Harrogate and District NHS
NHS Foundation Trust

The meeting of the Board of Directors held in public will take place on Wednesday 27 July 2016 in the Boardroom, Harrogate District Hospital, Lancaster Park Road, Harrogate, HG2 7SX
Start: 8.45am Finish: 12.45pm

	AGENDA		
Item No.	**Item**	**Lead**	**Paper No.**
8.45am Board Pre-brief Clinical Transformation Board			
9.00am General Business			
1.0	**Welcome and Apologies for Absence** *To receive any apologies for absence*	Mrs S Dodson, Chairman	
2.0	**Declarations of Interest and Board of Directors Register of Interests** *To declare any interests relevant to the agenda and to receive any changes to the register of interests*	Mrs S Dodson, Chairman	2.0
3.0	**Minutes of the Board of Directors meeting held on 29 June 2016** *To review and approve the minutes*	Mrs S Dodson, Chairman	3.0
4.0	**Review Action Log and Matters Arising** *To provide updates on progress of actions to the Board of Directors*	Mrs S Dodson, Chairman	4.1 4.2
9.15am – 11.00am			
	Overview by the Chairman	Mrs S Dodson, Chairman	
5.0	**Report by the Chief Executive** *To receive the report for comment*	Dr R Tolcher, Chief Executive	5.0
6.0	**Performance Against Strategic KPIs** *To receive the report for comment*	Dr R Tolcher, Chief Executive	6.0
7.0	**Patient Story** *To receive the patient story for reflection*	Mrs J Foster, Chief Nurse	-
8.0	**Integrated Board Report** *To receive the report for comment*	Dr R Tolcher, Chief Executive	8.0
9.0	**Report from the Chief Operating Officer** *To **approve** the Information Governance Toolkit baseline July submission;* *To **approve** the Q1 Governance section of the Risk Assessment Framework as Green for submission to NHS Improvement*	Mr R Harrison, Chief Operating Officer	9.0
10.0	**Report by the Finance Director** *To **approve** the Q1 Finance section of the Risk Assessment Framework to NHS Improvement*	Mr J McKie, Deputy Finance Director	10.0

11.00am – 11.10am – Break			
11.10am – 12.30pm			
11.0	**Report from the Chief Nurse** *To receive the report for comment*	Mrs J Foster, Chief Nurse	11.0
11.1	**Infection Prevention and Control Annual Report 2015/16** *To receive the annual report for comment*	Mrs J Child, Director of Infection Prevention and Control	11.1
12.0	**Report from the Medical Director** *To be considered for comment*	Dr D Scullion, Medical Director	12.0
12.1	**Responsible Officer Appointment** *To **approve** the appointment of the Responsible Officer*	Dr D Scullion, Medical Director	12.1
13.0	**Report by the Director of Workforce and Organisational Development** *To receive the report for comment*	Mr P Marshall, Director of Workforce & Organisational Development	13.0
14.0	**Oral Reports from Directorates** *14.1 Long Term and Unscheduled Care* *14.2 Planned and Surgical Care* *14.3 Children's and County Wide Community Care*	Mr A Alldred, Clinical Director Dr K Johnson, Clinical Director Dr N Lyth, Clinical Director	
15.0	**Committee Chair Reports** *15.1 To receive the report from the Quality Committee meeting held 6 July 2016*	Mrs L Webster, Non-Executive Director/Quality Committee Chair	15.1
12.30pm – 12.45pm			
16.0	**Other matters relating to compliance with the Trust's Licence or other exceptional items to report, including issues reported to the Regulators** *To receive an update on any matters of compliance*	Mrs S Dodson, Chairman	
17.0	**Any other relevant business not included on the agenda** *By permission of the Chairman*	Mrs S Dodson, Chairman	
18.0	**Board Evaluation**	Mrs S Dodson, Chairman	
Confidential Motion – the Chairman to move: *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, publicly on which would be prejudicial to the public interest.*			

Harrogate and District NHS
NHS Foundation Trust

BOARD OF DIRECTORS – REGISTERED DECLARED INTERESTS

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

The register is maintained by the Foundation Trust Office.

Name	Position	Interests Declared
Mrs Sandra Dodson	Chairman	1. Partner in Oakgate Consultants 2. Trustee of Masiphumelele Trust Ltd (a charity raising funds for a South African Township) 3. Trustee of Yorkshire Cancer Research 4. Chair of Red Kite Learning Trust – multi-academy Trust
Dr Ros Tolcher	Chief Executive	Specialist Adviser to the Care Quality Commission
Mr Jonathan Coulter	Deputy Chief Executive/ Finance Director	None
Mrs Jill Foster	Chief Nurse	None
Mr Robert Harrison	Chief Operating Officer	1. Appointed Voluntary Member of the Strategy and Resources Committee of the Methodist Church 2. Charity Trustee of Acomb Methodist Church, York
Mr Phillip Marshall	Director of Workforce and Organisational Development	None
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	1. Director and owner of SR Proctor Consulting Ltd 2. Chair, Safeguarding Board, Diocese of York 3. Member – Council of University of Leeds 4. Member – Council of NHS Staff College (UCLH) 5. Associate – Good Governance Institute 6. Associate – Capsticks
Dr David Scullion	Medical Director	1. Member of the London Radiology Group

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

July 2016

Harrogate and District NHS
NHS Foundation Trust

Report Status: Open

BOARD OF DIRECTORS MEETING

Minutes of the Board of Directors meeting held in public on Wednesday 29 June 2016 9.15am in the Boardroom, Trust Headquarters, Harrogate District Hospital

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

In attendance:
Mr A Alldred, Clinical Director for Long Term and Unscheduled Care
Dr K Johnson, Clinical Director for Planned and Surgical Care
Dr N Lyth, Clinical Director for Children's and County Wide Community Services
Dr C Hall, Deputy Medical Director
Ms D Henderson, Company Secretary

1. Welcome and Apologies for Absence

No apologies for absence had been received. Mrs Dodson welcomed two Governors and Dr Claire Hall to the meeting in her role as Joint Deputy Medical Director.

2. Declarations of Interest

Dr David Scullion requested an addition to the Register of Interests to reflect his membership of the London Radiology Group. There were no other declarations of interest relevant to items on the agenda.

3. Minutes of the meetings of the Board of Directors on 25 May 2016

The draft minutes of the meetings held 25 May 2016 were accepted as a true record, subject to the following amendments:

Page 9, paragraph 10.1 – delete 'of outcomes'
Page 10, paragraph 10.1.1 – delete 'Dr' and insert 'Mr'
Page 12, paragraph 11.2 – delete 'Mayer' and insert 'Maher'

APPROVED:

- **The Board of Directors approved the minutes of the meeting held 25 May 2016 as an accurate record of proceedings subject to the amendments in the minutes**

4. Review of Actions Schedule and Matters Arising

4.1 With regard to action number 1, Dr Johnson noted that no applicants had applied for the post of Consultant Elderly Care. A decision had been taken to advertise for a middle grade in the interim, whilst consideration was given to the future delivery of care in elderly medicine, to attract strong candidates to the post. Dr Tolcher requested further consideration be given to the appointment of a consultant nurse post.

4.2 Mr McLean queried whether the challenges to recruit had been due to a lack of resource nationally. Dr Johnson confirmed that recruitment in the field of elderly medicine had not been a challenge in the past. Mr Alldred suggested that the role had not reflected a traditional elderly care post and was a speciality based issue across disciplines. Dr Johnson noted the impact on the capacity within the team as a significant risk. Mrs Dodson emphasised the need for a strong focus and requested a further update in September.

There were no other matters arising.

5. Corporate Governance Statement

5.1 The Corporate Governance Statement and supporting documents had been circulated in advance of the meeting and were taken as read.

5.2 Mr Thompson clarified that Standing Financial Instructions had been approved by the Audit Committee, not the Finance Committee.

5.3 Mrs Dodson sought Board approval to sign and submit the Corporate Governance Statement to NHS Improvement, noting the amendment detailed in 5.2.

APPROVED:

- **The Board of Directors approved the Corporate Governance Statement for submission to NHS Improvement on 30 June 2016**

6. Terms of Reference for Approval

The Terms of Reference for the Remuneration Committee and Quality Committee had been circulated in advance of the meeting and were taken as read.

6.1 The cover report required amendment to refer to 'Remuneration Committee' terms of reference.

6.2 With regard to the Quality Committee Terms of Reference, Mr Thompson suggested that an amendment be included to specifically reflect Non-Executive Director membership of both the Quality Committee and Audit Committee to ensure appropriate triangulation.

APPROVED:

- **The Board of Directors approved the Terms of Reference for the Remuneration Committee and Quality Committee, subject to the inclusion of a statement in the Terms of Reference for the Quality Committee to reflect Non-Executive Director membership of both the Quality Committee and Audit Committee.**

Overview by the Chairman

Mrs Dodson referred to the meeting of the Shadow Board which took place on 27 June and noted that Mrs Webster had also attended the meeting in her role as Non-Executive Director. Mrs Dodson referred to a significant improvement in the Shadow Board's ability to consider and scrutinise strategic issues. The group also discussed some challenging issues including theatre utilisation, and Mrs Dodson again highlighted the calibre and insight of discussions. Mrs Webster supported Mrs Dodson's comments and reflected on a good meeting with strong insight, cross-challenge and triangulation.

Mrs Dodson outlined the overarching themes for the meeting, as identified by the Non-Executive Directors as; capacity and capability; capacity to complete actions, particularly with regard Serious Incidents Requiring Investigation (SIRIs) and Root Cause Analysis (RCAs); and forward financial and activity forecasting.

