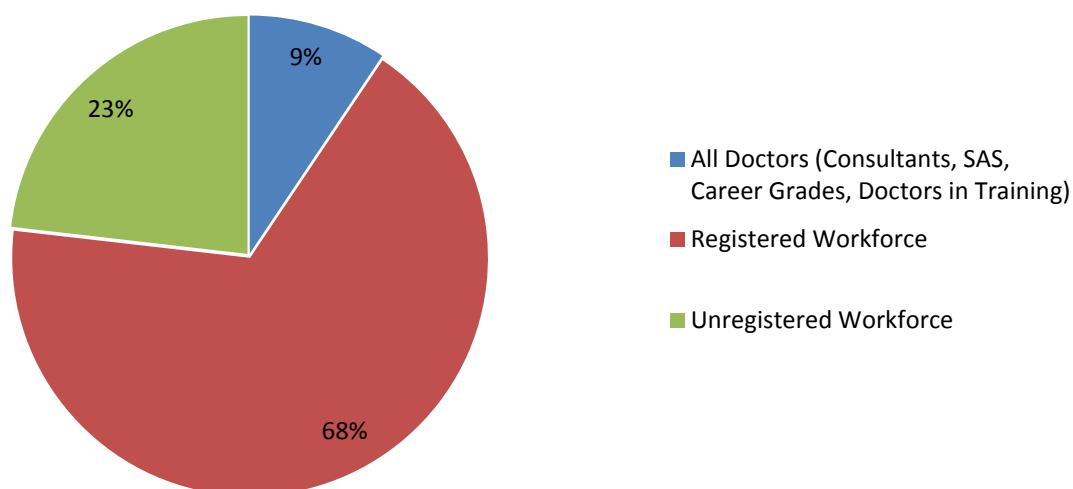


Figure 4.2 – Age Profiles

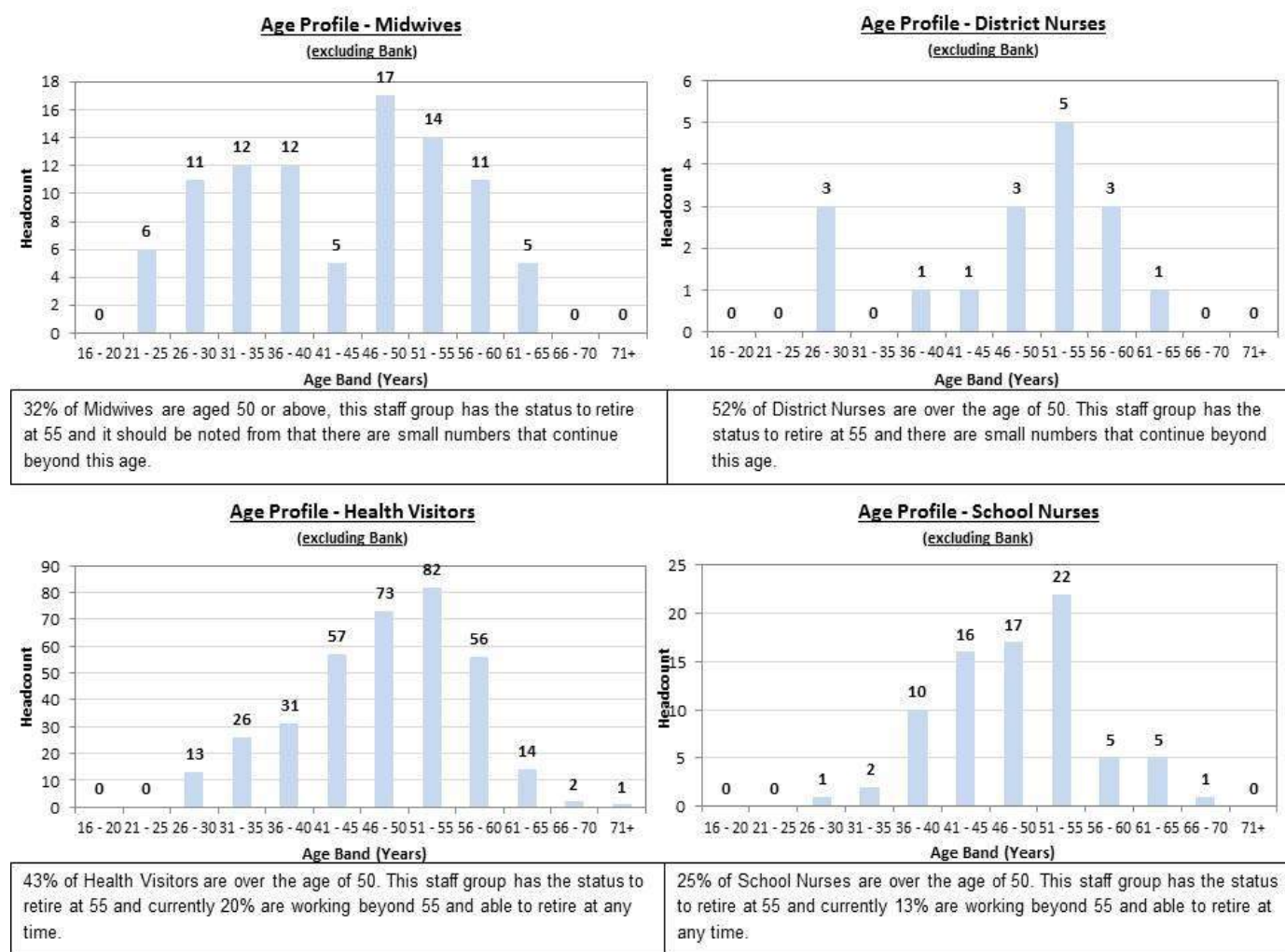


Figure 4.3 - Voluntary Resignation and Total Labour Turnover Rates by Organisation Size and Sector, 2015/2016

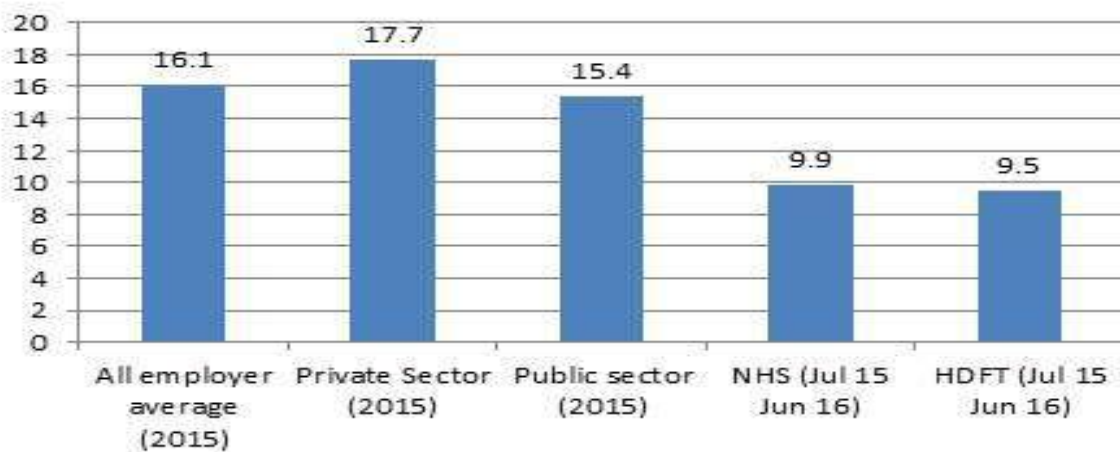
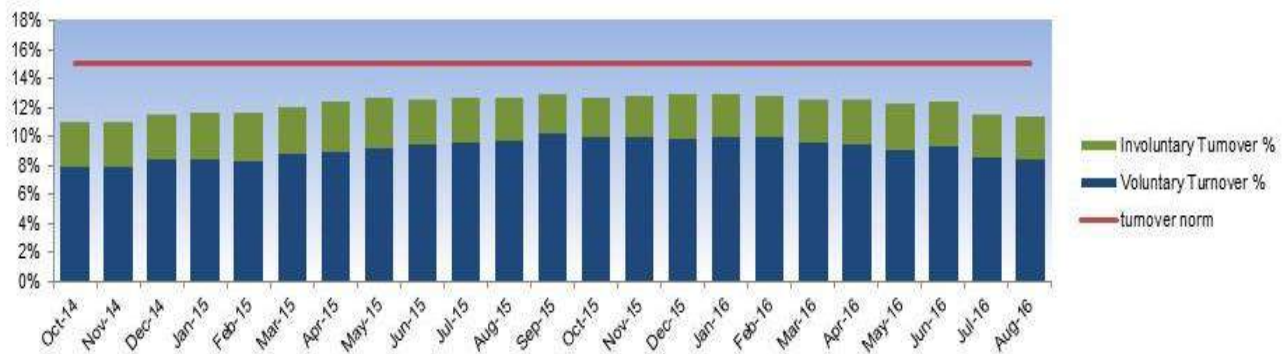


Figure 4.4 – Trust Wide Labour Turnover



The total Trust labour turnover as at 1<sup>st</sup> October 2016 was 11.5% for the rolling 12 month period (this excludes all Bank, Fixed Term Staff and Junior Doctors). Figure 4.4.1 shows the Trust labour turnover data since 2014. Data from the Times Top 100 Employers indicated a turnover rate norm of 15%.

Figure 4.5 - Clinical Workforce Labour Turnover

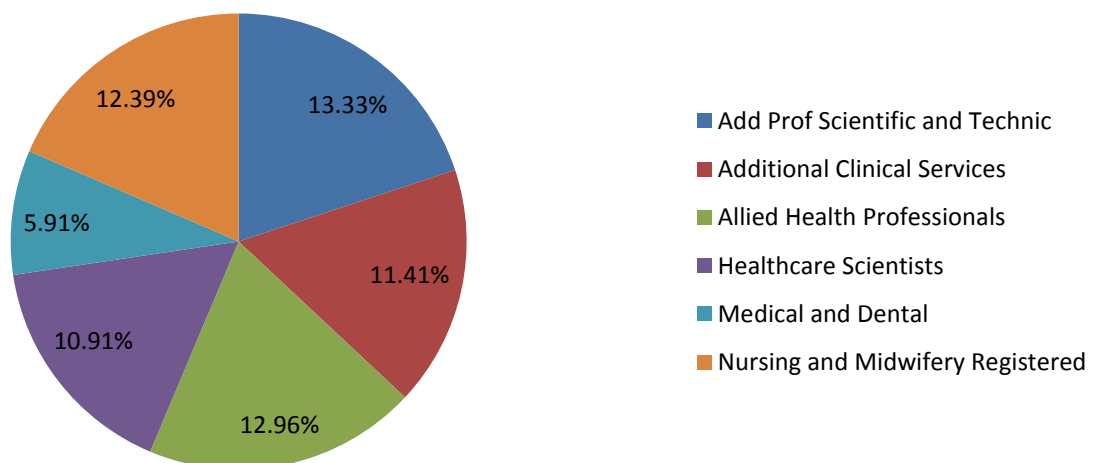


Figure 4.6 - Ethnicity profile of the Clinical Workforce (excluding bank)

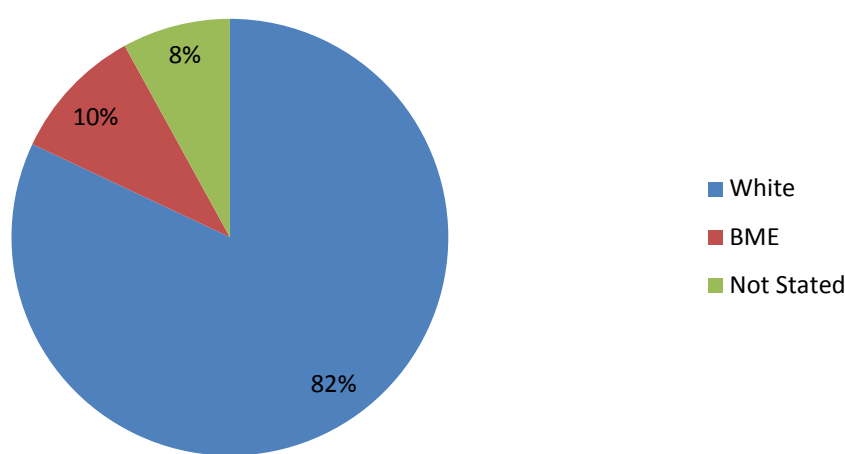


Figure 4.7 – Percentage of BME staff within Clinical Roles

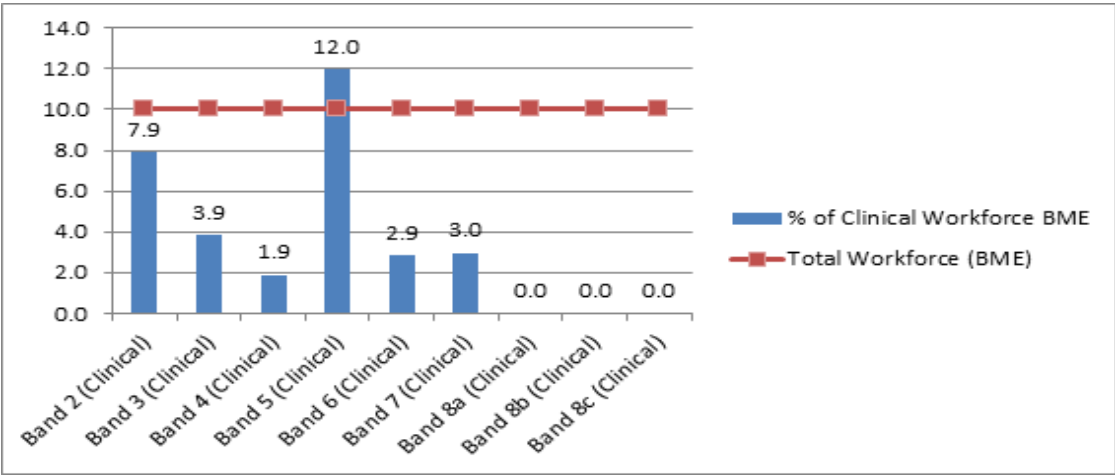


Figure 4.8 - Clinical Workforce Post Brexit EU Nationals

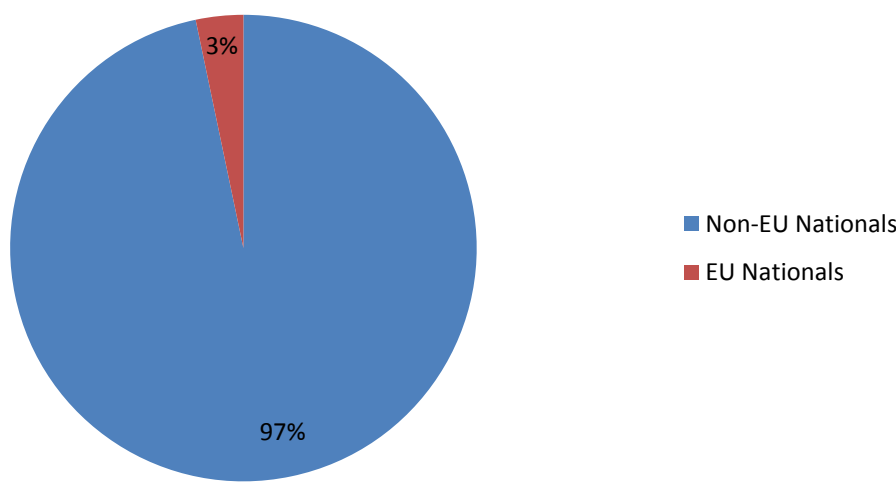


Figure 4.9 - Post Brexit EU Nationals by Clinical Staff Group

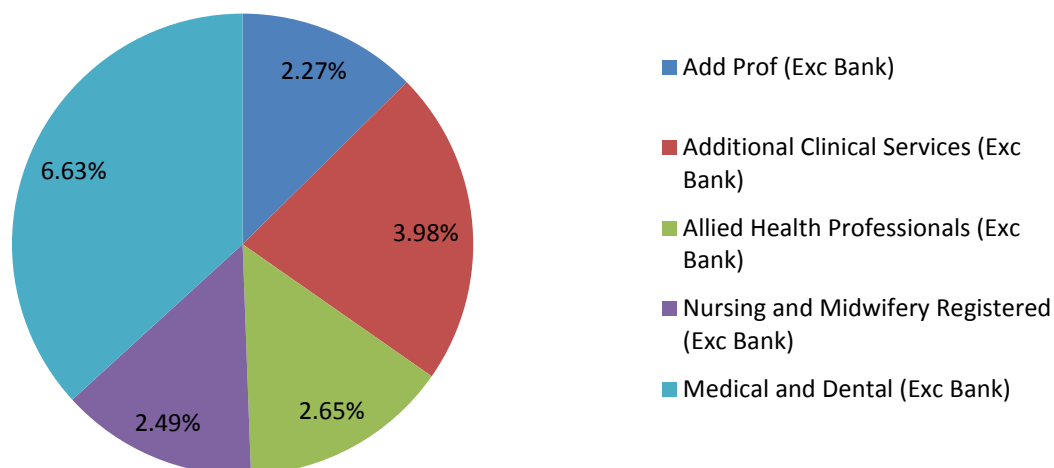
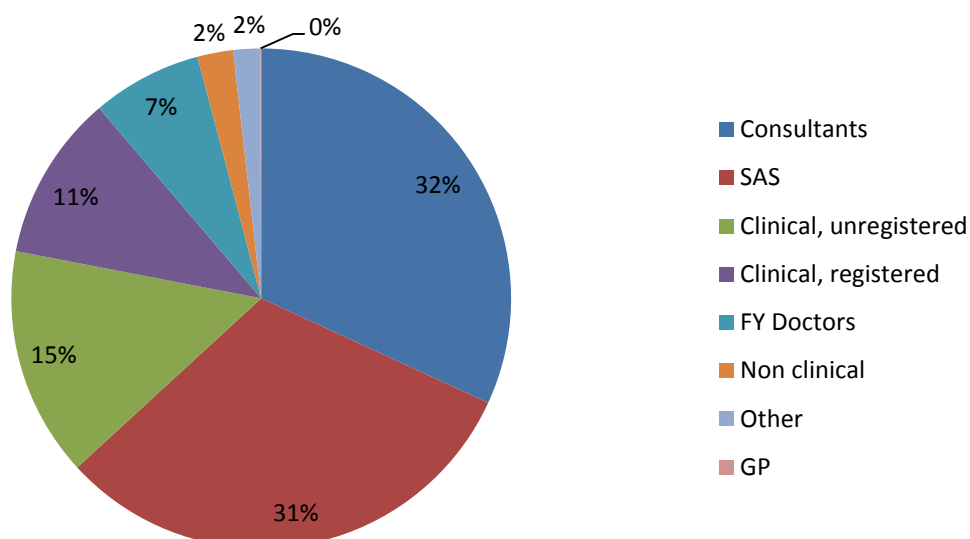


Figure 4.10 - Summary of the spend on agency and locums



Sum of 2015/16 Locum/Agency	
Consultants	£2,085,345.71
SAS	£2,049,109.15
Clinical, unregistered	£972,548.48
Clinical, registered	£703,354.30
FY Doctors	£466,265.30
Non clinical	£150,666.34
Other	£114,399.63
GP	£3,437.77
<b>Grand Total</b>	<b>£6,545,126.68</b>

Figure 4.11 - Gaps in the Doctor's in training rota's

	Start 2014	Mid 2014	Start 2015	Mid 2015	Start 2016	Mid 2016*
Medical Specialties	1	7	1	0	9	4
Surgical Specialties	0	1	2	0	3	1
Other	1	2	7	2	4	4
<b>Total</b>	<b>2</b>	<b>10</b>	<b>10</b>	<b>2</b>	<b>16</b>	<b>9</b>

Figure 4.12 - Breakdown of Gaps by Grade

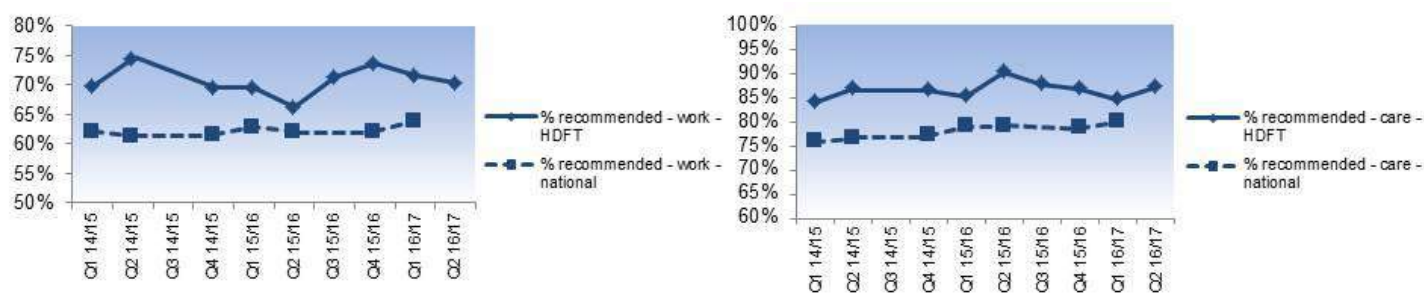
	Mid 2014	Start 2015	Start 2016
Foundation	2	3	4
Core Trainee	2	0	3
ST1-3	2	0	2
ST3+	4	7	7
Total Gaps	10	10	16
Total Doctors	113	116	118
% Gap	9%	9%	13.5%

*Source: HEE Y&H Learning and Development Agreement*



## Appendix 4 – Workforce Metrics

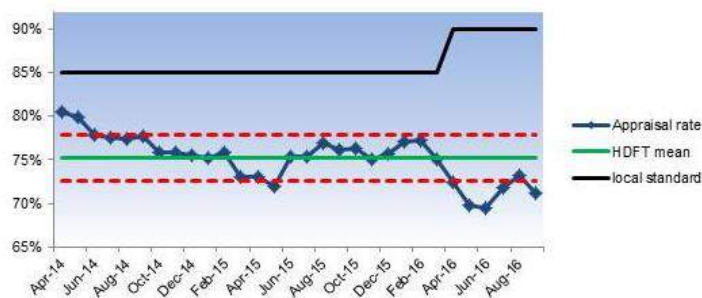
Figure 5.1 - Staff Friends and Family Test



The chart shows the percentage of staff that would recommend the Trust as a place to work. The Trust aims to feature in the top 20% of Trusts nationally which would typically mean that 71% of staff would recommend the Trust as a place to work. In Quarter 2, 70.4% of HDFT staff surveyed would recommend HDFT as a place to work, this remains above the most recently published national average of 64%.