7. Report by the Chief Executive

Dr Tolcher presented the report which had been circulated in advance of the meeting and was taken as read.

7.1 Dr Tolcher provided an update on the current position with regard to the contract with Harrogate and Rural District CCG (HaRD CCG) and noted that positive progress had been made during the period. Discussions continued to focus on challenging issues but both organisations had a shared commitment to agreeing a sustainable service for patients going forward.

7.2 HaRD CCG colleagues had undertaken a Quality Impact Assessment based on a proposed service specification provided to the Trust on 31st May. The Trust disagreed with the view of commissioning colleagues and requested a full Quality Impact Assessment in line with the requirements of the previously agreed Memorandum of Understanding. The original Quality Impact Assessment undertaken by the Commissioners had been based on an assumption that there would be no change in headcount in terms of resource as a result of the revised service specification. The commissioners had since accepted that there would be an impact in terms of workforce numbers. The full Quality Impact Assessment was being undertaken in collaboration with commissioning colleagues to ensure an aligned approach to the assessment.

7.3 The Service Line Review remained ongoing and commissioners had also acknowledged that the original request to rebase the tariff in terms of the Minor Injuries Service would need to be removed from the original proposal. Dr Tolcher confirmed that the objective remained to aim to deliver the new model for community services by 1 September 2016. Should this not be achieved further discussions would be required to agree mitigation of any risks and next steps.

7.4 Mr Alldred referred to constructive discussions and a clear understanding of the impact of new commissioning arrangements and acknowledged that both the Trust and commissioners had made good progress under challenging circumstances. Full staff engagement within the service had been undertaken.

7.5 Dr Tolcher provided an update on West Yorkshire Sustainability and Transformation Plan (WYSTP). There remained a requirement to identify priority clinical areas for development at a West Yorkshire level and the development of enabling strategies to support this. The first draft of the plan required submission on Thursday 30 June and Dr Tolcher noted that work to date had focused primarily on governance and collaboration. With regard to the plan in its current form, Dr Tolcher did not believe it included sufficient actions and further detail would need to be included.

7.6 Dr Tolcher referred to correspondence received from NHS Improvement regarding stringent targets and expectations on providers, and emphasised that the requirements would need to be considered as part of the STP arrangements, and the long terms strategic plan for the Trust.

7.7 The underlying financial position for the NHS as a whole had been identified as a £3 billion deficit. Dr Tolcher referred to the different approaches from the 'Centre' to address this issue in terms of reducing the planned higher levels of pay cost in some organisations, merger of back office functions, consolidation of pathology services, and consolidation of unsustainable services. Dr Tolcher noted that the WYSTP work had focused on clinical speciality areas which may be unsustainable, but noted that the system was being tasked with finding solutions very quickly.

7.8 STP Leads had been asked to consider clinical services where potential efficiencies could be made and had been asked to provide a response by the end of July. In light of Dr Tolcher's previous comments on the lack of reference to back office and pathology consolidations in the WYSTP, further work would be undertaken over the next few weeks with all stakeholders in the WYSTP system.

7.9 Following a query regarding the role of Non-Executive Directors and the Council of Governors in STP governance, Dr Tolcher noted there continued to be a lack of Non-Executive Director presence at the West Yorkshire STP level. This had been raised by Dr Tolcher several times and a discussion would take place at the forthcoming leadership day. Dr Tolcher confirmed that the HDFT Board would continue to be engaged in discussions regarding progress of STP development via Board meetings both formal and development.

7.10 Mrs Dodson informed members of the Board of a provider Chairs' meeting that had been arranged by NHS Providers to discuss key issues relating to STP governance and welcomed views and comments prior to 7 July. Dr Tolcher also offered to take forward the thoughts of Non-Executive Director colleagues at a West Yorkshire level.

7.11 Mr McLean expressed concern regarding the requirements and unrealistic timescales from regulators and asked at what stage providers should push back on impractical demands from the Centre. Dr Tolcher agreed that the demands were challenging and stated that discussions continued with acute Chief Executive colleagues regarding the approach to be taken.

7.12 Professor Proctor asked if there had been any insight into the position of NHS Providers in terms of supporting an immediate collective push back from providers. Dr Tolcher agreed that the approach to push back at a regional level would be reasonable, in terms of the immediate impact on local services.

7.13 With regard to the request from NHS Improvement to consider a merger of back office functions, consolidation of Pathology services and identification of unsustainable clinical services, Dr Tolcher referred to the impact on the Trust's business model and the need to consider opportunities to increase resilience in the system.

7.14 Professor Proctor referred to the work undertaken on leadership and governance and Simon Steven's reference to social care as the most significant risk and asked if appropriate representation was in place. Dr Tolcher confirmed that representation on the leadership team included Local Authorities, Commissioners, NHS Providers, Community and Voluntary Sector and private providers.

7.15 Professor Proctor referred to the financial challenges of other partners in the system and asked what the impact would be on reputational risk for the Trust. Mr Coulter referred to the arrangements for the Commissioners 1% top slice of funding which had been acknowledged as a risk to the Trust. The strong relationships and clinical networks already in place were also acknowledged.

7.16 A discussion took place regarding the level of freedom as a Foundation Trust (FT) and the sustainability of FTs going forward. Mrs Dodson suggested that the issue would be the focus of discussion at the NHS Providers Conference on 7 July. It was acknowledged that FTs are underpinned by legislation which would need to be considered in terms of accountability and responsibility as an independent organisation. Mr Harrison suggested that STPs would also help provide clarity regarding the statutory responsibilities of CCGs, and referred to the recently published consultation on the introduction of a Single Oversight Framework to align the regulatory requirements for FTs and Non FTs.

7.17 Dr Tolcher took an opportunity to remind Board members that within a time of significant pressure and uncertainty in the health sector, the Trust continued to demonstrate strong performance in terms of finance, quality, performance and business development, although acknowledged that significant challenge lay ahead to maintain the current position. Dr Tolcher stated that the Trust's biggest non-tangible asset remained its culture and ability to attract a strong workforce and emphasised the importance of considering any impact on this as a result of major change.

7.18 Dr Lyth recognised the time, energy and pace of work for acute services and noted that the Trust's footprint now expanded into County Durham, Darlington and Middlesbrough, and asked what consideration had been given to the wider patch in STP development. Dr Tolcher confirmed that meetings had taken place with the Chief Executive of Scarborough CCG and Mr Harrison also confirmed his membership of the York Provider Alliance Board.

7.19 Mr Thompson noted the significant strategic impact of STPs on the Trust, referring to the mosaic of services provided including community, acute and emergency services, and suggested avoiding a hasty reaction to the demands from the 'Centre', which could present a significant risk of adversely impacting on the Trust's strong position. Mr Thompson also took an opportunity to express his concern at the complexity and uncertainty of the health sector at the current time.

7.20 Mrs Dodson drew the discussion to a close and noted that the Board Strategy Away Day in July would serve as an opportunity to discuss the opportunities and risks associated with the STP, to enable the Board to react and plan accordingly using creativity and insight.

7.21 Dr Tolcher confirmed that the Trust had received the draft Care Quality Commission report. The process of reviewing the report for factual accuracy was underway and the Quality Summit had been arranged to take place on 29 July.

7.22 Dr Tolcher noted that the CQC had published its 5-year strategy 'Shaping the Future' which summarised the main changes the CQC would make over the next five years. The full strategy document was available in the Reading Room.

7.23 Dr Tolcher provided an update on Harrogate Vanguard following confirmation of the funding allocation for 2016/17 and the associated expectations and conditions of the New Care Models team in respect of delivery. Comprehensive work had been undertaken across providers to move forward with the Vanguard development, with a view to co-locating the team in July which would represent a significant step forward. A Memorandum of Understanding was under development which would reflect the national approach to the delivery of New Care Models.

7.24 In terms of financial performance, the Trust reported a surplus of £277k in May, £80k behind plan, which reflected an income shortfall in relation to elective care. At a West Yorkshire level, Dr Tolcher reminded Board members of the commitment to maintain the agency cap with the exception of circumstances where patient safety would be compromised. It was acknowledged that although HDFT had held the line on the rules associated with the agency cap, other providers had taken a different view on the definition of 'safety'. Dr Tolcher had been tasked with the development of standardised criteria to be used across the region.

7.25 Dr Tolcher referred to a typo in the report and noted that the third bullet point should read 78%, not 785. It was also acknowledged that close working with all directorates continued to ensure achievement of the Cost Improvement Programme.

7.26 With regard to the allocation of funding for the Harrogate Vanguard Programme, Mr Thompson requested assurance as to the extent to which the funding from original expectations had been reflected in expectations of deliverables. Dr Tolcher confirmed that there remained an expectation from NHS England to deliver a tangible impact on non-elective admissions and benefits realisation.

8. Integrated Board Report (IBR)

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

8.1 Mrs Taylor expressed concern regarding the eight cases of Clostridium Difficile (C. Diff) reported year-to date and requested an update on any specific issues. Mrs Foster noted that the completed RCAs for those cases as a result of a lapse of care identified issues relating to antibiotic prescribing. In terms of lessons learnt, work had continued to ensure all new members of staff were aware of the expectations and standards relating to antibiotic prescribing. Dr Scullion also stated that the number of cases reflected a similar performance pro-rata as 2015/16. Mr Alldred confirmed that the cases suggested an issue primarily with the completion of documentation and other measures relating to antibiotic prescribing performed above the national average.

8.2 Mrs Webster asked if RCAs were being completed within the required timescale. Mr Alldred stated that the challenge related to securing the availability of whole clinical teams within 10 days to ensure appropriate clinical ownership, but confirmed that an appropriate level of focus had been given to the issues and there was no evidence of complacency in the system. Mrs Dodson referred to anecdotal information raised at the Shadow Board meeting on capacity of people to undertake RCAs.

8.3 Mr McLean referred to reducing readmissions in older people and noted that performance had continued to decline since December 2015. Mr Harrison confirmed that the data was not statistically significant at this stage and a review over a longer time period would be required to provide assurance on performance. This had been reflected in the amber rating for confidence in data quality related to the metric. Mrs Webster suggested including more information on the caveat relating to data confidence within the narrative of the report. It was agreed to include information on real-cases, actual numbers and any key issues in the July report.

8.4 Mrs Webster requested a summary of the new approach to presenting data on SIRI and Never Events (NEs). Dr Scullion advised that as no national benchmarking data for SIRIs and NEs was available, the Trust had developed a bespoke metric which included comprehensive and concise cases from both community and acute services. This also included falls and pressure ulcers. The report also included an analysis of the monthly average from the previous

year to enable a comparison to be made. This had resulted in a stretch target of eight. Dr Scullion confirmed that the occurrence of one Never Event would automatically result in a 'Red' rating. It was agreed that the new approach was useful and would be reviewed and refined over time. Mr Harrison also noted that NHS Improvement had proposed SIRIs and NEs as a quality metric in the proposed Single Oversight Framework.

8.5 Mrs Webster referred to the safer staffing levels rating of 'Green' and noted the increase of Care Support Workers (CSWs) to supplement the reducing numbers of Registered Nurses. Mrs Foster confirmed that there was criteria identified in terms of an early warning indicator of safe staffing levels and expressed her confidence that the Trust had an appropriate level of Registered Nurses, supported by CSWs to maintain safe staffing levels. Mrs Foster emphasised that further granular detail continued to be provided in the Chief Nurse report to provide further assurance in ensuring safe, high quality patient care.

8.6 Mr Thompson asked if consideration had been given to pressures on staff within services in the community particularly the Wheelchair service and Podiatry and asked when the Board would be in a position to receive data on activity and performance in community services. Dr Tolcher referred to the results of the Staff Friends and Family test as a measure of pressures on the workforce and confirmed that key performance indicators (KPIs) related to the 0- 19 service would be included in the IBR from July. Dr Lyth also confirmed that work had continued to develop KPIs for wider community services which would be included within the IBR in due course.

8.7 Professor Proctor referred to theatre utilisation and the apparent fragility of teams, particularly in anaesthetics. Dr Johnson confirmed that 92 elective procedures had been cancelled, 67 of which had been due to an inability to staff theatres a result of the introduction of the agency cap rules. A discussion had taken place at Senior Management Team (SMT) to develop plans to minimise the impact.

8.8 Mrs Webster reflected on data presented to the Shadow Board meeting which showed a higher number of cancellations due to a lack of surgeon availability, suggesting that the introduction of the agency cap impacted on what was already a fragile service. Dr Hall stated that the data showed annual leave theatre lists as being 'cancelled' and suggested that further work was required to ensure appropriate cover for planned leave.

8.9 It was also noted that appropriate cover had not been secured for pre-planned audit days. Dr Johnson advised that this had been discussed at Directorate Board to ensure clarity on expectations and arrangements for the planning of audit days. Mr Harrison suggested that the issue related to unwillingness to backfill into additional sessions out-with normal job planning. Mr Thompson expressed concern with regard to the impact on patient care, activity and income and Mrs Dodson asked Dr Johnson to continue to work with the Executive Team to revise the approach and provide a verbal update on progress at the next meeting. Mr Ward suggested that the Trust take into consideration the forthcoming holiday period and the potential impact on consultant availability.

8.10 Dr Scullion suggested that the Board take into consideration the impact on staff morale in other areas should a decision be taken to breach the agency cap in theatres. Dr Tolcher and Mr Marshall also referred to the potential system wide impact as well as organisational benefit and supported Dr Scullion's views in relation to the cap. The Board noted that any requests to breach the cap were approved by Mr Harrison or Mrs Foster and a robust process was in place.

8.11 Mrs Taylor referred to the Cost Improvement Programme (CIP) and asked Clinical Directors for their views on confidence levels of achieving the target. Mr Alldred suggested that although it felt more challenging, approximately 95% of programmes had been planned following

risk adjustment, with the challenging areas being in the transformational pieces of work. Dr Johnson stated that weekly financial assurance meetings were taking place to hold teams to account, with approximately 50% of plans actioned. Dr Lyth stated that further assurance would be provided following the transfer of data to the new directorate footprint, but also noted that General Managers had expressed confidence in each area.

8.12 Mr Coulter advised Board members that in terms of assurance, the focus should remain on delivery of the £2.2m surplus in line with the plan.

8.13 Mr Ward referred to health visiting for new born visits and suggested the inclusion of a trajectory in the narrative to support progress on achievement of the target. Dr Lyth confirmed that more granular detail would be included in the September report.

8.14 Mrs Dodson referred to the number of cases of Grade 3 and 4 Pressure Ulcers and requested an update on the RCAs. Mrs Foster confirmed that there were no Grade 4 cases reported. Five Grade 3 RCAs had been completed with two cases deemed to be avoidable due to non-compliance with Trust policy. Mrs Dodson expressed her disappointment and referred again to capability and capacity issues. It was agreed to delegate responsibility for monitoring progress and performance on Pressure Ulcers to the Quality Committee with updates to Board via the Chair's report.

ACTION:

- **That additional information be included in the narrative of the IBR relating to readmissions of older people**
- **Inclusion of KPIs on Children's and Community Services to be included in the IBR**
- **A verbal update on the approach taken to ensure clinical cover for planned annual leave in theatres to be provided to the July meeting**
- **Further detail on metrics relating to health visiting for new born visits to be provided in the September IBR**
- **Delegated responsibility to the Quality Committee for monitoring Pressure Ulcer cases**

9. Report from the Chief Operating Officer

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

9.1 Mr Harrison updated the Board on the detailed clinical coding work undertaken on avoidable admissions, which highlighted large volumes of patients being admitted with seemingly low level health care needs. The Emergency Medicine team had been tasked to undertake further work to review the quality and completeness of information recorded in patient case notes to ensure availability of sufficient information to the Clinical Coding team. The teams would also review further opportunities for the development of assessment models in paediatrics, medicine, and surgery to ensure smoother and timelier patient flow. Mr Harrison took an opportunity to highlight the importance of the work in terms of New Care Models and the medium to long term impact on Emergency Department performance.

9.2 Dr Tolcher noted that the work had been based on codes which would be amenable to an ambulatory diagnosis and did not include patients admitted to hospital without an initial health indication, and asked if further work was underway to analyse those cases. Mr Alldred confirmed that a workstream had been established to analyse cases of attendance for non-medical reasons and referred to the link to integrated care models in community care services. It was envisaged that further information would be available following roll-out to the four localities.

9.3 Mrs Webster also asked if the 'see and treat' model of care had been considered. Mr Alldred stated that a wider programme of work had commenced across West Yorkshire to look at opportunities to reduce hospital admissions. This included work with GPs to identify higher risk patients and patients in care homes to avoid transfer where possible. Mrs Dodson asked for an update to Board in January.

9.4 Mr Harrison made particular reference to the results of the Sentinel Stroke National Audit Programme (SSNAP) which rated the Trust as 'D' (an overall score of 54) for quarter 4 2015/16 compared to a rating of 'C' (an overall score of 46) for quarter 3 2015/16. The score for quarter 4 had been impacted by the data quality adjustment. Mr Harrison confirmed that the Trust would aim to improve the standard going forward prior to any changes in reconfiguration of services. Mr Alldred referred to a request by the Quality Committee to review a previous report to ensure plans reflected the ambition of the Trust, particularly as providing high quality stroke care had been identified as one of the Trust's quality priorities for 2016/17.

9.5 Regarding the reduction in elective admissions from North Leeds CCG, Mr Harrison noted that this had been due to issues in the administrative process at Leeds Teaching Hospitals NHS Trust (LTH) and the team continued to work closely with LTH colleagues find a resolution.

9.6 Mr McLean referred to the results of the National In-patient Survey and although the Trust had been identified as 14th in the country, the analysis of responses showed the Trust as average. Mr Harrison confirmed that the Trust remained committed to improving outcomes relating to patient experience and sat within the top decile of performance overall. Action plans had been developed in the areas where improvements could be made. Mrs Foster confirmed that a section had been included in the Chief Nurse report highlighting how areas for improvement would be measured and the Learning from Patient Experience Group would continue to monitor this going forward.

9.7 Mr Ward referred to the rating of 'D' for SSNAP and required further understanding on the Trust's strategic plans for stroke care. Dr Tolcher advised that aiming to achieve an 'A' rating would be unreasonable due to potential negative impact elsewhere in the system. Dr Scullion advised that an 'A' rating would primarily be allocated to tertiary providers.

9.8 In light of the reduction in activity, Mrs Taylor asked if the Trust should take an opportunity to review its activity planning. Mr Harrison confirmed that the Trust continued to see high levels of non-elective and emergency care activity. At an out-patient level, unexpected staffing issues had an adverse impact on activity which could not have been forecast at the beginning of the year. Work remained ongoing at directorate level to address the issues; however, Mr Harrison suggested that consideration to revise income plans this early in the year would not be advised.