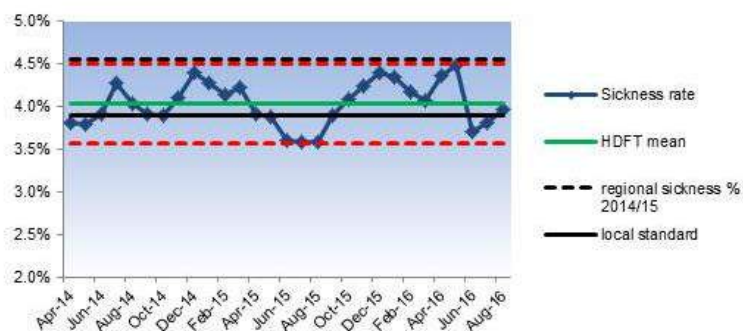
The chart shows the percentage of staff that would recommend the Trust as a place to receive care. The Trust aims to feature in the top 20% of Trusts nationally which would typically mean that 88% of staff would recommend the Trust as a place to receive care. In Quarter 2, 87.3% of HDFT staff surveyed would recommend HDFT as a place to receive care. This is above the most recently published national average of 80%.

Figure 5.2 - Staff Appraisals



The chart shows the staff appraisal rate over the most recent rolling 12 months. The Trusts aims to have 90% of staff appraised. The appraisal rate for the 12 months up to the end of September is 71.2%

Figure 5.3 - Sickness Absence

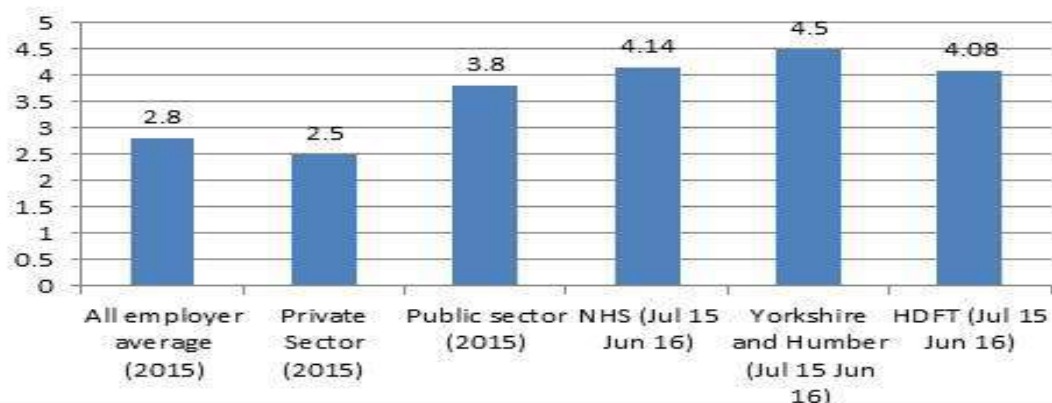


Staff sickness rate - includes short and long term sickness. The Trust has set a threshold of 3.9%. The sickness rate for August 2016 is 3.96%. Highest reason for sickness absence is due to stress, anxiety and depression accounting for 18% of absences.

Figure 5.4 - Mandatory and Essential Skills Training Compliance

Competence Name	% Completed	Competence Name	% Completed
Equality, Diversity and Human Rights - Level 1	92	Equality, Diversity and Human Rights - Level 1	42
Fire Safety Awareness	90	Fire Safety Awareness	50
Infection Prevention & Control 1	99	Infection Prevention & Control 1	97
Infection Prevention & Control 2	82	Infection Prevention & Control 2	49
Information Governance: Introduction	86	Information Governance: Introduction	46
Information Governance: The Beginners Guide	81	Information Governance: The Beginners Guide	-
Prevent Basic Awareness (December 2015)	99	Prevent Basic Awareness (December 2015)	41
Safeguarding Children & Young People Level 1 - Introduction	93	Safeguarding Children & Young People Level 1 - Introduction	94
The table shows the most recent training rates for all mandatory elements for substantive staff. The table excludes staff who TUPE transferred into the organisation on 1st April 2016. The overall training rate for mandatory elements in September 2016 for substantive staff in this group is 91%.		The table shows the most recent training rates for all mandatory elements for substantive staff. The table only includes staff who TUPE transferred into the organisation on 1st April 2016. The overall training rate for mandatory elements in September 2016 for substantive staff in this group is 56%.	

Figure 5.5 - Absence rates by sector and organisation size 2015: percentage of working time lost per annum



The national average stood at 2.8% of working time lost due to sickness absence in 2015, equivalent to 6.3 days per employee, according to Xpert HR's annual benchmarking survey. The results show that across the public sector and NHS it is significantly higher. Source: NHS Digital.



<b>Report to the Trust Board of Directors: 30 November 2016</b>	<b>Paper No: 11.0</b>
<b>Title</b>	<b>Chief Nurse Report</b>
<b>Sponsoring Director</b>	Mrs J Foster, Chief Nurse
<b>Author(s)</b>	Mrs J Foster, Chief Nurse
<b>Report Purpose</b>	To receive, note and approve the contents of the report
<b>Key Issues for Board Focus:</b>	
<p>The Board of Directors are asked to:</p> <ul style="list-style-type: none"> <li>- <b>Note</b> the results of Director Inspection Visits and red rating for Pannal Ward</li> <li>- <b>Note</b> the slight increase in the number of complaints received by the Trust in October</li> <li>- <b>Understand</b> the steps being undertaken to maintain safe staffing levels across the Trust and receive an update on the highest areas of risk: CATT; AMU; Byland; and Jervaulx</li> </ul>	
<b>Related Trust Objectives</b>	
To deliver high quality care	Yes – the report provides assurance that safe staffing levels are maintained throughout the Trust, and the actions taken for areas where staffing levels have not been maintained.
To work with partners to deliver integrated care	No.
To ensure clinical and financial sustainability	Yes – the report supports to Trust's objective to ensure quality of care is not compromised due to insufficient clinical staff.
<b>Risk and Assurance</b>	Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF 1: risk of a lack of medical, nursing and clinical staff; BAF 3: risk of a failure to learn from feedback and incidents; and BAF 13: risk of insufficient focus on quality in the Trust.
<b>Legal/regulatory implications</b>	The report does not highlight any legal/regulatory implications for the period.
<b>Action Required by the Board of Directors</b>	
The Board of Directors are asked to receive and note the content of the report.	

## Unannounced Directors' Inspections 2016-2017

Date	Ward/Dept.	Risk Rating	Critical Issues	Review Date	Outcome	Critical Issues
14/04/2016	Mortuary	Green				
26/04/2016	Endoscopy	Green				
06/05/2016	Day Surgery Unit (follow up visit)	Green				
12/05/2016	Acute Medical Unit	red	Lack of cannula VIP scores.	09/09/2016 Successful audit now compliant	Green	
06/06/2016	Medical Day Unit	Amber	Largely relating to the non-compliant chairs in the treatment room and waiting room.	<b>Update Sept</b> Treatment room chairs now replaced.  Waiting room chairs remain non-compliant.	Amber	
16/06/2016	Pannal (follow up visit)	red	Further review to be undertaken ( Lack of cannula VIP scores)	Remains red following re-visit failed again.	red	
24/06/2016	Harlow	red	Lack of cannula VIP scores	JF IPC re-audited Sept Harlow now compliant	Green	
14/07/2016	Whitby Dental Clinic	Green				
29/07/16	Ice Store, Knaresborough	red				
16/08/16	Dental Clinic Settle HC	Green				
23/8/16	Lascelles	Red		2/11/16	Green	
31/10/16	Operating Theatres	Green				

## Patient Safety Visits

Since the last report to Board, the following visits have taken place:

Date	Area
01/07/16	Orthopaedic Outpatients
13/07/16	Byland/ Jervaulx
02/08/16	Maternity
13/10/16	Kingswood Dental Surgery
25/11/16	Stanley Education Centre

## Complaints

The number of complaints received this month is 19.

Of the 19 complaints received in **October 2016**, there are 12 Yellow and 7 Green.

Total number of complaints by month for 2016/17 compared to 2015/16													
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
<b>2016/17</b>	18	16	23	21	25	18	19						
<b>2015/16</b>	26	18	30	15	17	26	11	9	12	12	21	16	<b>213</b>

## Nurse Recruitment

Each month I report the nurse recruitment campaign is continuing to be successful in that the number of registered nurses being recruited is exceeding the number of registered nurses leaving. We were expecting a number of newly qualified nurses to start in the Trust in September and October and I am pleased to confirm 24 did start with a number of others with delayed start dates. In addition 11 experienced registered nurses started in the in-patient wards.

We held a recruitment event in October. 14 conditional job offers were made 3 to registered nurses and 12 to students qualifying in September 2017.

We are continuing to attend open days at Universities and the monthly recruitment events.

## Actual versus Planned Nurse Staffing - Inpatient areas

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

In addition we are required to submit information on the total number of patients that were on each ward throughout the month – this is then used to calculate the new “Care Hours per Patient Day (CHPPD)” metric. Our overall CHPPD for October is 7.90 care hours per patient per day. NHS England will be publishing this data for every Trust but we don't know yet how our data will compare to that of other Trusts and as yet it is uncertain how this information is going to be used.

Oct-2016							
	Day		Night		Care hours per patient day (CHPPD)		
Ward name	Average fill rate - registered nurses/ midwives	Average fill rate - care staff	Average fill rate - registered nurses/ midwives	Average fill rate - care staff	Registered nurses/ midwives	Care Support Workers	Overall
AMU	90%	109%	97%	109%	4.26	2.53	6.79
Byland							
CATT	91%	136%	125%	137%	4.69	3.07	7.76
Farndale	85%	125%	106%	102%	3.27	3.99	7.26
Granby	96%	143%	102%	181%	3.20	3.27	6.47
Harlow	100%	100%	100%	-	2.24	0.65	2.88
ITU/HDU	86%	-	87%	-	23.69	2.09	25.78
Jervaulx	87%	152%	91%	120%	3.13	3.68	6.81
Lascelles	93%	101%	100%	100%	4.61	4.27	8.88
Littondale	82%	149%	97%	200%	3.09	2.87	5.96
Maternity Wards	89%	80%	98%	85%	10.18	2.56	12.75
Nidderdale	84%	113%	80%	168%	3.31	2.89	6.20
Oakdale	92%	128%	88%	148%	4.55	3.72	8.28

Special Care Baby Unit	90%	84%	100%	-	12.37	2.75	15.11
Trinity	99%	119%	100%	98%	3.70	3.79	7.49
Wensleydale	91%	141%	100%	134%	3.24	2.93	6.16
Woodlands	82%	123%	86%	103%	10.67	4.31	14.97
<b>Trust total</b>	<b>89%</b>	<b>125%</b>	<b>96%</b>	<b>124%</b>	<b>4.70</b>	<b>3.20</b>	<b>7.90</b>

ED staffing	89%	66%	103%	77%			
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### Further information to support the October data

On the medical wards Jervaulx, AMU and CATT where the Registered Nurse (RN) fill rate was less than 100% against planned; this reflects current band 5 Registered Nurse vacancies and is reflective of the local and national position in particular regarding the difficulties in recruiting Registered Nurses. The Trust is engaged in an extensive recruitment plan in response to this. Further care staff hours were required at times in these areas to provide intensive 1:1 patient support.

In addition planned staffing levels on Jervaulx and Byland ward have been combined into one care of the elderly unit and the hours have been reported through Jervaulx ward in October. This is part of the Trusts winter planning programme.

The Harlow suite was reopened towards the end of the month therefore the data is incomplete for October.

In October the actual staffing levels on Farndale and Nidderdale ward were adjusted to reflect the closure of some beds from the 22 October in response to RN vacancies and activity levels in these areas. This resulted in sufficient staff being on duty to meet the dependency needs of the patients at that time.

On Granby ward the increase in care staff hours above plan was to support the opening of additional escalation beds and to provide 1:1 intensive patient support as required.

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

On Littondale the day and night time RN hours in October were less than planned due to staff vacancies.

The planned staffing levels on the Delivery Suite and Pannal ward (maternity wards) have been combined to reflect the close working relationship of these two areas and the movement of staff between the wards in response to fluctuating occupancy and activity levels. Some of the RN gaps in October were due to staff sickness and the care staff gaps were due to vacancies; however a professional assessment was made on a shift by shift basis to ensure that nurse staffing numbers matched the activity.

In some wards the actual care staff hours show additional hours used for 1:1 care for those patients who require intensive support. In October this is reflected on the wards; CATT, Farndale, Granby, Jervaulx, Oakdale, Littondale, Oakdale and Wensleydale.

The planned staffing levels on Trinity ward remain adjusted to reflect the closure of beds in this area in response to RN vacancies 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.

The staffing complement for the children's ward, Woodlands, is designed to reflect varying levels of occupancy. Although the day and night time RN hours are less than 100% in October, 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. These figures also reflect increased investment in the Woodlands RN establishment and we are currently recruiting to this.

## What this means

The actual versus planned staffing information is an indication of where the gaps are and therefore the areas at increased risk to patient safety. The highest areas of risk due to nurse staffing levels continue to be on the acute floor, CATT and AMU and the frail elderly floor Byland and Jervaulx.

Nidderdale and Farndale have been under increasing pressure due to staffing gaps which after careful consideration resulted in beds being temporarily closed in both areas. Conversations with staff on the wards and in the emergency department generally relate to staff feeling under increased pressure and they are concerned about being able to care for our patients. Their concern is reflective of staff wanting to provide the best possible care in sometimes difficult and challenging circumstances.

I believe we are providing safe and effective care for patients but our ability to do so remains challenging. I am continuing to monitor for evidence of harm arising directly from staff vacancies and gaps.

## Serious Care Reviews

A Serious Case Review (SCR) takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. It looks at lessons learnt that can help prevent similar incidents from happening in the future.

HDFT now provides 0 – 19 Healthy Child Services in Middlesbrough, County Durham and Darlington as well as North Yorkshire. This is to provide the Board information regarding the SCR's the Trust is currently working with or responding to.

## County Durham

Durham Local Safeguarding Children Board published a report on 16 October 2016.

### Child A

County Durham SCB recently published a Serious Case Review in respect of the circumstances leading to the incident whereby Child A suffered serious harm.

## Recommendations for County Durham & Darlington NHS Foundation Trust which apply to HDFT

1. A single electronic midwifery record system needs to be introduced which will facilitate the sharing and flagging of safeguarding concerns to all staff involved in the care of a family. All midwifery staff working with the family should have access to the relevant information to inform decision making and risk assessment. **It should also facilitate a robust Midwife to Health Visitor handover process.**
2. Single agency safeguarding training should have a focus on challenge both to parents and professionals and include the LSCB escalation procedure.
3. Consideration needs to be given by County Durham Darlington Foundation Trust to extending the record keeping training to a full day to include practical exercises with a focus on evaluation and professional opinion.
4. Following contact by a social worker investigating safeguarding concerns the health professional should consider current health information with the new information and risk assess the impact of this on the child. The health professional should consider a home visit.
5. The care pathway for Midwives and **Health Visitors** should identify when professionals have concerns they should request access to and evaluate family's home, including sleeping and eating areas, of a child.
6. An anonymised summary of this case review is shared with all supervisors of midwives and health visitors to encourage supervisors to facilitate reflection on practice and interventions relating to complex cases during supervision.

There are two SCRs on-going both relating to long term neglect.

Case Number 1 – B (neglect)

Case number 2 - C Family

It was agreed that Panel members would review the composite chronology focussing on the period of the review and identify no more than six key practice episodes to be further considered and endorsed at the next meeting (November 2016).

### **North Yorkshire**

No SCR/LLR published during 2015/16.

There will be a Learning Lesson Review relating to a serious sexual assault on another young person. The date for the LLR to start has not been agreed.

### **Middlesbrough**

There has been one case discussed which was in relation to historical Child Sexual Exploitation. There has been a 'Learning Event' on 15 September to test if the current procedures would safeguard any children in similar situations now. The learning event was well received and highlighted that current procedures would safeguard but there was still some learning required as practitioners did not have a good understanding of the VEMT (Vulnerable, Exploited, Missing and Trafficked) process and what the intelligence form was (Operation Shield).

A case is being considered at present which involves one of HDFT's Named Child Protection nurses.

There is one SCR which has not been published as yet, due to the delay in the judicial process as the Mother has been poorly but this was started in 2014.

### **Darlington**

One physical abuse case recently discussed and waiting to hear from the National Panel if progressing to a SCR, I believe it will be an in-depth LLR.

# The Alan Wood Report

## Introduction

Director of Children's Services, Alan Wood CBE, has independently reviewed Local Safeguarding Children Boards (LSCBs), after the Prime Minister requested an urgent analysis back in December. The Wood Report outlines a new framework for improving the organisation and delivery of multiagency arrangements to safeguard and protect children. Recommendations for the considerations of the government are contained in the report, suggesting that appropriate steps should be followed to recast the statutory framework that underpins the model of LSCBs, serious case reviews (SCRs) and child death overview panels (CDOPs). In the report, Mr Wood comments:

**“On a scale of prescriptive to permissive arrangements, the pendulum has locked itself too close to a belief that we should say how things should be done as opposed to what outcomes we want for children and young people. Taken together, the recommendations I have made propose fundamental reform to the way we do things.”**

This summary outlines and explores the findings and suggestions from the Wood report.

## The case for fundamental change

According to the report, the case for fundamental reform is based on a widely held view that LSCBs are not sufficiently effective. Limitations of LSCBs in delivering their key objectives are exposed in this review and by the work of Ofsted. Confidence must be restored in the strategic multi-agency arrangements made to protect children, that they are fit for purpose, consistently reliable and able to ensure children are being protected effectively.

## Roles and expectations

The report found that there was a lack of clarity with regards to the role and expectations of an LSCB, and often the effectiveness of an LSCB is due to the ability of the chair. A dissonance among the partners between the accountability and the authority of an LSCB was also identified. Such issues have previously been identified, namely by Lord Laming, who proposed the need for a new model to ensure collective accountability.