ACTION:

- **An update on the programme of work to reduce hospital admissions to be provided to the January 2017 meeting of the Board**

10. Report by the Director of Finance

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

10.1 Mr Coulter confirmed that approximately 50% of the reduction in income and activity could be attributable to the introduction of the agency cap and the impact of the junior doctor industrial action earlier in the year. A detailed discussion took place at the Finance Committee on the Trust's current position.

10.2 Mr Coulter updated the Board on the conditions of securing the £4.6m Sustainability and Transformation Funding and confirmed that the funding would be available should be Trust achieve the planned £2.2m surplus.

10.3 In terms of national feedback, Mr Coulter reiterated that the Trust still reported a surplus, an enviable position in the current climate, and highlighted the significant risk as the ongoing negotiations to agree the contract with Harrogate and Rural District CCG.

10.4 Mr Ward referred to the detailed discussion held at Finance Committee, which had also been attended by Mrs Dodson as an observer, and stated that members of the committee felt confident in terms of the assurance provided.

10.5 Mr Thompson referred to agency expenditure and the apparent increase on temporary staffing costs year-on-year, and asked for assurance associated with plans regarding the challenging months ahead. Mr Coulter agreed that if full establishments were in place it would result in a significant positive impact on financial performance. However, in terms of a comparison to 2015/16, Mr Coulter confirmed that the agency cap rules came into force in December 2015; therefore, a change in the approach to use of agency staff would be required to significantly influence financial performance.

10.6 Mr Thompson referred to the debt related to the County Durham, Darlington and Middlesbrough and queried the value given the brevity of HDFTs responsibility of the service. Mr Coulter agreed to provide Mr Thompson with further detail out-with the meeting.

10.7 Mr Coulter requested that the Board confirm their acceptance of the process in relation to the reference cost submission, and take assurance from internal audit that a robust process for costing was in place. The Board were also asked to delegate authority to the Deputy Director of Finance to sign the final reference cost return on behalf of the Board prior to submission. Following a query from Mr Thompson, Mr Coulter confirmed that the capita review of costing had been taken into consideration.

APPROVE:

- **The Board confirmed its acceptance of the process in relation to the reference cost submission, and took assurance from internal audit that a robust process for costing was in place.**
- **The Board approved delegated authority to Mr Jordan McKie, Deputy Director of Finance to sign the final reference cost return on behalf of the Board prior to submission.**

11. Nursing and Midwifery Strategy

The Nursing and Midwifery Strategy had been circulated in advance of the meeting and was taken as read.

11.1 Mrs Foster noted that minor amendments had been suggested to the document primarily relating to formatting and images. Mrs Foster was proud to report that the document reflected the work of over 1000 members of nursing and midwifery staff and noted that the primary purpose of the strategy was to promote the commitment of staff and the excellent care delivered by the nursing and midwifery teams each time.

11.2 Mrs Foster confirmed that additional work was underway to ensure: the development of a work plan to monitor delivery of each element of the strategy; an Annual Report to the Senior

Management Team and Quality Committee; and the development of a communications plan to disseminate the strategy across the workforce.

11.3 In response to a query from Mr McLean regarding current progress on achievement of the strategy, Mrs Foster advised that approximately 60% of the objectives had already been undertaken to achieve the commitments outlined in the document. However, Mrs Foster also took an opportunity to suggest that although the Trust had made significant gains, these represented the platform to take the Trust from 'good' to excellent'.

11.4 Professor Proctor suggested that the Board receive assurance on progress of the strategy via clear milestones to obtain a sense of the Trust's ambition year-on-year.

11.5 Mrs Taylor stated that the document would benefit from clarity on the current position, a gap analysis, how the gaps would be closed, and an indication of timelines. Dr Tolcher suggested that while other strategies might contain this information, a review of nursing strategies in high performing Trust's reflected the approach taken in the HDFT document. Dr Tolcher also confirmed that to avoid restricting the Trust by analysing nursing workforce numbers in silo, the Trust had commenced the development of a Trust wide Clinical Workforce Strategy which would be presented to the Board in September. It was agreed to include reference to the Clinical Workforce Strategy in the Nursing and Midwifery Strategy to ensure appropriate triangulation.

11.6 From a nursing perspective, Mrs Webster complimented the strategy as a document which could be used to take forward the hearts and minds of a very large, and influential, part of the workforce. Mrs Dodson reminded Board members that the document had been written for the nursing workforce.

11.7 Professor Proctor referred to the purpose to harness and inspire the hearts and minds and suggested that graphics can often support and strengthen the approach. Professor Proctor also suggested that the foreword should be jointly presented by the Chairman and the Chief Executive to represent the Board's endorsement and support for the workforce.

11.8 Dr Lyth also endorsed the strategy and emphasised the importance of having a visionary document which could be used for recruitment purposes. It was agreed to upload the final strategy to the Reading Room.

APPROVAL AND ACTION:

- **The Board of Directors approved the Nursing and Midwifery Strategy subject to the amendments in the minutes**
- **Upload the Nursing and Midwifery Strategy to the Reading Room**

12. Report from the Chief Nurse

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

12.1 Mrs Foster reported that approximately 40 student nurses qualifying in September had committed their future to the Trust to date.

12.2 The Trust had benefited from small success as a result of the international recruitment campaign in the EU. Mrs Foster reported that discussions continued at the Nursing and Midwifery Council (NMC) with regard to a possible reduction in the standard for the International English Language Test.

12.3 With regard to actual versus planned staffing level during May 2016, Mrs Foster highlighted ongoing areas of concern on the medical and frail elderly wards, however, Mrs Foster reassured members of the Board that the actions taken to mitigate the risks had been appropriate to ensure continued safe and effective care for patients.

12.4 Mrs Foster took an opportunity to thank staff for their effort and support to ensure the requirements for Nursing and Midwifery Revalidation had been met.

12.5 Mrs Foster briefed the Board on the North Yorkshire County Council's forthcoming Ofsted inspection to identify the effectiveness in North Yorkshire in identifying and meeting the needs of children and young people who have special educational needs and/or disabilities (SEND). The inspection commenced on 27 June for five days. To date, positive feedback had been received.

12.6 Mrs Foster referred to the publication of the Alan Wood Report regarding the role and function of Local Children's Safeguarding Boards. The Children's Safeguarding Governance Group would consider implications for the Trust and report back to the Board in September.

12.7 Mr McLean referred to the nursing and midwifery revalidation and asked for clarification on the criteria for poor and/or strong performance. Mrs Foster reaffirmed the requirement for all nurses and midwives to confirm their compliance with revalidation standards every three years, and confirmed that the Trust was on track to revalidate all nursing and midwifery staff during the period. Mr McLean requested that the position against the trajectory be included in future reports.

12.8 Professor Proctor referred to unannounced Director inspections and expressed concern regarding the recurring area of concern relating to IV cannula and documentation, particularly in light of follow-up visits. Mrs Foster briefed the Board on the cultural issue of staff being required to adapt to a new system, and clarity on responsibility and accountability. Expectations had been made explicitly and auditing continued to be undertaken on a regular basis to ensure continual focus.

12.9 Dr Lyth emphasised the value of the unannounced visits and the impact they have on a promoting a proactive approach to escalation and ownership in responding to issues.

ACTION:

- **An update on the implications of the Alan Wood Report into Local Safeguarding Boards to be submitted to the Board in September**
- **Include the Trust's current position against trajectory in future Chief Nurse Reports relating to Nurse Revalidation**

13. Report from the Medical Director

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

13.1 Following a recent Cumulative Sum (CUSUM) alert regarding cerebrovascular deaths and the associated review of case notes, Dr Scullion confirmed that no evidence of a lapse in care was identified.

13.2 Dr Scullion referred to a meeting to discuss the implications of the Carter Report and briefed the Board on the proposals around Medical Director responsibilities which included: a focus on quality, outcomes, value for money and elimination of variation; roll-out of the 'Getting it Right First Time' (GIRFT) principles; alignment of consultant job plans to productivity and

organisational goals; and promotion of Rapid Process Improvement Workshop (RPIW) methodology.

13.3 With regard to Sepsis and in response to previous concerns raised in the meeting regarding antibiotic prescribing, Dr Scullion provided the Board with an update of the actions agreed to take forward improvements.

13.4 Mrs Webster referred to receipt of an Internal Audit with Limited Assurance at the Quality Committee regarding the documentation of discussions with patients in patient notes, and asked if changing the name of the Emergency Care and Treatment Plan (ECTP) documents would result in further confusion and risk. Dr Scullion confirmed that the audit reviewed the use of Do Not Attempt Resuscitation (DNACPR) forms and it was established that patient notes contained good documentation of appropriate discussions with patients and their families, and the changes would results in enhanced flexibility and patient and carer involvement.

14. Report by the Director of Workforce and Organisational Development

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

14.1 Mr Marshall referred to the recent change in reform taking place in Health Education England and noted the end of Kathryn Riddle's term as Chair. Mr Marshall took an opportunity to thank Kathryn Riddle on behalf of the Board for her continued support. Mrs Dodson agreed to write to Ms Riddle to express the Board's appreciation. As a result of the change in reform, the Trust would represent North Yorkshire and the Humber within the North of England structure.

14.2 Mr Marshall took an opportunity to thank all members of staff and the Dragons' Den judges for the success of the Celebrating Success Awards and Summer Fair. Particular thanks were given to Mrs Liz Pugh for her role in planning and promoting the event.