**“It is clear that the duty to cooperate has not been sufficient in ensuring the coherent and unified voice necessary to ensure multi-agency arrangements are consistently effective,”** wrote the report.

## Modelling effective partnership

According to the Wood Report, national government departments do not do enough to model effective partnership working between themselves for local agencies. In addition to this, the coordination demanded of local partners is not particularly evident at national level. As it stands, the cost of arrangements to key agencies such as the police, health authorities and local government is not sustainable, with too much of practice leaders' time taken up in servicing the architecture of multi-agency arrangements. Examples in the report, given by the police and crime commissioners, show that the wide variety of boards, committees and other bodies established to consider similar issues as LSCBs, compounds a growing demand on officers to attend meetings and produce reports. The report recommends that at a time of growing pressure on available resources, effort and money should be concentrated on front line service delivery and not diverted to bureaucracy and meetings.

## The proposed multi-agency arrangements

To carry out reform, the existing arrangements for LSCBs must be replaced with a new, more effective statutory framework that sets out the strategic multi-agency arrangements for child protection.

Key findings:

- The duty to cooperate is not a sufficient vehicle to bring about effective collaboration between key agencies of health, the police and local government
- These agencies should determine, for an identified area, multi-agency arrangements for protecting



and safeguarding children

- They should draw up a plan that describes how their services will deliver the new statutory framework
- New arrangements should require health, local authorities and the police to make clear their leadership responsibility for multi-agency arrangements, to include the identification of a chief officer in each of the agencies to have responsibility and authority for ensuring full collaboration with those statutory arrangements
- All areas should be required to move towards new multi-agency arrangements for protecting children within a prescribed period

According to the report, a more effective and defined statutory framework focused on protecting children allows for much more flexibility in terms of how arrangements are made. The report states:

**“We should be asking for outcomes for children and young people to be improved, not how they are organised. We are seeing innovation and flexibility in the way partnership working between the police, health and local government is responding to the needs of older people.**

We should seek that for children and young people too. We should look at incentivising all applicants for devolution deals to include arrangements for safeguarding children as part of their combined authority arrangements, but that is only a start.”

In order to do this, the report outlines two things that must be done:

- **Introduce a more effective statutory framework to focus the arrangements on child protection and ensure key agencies collaborate to deliver more effective services**
- **Move away from an over prescriptive system to one that encourages and authorises local areas to determine how they organise themselves to improve outcomes for children and meet the requirements of the new framework**

Should these two things be achieved, the impact they will have is to allow practice leaders the space to be more innovative in organising services to better protect children and to drive closer, more effective collaboration between key agencies.

## **Serious Case Reviews**

Currently, the UK does not have a national framework for considering the lessons of the tragic events that take a child's life or seriously harm them. Although there is guidance to the contrary, the model of serious case reviews has not been able to overcome the suspicion that its main purpose is to find someone to blame. Despite this, there has been some improvement in the quality of a selection of reviews, but the overall picture is not good enough, claims the report, and the lessons to be learned tend to be **“predictable, banal and repetitive”**.

The Wood report recommends that the government discontinues Serious Case Reviews, and establishes an independent body to oversee a new national framework for inquiries into child deaths and cases where children have experienced serious harm. The framework should be predicated on:

- High quality, published, local learning inquiries
- The collection and dissemination of local lessons
- The capacity to commission and carry out national serious case inquiries
- A requirement to report to the Secretary of State on issues for government derived from local and national inquiries

The report states that both local and national inquiries will be most effective if there is a skilled cohort of accredited reviewers. The new body should also be charged with setting out and consulting on a process of accreditation and on-going development for national reviews.

What factors characterise a good inquiry should also be considered by the new national body. According to the report, the body should consult with those who are most experienced in understanding and delivering models of review and draw up a good guidance framework.



In combination, the report believes these ideas will bring about a national resource of learning built on the foundations of effective local learning and skilled reviewers.

## **Child Death Overview Panels**

Although the report acknowledges how compassionate local CDOPs are about the work they do and the learning they identify, the report also states that child deaths must be reviewed over a population size that gives a sufficient number of deaths to be analysed for patterns, themes and trends of death.

The report encourages regionalisation as they provide a source of data and intelligence which, when analysed, leads to the identification of key issues relating to deaths.

A priority for implementation has to be the introduction of a national database which would assist the collection of local information and a national analysis of child deaths to inform regional CDOPs.

It is recommended that a new Healthcare Safety Investigation Branch (HSIB) sets a common, national standard for high quality serious incident investigations. In its first year of operation, the HSIB will prioritise maternity and is proposed to develop a standardised perinatal mortality review tool.

The way in which CDOPs consider child deaths is likely to be implicated by both of these developments. Research from the report revealed that over 80 per cent of child deaths have medical or public health causation. Clinicians estimate that only four per cent of child deaths relate to safeguarding or require a SCR to be carried out.

The report also states that ownership of the arrangements for supporting CDOPs should move from the Department for Education to the Department of Health.

## **Moving forward**

Recommendations in the report pave the way for a fundamental reform of the system for protecting and safeguarding children. The framework hopes to:

- Make sure contributions made by the health service; police and local government are better coordinated and deployed
- Clarify and outline the responsibilities of a lead chief officer in health, the police and local government in ensuring effective multi-agency arrangements
- Promote innovation and deliver efficiency in the design of local arrangements to safeguard children and young people
- Establish a National Learning Framework overseen by a new independent body
- Create a more effective model of learning from the deaths of children

It is hoped that a results-driven statutory framework will release resources to focus on the front line of practitioners engaging with children, young people and their families.

Outcomes of this will be measured in the development of more highly skilled practice leaders and practitioners using their professional skills and judgement in casework.

**The report concludes: “If we want to achieve a safer system to protect children, we must create the environment in which better skilled practitioners can practise and get on with the work of protecting children.”**

## **What’s happening now?**

Currently there have been no changes made or muted to the future role and function of the LSCB and CDOP but they will come.

There have been no firm decisions as to how the LSCB’s will look if they exist at all, I’ll update as we progress. As we establish our relationships we will look to influence any decision making to ensure we are key partners in any new structure.

**Jill Foster, Chief Nurse  
November 2016**

<b>Report to the Trust Board of Directors: 30 November 2016</b>	<b>Paper No: 11.1</b>
<b>Title</b>	<b>How HDFT ensures nurse and care staffing capacity and capability across the in-patient wards</b>
<b>Sponsoring Director</b>	Jill Foster, Chief Nurse
<b>Author(s)</b>	Jill Foster, Chief Nurse Alison Mayfield, Deputy Chief Nurse
<b>Report Purpose</b>	To assure the Board of Directors how nurse and care staffing capacity and capability across the in-patient wards is planned, delivered and monitored to ensure we have the “right staff with the right skills, in the right place at the right time” (National Quality Board 2016)
<b>Key Issues for Board Focus:</b>	
<p>The paper provides assurance on the quality monitoring systems in use for safe nurse and care staffing levels and identifies risks and challenges.</p> <p>The Board of Directors is asked to note how safe nurse staffing levels are planned, delivered and monitored and approve the recommendations of the report.</p> <p>The contents of this report reflect the focus on quality and safety standards with regard to nurse staffing levels which are integral to the Trust’s regulatory framework.</p>	
<b>Related Trust Objectives</b>	
To deliver high quality care	Yes – the right levels of staff with the right skills are key to delivering high quality care.
To work with partners to deliver integrated care	No
To ensure clinical and financial sustainability	Yes – to ensure the right levels of staff for the future
<b>Risk and Assurance</b>	Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF# 1: risk of a lack of medical, nursing and clinical staff.
<b>Legal/regulatory implications</b>	The report does not highlight any legal/regulatory implications for the period.
<b>Action Required by the Board of Directors</b>	
To note how safe nurse staffing levels are planned, delivered and monitored and approve the recommendations of the report.	

## Context

The impact of nursing, midwifery and care staffing capability and capacity on the quality of care experienced by patients and patient outcomes has been well documented in several high profile reports notably, Francis (2013), Keogh (2013), Berwick (2013).

## Introduction

Adult in-patient ward staffing levels have remained a key feature of the service developments at Harrogate and District NHS Foundation Trust (HDFT) with additional investment in 2016.

To date in England there are no mandated minimum nurse staffing levels for acute adult in-patient wards. NICE guidance states that there is no single staff to patient ratio that can be applied across all acute wards however suggests that Trusts take into account that there is “evidence of increased risk of harm associated with a registered nurse caring for more than 8 patients during the day shifts” (NICE 2014). It does indicate that the 1:8 ratios exclude the nurse in charge.

NICE also makes recommendations about determining ward establishments and “on-the-day assessments” of nursing staff requirements and individual patient care needs with the emphasis being on “safe patient care”. The importance of professional judgement linked with accredited decision support tools to assess dependency and acuity and the review of “safe nursing indicators” and “nursing red flag” events is stressed by NICE.

This has further being emphasised in October 2015 in a letter sent jointly by the TDA, Monitor, CQC and NICE to all NHS FT titled “Safe staffing and efficiency” which emphasises the importance of “a rounded view of staffing”, and looking “at staffing in a flexible way which is focused on the quality of care, patient safety and efficiency rather than just numbers and ratios of staff”. The letter stresses that a 1:8 ratio is “a guide not a requirement”.

## Background

Nurse staffing reviews at HDFT have all featured strong engagement of professional leaders including ward sisters, charge nurses and matrons. Nurse staffing tools (acuity tools) have been used to support decision making regarding required staffing levels and NICE (October 2014) has endorsed the Safer Nursing Care Tool (SNCT) which we use at HDFT in conjunction with professional judgement, patient feedback, patient safety incidents and key quality indicators.

This paper aims to provide an updated position status regarding the results of a recent dependency study using the Safer Nursing Care Tool. (SNCT - see Appendix 2).

## Guiding principles for adult in patient ward nurse staffing establishments at HDFT

- Professional judgement, Registered Nurse to patient ratios, skill mix, key performance indicators and the use of evidence based tools will be used guide decision making with regard to nurse staffing levels at HDFT.
- Ward sisters/charge nurses have 3 supervisory days factored into establishments on the adult in patient wards (with the exception of Harlow suite)
- All wards have 1.00 wte band 7 Sister/Charge Nurse and several wards have 2.00wte band 6 Sister/Charge Nurses, with a third rotational band 5 to 6 initiative in operation in some areas.
- Each ward has a ward clerk.
- Most wards have a nutritional assistant
- Headroom uplift to establishments per ward which includes annual leave 14.96%, Study leave 1.92%, Sickness 3.9%. Total 20.78%.

## The general ward establishments do not include:

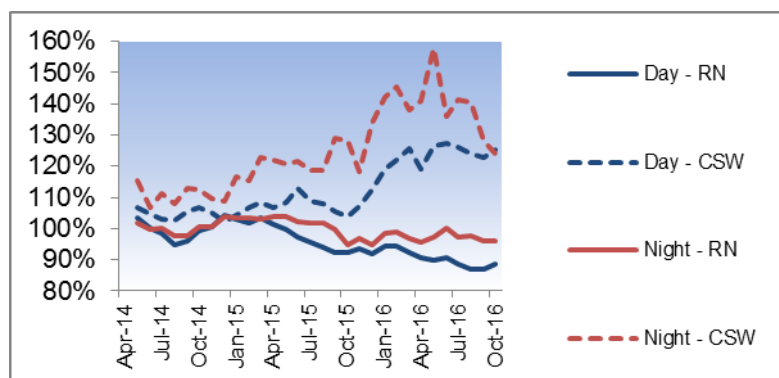
- Further 1 to 1 care requirements (in addition to recent investment)
- Winter pressures
- Maternity leave cover for staff (which is currently accommodated through a central resource which enables backfill)

## Hard Truths, 2014

In March 2014 NHS England and the Care Quality Commission issued joint guidance to Trusts on the delivery of the “Hard Truths” commitments associated with publishing staffing data regarding nursing, midwifery and care staff levels and this guidance follows on from the National Quality Board (NQB) guidance issued in (Nov 2013)

HDFT has been publishing registered and unregistered nursing fill rates actual versus planned since June 2014. In addition the daily actual versus planned staffing numbers are displayed in the inpatient ward areas. The table below shows the registered nurse and care support worker actual versus planned data since May 2014

**Table 1: Safer staffing data taken from HDFT Integrated Board Report October 2016**



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 break down of this data is published on the Trust website. The Trust aims for 100% staffing overall but staffing below or above this level on any given day is not necessarily indicative of an inappropriate or unsafe staffing level.

## Care Hours Per Patient Day (CHPPD)

From May 2016 all acute Trusts with inpatient wards/units began reporting monthly CHPPD data to NHS Improvement. This was a recommendation of the Lord Carter Review (2016) and Trusts are required to submit information on the total number of patients that were on each ward throughout the month – this is then used to calculate the new “Care Hours per Patient Day (CHPPD)” metric.

Our overall CHPPD from May-October 2016 have ranged from **7.81 to 8.52** CHPPD. NHS England will be publishing this data for every Trust but we don’t know yet how our data will compare to that of other Trusts

## Nursing dependency/Acuity studies

“The Safer Nursing Care Tool (SNCT) was originally developed in conjunction with the Association of UK University Hospitals (AUKUH), when it was known as the “AUKUH Patient Care Portfolio”. It has been widely used across the NHS, private sector and in some overseas hospitals. The Shelford Group commissioned a review of the tool and it has recently been relaunched as the Safer Nursing Care Tool (SNCT)” NQB 2013. NICE have recently endorsed this tool to be used alongside the NICE guidelines on safe staffing.

The tool comprises two parts: An acuity and dependency tool which can be used alongside nurse sensitive indicators which have been identified as quality indicators of care with specific sensitivity to nursing intervention or lack of intervention.

The SNCT is an evidence based tool that enables nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity/dependency terms.

The multiplier allows 22% uplift for annual leave/ study leave etc. At HDFT the multipliers have been adjusted slightly to accommodate for the 20.78% uplift which is inbuilt into the ward establishments. To date five acuity studies using the SNCT have been undertaken, the latest study being September/October 2016, the results of the last 4 studies are detailed in appendix 2. A further study is scheduled for January 2017.

The SNCT acuity studies have been undertaken across the general adult in patient wards with the exception of ITU/HDU.

Each study runs for 20 continuous days and each day a patients level of care is determined based on their care needs for the last 24 hours.

**Table 2: SNCT levels of care**

Level 0	Patient requires hospitalisation. Needs met by provision of normal wards cares
Level 1a	Acutely ill patients requiring intervention or those who are unstable with a greater potential to deteriorate
Level 1b	Patients who are in a stable condition but are dependent on nursing care to meet most or all of the activities of daily living.
Level 2	May be managed within clearly identified, designated beds, resources with the required expertise and staffing level or may require transfer to a dedicated Level 2 facility/unit.
Level 3	Patients needing advanced respiratory support and/or therapeutic support of multiple organs.

### September/October 2016 dependency study results

The table attached as Appendix 2 gives the results of the last four studies undertaken and the latest study gives detail regarding the current wte establishment for each ward (to note nutritional assistant posts and discharge coordinators are not included in the total ward nursing establishment figures), the average recommended establishment based on the results of the study and ward activity data. Data on the average number of empty beds per day has been added to reflect bed occupancy for the period of the study.

Based on the data “average of all days”(see appendix 2) taken from the latest dependency study it is suggestive that CATT, Farndale, Trinity and Wensleydale wards may require further nursing investment. The average does not specify grade of nurse required and this is open to local determination based on professional judgement and skill mix requirements. It is recommended that the dependency studies are undertaken at different times of the year to identify seasonal trends and support workforce planning. This study should be viewed in conjunction with professional judgement and nurse sensitive indicators. Further studies are planned for January and May 2017.

Further points to note with regard to the dependency/acuity study September/October 2016

- Jervaulx and Byland did not complete a full 20 days of individual data collection due to the joining of the wards over this period. This incomplete data makes it difficult to draw any conclusions from the data presented for these two areas.
- Harlow suite was closed during this period therefore there is no data.

- Specific acute assessment multipliers from the SNCT have been used for CATT ward in this study.
- Lascelles used this tool for the first time in September /October 2016.

### **Recommendations (November 2016)**

Ensure professional judgement exercised locally continues to be key determinant of safe staffing levels and continue to use this combined with RN: Patient ratios, skill mix, “Red flag events” (NICE 2014) dependency scoring and intelligence form Key Performance Indicators to determine the number of nurses required.

- Continue proactive nursing recruitment.
- Nursing sickness should be managed in line with HDFT sickness policy.
- The level of supervisory time for ward sisters/charge nurses should be kept under review.
- The Trust should continue to use the NICE endorsed SNCT and undertake a further study in January 2017 across the adult in patient wards.
- Further consideration to undertaking daily dependency scoring
- Continue to monitor key nurse sensitive indicators through the monthly quality and safety dashboard.
- Continue to display actual versus planned staffing levels in the ward areas and publish by ward data on the Trust website.
- Manage nursing agency staffing costs through use of approved frameworks.