14.3 With regard to staff engagement, Mr Marshall referred to the development of the Quality Charter and Quality of Care Champion Scheme the objective of which would be to recognise the work undertaken very day by members of staff to improve patient care.

14.4 Mr Marshall updated the Board on progress to develop the new pilot programme in partnership with Leeds Beckett University for ten 'non-commissioned' undergraduate nursing places to commence from January 2017. Graduates would be locally recruited and trained with all placements within the Trust to contribute to stability for the future workforce.

14.5 Mr Marshall also referred to a recent internal communication circular following the outcome of the recent EU referendum to acknowledge the support available for the Trust's EU members of staff.

14.6 With regard to appraisals, Mr Marshall reassured Board members that robust plans had been put in place to assist staff and managers in the completion of appraisals including training to enable delegation of responsibilities and the ability to undertake team based appraisals.

14.7 Mr Marshall provided an update on the process for the recruitment of the Trust's Guardian of Safe Working role and following interviews held on 22 June 2016, a formal announcement regarding the appointment would be made in due course.

ACTION:

- **Mrs Dodson to write Ms Kathryn Riddle, Chair of Health Education England on behalf of the Board**

15. Oral Reports from Directorates

Long Term and Unscheduled Care

15.1 Mr Alldred noted that the first Directorate Board meeting and time out had taken place and reflected on a positive meeting. With regard to Sustainability and Transformation Planning, the key issue remained a focus on discharge across the organisation.

15.2 In terms of high risks for Directorate, medical workforce issues remained a priority.

15.3 Mr Alldred referred to a paper submitted to the Senior Management Team outlining the issues relating to Emergency Department performance, the actions taken to date, and the short, medium and long term strategies to ensure sustained performance. The Trust had achieved the 95% standard for A&E 4-hour waiting times for April and May and it was envisaged that the target would be achieved for Quarter 1 as a whole.

15.4 Mr Alldred confirmed that the Trust had successfully appointed to the role of Operational Director to replace Mrs Joanne Crewe.

Planned and Surgical Care

15.5 Dr Johnson referred to consultant job planning and the recent data cleansing exercise which confirmed 80% of job plans were completed. Meetings had taken place for those which remained outstanding.

15.6 In terms of high risks, Dr Johnson informed the Board of high risk in terms of clinical vacancies within the Gastroenterology service. Although challenging, the team had worked tirelessly to provide additional support to the service, and it was acknowledge that the Rapid Testing Programme in collaboration with HaRD CCG and NHS England to identify opportunities for improving our collective ability to better manage and reduce demand for Elective Care Services may help manage these in the future.

15.7 Following the opening of the Alwoodley practice, Dr Johnson noted that a 'time out' session had been held which was attended by clinical and non-clinical staff. The session demonstrated strong engagement in understanding the priorities and objectives going forward.

Children's and County Wide Community Services

15.8 Dr Lyth referred to the North Yorkshire County Council Ofsted inspection which required focus groups for all elements of the service and took an opportunity to acknowledge the teams who had risen to the challenge.

15.9 Dr Lyth updated the Board on the annual review of the Family Nurse Partnership in Middlesbrough which involved nursing staff and health visitors providing input to families of greatest need. The review reflected very positive comments regarding the support provided.

15.10 Dr Lyth confirmed the appointment of Ms Lorraine Fox as the Head of Safeguarding. It was acknowledged that Ms Fox showed a strong understanding of the strategic level of the role as well as safeguarding.

15.11 In terms of high risks for the Directorate, the requests for wheelchairs continued to exceed the budget allocation and discussions were ongoing with CCG colleagues. Staffing

issues had been identified in paediatrics and nurse vacancies in dentistry, but gaps had been managed and the services remained safe.

15.12 Dr Lyth made reference to previous concerns regarding income for training of Speciality and Associate Specialist (SAS) doctors and confirmed that assurance had now been received that bids would be considered to secure central funding. Dr Lyth also confirmed that the SAS Charter would be circulated to Board members when available.

16. Committee Chair Reports

Report from the Quality Committee meeting held 1 June 2016

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

16.1 Mrs Webster noted that a robust discussion had taken place regarding staffing levels including the benefits of developing a programme for funding and recruitment of Advanced Care Practitioners (ACPs), and requested that the Board support this as a high priority action for the Trust.

16.2 The Clinical Effectiveness Annual Report was received and the committee had been disappointed that only 50% of audits requiring an action plan were found to have one included. A Clinical Effectiveness Strategy and Work Plan would be submitted to the committee to provide additional assurance in this area.

16.3 Mrs Webster referred to concerns raised from the National Paediatric Diabetes Audit self-assessment report. The committee requested the report be re-submitted at the July meeting for further assurance.

16.4 The committee was asked by the Audit Committee and Corporate Risk Review Group to review the DNACPR and Training Report in further detail. The committee did not receive appropriate assurance in all areas. Senior Management Team had been tasked to address the outstanding issues with a further report to be submitted to the October meeting of the committee.

Report from the Finance Committee meeting held 22 June 2016

16.5 Mrs Taylor referred to a discussion regarding the financial statement and whilst acknowledging the value of reporting progress against achievement of the control total, it was agreed that the statement be reviewed to focus on performance against the operational surplus target of £2.2m as this was the element within the Trust's control.

16.6 With regard to service line reporting, the committee acknowledged good progress and agreed to schedule specific review areas into the work-plan for future meetings.

16.7 Mrs Taylor brought to the Board's attention the very positive progress report on the Carbon Energy Scheme and confirmed that savings from the scheme were in line with the business case.

16.8 Mrs Taylor referred to a discussion regarding a 5 year contract for the renewal of SystmOne and it was confirmed that financial provision for 2016/17 had been included within the budget. The committee sought endorsement from the Board that Mr Robert Harrison, Chief Operating Officer and Mr Jonathan Coulter, Deputy Chief Executive/Finance Director sign the contract, as it was acknowledged that the Trust's Scheme of Delegation required Board approval for any new contract above the value of £200,000. However, it was noted that this was not a new contract.

APPROVED:

- **The Board of Directors approved delegation of authority to Mr Robert Harrison, Chief Operating Officer and Mr Jonathan Coulter, Deputy Chief Executive/ Finance Director, to sign the contract for the renewal of SystmOne.**

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

There were no other matters relating to compliance with the Trust's Licence or other exceptional items to report.

18. Any other relevant business not included on the agenda

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

19. Board Evaluation

Mrs Dodson stated that the Board discussion a range of areas but these had been in line with the overarching strategic themes identified by Non-Executive Directors at the beginning of the meeting.

Mr Ward proposed that the meetings commence earlier to avoid running later in the day. Mrs Webster responded to say that given the current uncertainties and major change within the health sector at the current time, it would be inevitable that important discussions would be required which could not often be planned in advance. It was agreed that it was the right thing to do to spend more time debating the strategic issues within the Chief Executive's report.

Mrs Taylor supported this and suggested that all issues required discussion and timings of meetings should not impede the necessity to engage in significant issues.

Mrs Foster reflected on an emotional patient story and Mr Harrison echoed the personal impact, at an individual level, on hearing the positive outcomes and impact on patient care as a result of business cases and service change.

Mr McLean suggested that a pre-brief on the theme of the patient story in advance of the meetings would be helpful in future.

ACTION:

- **Circulate a pre-brief of the Patient Story theme prior to meetings**

20. Confidential Motion

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

The Board agreed the motion unanimously.

The meeting closed at 1.20pm

Harrogate and District NHS
NHS Foundation Trust

HDFT Board of Directors Actions Schedule – July 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
Risks relating to safeguarding children would be incorporated into the Chief Nurses report for the May meeting of the Board (7.12 – April 16)	Mrs J Foster, Chief Nurse	May 2016	Complete – included in the CNs report
Upload the Health Education England – Yorkshire and Humber Report and associated action plan to the Reading Room (7.24 – April 16)	Mr P Marshall, Director of Workforce & Organisational Development	May 2016	Complete
To include an update on New Care Models Vanguard and DDM Children's Services Contracts to the Board to Board meeting in May (10.1 & 10.8 – March 16)	Mr J Coulter, Finance Director and Mr Robert Harrison, Chief Operating Officer	May 2016	Complete – agenda confirmed and distributed
Approval be sought from the Council of Governors at the May meeting to delay the external auditor appointment process until Q2 16/17	Mr J Coulter, Deputy Chief Executive/Finance Director	May 2016	Complete – paper presented to CoG 18.5.16
Rebase the financial information in relation to new business in future Finance Director reports to enable comparison with previous years (May 16)	Mr J Coulter, Deputy Chief Executive/Finance Director	June 2016	Complete
Issue of the inclusion of lay-member representatives as part of the WY STP leadership Group discussed at the group and Chairman's Forum (5.10 – May 16)	Dr R Tolcher, Chief Executive/ Mrs S Dodson, Chairman	June 2016	Complete
Circulate dates of ILN Shadow Board meetings (May 16)	Ms D Henderson, Company Secretary	June 2016	Complete
Paper on initiatives to address ED performance to be submitted to Board (6.2 – May 16)	Mr A Alldred, Clinical Director	June 2016	Complete – verbal update to June meeting
Narrative on avoidable admissions to be included in the June Chief Operating Officer Report (7.4 – May 16)	Mr R Harrison, Chief Operating Officer	June 2016	Complete
Develop process for improving patient feedback on quality of care (12.6 – Feb 16)	Mrs J Foster, Chief Nurse	June 2016	Complete – included in CN report
Reflect and review the thresholds related to SIRI's and NEs to consider Amber rating for SIRIs and the inclusion of month on month performance (6.8 – Mar 16)	Dr R Tolcher, Chief Executive/ Dr D Scullion, Medical Director	June 2016	Complete – included in June IBR report
Personal note to be sent to those members of staff retiring and resigning on behalf of the Board of Directors	Mrs S Dodson, Chairman	June 2016	Complete
Undertake a refresh of the Trust's approach to raising the profile of appraisals (Apr 16)	Mr P Marshall – Director of Workforce and Organisational Development	July 2016	Complete – updates included in the DWOD report

Item Description	Director/ Manager Responsible	Date of completion/ progress update	Confirm action Complete
Amendment to the Quality Committee terms of reference to reflect NED membership of both the Quality Committee and Audit Committee to ensure appropriate triangulation (Jun 16)	Dr S Wood – Deputy Director of Governance	July 2016	Complete
Responsibility for monitoring cases of Grade 3 and 4 Pressure Ulcers to be delegated to the Quality Committee (Jun 16)	Mrs L Webster, Non-Executive Director/ Quality Committee Chair	July 2016	Complete
Nursing and Midwifery Strategy to be uploaded to the Reading Room (Jun 16)	Ms D Henderson, Company Secretary	July 2016	Complete
A briefing on the patient stories to be circulated in advance of meetings for future Board meetings (Jun 16)	Ms D Henderson, Company Secretary	July 2016	Complete
Mrs Dodson to write to Kathryn Riddle, Chair of HEE on behalf of the Board (Jun 16)	Mrs Dodson, Chairman	July 2016	Complete
Progress updates on Quality Objectives to be included in the IBR (May 16)	Mrs J Foster, Chief Nurse	July 2016	Complete – within CN Report
Paper on progress of e-rostering implementation (May 16)	Mrs J Foster, Chief Nurse	July 2016	Complete – **verbal update to be provided at the July meeting**
Include the Trust's current position against trajectory for nurse validation in the CN report (Jun 16)	Mrs J Foster, Chief Nurse	July 16	Complete – within CN Report
Verbal update to be provided as part of the Quality Committee Chair's report on performance relating to completion of complaint action plans (11.5)	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 (8.13)	Dr N Lyth, Clinical Director	September 2016	Complete – paper included in Board pack for July meeting

HDFT Board of Directors Actions Schedule – Outstanding Actions July 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	June 2016	Inclusion of KPIs on Children's Services and Community Services to be included in the IBR (8.6)	Dr N Lyth, Clinical Director	July 2016	Children's Services data from July Community Services data TBC
2	June 2016	Verbal update on the approach taken to ensure adequate clinical cover for planned leave in theatres (8.9)	Dr K Johnson, Clinical Director	July 2016	
3	June 2016	Additional information to be included in the IBR relating to readmissions of older people (8.3)	Mr R Harrison, Chief Operating Officer	September 2016	
4	March 2016	Submission of a Research and Development Strategy for Board approval	Dr A Layton - Associate Medical Director for Research	September 2016 (prev. July 16)	Deferred to September 2016
5	May 2016/ June 2016	Progress with regard to the appointment of Consultant Elderly Care post as part of the oral directorate report (12.8)	DR K Johnson, Clinical Director	September 2016	
6	June 2016	Update on the action plan following the Alan Wood Report into Local Safeguarding Boards (12.6)	Mrs J Foster, Chief Nurse	September 2016	
7	January 2016	Review and revise questions in annual Audit Committee survey (14.1.3)	Mr C Thompson, Non-Executive Director	November 2016	
8	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	
9	June 2016	Update on the programme of work to reduce hospital admissions (9.3)	Mr A Alldred, Clinical Director	January 2017	
10	January 2016	Update Board on progress with EDS2 action plan (11.10)	Mrs J Foster – Chief Nurse	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	

Response to Board of Directors Action Log to provide further detail on metrics relating to health visiting for new born visits to be provided in the IBR

Healthy Child Programme

Pregnancy and the first five years of life

Introduction

The Healthy Child Programme (HCP) begins in early pregnancy and ends at adulthood, and is commissioned as one programme covering all stages of childhood. There has been significant change in the evidence available across the first 5 years of a child's life. However the health of older children, in particular during adolescence, remains a priority: an integrated HCP from pregnancy to adulthood is essential.

There is a strong base for the HCP, as set out in *Health for All Children* (Hall and Elliman, 2006). The most up to date HCP guidance continues to adopt the recommendations of *Health for All Children* as the underpinning universal programme. This has been supplemented by guidance from the National Institute for Health and Clinical Excellence (NICE) and a review of health-led parenting programmes by the University of Warwick.

Health Visiting Service

The Health Visiting Service workforce consists of specialist community public health nurses (SCPHN) and teams who provide expert information, assessments and interventions for babies, children and families including first time mothers and fathers and families with complex needs. HVs help to empower parents to make decisions that affect their family's health and wellbeing and their role is central to improving the health outcomes of populations and reducing inequalities.

The four contemporary principles of health visiting were first published in 1977. They are:

1. Search for health needs;
2. Stimulation of an awareness of health needs;
3. Influence policies affecting health;
4. Facilitate health enhancing activities.

The Health Visiting Service works across a number of stakeholders, settings and organisations to lead delivery of the Healthy Child Programme 0-5 (HCP), a prevention and early intervention public health programme that lies at the heart of the universal service for children and families and aims to support parents at this crucial stage of life, promote child development, improve child health outcomes and ensure that families at risk are identified at the earliest opportunity.

This includes safeguarding children and working to promote health and development in the '6 high impact areas' for early years.

- Transition to parenthood and the early weeks
- Maternal mental health (perinatal depression)
- Breastfeeding (initiation and duration)
- Healthy weight, healthy nutrition and physical activity
- Managing minor illness and reducing hospital attendance and admission
- Health, wellbeing and development of the child age 2 – 2.5 year old review (integrated review) and support to be 'ready for school'.

As a provider this guidance has supported us to develop an integrated approach to meeting the needs of young children and their families and the delivery of improved outcomes. Health Visitors' lead delivery of the HCP and work in partnership with maternity services, local authority-provided or commissioned early years services, voluntary, private and independent services, primary and secondary care, schools, health improvement teams, Family Nurse Partnership (FNP) colleagues and children's social care services.

The Evidence

Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are set in place during pregnancy and in early childhood. What happens during these early years has lifelong effects on many aspects of health and wellbeing, educational achievement and economic status. Universal and specialist public health services for children are important in promoting the health and wellbeing of all children and reducing inequalities including:

- Delivery of the HCP;
- Assessment and intervention when a need is identified; and
- On-going work with children and families with multiple, complex or safeguarding needs in partnership with other key services including early years, children's social care and primary care.

Successive academic and economic reviews have demonstrated the economic and social value of prevention and early intervention programmes in pregnancy and the early years. In fact, the evidence-base for improved health, social and educational outcomes from a systematic approach to early child development has never been stronger and has been described as a powerful equalizer which merits investment (Irwin et al 2007, Marmot 2010).

During pregnancy and in the first 2 years, a baby's brain and neurological pathways are being laid down for life with 80% of a baby's brain development taking place during this time. It is therefore the most important period for brain development, and is a key determinant of intellectual, social and emotional health and wellbeing. Research studies in neuroscience and developmental psychology have shown that interactions and experiences with caregivers in the first months of a child's life determine whether the child's developing brain structure will provide a strong or weak foundation for their future health, wellbeing, psychological and social development1

The following are the most appropriate opportunities for screening tests and developmental surveillance, for assessing growth, for discussing social and emotional development with parents and children, and for linking children to early year's services:

- by the 12th week of pregnancy;
- the neonatal examination;
- the new baby review (around 14 days old);
- the baby's six to eight-week examination;
- by the time the child is one year old; and
- between two and two-and-a-half years old

10-14 New Baby Review

We are measured against our performance of the new baby review which is expected to take place between 10 and 14 days post-delivery. To ensure consistency everyone is trained to understand that the day a baby is born will be day 0. The performance across North Yorkshire has significantly improved over the last 12 months and has at times reached 85% with some individual areas consistently achieving 100%. We will be sharing data with individual practitioners to be consistent with our new colleagues from County Durham, Darlington and Middlesbrough to support the continuous improvement in achieving above 90% for this specific contact.

Parents eligible for the new birth contact for Q1 2016

		April	May	June	Q1 Total
Number turning 30 days					
	Durham	441	483	430	**1354**
	Darlington	103	101	99	**303**
	Middlesborough	132	152	155	**439**
	North Yorkshire	464	487	506	**1457**
% with a 10-14 day visit					
	Durham	94.1%	95.2%	91.4%	**93.6%**
	Darlington	97.1%	92.1%	96.0%	**95.0%**
	Middlesborough	99.2%	98.0%	96.8%	**97.9%**
	North Yorkshire	96.3%	98.4%	96.6%	**97.1%**
% with 10-14 day visit by 14 days					
	Durham	83.0%	88.8%	83.0%	**85.1%**
	Darlington	83.5%	86.1%	85.9%	**85.1%**
	Middlesborough	86.4%	90.8%	89.7%	**89.1%**
	North Yorkshire	78.7%	84.0%	81.2%	**81.3%**
% 10-14 day visit after 14 days					
	Durham	11.1%	6.4%	8.4%	**8.6%**
	Darlington	13.6%	5.9%	10.1%	**9.9%**
	Middlesborough	12.9%	7.2%	7.1%	**8.9%**
	North Yorkshire	17.7%	14.4%	15.4%	**15.8%**

A number of factors can impact on the performance of this contact

- The date/time may not be suitable for the family
- If the baby is in Special Care Baby Unit
- The family may be staying out of the area (this is seen frequently with the military)
- The caseload size held per whole time equivalent
- Failed contact
- Quality of the data

In County Durham, Darlington and Middlesbrough the average caseload size is 250 per WTE compared to North Yorkshire where it is 400.