## Appendix 1 – Changes in budget Adult Ward Establishments 07/08-16/17

Changes in budgeted Adult Ward Establishments - 07/08 to 16/17

WARD	Original wte total 07/08	Develop ments Aug 2008 & internal skill mix reviews	Develop ments Apr 2010 (wte)	Recon figuration commence d Aug 2012 (wte)	Develop ment of Stroke services Dec 2012 (wte)	April 2013 investment / infra structure funded	2013 & 2014 develop ments	Long day and Study leave adj	2015 develop ments	2016 Develop ments	Revised wte total	Overall increase from Aug '08 to Oct '15 (wte)
<b>Harlow</b>												
Registered	8.7			2.4			0.9	-0.5			11.5	2.8
Unregistered	4.0	0.1		-2.0			1.4	-0.1			3.5	-0.5
<b>Total</b>	<b>12.7</b>	<b>0.1</b>	<b>0.0</b>	<b>0.4</b>	<b>0.0</b>	<b>0.0</b>	<b>2.4</b>	<b>-0.6</b>	<b>0.0</b>	<b>0.0</b>	<b>15.0</b>	<b>18%</b> <b>2.3</b>
<b>Farndale</b>												
Registered	16.3	0.2		0.0			-0.4	-1.2			14.9	-1.4
Unregistered	13.2	4.1		-0.3		-0.4	0.8	-1.0			16.3	3.2
<b>Total</b>	<b>29.4</b>	<b>4.3</b>	<b>0.0</b>	<b>-0.3</b>	<b>0.0</b>	<b>-0.4</b>	<b>0.4</b>	<b>-2.2</b>	<b>0.0</b>	<b>0.0</b>	<b>31.2</b>	<b>6%</b> <b>1.8</b>
<b>Wensleydale (prev Swale)</b>												
Registered	12.2	-1.9		5.8		3.6		-2.0			17.7	5.6
Unregistered	4.9	1.9		2.7		3.2	0.0	-0.2			12.5	7.6
<b>Total</b>	<b>17.1</b>	<b>0.0</b>	<b>0.0</b>	<b>8.5</b>	<b>0.0</b>	<b>6.8</b>	<b>0.0</b>	<b>-2.2</b>	<b>0.0</b>	<b>0.0</b>	<b>30.3</b>	<b>77%</b> <b>13.2</b>
<b>Nidderdale</b>												
Registered	19.9	0.1		1.1				-1.8	1.0		20.3	0.5
Unregistered	8.3	2.1		0.6		1.8		-1.3	1.8	1.8	14.9	6.6
<b>Total</b>	<b>28.1</b>	<b>2.2</b>	<b>0.0</b>	<b>1.7</b>	<b>0.0</b>	<b>1.8</b>	<b>0.0</b>	<b>-3.1</b>	<b>2.8</b>	<b>1.8</b>	<b>35.2</b>	<b>25%</b> <b>7.1</b>
<b>Littondale</b>												
Registered	22.5	-0.6		0.0				-1.6			20.3	-2.2
Unregistered	10.0	0.4		1.5		0.4		-0.6			11.7	1.7
<b>Total</b>	<b>32.5</b>	<b>-0.2</b>	<b>0.0</b>	<b>1.5</b>	<b>0.0</b>	<b>0.4</b>	<b>0.0</b>	<b>-2.2</b>	<b>0.0</b>	<b>0.0</b>	<b>32.0</b>	<b>-2%</b> <b>-0.5</b>
<b>AMU</b>												
Registered	16.4	1.9		0.0			1.8	0.3	6.1		26.4	10.0
Unregistered	8.4	2.3		0.0		4.8	0.0	-1.6	-1.0		12.9	4.5
<b>Total</b>	<b>24.8</b>	<b>4.2</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>4.8</b>	<b>1.8</b>	<b>-1.3</b>	<b>5.1</b>	<b>0.0</b>	<b>39.3</b>	<b>59%</b> <b>14.5</b>
<b>Jervaulx</b>												
Registered	18.0	-1.9		1.7			6.0	-1.7			22.1	4.1
Unregistered	11.5	1.9		1.6			0.1	-1.1	0.4		14.3	2.8
<b>Total</b>	<b>29.5</b>	<b>0.1</b>	<b>0.0</b>	<b>3.3</b>	<b>0.0</b>	<b>0.0</b>	<b>6.1</b>	<b>-2.9</b>	<b>0.4</b>	<b>0.0</b>	<b>36.4</b>	<b>23%</b> <b>6.9</b>
<b>Byland</b>												
Registered	18.4	-1.8	1.8	-0.5		6.0	0.0	-1.7			22.1	3.7
Unregistered	10.6	2.6		1.8			0.1	-1.5			13.5	2.9
<b>Total</b>	<b>29.0</b>	<b>0.7</b>	<b>1.8</b>	<b>1.3</b>	<b>0.0</b>	<b>6.0</b>	<b>0.1</b>	<b>-3.3</b>	<b>0.0</b>	<b>0.0</b>	<b>35.6</b>	<b>23%</b> <b>6.6</b>
<b>Oakdale</b>												
Registered	21.0	1.9		5.8	1.8		-0.3	-2.7			27.4	6.5
Unregistered	12.1	-0.1		0.2	2.2		0.2		0.8		15.3	3.2
<b>Total</b>	<b>33.1</b>	<b>1.8</b>	<b>0.0</b>	<b>6.0</b>	<b>4.0</b>	<b>0.0</b>	<b>-0.2</b>	<b>-2.7</b>	<b>0.8</b>	<b>0.0</b>	<b>42.8</b>	<b>29%</b> <b>9.7</b>
<b>Lascelles</b>												
Registered	13.6	0.7		0.0		-0.2	0.1	-0.3	0.2		14.0	0.4
Unregistered	6.5	2.6		0.0			0.2	-0.4			8.9	2.4
<b>Total</b>	<b>20.1</b>	<b>3.3</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>-0.2</b>	<b>0.3</b>	<b>-0.7</b>	<b>0.2</b>	<b>0.0</b>	<b>22.9</b>	<b>14%</b> <b>2.8</b>
<b>CATT</b>												
Registered	24.2	2.1		0.0		4.4	0.0	-2.0	-4.8		23.8	-0.4
Unregistered	8.1	1.6		0.0		2.5	0.0	-0.6	1.2		12.9	4.7
<b>Total</b>	<b>32.4</b>	<b>3.6</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>6.9</b>	<b>0.0</b>	<b>-2.6</b>	<b>-3.6</b>	<b>0.0</b>	<b>36.7</b>	<b>13%</b> <b>4.3</b>
<b>Granby</b>												
Registered	15.7	0.3		-16.0		12.4	1.8	-0.4			13.9	-1.8
Unregistered	11.6	0.5	3.4	-15.5		10.4	0.0	-0.5			9.9	-1.7
<b>Total</b>	<b>27.3</b>	<b>0.8</b>	<b>3.4</b>	<b>-31.5</b>	<b>0.0</b>	<b>22.8</b>	<b>1.8</b>	<b>-0.9</b>	<b>0.0</b>	<b>0.0</b>	<b>23.8</b>	<b>-13%</b> <b>-3.5</b>
<b>Trinity</b>												
Registered	10.1					3.4		-1.0			12.5	2.4
Unregistered	11.4					-4.8			0.5	0.1	7.2	-4.2
<b>Total</b>	<b>21.5</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>-1.4</b>	<b>0.0</b>	<b>-1.0</b>	<b>0.5</b>	<b>0.1</b>	<b>19.7</b>	<b>-8%</b> <b>-1.8</b>
<b>Grand Total</b>												
Registered	216.9	1.1	1.8	0.3	1.8	29.6	9.8	-16.7	2.5	0.0	247.1	14%
Unregistered	120.6	19.8	3.4	-9.5	2.2	17.9	2.8	-9.0	3.6	1.9	153.9	28%
<b>Combined</b>	<b>337.6</b>	<b>20.8</b>	<b>5.2</b>	<b>-9.2</b>	<b>4.0</b>	<b>47.5</b>	<b>12.6</b>	<b>-25.6</b>	<b>6.1</b>	<b>1.9</b>	<b>401.0</b>	<b>19%</b> <b>65.2</b>
<b>Number of beds (incl Trinity)</b>	<b>321</b>										<b>313</b>	<b>-2%</b> <b>-8</b>

### Comments

Includes nutritional assistants.

Includes ward manager clinical and management time

The changes in April 2010 to Granby and Byland were agreed and funded through service development via the annual planning process

The Sept 2013 developments include the provision of 3 qualified staff on an early shift on Granby, which is being funded centrally.

Regarding Trinity, the 07/08 wte numbers are assumed to be the same level as those that transferred to the Trust in 11/12.



## Appendix 2 – Summary of safer nursing care tool data

### Summary of safer nursing care tool data - Sep/Oct 2016

Staffing levels indicated by tool					Average daily totals reported:											
Ward	Ward ** Establishments	Average of all days	Maximum daily requirement	Minimum daily requirement	Empty Beds	Acute Admissions	Elective Admissions	Discharges	Transfers In	Transfers Out	Ward attenders	Deaths	Escorts on Site	Escorts off Site	Number Patients requiring 1-1 care	Patient Outliers
CATT	35.7	39.68	51.11	24.99	8.29	16.81	0.00	8.67	0.81	5.52	0.52	0.14	0.15	0.00	0.15	0.00
CATT Escalation	Ward not open during Sept/Oct 16															
Byland*	35	37.50	0.00	33.74	10.90	0.00	0.00	1.57	0.76	0.00	0.00	0.14	0.11	0.00	1.44	0.00
Farndale	29.2	31.54	36.52	25.90	3.24	1.10	0.48	2.05	0.71	0.43	0.14	0.00	0.00	0.00	1.37	1.71
AMU	39.3	37.41	44.79	31.83	4.00	1.86	0.10	4.95	3.24	1.14	0.05	0.00	0.05	0.00	0.25	0.71
Granby	22.8	19.32	22.88	18.38	1.67	0.05	0.00	1.81	1.14	0.00	1.95	0.24	0.25	0.00	0.90	0.00
Granby Escalation	Ward not open during Sept/Oct 16															
Harlow	15 Ward closed during period of study															
Jervaulx*	35	32.62	35.65	29.36	17.76	0.05	0.00	1.24	0.62	0.10	0.00	0.19	0.25	0.00	0.42	0.14
Littondale	31	30.24	33.35	23.38	7.81	4.00	0.43	7.57	3.38	1.57	0.62	0.05	0.00	0.00	1.26	1.67
Nidderdale	34.2	26.51	32.62	19.35	7.14	4.05	0.86	7.67	1.14	2.48	3.33	0.10	0.00	0.00	0.19	1.29
Oakdale	41.8	35.06	39.14	29.88	4.43	0.48	0.05	1.76	0.71	0.14	0.00	0.33	0.00	0.00	1.10	0.00
Swaledale	Ward not open during Sept/Oct 16															
Trinity	19.7	23.27	24.60	20.69	0.71	0.10	0.00	0.38	0.00	0.00	0.00	0.05	0.00	0.00	0.10	0.24
Wensleydale	29.3	30.85	35.02	25.24	3.00	0.90	2.29	4.67	1.52	1.76	0.00	0.00	0.00	0.00	2.88	0.00
Lascelles	22.9	17.18	19.91	14.54	3.05	0.10	0.00	0.19	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00

\*Byland & Jervaulx did not have complete data due to the joining of the wards over this period

\*\*Nutritional assistants, discharge coordinators and ward clerks are not included in the establishment numbers

### Summary of safer nursing care tool data - Jul/Aug 2015

Staffing levels indicated by tool					Average daily totals reported:											
Ward	Ward Establishments	Average of all days	Maximum daily requirement	Minimum daily requirement	Empty Beds	Acute Admissions	Elective Admissions	Discharges	Transfers In	Transfers Out	Ward attenders	Deaths	Escorts on Site	Escorts off Site	Number Patients requiring 1-1 care	Patient Outliers
Bolton	[40.34]	38.38	43.37	33.17	0.71	0.24	0.06	3.82	4.18	1.47	0.00	0.18	0.06	0.06	0.06	0.29
Bolton Escalation	ward not open during Jul/Aug 15															
Byland	35.6	35.17	46.01	29.07	0.56	0.11	0.00	1.61	0.50	0.11	0.00	0.22	0.00	0.11	2.44	0.00
Farndale	31.24	26.40	34.59	15.93	4.00	2.30	0.20	2.90	0.40	0.10	0.00	0.00	0.05	0.00	0.00	3.65
Fountains	[36.7]	33.28	40.99	19.66	3.83	19.22	0.00	9.06	1.00	7.22	0.33	0.39	3.61	0.06	0.22	0.00
Granby	23.79	19.09	20.68	17.31	0.27	0.09	0.00	1.00	1.09	0.18	3.18	0.09	0.00	0.00	0.00	0.00
Granby Escalation		4.02	4.71	3.33	2.50	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.00	0.00	0.00	0.00
Harlow	14.96	6.75	9.78	3.91	3.10	0.52	0.90	3.00	1.57	0.19	0.19	0.05	0.00	0.00	0.00	0.00
Jervaulx	36.4	45.95	51.07	38.62	0.90	0.14	0.00	1.67	0.71	0.14	0.00	0.24	0.00	0.00	4.00	0.00
Littondale	32.01	26.90	35.97	15.06	7.95	3.30	0.85	5.90	2.40	2.35	1.25	0.05	0.00	0.00	0.20	2.30
Nidderdale	33.48	28.38	31.17	24.44	2.45	3.35	0.85	5.85	2.15	1.55	3.20	0.10	0.00	0.00	0.15	2.15
Oakdale	42.75	38.45	42.79	34.29	2.38	0.38	0.00	1.76	1.19	0.48	0.00	0.33	0.00	0.05	0.67	0.00
Swaledale	ward not open during Jul/Aug 15															
Trinity	19.64	25.59	27.45	22.35	0.10	0.24	0.05	0.57	0.05	0.05	0.00	0.05	0.00	0.00	0.71	0.00
Wensleydale	30.24	17.55	25.88	11.73	10.90	0.76	2.86	4.81	1.00	0.33	0.05	0.00	0.00	0.00	0.38	0.00



### Summary of safer nursing care tool data - Jan/Feb 2015

		Staffing levels indicated by tool			Average daily totals reported:											
Ward		Average of all days	Maximum daily requirement	Minimum daily requirement	Empty Beds	Acute Admissions	Elective Admissions	Discharges	Transfers In	Transfers Out	Ward attenders	Deaths	Escorts on Site	Escorts off Site	Number Patients requiring 1-1 care	Patient Outliers
Bolton		38.87	45.87	24.92	2.88	1.19	0.00	5.13	6.31	3.19	0.00	0.31	0.56	0.00	1.63	0.00
Bolton Escalation		7.27	9.25	5.67	0.40	0.10	0.00	1.00	1.90	1.40	0.00	0.00	0.10	0.00	0.00	0.00
Byland		38.97	46.67	29.13	1.13	0.06	0.00	1.44	1.00	0.25	0.00	0.19	0.13	0.00	1.44	0.06
Farndale		35.99	39.19	29.73	1.05	1.38	0.05	1.10	0.14	0.33	0.00	0.14	0.05	0.00	2.48	1.81
Fountains		35.83	44.30	23.32	3.52	19.05	0.00	7.95	0.71	9.86	0.43	0.33	1.81	0.86	0.52	0.00
Granby		22.27	23.84	20.15	0.40	0.20	0.05	2.00	1.35	0.35	2.30	0.05	0.00	0.00	0.95	0.00
Granby Escalation		3.59	5.93	0.00	2.37	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.00	0.00	0.00	0.00
Harlow		8.68	11.10	6.92	1.60	1.00	0.80	2.40	0.70	0.30	0.20	0.00	0.00	0.00	0.05	0.00
Jervaulx		42.69	46.99	31.68	0.90	0.10	0.00	2.10	1.70	0.15	0.00	0.40	0.60	0.00	2.35	0.00
Littondale		35.21	42.72	26.93	2.44	3.33	0.39	5.00	2.50	2.67	0.83	0.11	0.00	0.00	0.00	3.72
Nidderdale		35.94	42.03	28.37	4.82	3.06	0.82	7.06	2.94	1.41	3.06	0.12	0.00	0.31	0.56	5.94
Oakdale		39.62	42.27	35.66	1.80	0.30	0.05	1.40	1.20	0.50	0.00	0.20	0.10	0.10	0.25	0.05
Swaledale		15.96	21.39	5.93	2.24	0.00	0.00	0.00	3.24	0.88	0.00	0.00	0.18	0.00	0.00	4.65
Trinity		no data submitted yet (20/02/15)														
Wensleydale		30.42	45.45	21.70	3.62	1.43	2.86	5.57	2.05	1.19	0.00	0.14	0.00	0.00	0.00	2.90

### Summary of safer nursing care tool data - Sep/Oct 2014

Staffing levels indicated by tool				Average daily totals reported:											
Ward	Average of all days	Maximum daily requirement	Minimum daily requirement	Empty Beds	Acute Admissions	Elective Admissions	Discharges	Transfers In	Transfers Out	Ward attenders	Deaths	Escorts on Site	Escorts off Site	Number Patients requiring 1-1 care	Patient Outliers
Bolton	35.59	44.26	26.75	2.76	0.38	0.00	4.81	5.90	2.38	0.00	0.10	2.24	0.00	0.43	0.00
Bolton Escalation	0.65	5.92	0.00	5.43	0.00	0.00	0.24	0.57	0.33	0.00	0.00	0.00	0.00	0.00	0.00
Byland	41.10	44.16	37.23	1.25	0.20	0.00	1.70	1.50	0.30	0.00	0.40	0.65	0.00	0.25	0.00
Farndale	27.42	32.22	21.09	3.48	2.95	0.10	3.14	0.33	0.38	0.05	0.00	0.24	0.00	0.76	2.24
Fountains	41.15	52.50	21.16	3.94	18.00	0.06	7.22	0.72	10.89	0.11	0.28	11.83	0.00	0.11	0.00
Granby	19.01	21.40	13.79	0.90	0.10	0.10	1.86	1.48	0.38	2.67	0.05	0.05	0.00	0.24	0.05
Harlow	8.93	11.50	6.92	1.81	0.48	0.95	2.19	1.24	0.43	0.00	0.00	0.00	0.00	0.00	0.00
Jervaulx	44.17	47.31	39.75	0.81	0.14	0.00	1.48	1.38	0.48	0.00	0.10	0.10	0.00	4.43	0.00
Littondale	29.79	35.16	22.57	8.00	3.38	0.48	6.33	2.90	2.81	0.71	0.19	0.00	0.00	0.05	2.48
Nidderdale	29.99	33.77	21.52	3.25	3.55	1.00	6.35	2.00	2.20	3.50	0.15	0.00	0.10	1.10	6.05
Oakdale	35.62	40.08	26.55	4.19	1.29	0.00	2.67	2.33	1.14	0.00	0.24	0.00	0.00	0.00	0.00
Trinity	22.90	25.77	18.17	2.38	0.14	0.00	0.57	0.38	0.14	0.00	0.05	0.00	0.00	0.00	0.00
Wensleydale	18.67	25.51	5.93	9.86	0.76	3.29	5.57	1.67	0.76	0.19	0.00	0.00	0.00	0.00	0.19

<b>Report to the Trust Board of Directors: 30 November 2016</b>	<b>Paper No: 12.0</b>
<b>Title</b>	<b>Medical Director's Report</b>
<b>Sponsoring Director</b>	Dr D Scullion, Medical Director
<b>Author(s)</b>	Dr D Scullion, Medical Director
<b>Report Purpose</b>	To receive an update on clinical issues
<b>Key Issues for Board Focus:</b>	
<p>The Board of Directors are asked to:</p> <ul style="list-style-type: none"> <li>- Note that the HSMR and SHMI remain within expected range.</li> <li>- Note the recommendation that the Board receive detail of the Patient Safety Alert from NHS Improvement on Nasogastric tube placement.</li> <li>- Acknowledge the proposed reform relating to NHS Litigation Authority system.</li> <li>- Note the national rise across the NHS in complaints.</li> </ul>	
<b>Related Trust Objectives</b>	
To deliver high quality care	Yes – the report provides an update on clinical issues which may impact on the delivery of high quality care
To work with partners to deliver integrated care	Yes – the report provides assurance that the Trust continues to work with partners and colleagues at a national and local level, in preparation for forthcoming changes to guidance of a clinical nature.
To ensure clinical and financial sustainability	Yes – the report provides assurance that the Trust continues to deliver clinically sustainable services.
<b>Risk and Assurance</b>	Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF 1: risk of a lack of medical, nursing and clinical staff; BAF 13: risk of insufficient focus on quality.
<b>Legal/regulatory implications</b>	The report does not highlight any legal/regulatory implications for the period.
<b>Action Required by the Board of Directors</b>	
The Board of Directors are asked to receive and note the content of the report.	

## Report by the Medical Director - November 2016

### 1 Mortality

The latest Hospital Standardised Mortality Ratio (HSMR) has decreased to 100.43 and the Summary Hospital-level Mortality Indicator (SHMI) has fallen to below expected levels at 93.03. We have received a Cumulative Sum of Outcomes alert (CUSUM) with regard to pneumonia (CUSUM score 3.7). I will be discussing this alert with the Mortality Review Group when we meet on 24 November to discuss the National Mortality Case Record Review process so far.

I presented our early experience of this project at the Science of Improvement Conference in Harrogate on 21 November in Harrogate. It is clear that there is still some lack of clarity and great variance in practice around how case note reviews are undertaken across acute NHS Trusts. The sharing of ideas and concerns was of great benefit. I also participated in the national roll out of the project on the same evening. Harrogate remains a pilot site and further structured reviews locally are planned. The national programme for case note review of in-hospital deaths of patients with Learning Difficulties also went live on November 1st. I am liaising with Ben Haywood, Acute Liaison Nurse/Learning Disabilities Lead locally to ensure all relevant cases are captured (numbers will be small). The fundamental objective remains zero avoidable deaths.

### 2 Ensuring safe placement of nasogastric (NG) feeding tubes

NHS Improvement published a Patient Safety Alert on 22 July 2016 entitled: Nasogastric tube misplacement: continuing risk of death and severe harm. The recommendation is that this alert is shared at Board level. Incidents of harm are still being reported across the NHS as a result of lack of recognition of misplaced feeding tubes, leading to serious harm or death.

By 21 April 2017, all organisations where nasogastric or orogastric tubes are used for NHS patients are required to:

- Use the resources provided with the alert to undertake a centrally co-ordinated assessment of whether the organisation has robust systems for supporting staff to deliver safety-critical requirements for initial nasogastric or orogastric tube placement checks.
- Use the resources to develop and implement an action plan to ensure all safety-critical requirements are met.
- Share the assessment and agree any related action plan within commissioner assurance meetings.
- Share the key findings of the assessment and the main actions that have been taken in a public board paper.

An assessment has been undertaken and shared with the Improving Patient Safety Steering Group. This identified:

1. The Trust's "Policy for adults requiring enteral nutrition via a nasogastric tube and/or unable to swallow" is currently 50 pages long. This needs to be shorter, and to strengthen some requirements and make the key information clear.
2. A framework of evidence training and competence in confirming placement of NG tubes is required. This relates to pH testing (nursing staff), and x-ray testing (doctors). Work is progressing in relation to establishing a competency framework, and to implement a process to ensure trained radiologists confirm placement of NG tubes.