Conclusion

It is important to avoid a 'tick box approach' when undertaking a health and development review, and it should always be undertaken in partnership with the parents. Parents want a process that recognises their strengths, concerns and aspirations for their child. Health professionals need to use consultation skills, purposeful listening skills and guiding questions to ensure that the goals of the HCP are aligned with the goals of the parents – while not losing the focus of the review.

However we are committed to ensure that our workforce fully understands the need to perform to the highest possible level and this is fostered at all times. Team Leaders will be required to analyse the data they receive on a monthly basis to identify where the target have not been achieved and provide exception reports. Key messages regarding targets are consistently given at key meetings such as the Healthy Child programme steering group and team meetings.

Dr N Lyth
Clinical Director
Children's and County Wide Community Care Directorate

Report to the Trust Board of Directors: 27th July 2016	Paper No: 5.0

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 Trust has achieved a year to date surplus of £165k with an associated risk rating of 4. The adverse position is driven by a combination of income and CIP shortfalls.
- The Community Services Contract for 2016/17 remains unsigned. An implied contract prevails and services continue to be delivered and funded.
- The Trust has received clarity on the criteria to access Sustainability and Transformation Funding.
- The comprehensive programme of work to develop the West Yorkshire STP continues and the collaborative West Yorkshire STP was submitted as required by 30 June.
- The Trust is in receipt of the draft Care Quality Commission report. The final report will be published on the CQC website on either 25th or 26th July and a Quality Summit to discuss the Trust's response to the report has been arranged to take place on Friday 29th July 2016.

Related Trust Objectives:

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

Risk and Assurance	No significant issues to note
Legal implications/ Regulatory Requirements	Nil

Action Required by the Board of Directors

- The Board is requested to **note** the strategic and operational updates
- The Board is asked to **note** progress on risks recorded in the BAF and Corporate Risk Register and confirm that progress reflects the current risk appetite.

1.0 MATTERS RELATING TO QUALITY AND PATIENT EXPERIENCE

1.1 2016/17 Contract Update

As the Board will be aware, the community services contract is not yet signed due to the need to undertake Quality Impact Assessments (QIA) for the services affected by the proposed commissioning changes. A QIA session in relation to the New Care Models team was held on 7th July, and whilst this has not yet been finally signed off, we are now in a position to implement the changes. We have committed to implementing the changes in a way that delivers the cost reductions as quickly as possible whilst protecting staff working in the service, recognising the status of the Memorandum of Understanding (MoU) and the necessary notice period.

With regards to the Living with Pain service, further work is required to assess the potential service changes before a decision can be taken, and in relation to the Wheelchair Service we are working with Harrogate and Rural District CCG (HaRD CCG) through the procurement process, given that we have decided not to pursue continued provision of this service from 1st December.

Regarding the acute contract, the outstanding issue relates to the inclusion of improvement trajectories within the contract and the link to System Resilience Group (SRG) funding previously received from the CCG.

A helpful conference call with NHS Improvement took place on Monday 18th July and we are awaiting further feedback from NHS Improvement in relation to finalising both contracts. A verbal update will be given at the Board meeting.

1.2 Sustainability and Transformation (S&T) Funding criteria

A letter was received detailing the criteria that each organisation will need to meet in order to access the S&T funding for 2016-17. Further clarification was then received by means of a 'Frequently Asked Questions' communication. An extract from the letter is set out below:

Access to S&T funding will operate on the following basis:

- *The financial control totals are a binary on/off switch to secure S&T Funding – i.e. having achieved the year-to-date control total in a quarter, the organisation becomes eligible for funding, the size of which is determined by the level of success with the other criteria;*
- *Achievement of the year-to-date financial control total for the quarter is weighted at a minimum of 70% dependant on the range of agreed performance trajectories;*
- *The year-to-date financial control total being measured is excluding any S&F Funding, hence avoiding any a situation where a provider is penalised twice for a single issue i.e. withholding a proportion of the fund because of a performance failure that results in the provider missing its financial control total; and*
- *Performance against agreed trajectories is weighted at 30%, with Referral to Treatment (RTT) and Accident and Emergency accounting for 12.5% each, Cancer 62 days at 5%. Diagnostics has also been included as improvement trajectories were collected but will carry a 0% weighting.*

The emphasis is clearly on financial delivery. Further clarification is that the failure to earn the S&T Funding in a quarter can be recovered if the year to date position is as planned in the subsequent quarter, and also that if S&T Funding is earned in one quarter it cannot then be lost if performance in subsequent quarters deteriorates.

Payment of the S&T fund will be quarterly in arrears, except for Quarter 4 when payment will be based on year end forecast and transacted in March.

These criteria reinforce the need to deliver the financial plan alongside the performance standards, with the incentive being the receipt of £4.6m this year.

2.0 STRATEGIC UPDATE

2.1 West Yorkshire Sustainability and Transformation Plan (WYSTP)

The comprehensive programme of work to develop the West Yorkshire STP continues and the collaborative West Yorkshire STP was submitted as required by 30th June. This document sets out the high level ambition for achieving long term sustainability of services at a West Yorkshire level, and some of the underpinning transformation schemes which will enable this. The document covers the three aims relating to health and wellbeing, care quality, and financial sustainability.

In relation to the financial submission, this described the 'do nothing' position, where a gap across the West Yorkshire health and care system of nearly £1bn was identified. A piece of work has been undertaken by each of the six local STP areas to describe the current position in relation to plans to close the financial gap as part of a 'do something' option. For Harrogate, our collective position is that the gap closes from the 'do nothing' position of £45m to a more realistic £15m. This position is in the process of being combined with the other five local systems to generate a West Yorkshire position.

A meeting was held on 13th July to review the West Yorkshire draft submission. This meeting included Jim Mackey, Chief Executive of NHS Improvement and Simon Stevens, Chief Executive of NHS England, as well as other representatives from arms lengths bodies. The key messages following this review were:

- Recognition that we had made progress in respect of governance and relationships across West Yorkshire;
- That we were in a reasonable place so far;
- That the next 6-8 weeks will be crucial and we need to set out what in practice we are going to do and then quantify in each of the three areas what the impact will be. i.e.:

    - How much will care and quality be improved through our actions?
    - How much will health and wellbeing be improved through our actions?
    - How will the financial gap be closed through our actions?

- That the West Yorkshire Association of Acute Trusts (WYAAT) work (supported by PwC) to explore the potential options for collaboration will be helpful and needs to be reported back as part of STP submission in September. Also, the work needs to make sure it triangulates with the commissioning work being done (e.g. on the stroke pathway);
- Are there opportunities in each of the 6sixarea STPs that can be replicated across the others? (e.g. telehealth at Airedale);
- What is our response to the requirement to examine pathology consolidation and sharing of back office functions?; and
- That the overall narrative needs to be 'sharper' (say what we are doing, and how and when).

Overall the review meeting was positive, but we collectively need to do a lot of work over the next 6-8 weeks before the next submission in September.

The WYAAT commissioned assignment (to be undertaken by PwC) to support the case for change and to identify and explore the opportunities for further collaboration across acute trusts has just begun, and Mr Jonathan Coulter, Deputy Chief Executive/Finance Director, along with

his counterpart from Leeds Teaching Hospitals NHS Trust and the WYAAT Programme Director, met PwC for the initial engagement meeting and will be overseeing the project.

As the development of the STP progresses alongside the PwC assignment, I will ensure that the Board is kept fully briefed.

2.2 Care Quality Commission (CQC) Report

Following the Trust's formal CQC inspection carried out in February 2016 a draft report was received by the Trust on 24th June. Trust representatives have undertaken the factual accuracy check and returned the feedback to the CQC as requested on 12th July. The final report will be published on the CQC website on either 25th or 26th July and a Quality Summit to discuss the Trust's response to the report has been arranged to take place on Friday 29th July 2016. We are liaising with the CQC to coordinate our communication of the report both internally with our staff and externally with our stakeholders and members of the public.

3.0 NATIONAL COMMUNICATIONS RECEIVED AND ACTED UPON

3.1 Consultation on the Single Oversight Framework

On 28th June, NHS Improvement published its consultation on the Single Oversight Framework. The consultation document sets out the approach NHS Improvement proposes to take in overseeing providers using a Single Oversight Framework for both NHS Trusts and Foundation Trusts and shaping the support they provide. It describes their proposed approach to:

- The main areas of focus of their regulatory oversight;
- How they will collect the information required from providers;
- How they will identify potential concerns with a provider's performance; and
- How they will segment the provider sector according to the level of challenge each provider faces, and the associated support they will require.

The consultation ends on 4th August and the full consultation document is available in the Reading Room. A collective response is being collated and any contributions to the response should be forwarded to Ms Debbie Henderson, Company Secretary.

3.2 NHS Improvement Business Plan and Objectives 2016/17

NHS Improvement has published their 2016/17 business plan and objectives to 2020. The plan explains the role of NHS Improvement in providing the national leadership, oversight and practical support that providers will need to deliver urgent improvements at the frontline and how they will work towards long term sustainability. The full document is available in the Reading Room.