3. Guidance and policies relating to incident investigation should be strengthened to ensure formal sources of guidance, such as Patient Safety Alerts or NICE guidance are used to set the standard on “what should have happened” as part of every investigation.
4. We have implemented processes to involve the Medical Devices Safety Officer, nursing and Infection Prevention and Control as standing members of the Product Choices Group with other clinicians/practitioners invited as required to ensure procurement decisions always include clinical advice on patient safety considerations. We need to be confident that all stocks not conforming to recommendations are reliably removed following withdrawal on safety grounds.
5. The last NG tube audit was undertaken in 2013, with re-audit on the audit plan but delayed. Another audit needs to be prioritised and include staff feedback. This will inform the policy and care pathway review, and ensure the care pathway is clear and helpful to staff.
6. The NG tube care pathway needs to be amended to reflect changes to policy and to ensure it helps staff take and record all necessary checks.
7. A high profile re-launch of the revised policy and care pathway will be required.
8. The Trust needs to consider assurance that “actions required” that are implemented from Patient Safety Alerts are taken and monitored on a regular basis. Relevant actions should be highlighted for inclusion in the annual audit programme.

The self-assessment tool is in the reading room. From this, an action plan is being formulated.

### **3. NHS Litigation Authority Update**

Following an earlier consultation process, the NHSLA is embarking on a programme of reform to the current system. One of them will be early and enhanced support for Trusts where a high value and life-long claim (i.e. obstetric injury) is anticipated. Details of this support are to follow and it is planned to go live in April 2017. The consultation process was overwhelmingly supportive of NHSLA activity to learn from serious incidents and claims. There is an indication that future pricing approach will centre on evidence of safety improvement initiatives rather than past performance. The consultation has also signalled a move away from the “one size fits all” approach and a more tailored bespoke approach to the particular needs of individual member organisations that may face differing risks and challenges.

The Secretary of State has also recently announced an intention to consult on a new maternity “Rapid Resolution and Redress” scheme to develop a new approach to early compensation of birth injuries. This serves the dual advantage from early legal resolution and learning. Further information on the outcome of this consultation will follow.

The Trust has recently received notification of its NHSLA contribution for 2017/18. The cost to the Trust has increased over and above the national average.

### **4. Getting it Right First Time (GIRFT)**

The national roll-out into non-Orthopaedic specialties is now ongoing. Our Urology service recently met with the national GIRFT lead for urology. I will be meeting with our clinical lead to discuss the outcomes from this meeting and any potential local service recommendations. Further meetings are planned in ENT. This will take place in York as this is part of the clinical alliances service provision.

Any local repercussions will be fed back as they are made known. Further specialty meetings are promised though not yet diarised.

## **5. Complaints/Incidents Update**

Latest information suggests a 10-15% rise in complaints against acute Trusts across the NHS. Locally we seem to be bucking this trend. Importantly, in Q1/2 of 2016/17, a total of 11 complaints were received by the Parliamentary Health Service Ombudsman (PHSO) from this Trust. Two of these were accepted for investigation. One complaint was discontinued or resolved without a finding and a second investigated but not upheld.

The Trust remains around the 50<sup>th</sup> centile for reporting of incidents. Whilst there remains room for improvement, we have a relatively low ratio of low to moderate harm incidents. There are a number of potential reasons for this, though one recently put forward relates to the complexity of the Datix reporting process. This is currently being addressed through recruitment of specialist Datix expertise into the Risk Management Team.

## **6. Consultant Appointments**

I am pleased to announce the appointment of Mr Isa Edhem, Consultant Urologist with a specialist interest in Andrology. Mr Edhem joins us from Rotherham having set up a similar and highly regarded service locally. His skills will be a welcome addition to the current Urology team. The appointment for a Consultant Paediatrician with a specialist interest in neuro-disability is due to take place on 1 December. The applicant field looks strong.

Dr David Scullion, Medical Director  
24 November 2016

<b>Report to the Trust Board of Directors: 30 November 2016</b>	<b>Paper No: 13.0</b>
<b>Title</b>	<b>Workforce and Organisational Development Update</b>
<b>Sponsoring Director</b>	Mr Phillip Marshall, Director of Workforce and Organisational Development
<b>Author(s)</b>	Mr Phillip Marshall, Director of Workforce and Organisational Development
<b>Report Purpose</b>	To provide a summary of performance against key workforce matters
<b>Key Issues for Board Focus:</b>	
<p>The Board are asked to note:</p> <ol style="list-style-type: none"> <li>1. <b>Apprenticeship Strategy</b> – approval of the Business Case for a 12-month programme</li> <li>2. <b>Health Education England (Yorkshire and Humber) (HEE) visit</b> - 4 October 2016 – final report awaited but Core trainees in medicine remain subject to enhanced monitoring by HEE and the GMC until 31 December 2016</li> <li>3. <b>Appraisals</b> – improved position although not yet at target completion rate</li> <li>4. <b>NHS Improvement Agency Self-certification Checklist</b> – for discussion and approval</li> </ol>	
<b>Related Trust Objectives</b>	
To deliver high quality care	Yes – Through the pro-active management and development of the workforce, including recruitment, retention and staff engagement.
To work with partners to deliver integrated care	Yes – Working with external organisations, including NYCC, Health Education England and NHS Employers, to provide a qualified and professional workforce fit to deliver services.
To ensure clinical and financial sustainability	Yes – By seeking to recruit and retain our workforce to full establishment and minimise the use of agency staff.
<b>Risk and Assurance</b>	Any identified risks are included in the Directorate and Corporate Risk Registers and the Board Assurance Framework.
<b>Legal/regulatory implications</b>	Health Education England and the Local Education and Training Board have access to the Trust's workforce data via the Electronic Staff Records system. Providing access to this data for these organisations is a mandatory requirement for the Trust.
<b>Action Required by the Board of Directors</b>	
<p>The Board is invited to <b>approve</b> the draft Agency Self-Certification Checklist.</p> <p>The Board is invited to note and comment on the update on matters specific to Workforce, Training and Education, Service Improvement and Innovation and Organisational Development.</p>	

### **a) Workforce Race Equality Standard (WRES)**

We have recently completed the 2016 round of monitoring for the Workforce Race Equality Standard and the report and action plan will soon be published on the Trust website. Last year, following the first ever round of the WRES, the Trust launched a new workforce equality group comprising of volunteers from a variety of roles across the Trust. The purpose of the group is to take forward equality initiatives and to consider the findings of the WRES report and other sources of information about potential workforce equality and diversity issues. The WRES survey results were shared with the Senior Management Team (SMT) at the October meeting, where it was agreed that they could be published on the Trust Intranet, along with an action plan. The latter has now been completed and is attached at Annex, for information.

### **b) Apprenticeship Strategy**

The Trust Apprenticeship Strategy Business Case has been developed and was approved at the SMT meeting on 23 November. It supports the introduction of a Clinical Healthcare Support Worker Apprenticeship programme across hospital-based services, in the first instance. There are both economic and social benefits to the programme, which will run for 12 months from May 2017, and it reflects the Government priority to increase the number of apprentices in the work force, as outlined in 2020 Vision for English Apprenticeships which recommends statutory targets of 2.3% for public sector bodies (including the NHS) with a workforce of 250 or more in England. The NHS is committed to delivering over 17,000 apprenticeships during 2015/16 and reaching more than 100,000 in 2020. In addition, regionally, Health Education England Yorkshire and Humber has encouraged Trusts to increase apprenticeship numbers with a drive to double the number of apprenticeships year on year.

### **c) Sickness Absence**

Trustwide sickness absence figures showed a decrease during September 2016 to 3.90% from August's 3.99% figure. Overall, this represents a downward trend and the absence level does remain below the corresponding period from last year. We continue to have concerns in relation to the accuracy and timeliness of absence reporting; however, it is worthy of note that there appear to have been no amendments within the Children's and County Wide Community Care Directorate during September.

Three of the four Directorates have shown decreases in sickness absence, with the most significant decrease being within Planned & Surgical Care, where high levels of absence have been observed previously in the theatre areas and Harlow suite. The exception is in Long Term and Unscheduled Care.

Stress, anxiety and depression-related absence continue to cause the loss of the most working days through sickness absence across the Trust. Levels of absence for these reasons have increased both proportionately and in terms of Whole Time Equivalent days lost. The most common cause of episodes of sickness absence in September was gastrointestinal issues. Current training courses - Mental Health First Aid and Mentally Healthy Workplace - are being well attended although there has been a lack of uptake in community-based courses. The first of the Schwartz Rounds is also scheduled for November, further underlining the Trust's commitment to addressing the effects of stress and anxiety on staff.

"Other known causes" remain the second highest quoted reason for absence despite a decrease in the use of this classification, but worryingly there has been an increase in "unknown causes" being used as a classification category. Work has been undertaken with

specific managers of large staff groups to highlight the need for accurate classification of absence, and a wider message is being distributed to all senior managers.

There has been an overall decrease in the number of staff reported as being on long-term sickness absence. This has been in part due to conclusion of some cases through Ill Health Retirement routes and also through the successful return of staff to the workplace. The month of October has seen an increase in staff reaching the Stage 3 Final Review level due to short-term sickness absence, with a number of meetings being scheduled throughout November.

#### **d) Freedom to Speak Up Guardian**

The appointment of a National Guardian for speaking up freely and safely, and Freedom to Speak Up (FTSU) guardians in NHS Trusts, were recommended by Sir Robert Francis, following his review of, and subsequent report into, the failings in Mid-Staffordshire. FTSU guardians have a key role in helping to raise the profile of raising concerns in their organisation and provide confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concern has been handled. Guardians do not become involved in investigations or complaints, but help to facilitate the process for raising concerns where needed, and ensuring organisational policies are followed correctly.

Dr Henrietta Hughes has been appointed as the National Guardian, and the Trust has nominated Dr Sylvia Wood to act as our FTSU Guardian. Dr Wood attended a conference hosted recently by the FTSU Office which outlined the national support available for the local FTSU Guardians. The Trust Whistleblowing policy has been revised in accordance with the outline of the national template; it outlines the role for the FTSU and the avenues and routes available to staff who wish to raise concerns and how they can do that. It also defines the undertaking that the Trust gives in ensuring that all concerns are dealt with in an appropriate manner. The revised policy is due for ratification by the Policy Advisory Group at its next meeting on 24 November.

#### **e) Health Education England (Yorkshire and Humber) (HEE) visit - 4 Oct 2016**

The initial draft visit report has been reviewed by the Director of Medical Education (DME) for factual accuracy and the Trust has responded to HEE. The Trust now awaits the final draft report, which will be shared with SMT at its December meeting, as planned.

The Planned and Surgical Care Directorate is currently working on solutions to ensure that the Trust meets the immediate condition issued on the day regarding availability of on-site senior support for surgical Foundation Year doctors. A surgical middle grade locum has been employed in the interim to provide this support until a sustainable solution has been agreed with the surgical teams.

Due to none of the Elderly Medicine and Gastroenterology trainees being in post at the point of the visit in October, the HEE team returned on Wednesday 23 November to meet with one higher trainee (ST3+) and their respective trainers.

Following the visit in January 2016, The Trust was placed in enhanced monitoring with the GMC with regard to insufficient Clinic attendance for Core Medical Trainees. At the recent visit in October, HEE advised it was content that the Trust had met the condition with the evidence provided, and would close the condition. Subsequent feedback from the GMC was that it wishes to impose a further monitoring period to ensure the arrangements are truly embedded for Core Medical Trainees and that the attendance has been sustained.



#### **f) Doctors in Training – new contract update**

There have been two national developments over the new contract. The chair of the BMA Junior Doctors' Committee, Dr Ellen McCourt, resigned on 3 November and the BMA Council confirmed subsequently that it was calling off all proposed industrial action and intended to work with the Department of Health and employers to ensure that the implementation of the new Terms and Conditions was as effective as possible and protected the interests of both doctors in training and patients.

Within the Trust the FY1 doctors in training who are due to start working under the 2016 Terms and Conditions have been served formally with one month's notice for their current contracts, which expire on 6 December. The Payroll team is continuing to work up the 'cash floor' pay figure for individual doctors, which will guarantee that they are paid in accordance with the new Terms and Conditions.

The Postgraduate Medical Education team is taking forward arrangements for the first meeting of the statutory Doctors in Training Forum, the membership of which is specified as including the Guardian of Safe Working, the Director of Medical Education, the Chairman of the Local Negotiating Committee (LNC), the representative of doctors in training on the LNC, doctors in training elected from amongst their number and representatives of the Workforce and Organisational Development team. The meeting is currently planned for 28 November.

#### **g) Appraisals**

The Operational Directors have met with the Director and Deputy Director of Workforce and Organisational Development, along with the relevant HR Business Partner for the Directorate, to discuss the action plans in place and further support that can be given to achieve the 90% compliance rate by December 2016. There have been discussions regarding the approach of team appraisals, which are being trialled within the Planned and Surgical Care Directorate, and are already in place within the Corporate Directorate. Should any manager wish to explore this approach then HR Business Partners remain happy to provide advice and support. Managers are issued a monthly report and if there are any changes regarding starters, leavers or long-term absences that are not being reflected in these reports the Workforce Information team are happy to advise and support.

Appraisal rates are improving and departments are undertaking action plans to achieve compliance of 90% by December 2016. Since July 2016 to October 2016 the following improvements have been made:

- Children's and County Wide – July 54.83% October 69.57% with 27% of departments having 90% or more compliance
- Corporate Directorate – July 60.41 % October was 86.33% with 74% of departments having 90% or more compliance
- Long Term and Unscheduled Care – July 63.76% October was 69.35% with 32% of departments have 90% or more compliance
- Planned and Surgical Care – July 61.26% October was 65.10% with 26% of departments having 90% or more compliance

These figures show an improvement in the rate of appraisal across the Trust to a level of **76.64%** overall. This excludes our TUPE transferred Children's Services staff from County Durham, Darlington and Middlesbrough. The TUPE staff standalone appraisal rate is currently at **75.58%**.

## h) Job Planning

The latest job planning figures for Consultants and Specialty Doctor and Associate Specialist grades as at 31 October 2016 are shown in the table below. Overall progress in completed Job Plans month on month is shown as a RAG rating. A number of those Job Plans shown as out of date or not recorded have been completed in early November.

NOVEMBER 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	%	In progress	Notes	RAG
C & CWCC	9	9	100.00%	0	0.00%	0	0.00%	0	One on maternity leave	
LT & UC	55	45	81.82%	6	10.91%	4	7.27%	0		
P & SC	67	49	73.13%	10	5.00%	8	11.94%	0	One on maternity leave	
<b>Total</b>	<b>131</b>	<b>103</b>	<b>78.63%</b>	<b>16</b>	<b>12.21%</b>	<b>12</b>	<b>9.16%</b>	<b>0</b>		

NOVEMBER 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	%	In progress	Notes	RAG
C & CWCC	6	6	100.00%	0	0.00%	0	0.00%	0		
LT & UC	11	1	9.09%	3	27.27%	7	63.64%	0		
P & SC	37	10	35.30%	3	8.11%	24	64.86%	0		
<b>Total</b>	<b>54</b>	<b>17</b>	<b>31.48%</b>	<b>6</b>	<b>11.11%</b>	<b>31</b>	<b>57.41%</b>	<b>0</b>		

Change from previous month (in-date JPs)		Improved		No change		Worse				
NB Substantive new starters now included as compliant for first six months as per current Job Planning policies										

The Job Planning Working Group met on 8 November and refined the proposed review of Category A and B on-call payments to doctors. The short survey which Clinical Leads would be invited to complete will be more precise about the information it was seeking. It would also be made clear that the survey was in pursuit of good governance rather than seeking to make significant changes to categories of payment to individual specialities. The revised Job Planning Policy would be circulated before the next meeting, with the intention of including it in papers for the LNC on 1 December. Progress was also being made in defining datasets to support the job planning process. There was also considerable discussion and emphasis around job planning for SAS doctors and the Directorates were reminded of their obligations to this important staff group.

## j) Flu

Please see the updated figures below for the flu vaccination uptake of clinical staff as at 31 October 2016.

Staff Group	Number of HCWs	Number Vaccinated	% Vaccinated
All Doctors	320	131	40.9%
Registered Nurses	1,287	369	28.7%
Qualified Support Staff	471	89	18.9%
Unqualified Support Staff	789	210	26.6%
<b>TOTAL</b>	<b>2,867</b>	<b>799</b>	<b>27.9%</b>

Please note the figures exclude bank staff, GP OOH and those on long term absence as at 1 October (for example long term sick, career break, and maternity leave).

As at this point in time in previous years, the uptake has been **43.3%** in 2014/15 and **40.3%** in 2015/16.

The figures for staff in the acute Trust only ie excluding community staff (as at 22 November) were as follows:

	<b>TOTAL STAFF</b>	<b>VACCINATED</b>	<b>% UPTAKE</b>
Doctors	290	130	44.8%
Non Clinical	734	327	44.6%
Qual Nurses	680	300	44.1%
Qual Other	331	155	46.8%
Unqual Support	548	262	47.8%
<b>TOTAL</b>	<b>2,583</b>	<b>1,174</b>	<b>45.5%</b>

Health and Wellbeing (including achieving flu vaccination uptake of 75% for frontline staff) was a national CQUIN for 2016-17 but HaRD CCG applied local variation to the CQUIN scheme. As a result it was not applicable to HDFT and resource for the vaccination programme was not prioritised as it might have been. However, it is not clear why there is a lower rate of uptake at this stage of the programme compared with previous years. In each of 2017-18 and 2018-19 there will be a national CQUIN which requires the Trust to achieve flu vaccination levels for frontline staff of 70% (2017-18) and 75% (2018-19), with a sum of approximately £100,000 in the contract value each year, dependent on the Trust achieving these levels of uptake. A Business Case is being prepared to support the investment required in the flu vaccination programme in each of 2017-18 and 2018-19.

#### **k) Local Workforce Action Board**

The West Yorkshire and Harrogate Sustainability Transformation Board has established a Local Workforce Action Board which has now defined four main workstreams as follows:

- Primary, community care and public health
- Registered workforce initiatives
- Non-registered workforce initiatives
- Workforce flexibility and enablers

Work is now underway to build on the workforce content of the October 2016 STP submission to NHS England by developing programme outlines which cover the requirement for a clearly described vision for the programme, the risks and issues, potential challenges and solutions and the key projects within the programme. For each of the latter, work will be needed to develop the project definition, the deliverables and core outputs and realistic timescales in which they will be achieved. It is intended to table the initial versions of these programme plans at the next meeting of the LWAB on 20 December.

#### **l) Community Staff Survey**

The aim of the survey of community staff was to understand their preferences for how we communicate and ask about any improvements that could be made. There were technical difficulties in sending out the survey via a link to *Survey Monkey* which meant that only approximately half of the community staff received the survey direct to their e-

mail. The link was shared in Trust Bulletins, however, so all community staff had access to the survey in one way or another. The overall response rate was 8.4% of community staff. Around 66% of respondents were positive about feeling part of the Trust as a whole and there was a balanced positive and negative view of whether they felt the Trust listens to them. Encouragingly there was a strongly positive response that staff know how to feedback opinions and questions. The overall preferences for giving and receiving information were via line manager and in team meetings.

When asked to comment on what the Trust can do to make sure that their opinions and questions are being heard, the three main responses from community staff were:

- To provide feedback on what they raise
- To show that the Trust is listening
- To be more visible

Consideration of the results of the survey is continuing and actions will be put in place to address these staff priorities. The possibility of repeating the survey is also being considered now that the IT issues have been resolved. Whilst a low return rate is noted the feedback remains valid and requires focussed attention.

#### **m) Supporting Transition Programme**

The Trust has secured £15,000 of funding for a Supporting Transition Programme which is designed to provide Leadership and Management training for Clinical Leads. It is provided by the Inspiring Leaders Network which has three key principles in developing leaders – they should become perceptive, proactive and protective. The programme consists of six linked modules and will be clinically-led by Dr Natalie Lyth, Clinical Director of the Children's and County Wide Community Care. Up to fifteen Clinical Leads will be involved and the one day modules will run at one per month over a six month period.

#### **n) Global Health Exchange Initiative**

A small team of visitors from the Apollo Group and HEE, which are running the Indian element of the Global Health Exchange initiative, visited the Trust on 22 November. This was a reciprocal visit and included Trust presentations by the Chief Executive, Chief Nurse and the Director of Workforce and Organisational Development to a large and diverse audience of Trust staff, as well as tours of the hospital. The Chief Executive of the Apollo Group visited the Trust separately on 23 November and toured the hospital. Meanwhile interviews have taken place for the first cohort of nurses under the Initiative and subsequently work is underway with HEE to move towards making conditional offers of employment to a number of candidates.

#### **o) Agency Self-certification Checklist**

NHS Improvement is continuing to scrutinise spending on agency staff and issued a checklist for completion by Trusts. The self-certification is designed for Trusts to show that there are robust processes in place, with appropriate oversight and senior and executive level approval. The response is due to be forwarded to NHS Improvement by close of play on 30 November and Board **approval** is sought for the draft at Appendix to this report.

**Phillip Marshall**

**Director of Workforce and Organisational Development**

November 2016

Annex: Workforce Race Equality Standard Action Plan

Appendix: Draft Agency Self-certification Checklist

Self-certification checklist Please discuss this in your board meeting		Yes - please specify steps taken	No. We will put this in place - please list actions
<b>Governance and accountability</b>			
1	Our Trust's Chief Executive has a strong grip on agency spending and the support of the agency executive lead, the nursing director, medical director, finance director and HR director in reducing agency spending.	Chief Executive sighted on all aspects of agency spending, supported by robust Board-level escalation approval procedure in place. Director of Workforce and Organisational Development (Executive Director) has been assigned as the executive lead to control agency spend. Information regarding agency spending is provided to the Board of Directors, Senior Management Team (SMT) and Directorate Boards. Agency spending is a regular topic of focus at weekly Operational Delivery Group (ODG) and monthly SMT and Board meetings.	Establish Strategic group (Director of Finance, Chief Nurse, Medical Director, Director of WOOD) to meet monthly and consider overall approach to all temporary staffing issues
2	Reducing nursing agency spending is formally included as an objective for the nursing director and reducing medical agency spending is formally included as an objective for the medical director.	The principle has been agreed with relevant postholders at an executive development session, subject to inclusion in personal objectives.	Objectives to be included in revised annual objectives for Chief Nurse and Medical Director, at next available review
3	The agency executive lead, the medical director and nursing director meet at least monthly to discuss harmonising workforce management and agency procurement processes to reduce agency spending.	The executive lead and the directors referenced all attend the Board of Directors where regular discussion takes place concerning workforce management and agency procurement processes.	Establishment of Strategic group (see 1) will strengthen oversight and provide opportunity for further development of controls to reduce agency spending
4	We are not engaging in any workarounds to the agency rules.	The Trust does not engage in workarounds. Staff at all levels understand that it is explicit that breaches must be avoided if at all possible. Only where there is clear potential for a threat to patient safety is escalation process invoked.	
<b>High quality timely data</b>			
5	We know what our biggest challenges are and receive regular (eg monthly) data on: - which divisions/service lines spend most on agency staff or engage with the most agency staff - who our highest cost and longest serving agency individuals are - what the biggest causes of agency spend are (eg vacancy, sickness) and how this differs across service lines.	The Trust employs a neutral vendor model of locum procurement via Comensura. This provides us with access to detailed management information. The Trust contracts NHS Professionals (NHSP) for the provision of temporary/agency nursing staff. Detailed management information is available, and closely scrutinised, on a weekly basis.	The Trust will continue to refine management information requirements
<b>Clear process for approving agency use</b>			
6	The trust has a centralised agency staff booking team for booking all agency staff. Individual service lines and administrators are not booking agency staff.	The Trust operates a robust devolved booking model for locums with authorised booking managers within Directorates, rather than individual services, able to make bookings. NHSP bookings in hours are devolved to Directorate level. Out of hours this is delegated to the centralised Site Co-ordinator	The Trust will audit the booking model as part of an internal audit programme
7	There is a standard agency staff request process that is well understood by all staff. This process requires requestors and approvers to certify that they have considered all alternatives to using agency staff.	There is a well understood agency staff request process, which operates effectively.	Bookers are not currently required to document and certify that they have considered all other alternatives. Process to be put in place to ensure audit trail for certification available.
8	There is a clearly defined approvals process with only senior staff approving agency staff requests. The nursing and medical directors personally approve the most expensive clinical shifts.	There is a clearly defined process for rate escalation although the approval of requests does vary between staff group and directorate. Typically this process requires authorisation to be sought from senior staff ie Matron for nursing, General Manager or Operational Director for locum medical staff. For rates above wage and/or rate cap personal approval by Chief Operating Officer or Chief Nurse is required. They may refer to the Chief Executive, either prospectively or retrospectively, in situations where the proposed rate per hour exceeds £120.	Whilst there is a process in place, action will be taken to ensure that it is more consistent across the Directorates and thus more 'clearly defined'.
<b>Actions to reducing demand for agency staffing</b>			
9	There are tough plans in place for tackling unacceptable spending; eg exceptional over-reliance on agency staffing services radiology, very high spending on on-call staff.	Where agency expenditure is high this is carefully considered and corrective action agreed where possible. Agency rates are negotiated on an individual basis if necessary to ensure they are below rate caps where possible. Only once every other avenue has been explored are they accepted. Difficult areas remain, eg ED and theatre staff, where staff may not be available at any rate or, if available, will not work for rates at or below the rate/wage caps, which therefore presents the Trust with safety considerations for both patients and staff	The Trust will continue to identify particular staffing 'hot spots' and, if possible, take appropriate action to reduce the use of agency staff
10	There is a functional staff bank for all clinical staff and endeavour to promote bank working and bank fill through weekly payment, auto-enrolment, simplifying bank shift alerts and request process.	NHSP provides a nursing bank service for the Trust. There is a local bank of contracted medical staff which is always used as the first option	The Trust does not currently operate a facility for weekly payment. West Yorkshire and Harrogate STP has agreed to establish an internal bank as a priority and move to establish a collaborative bank to service the STP footprint.
11	All service lines do rostering at least 6 weeks in advance on a rolling basis for all staff. The majority of service lines and staff groups are supported by eRostering.	There is a comprehensive e-rostering system in place, and utilised, for in-patient nursing staff, which publishes rosters four weeks in advance. The timeliness of rosters is monitored through the Integrated Board Report process at SMT and Trust Board	The Trust does not have e-rostering in place for doctors. Medical rosters are planned in advance with more than 6 weeks' notice. The Trust will take action to ensure that all rosters are published with at least 6 weeks' notice.
12	There is a clear process for filling vacancies with a time to recruit (from when post is needed to when it is filled) of less than 21 days.	The Trust has a clear process for filling vacancies when they arise. The established timeframes for the recruitment process technically allow for the full completion of employment checks within a 3 week period (where the process is followed fully by the recruiting manager and candidates and referees comply promptly with requests for information)	The practicality of this recommendation is particularly difficult for the AAC process for recruiting consultant medical staff
13	The Board and executives adequately support staff members in designing innovative solutions to workforce challenges, including redesigning roles to better sustain services and recruiting differently.	The Trust has agreed a Clinical Workforce Strategy and is participating in an Advanced Clinical Practitioner programme. Design of new posts and redesign of existing posts is both encouraged and supported.	The Trust frequently needs to adjust services and rosters when the allocation of doctors in training by HEE (Y&H) causes gaps, often at short notice, which can lead to sub-optimal solutions.
14	The Board takes an active involvement in workforce planning and is confident that planning is clinically led, conducted in teams and based on solid data on demand and commissioning intentions.	The Board has endorsed the Clinical Workforce Strategy and approves the Annual Plan.	The Trust Board continues to review opportunities for deeper involvement in workforce planning.
<b>Working with your local health economy</b>			
15	The Board and executives have a good understanding of which service lines are fragile and currently being sustained by agency staffing.	The ODG reviews staffing on service lines on a regular basis; SMT and the Trust Board review the expenditure on temporary staff monthly through the Integrated Board Report. Agency spend for the Trust is currently well below the NHSI ceiling figure	The Trust Board is aware of the danger of complacency and will continue to monitor the trends of agency spending as the year progresses, intervening where necessary.
16	The Trust has regular (eg monthly) executive-level conversations with neighbouring trusts to tackle agency spend together.	Regular conversations, both formal and informal, take place between the Trusts in the West Yorkshire Alliance of Acute Trusts (WYAAT) at both Chief Executive and Director of Workforce and Organisational Development level, with significant sharing of information around reducing agency spending across the West Yorkshire and Harrogate STP footprint.	More detailed discussions and planning to reduce agency spending and improve staffing levels will develop as the STP matures.

Signed by

[Date] 30 November 2016

Trust Chair: Mrs Sandra Dodson

[Signature]

Trust Chief Executive: Dr Ros Tolcher

[Signature]

Please submit signed and completed checklist to the agency inbox (NHSI.agencyrules@nhs.net) by 30 November 2016

## Annex 13.0 - DRAFT WRES action plan

Number	Indicator	Data for reporting year
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	BME representation in whole workforce = 7.55%
2	Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts.	Relative likelihood of White staff being appointed from shortlisting compared to BME staff: 1.11
3	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation* *Note: this indicator will be based on data from a two year rolling average of the current year and the previous year.	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff: 0.51
4	Relative likelihood of BME staff accessing non-mandatory training and CPD as compared to White staff	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff: 0.91
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White- 21.83 BME-17.39
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White-19.86% BME-27.27%

7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion	White- 92.05% BME- 100%
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White-5.26 BME- 9.09
9	Percentage difference between the organisations' Board voting membership and its overall workforce.	Percentage difference between BME Board and BME workforce: - 7.4%

## Narrative - the implications of the data and any additional background explanatory narrative

BME representation in whole workforce = 7.55%

BME over-represented in:

- Non-clinical B1
- Clinical B2, B5 + B8D

BME under-represented in:

- Non-clinical under B1 and B2+
- Clinical under B1, B1, B3, B4, B6+

White candidates are more likely to be appointed than BME candidates. This is a reversal from the last reporting period where BME staff were significantly more likely to be appointed. This significant shift will, in part, be explained by large overall effects from moderate changes to a small sample.

BME staff continue to be less likely to enter the formal disciplinary process than white staff

BME staff continue to be more likely to access non-mandatory training than white staff

BME staff report lower levels of bullying and harassment from patients than white staff, this is an improvement on last year's results.

BME staff report higher levels of bullying and harassment from staff than white staff, this is still, however, an improvement on last year's results. There is a 7.41% difference this year compared with 11.03% last year



100% of BME staff have reported believing the Trust provides equal opportunities for career progression, over the past two years
A higher proportion of BME staff report experiencing discrimination from a manager/colleagues than white staff - 3.83% difference
There is no BME Board representation

Actions required	Owner	Timescale
1. Promotion of career development, support and coaching. 2. Introduction of a senior sponsor for BME staff seeking progression in conjunction with Workforce Development and the Workforce Equality Group	all	June 2017 Board meeting
1. Review existing equality elements of the recruitment training	Workforce Equality Lead	June 2017 Board meeting
No action required at this time	N/A	N/A
No action required at this time	N/A	N/A
No action required at this time	N/A	N/A
1. Workforce Equality Group to investigate further with the workforce in a format the group consider to be appropriate and deliver to staff.	Workforce Equality lead and Workforce equality group	June 2017 Board meeting

No action required at this time	N/A	N/A
1. Workforce Equality Group to investigate further with the workforce in a format they consider to be appropriate and deliver. Note* reporting the nature of the of the reasons is is undefined i.e. may not necessarily be related to race.	Workforce Equality Group	N/A
*note for discussion at SMT and with the Board to consider greater active seeking of applications from BME groups. Feedback requested to consider for when there is a next recruitment process (likely to be new Chairman mid-2017).	Board	ongoing

## Board Committee report to the Board of Directors

<b>Committee Name:</b>	Quality Committee (QC)
<b>Committee Chair:</b>	LA Webster
<b>Date of last meeting:</b>	02/11/2016
<b>Date of Board meeting for which this report is prepared</b>	30/11/2016
<b>Summary of live issues and matters to be raised at Board meeting:</b>	
<ol style="list-style-type: none"> <li><b>Hot Topic</b> – The Committee heard that activity is underway to provide additional leadership support into our satellite units at Ripon and Selby</li> <li><b>Quarterly update received on Quality Priority – Improving Care of People with Learning Disabilities</b> – Good progress being made towards delivering the action plan associated with this priority.</li> <li><b>Quarter 2 NICE Compliance Report received</b> – As per the previous quarterly report; there are still a number of items where the Trust is non-compliant with guidance. The issue remains on the Risk Management and Clinical Effectiveness Risk Register rated as amber. The Directorates continue to focus on working to close the gaps where it is appropriate to do so.</li> <li><b>The role of the Non-Executive Director at the close out of a SIRC action plan</b> – Assurance was received that there is a robust process followed by the Complaints and Risk Management Group to ensure that all appropriate actions have been completed in respect of all SIRC action plan and audits before they can be closed. Such closure is currently communicated to the clinical lead involved, it was agreed that the same communication would be sent to the relevant NED to provide assurance. It was noted that the policy for dealing with SIRC's was under review and would be ratified by the QC in due course.</li> <li><b>Update on recent bed re-configuration-</b> The activity relating to the merging of 2 elderly care wards was described and assurance was received on the progress to support the work being carried out in the acute unit to support the new models of care in the community.</li> </ol>	
<b>Are there any significant risks for noting by Board? (list if appropriate)</b>	
<b>Pressure Sores in the Community</b> – the proposed reduction in numbers in the year of 20% may require a review as the initial base-line numbers are now being questioned. Further work is to be done to gain assurance in the numbers. This item will remain as a focus for the QC	
<b>Matters for decision</b>	
<b>None</b>	
<b>Action Required by Board of Directors:</b> To note and approve the updated Terms of Reference for the committee	

## Terms of Reference

### Quality Committee

#### 1. Accountable to Board of Directors

The Quality Committee is a committee of the Board of Directors. As such it will, on behalf of the board contribute to setting strategy as this relates to quality, safety and patient experience; oversee arrangements for quality governance and seek assurances on the delivery of high quality care and regulatory compliance.

#### 2. Purpose of the Committee

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

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

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

#### 3. Responsibilities

The key responsibilities of the committee are to:

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

- reviews relating to quality by DH arm's length bodies, regulators and professional bodies, inspections and peer reviews etc.
- Research and development, quality improvement and innovation, including rapid process improvement workshops and delivery of CQUIN.
- Receive key reports for example:
  - Infection prevention and control annual report;
  - Local Supervising Authority audit report;
  - Maternity screening report;
  - Health and Safety annual report;
  - Patient experience including complaints, concerns and compliments annual report;
  - Staff survey as it relates to the quality of care
  - CQC action plans and progress reports as applicable

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

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

## 4. Membership

The core membership comprises:

<b>Title</b> <i>List members by title and indicate Chair and Deputy Chair</i>	<b>Deputy</b> <i>Deputies are welcome to attend any meetings</i>
Lesley Webster (NED) – Chair	Non-Executive member of the Committee
Sue Proctor (NED)	N/A
Neil McLean (NED)	N/A
Chief Nurse	Deputy Chief Nurse
Deputy Medical Director – Clinical Audit	Medical Director
Chief Operating Officer	Deputy Director of Performance and Information
Director of Workforce and Organisational Development	Deputy Director of Workforce and Organisational Development/ Deputy Director of Partnerships and Innovation
Deputy Director of Governance	Company Secretary
Head of Risk Management	Clinical Effectiveness and NICE Manager / Risk and Complaints Manager
Clinical Director Children's and County Wide Community Care directorate	Operational Director Children's and County Wide Community Care directorate
Clinical Director Long Term and Unscheduled Care directorate	Deputy Clinical Director Long Term and Unscheduled Care directorate
Clinical Director Planned and Surgical Care directorate	Deputy Clinical Director Planned and Surgical Care directorate

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

The Chief Executive, as Accountable Officer for the Trust, will be invited to one meeting per year when discussing the final review of the Trust's Quality Account.

At least one member of the Audit Committee will also be a member of the Quality committee to ensure appropriate triangulation.

## **5. Quorum**

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

## **6. Administrative support**

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

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

## **7. Frequency of meetings**

The meeting will be timetabled to take place monthly.

## **Communication**

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

## **8. Reporting**

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

## **Review**

The terms of reference will be reviewed annually.

## **9. Date**

27 October 2016

# Harrogate and District

NHS Foundation Trust

## Council of Governors

Minutes of the public Council of Governors' meeting held on 3 August 2016 at 17:45 hrs  
at The Pavilions of Harrogate, Great Yorkshire Showground, Harrogate, HG2 8NZ

- Present:**
- Mrs Sandra Dodson, Chairman
  - Ms Pamela Allen, Public Governor/Deputy Chair of Council of Governors
  - Cllr. Bernard Bateman, Stakeholder Governor
  - Dr Sally Blackburn, Public Governor
  - Mrs Yvonne Campbell, Staff Governor
  - Mrs Angie Colvin, Corporate Affairs and Membership Manager
  - Ms Clare Cressey, Staff Governor
  - Mrs Liz Dean, Public Governor
  - Mr Tony Doveston, Public Governor
  - Mrs Emma Edgar, Staff Governor
  - Mrs Jill Foster, Chief Nurse
  - Mrs Joanne Harrison, Deputy Director of Workforce and Organisational Development
  - Ms Debbie Henderson, Company Secretary
  - Mrs Pat Jones, Public Governor
  - Mrs Sally Margerison, Staff Governor
  - Mr Jordan McKie, Deputy Director of Finance
  - Mr Neil McLean, Non-Executive Director
  - Mr Paul Nicholas, Deputy Director of Performance and Delivery
  - Mrs Joanna Parker, Stakeholder Governor
  - Mr Peter Pearson, Public Governor
  - Prof. Sue Proctor, Non-Executive Director
  - Mrs Joyce Purkis, Public Governor
  - Dr Daniel Scott, Staff Governor
  - Dr David Scullion, Medical Director
  - Mr Chris Thompson, Non-Executive Director
  - Dr Ros Tolcher, Chief Executive
  - Mr Ian Ward, Non-Executive Director
  - Mrs Lesley Webster, Non-Executive Director
  - Dr Jim Woods, Stakeholder Governor
- In attendance:**
- 2 members of the public
  - Mr Kallum Taylor, Volunteering and Engagement Officer, Healthwatch North Yorkshire
  - Mr Andy Smith, Director, KPMG



**1. Welcome to the public and setting context of the meeting, including apologies for absence and introductions**

Apologies were received from Mr Michael Armitage, Public Governor, Mrs Cath Clelland, Public Governor, Mr Jonathan Coulter, Director of Finance/Deputy Chief Executive, Dr Sarah Crawshaw, Stakeholder Governor, Mrs Beth Finch, Stakeholder Governor, Mr Robert Harrison, Chief Operating Officer, Mrs Jane Hedley, Public Governor, Mr Phillip Marshall, Director of Workforce and Organisational Development and Mrs Maureen Taylor, Non-Executive Director.

Mrs Hedley sent a message to thank fellow Governors for the flowers she had received following a recent operation. She also complimented staff on Wensleydale Ward for their superb care.

Mrs Dodson offered a warm welcome to the members of the public and was delighted to introduce Mr Taylor from Healthwatch North Yorkshire and Mr Smith from KPMG. Mrs Dodson was expecting late arrivals from Cllr Ivor Fox, newly nominated Stakeholder Governor for Harrogate Borough Council to replace Cllr John Ennis who had stepped down, and Mrs Zoe Metcalfe, Public Governor. She welcomed questions for item 9 on the agenda and asked for these to be submitted during the break.

**2. Minutes of the last meeting, 18 May 2016**

The minutes of the last meeting were agreed as a true and accurate record.

**3. Matters arising and review of actions schedule**

Mrs Dodson confirmed that the outstanding actions on the schedule at Paper 3.0 were ongoing.

**4. Declaration of interests**

Mrs Dodson confirmed that both she and Professor Proctor had a declaration of interest in item 11 on the agenda and would leave the meeting at that stage. Mr Ward, in his role as Senior Independent Director, would take over as Chair for this item with support from Ms Allen.

**4.1 Council of Governors' Declaration of Interests**

There were no declarations of interests from Governors.

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 was delighted that the Trust had received such a positive report from the Care Quality Commission (CQC) following their inspection in February. The Trust had received an overall 'Good' rating with 'Outstanding' in the 'Caring' domain; everyone was extremely proud. At the Quality Summit held on 29 July, the representative from the regulator NHS Improvement (formally known as Monitor), strongly endorsed the report saying the Trust was 'in touching distance' of an overall Outstanding result and one of the best Trusts in the country. Dr Tolcher would provide further detail in her presentation.

## **6. Annual Report and Accounts 2015/16 (including the External Audit Assurance Reports to the Council of Governors)**

Mr McKie provided a summary of the annual accounts 2015/16 confirming the Trust ended the year with a break-even position. Whilst this was behind the original plan to deliver a surplus of £1.8m, when compared to many other Trusts across the NHS, this had been a positive achievement. In particular, the planned £10.2 million efficiency programme had been delivered and Mr McKie thanked staff for their hard work and commitment to achieving this goal. He highlighted pressures in relation to agency staffing which had impacted on the financial plan. The Trust ended the year with a Monitor financial sustainability risk rating of 3 (Risk Assessment Framework rating ranges from 1, the most serious risk, to 4, the lowest risk).<sup>1</sup>

To end his presentation, Mr McKie summarised the Quality Priorities for 2015/16 and those for the coming year, 2016/17, as follows:

- to reduce morbidity and mortality related to sepsis;
- to improve the care of people with learning disabilities;
- to provide high quality stroke care – demonstrated by improvement in national indicators; and,
- to improve the management of inpatients on insulin.

Mrs Dodson welcomed Mr Smith from KPMG to present the annual external audit report to the Council of Governors. Mr Smith took this opportunity to provide a brief summary of KPMG's experience in providing audit services across the NHS; this included 60 Foundation Trusts.

The Annual External Audit Report 2015/16 had been circulated prior to the meeting. Mr Smith highlighted the following key messages from the report:

- Explanation of what they do – based on the Audit Code, which sets out the rules and regulations of their work, they provide an opinion on the Trust's accounts.

Mr Smith described the benefits of their work as 'adding a layer of credibility' to the Trust's financial statements. He explained the importance of an external eye on the accounts to provide assurance to Governors and the general public; similar to the CQC focussing on the quality of service.

- A description of the value for money – External Audit were required to issue a value for money conclusion taking into account the Trust having adequate

arrangements to secure economy, efficiency and effectiveness in its use of resources.

Mr Smith provided examples where the audit process had focussed on the Trust's arrangements, including the new Children's Services contracts, the new Department of Health agency cap, and compliance with national and local performance targets.

- Quality Report - KPMG provided a clean (limited assurance) opinion on the content of the Trust's Quality Report.

Mr Smith described how this opinion could be referenced to the supporting information and evidence they had looked at in detail. Three indicators audited included the following two mandated indicators:

- the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and,
- the percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.

The third local indicator, as selected by Governors, was emergency re-admissions within 28 days of discharge from hospital.

Mr Smith explained that the clean limited assurance opinion was the best opinion and as good as a Trust could get from an External Audit. He reassured Governors that many Trusts were not in fact receiving this opinion.

Mr Smith confirmed an unqualified audit opinion of the accounts; this included consideration over the content of the Annual Report (including the Remuneration Report) and review of the Annual Governance Statement. He highlighted the fact that there was no audit differences found which was extremely good and he acknowledged the work of the Trust's Finance Team and thanked them for their support.

Mrs Dodson asked the following question on behalf of Cllr Fox who was not in attendance:

"I note that the External Auditor, KPMG, have concluded that the Trust has adequate arrangements to secure economy, efficiency and effectiveness in its use of resources. In view of the increasing public and parliamentary demands and expectations in respect of audit and governance standards, what level of 'arrangements' above adequate do KPMG believe should be a target for 2016/17?"

Mr Smith explained that the Audit Code required the External Auditor to say whether the arrangements were either adequate or not; a binary opinion. He confirmed there was no higher opinion which could be provided under the Code. If an audit identified issues, this would always be reported and there would be discussions with the management team.

Mrs Dodson reiterated that the Trust would always be looking at ways to improve efficiency and effectiveness going forward.

Cllr Bateman, Stakeholder Governor for North Yorkshire County Council congratulated the Trust on this achievement.

Mrs Dodson thanked Cllr Bateman for his kind words and paid tribute to Mr Smith and his team along with the Trust's finance team.

Chair of the Trust's Audit Committee and Non-Executive Director, Mr Thompson echoed Mrs Dodson's comment that the achievement paid testament to the hard work of the finance team and he offered his congratulations.

There were no further questions and therefore Mrs Dodson thanked Mr Smith for his presentation and commented that both Governors and Board colleagues were reassured by the detailed and positive report.

## **7. Governor Sub-Committee Reports**

Mrs Dodson moved on to clarify the role of the two formal sub committees and the Patient and Public Involvement, Learning from Patient Experience Group. She said how important it was for the general public to hear about the work of these sub-committees and thanked Governors for their commitment and involvement.

### **7.1 Volunteering and Education**

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

In Mrs Hedley's absence, Mrs Edgar highlighted the Work Experience programme which was now being undertaken by the Corporate Team. She provided an update and confirmed the Trust had provided 117 placements over the last year: 33 of those were with Consultants, 71 clinical and ward based placements and 13 non-clinical placements. On behalf of the Council of Governors, Mrs Edgar thanked the team for their hard work.

There were no questions for Mrs Edgar.

Mrs Dodson reiterated how proud the Trust was to have such a positive interface with the educational establishment and how important it was to dedicate time and knowledge to our future workforce.

Mrs Harrison congratulated the team on their work and briefly mentioned that her team was currently undertaking work on the Clinical Workforce Strategy and Governors would be kept up to date with its progress.

### **7.2 Membership Development and Communications**

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

Ms Allen highlighted the new Youth Members' Forum detailed in her report and was pleased to say the Corporate Team would be supporting this new initiative. The Forum would target people aged between 13 and 19 years and bi-monthly meetings would be run by the youth for the youth, supported and guided by Trust staff and Governors. There would be a stand at the forthcoming Open Event to promote the new Forum and Governors would be kept up to date on developments.

Cllr Bateman offered his help and informed fellow Governors that North Yorkshire County Council and York City Council had their own Youth Councils which we could link up with.

There were no questions for Ms Allen.

### **7.3 Patient and Public Involvement**

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

Mrs Dean commented that the last meeting covered the core detail however there were a number of apologies due to holidays and therefore attendance was low. She referred to the Quality and Patient Experience Reports detailed in Paper 7.3 and highlighted the issues raised with the Directorate representatives at the meeting; hopefully these would be resolved for the meeting in September. In addition, Mrs Dean talked about nurse recruitment and reassured fellow Governors that the Trust was actively focussed on attracting new staff. Recruitment remained a challenge nationally and the Trust was looking further afield for potential recruits; the English language qualification to work in the UK was having a significant impact on available candidates from the European Union.

Mrs Foster provided reassurance that the meeting process issues Mrs Dean had highlighted in her paper would be resolved for the meeting in September. She was also pleased to inform the Council of Governors that Mr Marshall had visited India and was working with NHS England on a Global Exchange Programme for the recruitment of nursing staff.

Mr Taylor, Volunteering and Engagement Officer from Healthwatch North Yorkshire, asked if Government plans for tuition fees added to our concerns for nurse recruitment.

Mrs Harrison responded, confirming the Trust was concerned with the overall ongoing issue of nurse recruitment however we were looking into a local training programme with Leeds University.

Mrs Foster reiterated the Trust's concerns and commented that a high rate of students were not completing their degrees to go into nursing. Trusts offering funding were seeing evidence of improved staff retention and motivation

Mrs Dodson and Dr Tolcher endorsed the Trust's proactive approach to recruitment and focus on retaining a skilled workforce.

## 8. Chief Executive's Strategic and Operational Update including Integrated Board Report

Dr Tolcher presented the following headlines:

### Current Performance

Dr Tolcher referred to the Integrated Board Report which had been circulated prior to the meeting. She was pleased to report that the Trust continued to perform well delivering the Key Performance Indicators (KPI's) which were fundamental to local people including, the delivery of 18 weeks and all cancer waiting times standards and the improvement in the A&E 4-hour standard.

Dr Tolcher explained some of the detailed information which related to the red-rated areas in the report taken from the Quality, Finance and Efficiency and Operational Performance Indicators and described actions the Trust was taking to make improvements. Quality had three red rated KPI's including: falls causing harm, the number of Serious Incidents Requiring Investigation (SIRIs), and staff appraisal rates. The rate of inpatient falls had increased slightly but Dr Tolcher was pleased to report that falls sensors were now in place on Byland, Jervaulx and Farndale wards and there was a plan to roll these out to other ward areas. The Trust was working hard to reduce the number of SIRI's, focussing on falls and pressure ulcers. The appraisal rate stood at 69.5% however follow-up emails had been sent to areas of poor compliance requesting an action plan to achieve the 90% target.

Moving on to finance and efficiency with three red-rated KPI's in surplus/deficit variance, cash balance and cost improvement programme achievement, Dr Tolcher confirmed that the operational budgetary position was approximately £600,000 behind plan. She reminded Governors that the Trust would receive £4.6 million sustainability and transformation funding if the Trust delivered the £2.2 million financial plan and there would be a strong focus on this in order to invest in service development and improvement.

The Operational Performance summary demonstrated one red-rating KPI in recruitment to National Institute for Health Research (NIHR) adopted research studies. Dr Tolcher expressed the importance of research and was assured that the Trust would recover over the year.

### Care Quality Commission (CQC) Inspection Report

Dr Tolcher was proud to confirm the Trust had received an overall rating of 'Good' following the CQC's inspection in February. This included the following ratings:

- Are services at this trust safe? – Requires Improvement
- Are services at this trust effective? - Good
- Are services at this trust caring? - Outstanding
- Are services at this trust responsive? - Good
- Are services at this trust well-led? - Good

She described how each core service (Urgent and emergency services, Medical care, Surgery, Critical Care, Maternity and gynaecology, Services for children and young people, End of life care, and Outpatients and diagnostic imaging) was rated



using five key questions (Safe, Effective, Caring, Responsive, and Well-led) and rated accordingly. She assured the Council of Governors that where the CQC gave an overall rating of 'Requires improvement' for Safety, they found no patients suffering from harm. The rating referred to 'warning signs' such as staff not following policies or mandatory training and staffing levels. Dr Tolcher's presentation detailed both Harrogate District Hospital and Community Service ratings and she highlighted each area of 'Outstanding'; in particular the rating and tremendous feedback from the CQC regarding the Community Health Dental Services.

A CQC Quality Summit was held on 29 July attended by key stakeholders including representatives from commissioners, NHS Improvement and NHS England and Dr Tolcher was pleased that Ms Allen could attend on behalf of the Council of Governors. She was extremely proud of the comment from NHS Improvement stating the Trust was 'within touching distance of Outstanding' and regarded as one of the best Trusts nationally. The CQC confirmed they had confidence in the Trust's leadership and was supportive of the action plans going forward.

The Trust's presentation at the Quality Summit covered what had been learned from the inspection; areas requiring improvement separated into three broad themes – workforce, policies and compliance, and the environment. Examples included the Emergency Department which was too small for the level of demand and arrangements in the mortuary. Dr Tolcher was pleased to report that the relatives viewing area in the mortuary had already been refurbished however the lack of facilities for bariatric patients could not be resolved as easily due to the significant associated costs.

In April, following the CQC inspection in February, the Trust commenced the provision of Children's Services in Darlington, County Durham and Middlesbrough becoming the largest provider of Children's Services in the country. A re-structure of Directorates across the Trust had created a Clinical Directorate for children, families and county wide services and Mrs Foster and Mr McLean would be the Executive and Non-Executive leads. The development of a Strategy for Children and Young People was underway and Dr Tolcher was keen for the new Youth Forum, highlighted in Ms Allen's Governor report, to feed into this.

Dr Tolcher also summarised how the Trust would build assurance and monitor policies and compliance and safe staffing in the action plans.

#### Sustainability and Transformation Planning

Dr Tolcher described Sustainability and Transformation Programmes (STPs) as implementation vehicles to close three critical gaps as set out in the NHS Five year Forward View; a national document which sets out how the health service needs to change towards a more engaged relationship with patients, carers and citizens to promote wellbeing and prevent ill-health. It sets out a vision of a better NHS, the steps needed to get there, and the actions needed from others. These gaps were described as:

- The care and quality gap.
- The health and wellbeing gap.
- The finance and efficiency gap.

The Trust would be part of West Yorkshire STP footprint (shown at Appendix 1); one of 44, nationally. There would be an over-arching West Yorkshire plan and six local STP plans; Bradford, Harrogate, Wakefield, Kirklees, Calderdale and Leeds. The STP would encompass all NHS providers, Clinical Commissioning Groups and Local Authorities and covers a population of approximately 2.6 million people.

Dr Tolcher summarised the challenges ahead to close the finance and efficiency gap and the vision in order to achieve sustainability by 2020/21. The 'do nothing' position would leave a funding gap of approximately £988 million by 2020/21. The plan going forward would be based on collaborative work, a focus on productivity and driving efficiency. Examples included the consolidation of centres of excellence, standardisation such as procurement to drive up potential in buying power, clinical networks and alliances, workforce planning such as training, and economies of scale in back office and support functions. The clinical priorities would be:

- Prevention at scale.
- Cancer services.
- Urgent and Emergency care.
- Specialised commissioning.
- Hyper-acute stroke.
- Mental health.

Dr Tolcher talked about what West Yorkshire STP would mean for the Trust. The focus would be on back office functions, Pathology services and unsustainable services. She explained that the Trust needed to embrace this challenge and was pleased that we were already in front and comfortable in terms of alliances and networks. It would be important for us to protect our local identity and brand which was recognised and reflected in the recent CQC inspection.

Finally, Dr Tolcher summarised her presentation confirming the Trust's year to date performance remained strong, but finances needed to improve, a 'Good' rating from the CQC was a result to be proud of and build upon, and participating in STP initiatives was a significant demand, opening up new opportunities and risks.

Dr Woods highlighted the current clinical alliances with other Trusts who were not part of the West Yorkshire STP and asked if this put the Trust under any pressure. Dr Tolcher commented that this had not been picked up as yet and present services would continue to be provided with clinicians from York and Leeds.

Mr Ward and Dr Scullion made comments regarding financial and timeframe challenges with clinical alliances outside of the West Yorkshire STP.

Dr Tolcher agreed that the timescale would be a challenge and further meetings between Simon Stevens, Chief Executive of NHS England and Jim Mackey, Chief Executive of NHS Improvement were to take place before September. It was hoped that West Yorkshire STP would receive £150 million of the £1.8 billion national STP funding.

There were no further questions for Dr Tolcher and Mrs Dodson called for a refreshment break.



## **9.0 Question and Answer session for members of the public and Governors**

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

**Dr Blackburn, Public Governor had submitted the following question:**

**“In view of recent media in the newspapers, can I ask if any of our managers are ‘interim’ and paid monthly £49,000 to £60,000.”**

Mrs Harrison provided full assurance to Governors that the Trust did not have any interim managers paid this amount and was committed to promoting talent within the organisation.

**Cllr Bateman, Stakeholder Governor, asked for an update regarding the Ripon development.**

Dr Tolcher reminded Governors about the Ripon development which included input from Harrogate and Rural District Clinical Commissioning Group (HaRD CCG), Harrogate and District NHS Foundation Trust, Harrogate Borough Council, North Yorkshire County Council, GPs and the voluntary sector. The project to look at providing a fit for purpose hospital and enhanced leisure facilities was ongoing and the most recent update from the last meeting, which Mr Coulter attended, was that the CCG was taking forward a proposal to NHS England and further conversations were needed. Dr Tolcher did comment that there had been changes since the start of what was a challenging project.

In response to a further comment from Mr Pearson, Dr Tolcher confirmed that plans involved looking at the Ripon Community Hospital site for an improved health facility and that the swimming pool may be located at an alternative site. Mr Pearson clarified this was consistent with the Ripon City plan.

## **10. Update from the Deputy Chair of Governors on Non-Executive Director Appraisals**

Ms Allen confirmed the Non-Executive Director appraisals had taken place and the meetings had been robust and energetic. Ms Allen and Mrs Dodson had carried out the Non-Executive Director appraisals and Ms Allen and Mr Ward had carried out the Chairman’s appraisal. She expressed her thanks to fellow Governors for their helpful feedback and applauded the new Governors for their input as well. Mrs Colvin had circulated each individual Non-Executive Director’s objectives to Governors and Ms Allen asked her fellow Governors to use them for continual assessment towards next year’s appraisals.

Ms Allen praised the collective wisdom of the Non-Executive Directors and their valuable contribution to the organisation.

Mrs Dodson asked Ms Henderson, new Company Secretary, if other Trusts shared the Non-Executive Directors’ objectives with Governors. Ms Henderson confirmed they did however, she noted that we provided more detail which was imperative for

Governors to fulfil their assessment process. Ms Henderson thanked Ms Allen for her leadership and enthusiasm in the appraisal process and confirmed there was a strong relationship between the Council of Governors and the Board.

## **11. Report from the Nominations Committee**

Mrs Dodson and Professor Proctor left the room at this stage in the meeting and Mr Ward took over as Chair assisted by Ms Allen.

Mr Ward summarised Paper 11.0 which had been circulated prior to the meeting and the recommendations of the Nominations Committee to the Council of Governors.

The Nominations Committee had met on 25 July to discuss the reappointment of Professor Proctor to a second term of office as Non-Executive Director/Vice Chair from 1 August 2016 to 31 July 2019 and the annual reappointment of Mrs Dodson, Chairman, from 1 October 2016. Of note was this would be Mrs Dodson's last year as Chairman as she would come to the end of her three terms of office on 30 September 2017.

Mr Ward referred to the minutes of the meeting held on 25 July and the Terms of Reference of the Nominations Committee and these were approved.

Moving on to the recommendation for the reappointment of Professor Proctor, Mr Ward asked if there were any questions or indeed any comments from the Governors who had been involved in the Nominations Committee. Ms Allen confirmed that Professor Proctor had achieved her objectives and brought a vast amount of experience to support the Trust in providing high quality care and she fully endorsed the recommendation.

The Council of Governors were in unanimous agreement and approved the recommendation.

Finally, Mr Ward moved on to the recommendation for the annual reappointment of Mrs Dodson commenting on the exemplary skills she brought to the role and her tremendous dedication to the organisation and its values. Again Ms Allen fully endorsed the recommendation and there were no further questions.

The Council of Governors were in unanimous agreement and approved the recommendation.

Ms Henderson confirmed that the Nominations Committee would reconvene later in the year to discuss the timeframe and process to reappoint a new Chairman and Mrs Dodson was keen for a robust handover period.

Mrs Dodson and Professor Proctor returned to the room at this stage of the meeting and Mr Ward was pleased to report that the recommendations had unanimously been approved.

## **12. Audit Committee update on the External Auditor Performance**

Mr Thompson, Non-Executive Director and Chair of the Audit Committee summarised Paper 12.0 which had been circulated prior to the meeting and taken as read.

Mr Thompson referred to the role of the External Auditor which Mr Smith had described clearly in his presentation earlier in the meeting. He also clarified that it was the Audit Committee's responsibility to evaluate the performance of both the Trust's External and Internal Auditors each year which in turn supports the Council of Governors appointment of the External Auditor. He added that in addition to this, the Audit Committee also evaluated its own performance as well.

Mr Thompson highlighted the additional work undertaken by KPMG during the last year and confirmed this was approved by the Audit Committee at an additional £5,000 above the standard audit fee.

Finally, Mr Thompson summarised the External Audit Effectiveness Assessment scores undertaken in April 2016 which were tabled in the paper. He was pleased to report there were no areas of concern to bring to the attention of the Council of Governors or the Board.

Mrs Dodson thanked Mr Thompson and highlighted to the public that a Governor observed each Audit Committee meeting. She expressed this was a complex committee which scrutinised both financial and audit papers and was an important element of governance assurance for the Council.

There were no questions for Mr Thompson.

## **13. External Auditor Appointment Process Update**

Ms Henderson provided an update on the process and timeline for the appointment of the Trust's External Auditor detailed in Paper 13.0. A typing error was noted on page 2 - invite bidders to submit proposals for consideration (issue documents) should read, 5 August and not 5 July. Ms Henderson thanked the Governors who had volunteered to be involved in the Auditor Selection Panel with support from the Finance Team, Internal Audit and Mr Thompson.

Mrs Dodson commented that the process was both robust and competitive.

There were no questions for Ms Henderson.

## **14. Any other business**

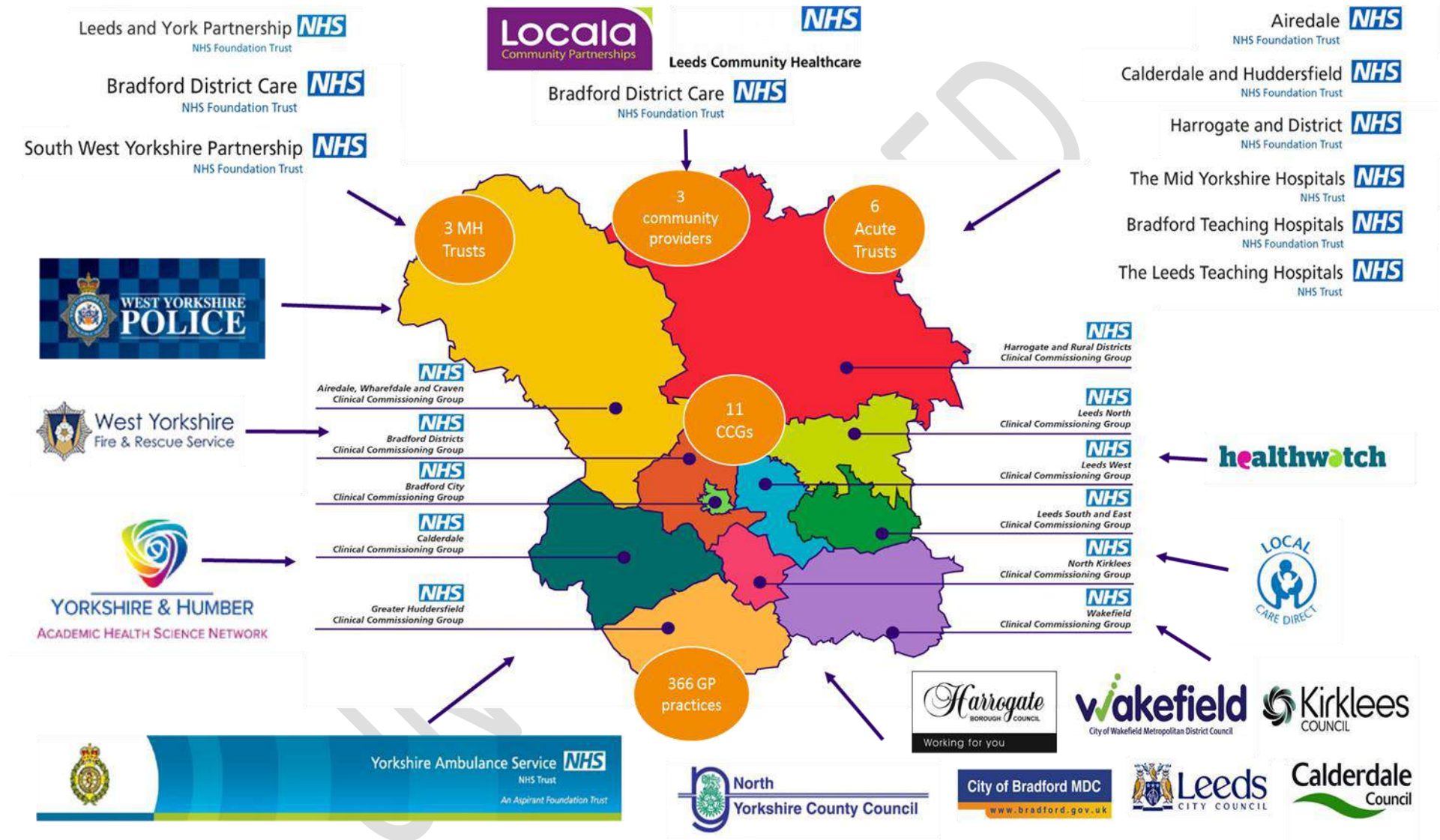
Mrs Dodson looked forward to seeing as many people as possible at the Annual Members' Meeting being held on 13 September at The Cedar Court Hotel in Harrogate from 6-8pm and also at the annual Open Event on 29 September between 3.30-7pm.

She thanked everyone for attending and confirmed the next meeting would take place on Wednesday, 2 November 2016 at 5.45 pm at St. Aidan's Church of England High School in Harrogate.

1. <https://improvement.nhs.uk/resources/risk-assessment-framework/>

Signed:.....

UNCONFIRMED



<b>Report to the Trust Board of Directors: 30 November 2016</b>	<b>Paper No: 17.1</b>
<b>Title</b>	<b>Well Led Review Action Plan Update</b>
<b>Sponsoring Director</b>	Mrs S Dodson, Chairman
<b>Author(s)</b>	Ms D Henderson, Company Secretary
<b>Report Purpose</b>	To provide the Board with an update on the action plan following the Trust's independent review against the Well Led Framework
<b>Key Issues for Board Focus:</b>	
<p>Following the Trust's independent assessment against Monitor's Well Led Governance Framework in December 2015, this report provides an update on the completed actions, actions which remain outstanding and those areas which have been identified as requiring continual oversight via the Trust's existing governance framework. The Board of Directors are asked to note that:</p> <ul style="list-style-type: none"> <li>All actions are complete with the exception of action 3 (the requirement to undertake an independent Board effectiveness review within 12 months), and action 9 (review of the effectiveness of the Trust's Quality of Care Teams).</li> <li>To note the areas which have been highlighted as broader themes rather than that identified as a specific 'one-off' action, and receive assurance that these will continue to be monitored via the Trust's existing governance framework.</li> </ul>	
<b>Related Trust Objectives</b>	
To deliver high quality care	Yes – the Well Led Review provides assurance that the Board of Directors maintains its focus on the delivery of high quality care.
To work with partners to deliver integrated care	Yes – the Well Led Review provides assurance that the Board of Directors continues to develop its strategy in consultation with a wide range of stakeholders.
To ensure clinical and financial sustainability	Yes – the Well Led Review provides assurance that the Trust's structures and processes ensuring robust information and reporting at Board and Directorate level.
<b>Risk and Assurance</b>	N/A
<b>Legal/regulatory implications</b>	All NHS Foundation Trusts are required to carry out an independent assessment against the requirements of the Well Led Framework at least once every 3 years. The framework is currently under review by NHS Improvement.
<b>Action Required by the Board of Directors</b>	
The Board of Directors are asked to receive and note the content of the report.	



**Well Led Governance Review  
Progress Report – November 2016**

**1. Introduction and Overview**

Following the Trust's independent assessment against Monitor's Well Led Governance Framework, significant work has been undertaken to address the actions and recommendations highlighted in the final report issued by Deloitte. This paper provides confirmation of completion of all actions (with the exception of two highlighted), and the areas which have been identified as requiring continual improvement and where these sit within the Trust's existing governance framework to ensure they become 'business as usual', and are subject to continual review by the Board of Directors.

**2. Areas for Improvement in the Longer Term**

The areas below have been highlighted as being broader issues than that identified as a specific one-off action from the Well Led Review Process. The table identifies:

- The area requiring continual focus;
- The function and methodology within the Trust's existing framework within which monitoring will take place; and
- Key Responsible Officers.

Area of continual focus/development	Governance Framework and methodology for review	Responsible officer(s)
<u>Strategy and planning</u> Explicit tracking and monitoring of progress against strategic objectives and milestones at Board, committees and directorate board meetings.	Board Strategic Review process and annual planning round to review strategy and business planning.  All Board Strategy Days will include an item on 'strategic overview' to ensure the Trust continually considers strategic development and alignment to enabling strategies and short/medium term business planning.  Strategic KPIs to be monitored at Board on a quarterly basis.  Board Assurance Framework (BAF) review at all Board meetings. High level review of the BAF to be undertaken by the Board on a monthly basis and in-depth review on a quarterly basis.  BAF specific objectives and associated risks to be monitored at Committee level on a regular basis.  Enabling strategies to support the overall	Executive Team  Board of Directors (led by the Chairman/Chief Executive)  Board of Directors (led by Deputy Chief Executive/ Finance Director)  Board of Directors (led by the Chief Executive)  Committee Chairs (supported by the Company Secretary and Executive Leads)

	<p>strategic objectives to be monitored and reviewed at Senior Management Team and Directorate Board meetings.</p> <p><u>Key forums: Board of Directors; Finance Committee; Audit Committee; Quality Committee; Senior Management Team; Directorate Board</u></p>	Executive Leads/ Clinical Directors
<p><u>Process and structure</u> Restating the roles of the Board committees to ensure they have sufficient time to cover the accountabilities set out in their terms of reference, and that the expectations of assurance reporting into them from directorates are both clarified and standardised.</p>	<p>Annual Review of Committee Terms of Reference to be undertaken with TORs receiving Board approval.</p> <p>Annual review of effectiveness of committees to ensure that they continue to function in line with delegated responsibilities and accountabilities. This includes a review of the governance structure beneath committee level with input from Clinical Directors and service leads.</p> <p>Annual review of the Trust's Scheme of Delegation and SFIs to ensure delegation is appropriate and commensurate with forums/ and individual accountabilities.</p> <p>Annual reports from all Committees to be submitted to the Board to provide assurance on the continued added value of each forum.</p> <p><u>Key forums: Board of Directors; Audit Committee; Finance Committee; and Quality Committee</u></p>	<p>Committee Chairs (supported by the Company Secretary)</p> <p>Committee Chairs (supported by the Company Secretary)</p> <p>Deputy Chief Executive/ Finance Director</p> <p>Committee Chairs (supported by the Company Secretary)</p>
<p><u>Capability and culture</u> Increase the opportunities for engagement with staff working in community services.</p>	<p>Workforce and Organisational Development Strategy to be reported to the Board on a monthly basis via the Director of Workforce and OD report.</p> <p>Development of, and continual review of, the Patient and Public Involvement Strategy by the Quality Committee from Q4 2016/2017.</p> <p>Annual Report to be received by the Board on the Trust's Membership and Engagement Strategy commencing from Q1 2017/18 to ensure that the Board remain accountable for receiving feedback and views of the Governors, membership and local community.</p> <p>Ongoing development of the Board as a unitary Board including developmental initiatives to build on cohesive and relationships.</p> <p><u>Key forums: Board Strategy Away Days</u></p>	<p>Director of Workforce &amp; Organisational Development</p> <p>Chief Nurse</p> <p>Company Secretary</p> <p>Chairman/ supported by the Director of Workforce and Organisational Development</p>



### **3. Recommendation**

The Board of Directors are asked to:

- Agree that all actions following the Trust's independent assessment against Monitor's Well Led Framework are now complete (with the exception of the two highlighted); and
- Agree the wider governance issues for inclusion in the existing governance framework for continual review, as per the table above.

Dr Ros Tolcher  
**Chief Executive**  
**24 November 2016**

No	RECOMMENDATION	ACTION REQUIRED	RESPONSIBLE	TARGET DATE	PROGRESS
1	The approach used by Directorate Boards to monitor progress against delivering their business plans should be more clearly aligned to strategic objectives and milestones articulated in the Trust's 5 year plan.	<ul style="list-style-type: none"> <li>Directorate Boards to review, and where necessary, realign their business plans with strategic objectives in 5-year plan.</li> <li>New Directorate business plans to align with Trust strategic objectives in refreshed long-term plan.</li> </ul>	CDs/ODs	June 2016	Complete
			CDs/ODs	June 2016	Complete
2	Standardise and strengthen the arrangements for post-implementation monitoring and assurance reporting of the quality impact of CIPs at the Quality Committee.	<ul style="list-style-type: none"> <li>Quality Committee to consider whether any additional reporting in respect of CIPs is required, particularly in terms of assurance about the process and post-implementation monitoring.</li> <li>Committees of the Board to undertake greater scrutiny of BAF risks where relevant.</li> <li>Board development time to include deep dive of BAF entries as a standing item.</li> </ul>	LW/SW	Mar 2016 ( <i>revised to September 16</i> )	Complete
			SD/LW/DH CT/MT	Mar 2016 ( <i>revised to July 16</i> )	Complete – as of November reporting cycle
			SD/DH	Jan 2016	Complete
3	Undertake an independent Board effectiveness review over the next twelve months to assess the impact of the Board's refreshed governance structures as they become further embedded.	Board Effectiveness Review to be commissioned and completed	SD/DH	Sep 2016	Awaiting further guidance following NHS Improvement review of the Well Led Review framework
4	While we acknowledge the tension between ensuring Executive Team cohesion in the public Board meeting and the risk of duplicating debate from SMT, we concur that Board debate would be further enhanced through increased ED challenge and contribution outside of their own portfolio.	<ul style="list-style-type: none"> <li>Facilitation and encouragement of cross portfolio discussion and challenge</li> <li>Executive Directors to demonstrate greater inter-disciplinary challenge at Board meetings (and, where applicable, at Committee meetings)</li> <li>Minutes of Board meetings to ensure that challenge is reflected appropriately</li> </ul>	SD	Jan 2016	Complete
			All EDs	Jan 2016	Complete
			DH	Jan 2016	Complete
5	The Board would benefit from more frequent explicit progress reporting in relation to the delivery of the Workforce and OD Strategy.	Include in monthly report for Jan 2016 and quarterly thereafter	PM	Jan 2016	Complete

6	Processes regarding learning lessons could be enhanced throughout the Trust by: –Strengthening Board reporting on SIRIs with a focus on themes, actions and impact; –Agreeing a process for sharing learning across teams following incidents and serious complaints; and –Assigning ownership for embedding learning and monitoring impact to the Quality Committee.	<ul style="list-style-type: none"> <li>Quality Committee to review individual SRI reports on behalf of Board of Directors.</li> <li>Summary Report and commentary on themes and trends to be developed for Board</li> <li>Ensure that recommendations made as a result of SIRIs are real and SMART</li> <li>Quality Committee to seek assurances on the impact of actions taken as a result of SIRIs. Changes made as a result of SIRIs to be subject to clinical audit and embedded within annual clinical audit plan.</li> <li>SMT to implement system for overseeing compliance with SRI action plans and provide assurance on this to Quality Committee</li> </ul>	N/A	N/A	<b>Action obsolete</b> , SRI reviews remains the responsibility of the Board. <b>Action obsolete</b> , see above.  Complete  Complete  Complete
			N/A	N/A	
			Executive sponsors LW/SW/JF	Mar 2016  Mar 2016	
			RT	Mar 2016	
7	As the Quality Committee continues to mature it is important that the committee clarifies lines of reporting into it and the balance of assurance being presented to it from directorates and key quality governance sub-groups. Aligned to this, there is a need to clarify the expectations of directorates when reporting into the committee along with introducing standardised reported templates through which this can occur.	<ul style="list-style-type: none"> <li>Deloitte to offer advice and best practice examples and these to be considered and discussed by Board</li> <li>Steven Picken (Deloitte – SP) to meet Sylvia Wood (SW) then Lesley Webster (LW)</li> <li>SP to observe Quality Committee meeting</li> <li>SP to debrief SW/LW</li> <li>Feedback to SD/RT and Board</li> <li>Develop templates for subgroup reporting to Quality Committee</li> <li>Format of Quality Committee agenda to be reviewed</li> </ul>	SD/RT	Jan 2016	Complete
			LW/SW	29 Jan 2016	Complete
			LW/SW	3 Feb 2016	Complete
			LW/SW	Feb 2016	Complete
			LW/SW	Feb 2016	Complete
			LW/RT/SW	Feb 2016	Complete
8	The Trust would find it useful to re-affirm the roles of the committees in order that all BMs are clear about which aspects of assurance they are receiving. In addition the Trust should increase the frequency and / or duration of the Finance Committee to enable a broader focus on assurance relating to the Trust's financial position and performance.	<ul style="list-style-type: none"> <li>Terms of Reference of Board Committees to be reviewed and approved by Board</li> <li>Finance Committee schedule and duration of meetings to be reviewed</li> <li>Finance Committee to provide scrutiny of BAF entries relating to finances, on behalf of Board of Directors</li> </ul>	LW/SW	Feb 2016	Complete
			DH/MT/CT/ LW MT	June 2016  Jan 2016	Complete  Complete
			MT	Feb 2016	Complete

9	Undertake a review of the effectiveness of the Quality of Care Teams across the Trust to identify those areas where improvement is required. Aligned to this, periodically review effectiveness in this area through directorate assurance reports to the Quality Committee.	<ul style="list-style-type: none"> <li>Review and re-issue the Terms of Reference for Quality of Care teams.</li> <li>Directorates to review membership and operation of Quality of Care teams and ensure effectiveness reviewed at least quarterly.</li> </ul>	JF/SW JF/CDs/SW	June 2016 June 2016	Complete Consistency of the quality and value of the QoCTs across directorates remains outstanding
10	The Board would benefit from a more structured approach to escalation and reporting from committees via a short standardised template to be used by all Board committees.	<ul style="list-style-type: none"> <li>Standardised template to be agreed following pilot.</li> </ul>	MT/CT/LW/DH	Feb 2016	Complete
11	To maximise the value of BM service visits, agree a process for monitoring actions raised as a result of Director inspections and patient safety visits.	<ul style="list-style-type: none"> <li>Action points from DIs and PSVs to be captured</li> <li>Progress of Action Points to be reported to Board by Chief Nurse</li> </ul>	JF JF	Jan 2016 Feb 2016	Complete Complete
12	In line with reviewing and improving the consistency and effectiveness of Quality of Care Teams the Trust should also focus on how these front line teams systematically use patient feedback to inform service improvement and development.	<ul style="list-style-type: none"> <li>Directorates to ensure effective operations of Quality of Care team including the use of patient feedback</li> </ul>	CDs/ODs/SW	Feb 2016	Complete
13	Design a clear strategy for systematically engaging with community staff in order to ensure their voice is heard more clearly through the Trust's meeting and committee structure.	<ul style="list-style-type: none"> <li>Link to Communication and Marketing Strategy</li> <li>Establish Task and Finish group of community staff (incl Staff Governors) to review current levels of engagement and propose effective new arrangements and strategy to Senior Management Team</li> <li>Explore opportunities for greater use of social media/ teleconferencing</li> </ul>	JC/PW PM/PW  JC/PW	Feb 2016 July 2016  Feb 2016	Complete Survey Complete – analysis of results to be undertaken  Complete
14	Continue to develop the IBR to promote: <ul style="list-style-type: none"> <li>An overview of performance through the introduction of a dashboard to preface the report;</li> <li>Clearer links to strategic objectives;</li> </ul>	<ul style="list-style-type: none"> <li>Board feedback after trial of dashboard</li> <li>Link operational KPIs to strategic objectives (under strategic KPI work)</li> <li>Inclusion of community metrics in Board IBR reporting</li> </ul>	Whole Board JC  RH	Feb 2016 July 2016  June 2016	Complete   Complete

	<ul style="list-style-type: none"> <li>• A greater breadth of community-focussed metrics;</li> <li>• Presentation of analysis which provides most insight; and</li> <li>• A ward to board approach to performance reporting through alignment of directorate dashboards to the new IBR.</li> </ul>	<ul style="list-style-type: none"> <li>• Address individual points raised as part of continuous review and evolution of Integrated Board Report</li> </ul>	RH	June 2016	Complete
15	As part of the evolution of the recently introduced IBR, incorporate greater use of benchmarking with similar and high-performing peer trusts.	<ul style="list-style-type: none"> <li>• Examine potential for benchmarking with peer Trusts</li> <li>• Select appropriate benchmarking metrics on IBR metrics where available</li> <li>• Report monthly to Board in IBR</li> </ul>	RH  RH  RH	Feb 2016  Feb 2016  Mar 2016	Complete  Complete  Complete
16	Increase the level of granularity in performance reporting presented to <u>Committees</u> in order to aid them in their role undertaking deeper dives into assurance around quality, safety and the financial position behalf of the Board.	<ul style="list-style-type: none"> <li>• Committees to review breadth and depth of performance information currently available</li> <li>• Committees to consider what increased level of information necessary to improve assurance on quality, safety and finance</li> </ul>	MT/CT/LW with EDs MT/CT/LW	Mar 2016  Jun 2016	Complete  Complete
17	As planned, introduce reporting to the Board on the data quality of the metrics included within the recently introduced IBR.	<ul style="list-style-type: none"> <li>• Continue with work in hand to define data quality kitemark</li> </ul>	RH	Mar 2016	Complete