4.0 WORKING IN PARTNERSHIP

4.1 Harrogate Clinical Board

Following the launch on 16th June, the Elective Care Rapid Testing Programme had progressed to look at new ways of working across referrals from Primary and Secondary care, shared decision making and outpatient processes. The three specialty areas are gastroenterology, orthopaedics and dermatology and it is envisaged that ideas with be rolled out from October onwards. Early indications from team members are positive and the Clinical Board continues to provide executive oversight and support.

The Clinical Board supports efforts to reduce unnecessary outpatient follow-ups and work to code all follow-ups has commenced to allow clinicians to have a point of care reminder to ensure follow-up is required, and to obtain data on the conditions requiring follow-up.

New pathways and guidance has been developed following strong clinical engagement between GPs and hospital Consultants and the Clinical Board continues to encourage opportunities for joint working going forward.

4.2 Harrogate Health Transformation Board (HHTB)

The next meeting of the Harrogate Health Transformation Board is on 28th July and a verbal update following the meeting held 23rd June was provided to the Board of Directors meeting on 29th June.

The Key Messages from the 28th July meeting will be placed in the Reading Room in due course.

5.0 FINANCIAL POSITION

The reported position at the end of Month 3 (June) is that we have delivered our year to date plan of a surplus of £165k (actual surplus £271k) with an associated risk rating of 4. This position means that we will be accessing the first quarter of the S&T Fund as described in the criteria in section 1.2 above. Delivery of the quarterly position has been achieved through use of contingencies that would normally be held to meet pressures later in the year, therefore the operational budgetary position of the Trust is that we remain behind where we planned to be by directorate by around £600k in quarter. This is a concern and the pressures remain in terms of delivering our activity, managing pay pressures on our wards and delivery of our efficiency programme. Further information is contained within the report from the Finance Director.

6.0 SENIOR MANAGEMENT TEAM (SMT) MEETING

The SMT met on 20th July. Key issues discussed and for noting by the Board of Directors are as follows:

- Feedback from the CQC following our comments on the draft report was outlined and welcomed by all;
- A number of infection control issues were discussed. Work is ongoing to improve compliance with hand hygiene requirements, with the first step being the consistent undertaking of the necessary hand hygiene audits. TACCORD compliance was picked up as part of the debate, and in particular the continued challenge of ensuring that the necessary checks are undertaken and documented. Particular reference was made to a recent case involving oxygen prescribing, and also the continued limited assurance received in relation to cannula care;
- Feedback from junior doctors in relation to patient track, and the actions that have been taken, and will be taken, to improve the processes around the use of the system;
- Feedback from junior doctors in relation to concerns raised as part of the triggered visit, and the actions that we are taking;
- Financial performance at the end of Quarter 1 with a discussion focused on recovering our activity and income position over the rest of the year. This discussion included the need to agree criteria for Consultants in terms of taking annual leave and ensuring sufficient cover within individual specialties or sub-specialties. It was recognised that there are ongoing staffing issues that are compromising the delivery of activity which have been exacerbated by the agency cap;

- Mark Farndon presented the 'Getting it right first time (GIRFT)' information for our orthopaedic service. HDFT compares very favourably across a range of benchmarks in terms of both quality and efficiency. There are some areas to strengthen that require further discussion and action, including the potential to ring-fence orthopaedic elective beds and the consistent delivery of best practice in relation to our fractured Neck of Femur pathway;
- Social media policy was approved, and the existing smoke free policy was confirmed, though there is now work to take forward to ensure compliance with the policy;
- Allocation of incidents to the new Directorates to ensure that actions are identified and followed through. A timetable of September was proposed, although we will be working to expedite this as soon as is possible
- Feedback in relation to the limited assurance audit reports following both the meetings with the Chief Executive and the recent Audit Committee. A commitment was reiterated in relation to the areas of discharge, cannula care, and rostering, and the agreed actions to be followed through; and
- A general recognition that it remains challenging for staff across the Trust as we seek to maintain quality and deliver on the performance and finance. Whilst the national emphasis has swung heavily towards financial delivery over anything else, collectively we are committed to delivering quality, finance and performance together and are agreed that this is the bedrock of our success. We would communicate this message through Directorates.

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

7.0 LEASE AGREEMENT

The Heatherdene Unit is part of the Trust's estate located on the periphery of the Harrogate District Hospital Site. York Teaching Hospitals NHS Foundation Trust (YTHT) has used accommodation within this unit for many years to provide the following services:

- Renal/dialysis care on the ground floor, under a formal lease agreement; and
- Genito Urinary Medicine (GUM) services on the 1st floor and CaSH services provided by HDFT.

No formal lease was put in place for the use of the 1st floor space, as historically it had been agreed that formal arrangements could be waived as both organisations used the facilities as part of our Clinical Alliance. YTHT successfully tendered for the CaSH service in July 2015 and as such now use this 1st floor accommodation to provide both GUM and CaSH services. In view of this change it was agreed that the use of the accommodation needed to be formalised through a lease agreement.

The Board of Directors is asked to note the formal lease agreement between HDFT and YTHT for the occupation of accommodation on the 1st Floor Heatherdene for CaSH and GUM services by YTHT. The lease will be signed by Dr Ros Tolcher, Chief Executive and Mrs Sandra Dodson, Chairman under the Trust's seal.

8.0 BOARD ASSURANCE AND CORPORATE RISK

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

8.1 Board Assurance Framework (BAF)

The BAF was reviewed by the Executive Directors during week commencing 18 July. No risks were removed, and all risks have action plans to address the gaps in controls. All BAF entries have action plan 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.

Eight risks (BAF numbers 2, 6, 7, 8, 9, 11, 12, and 13) are currently assessed as having achieved their target risk score. There are five strategic risks (BAF numbers 1, 4, 12, 14 and 15) which are assessed at a risk score of 'Red' 12. No BAF entries have scores greater than 12.

There have been no changes to the residual (current) risk score for any risks since the Board meeting in June. The Board of Directors considered the risks associated with the national approach to planning through Sustainability and Transformation Plans and these have been reflected within the current scope of the BAF. A separate risk including detail of key controls, gaps in assurances and actions to close the gaps will be incorporated in September as part of the full quarterly review of the BAF.

The Board of Directors took an opportunity to review the content and purpose of the full BAF at the Board Strategy Away Day held on 11 July and agreed that the BAF continued to reflect the Trust's principal risks and was a key source of assurance for the Board.

The Board also examined BAF 6 in detail at the Board Strategy Away Day as part of the detailed review of all risks in the BAF across the year. The strategic risks are as follows:

Ref	Description	Risk score	Progress score
BAF 1	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 of a lack of understanding of the market	*Amber 8 ↔*	*Improved to 1*
BAF 7	Risk of a lack of a robust approach to new business	*Yellow 4 ↔*	*Improved to 1*
BAF 8	Risk to visibility and negative impact on reputation	*Amber 8 ↔*	*Decreased to 2*
BAF 9	Risk of a failure to deliver the Operational Plan	*Amber 8 ↔*	*Unchanged at 2*
BAF 10	Risk of breaching the Trust's Licence to operate	*Amber 10 ↔*	*Unchanged at 2*
BAF 11	Risk to current business	*Yellow 4 ↔*	*Unchanged at 1*
BAF 12	Risk of external funding constraints	*Red 12 ↔*	*Decreased to 2*
BAF 13	Risk of a reduced focus on quality	*Yellow 4 ↔*	*Improved to 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*

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/behind plan*
4. *Actions defined – work not yet commenced*

8.2 Corporate Risk Register (CRR)

The CRR was reviewed at the monthly meeting of the Corporate Risk Review Group on 8th July 2016. The Corporate Risk Register contains eight risks. Changes to the CRR are as follows:

New Risks

CR12 – Risk to HDFT's financial sustainability from failure to deliver the engagement for, and the pace and scale of, transformation required through the Clinical Transformation programme – was escalated to the CRR with a risk score of 'Red' 12.

Changes to the Corporate Risk Register

The risk score for CR5 – risk of patient harm due to lack of experienced qualified nurses due to a national shortage in registered nurses – was reduced from 'Red' 15 to Red '12', due to the completion of actions to mitigate the risk.

The risk score for CR7 – risk of failure to meet the 4-hour A&E waiting time national standard – was reduced from 'Red' 16 to 'Red' 12. This was due to the Trust achieving the 95% standard; however, the group agreed that continual monitoring as a high risk was required due to the associated consequences.

The risk score for CR8 – risk of harm to ophthalmology patients of potentially being lost to follow up – was reduced from 'Red' 12 to 'Amber' 8 as a result of the ongoing work which had been undertaken to review the appointment booking process. The risk was therefore removed from the Corporate Risk Register to continue to be managed on the Planned and Surgical Care Directorate risk register.

The risk score for CR11 – financial and regulatory risk due to non-compliance with agency cap rules – was increased from a score of 'Red' 12 to 'Red' 16. It was acknowledged that the risk related to compliance with the agency cap rules and the current gap in control reflected the absence of a plan to recovery activity.

The current risk scores for CR9 remained the top scoring risks at Red 16:

- CR9: Risk to the sustainability of service delivery and acute rotas due to withdrawal of trainees in Medicine.
- CR11: Financial and Regulatory risk due to non-compliance with agency cap rules.

Risks CR9, CR10, CR11 and CR12 have reported actions behind plan with the progress score of 3.

Dr Ros Tolcher
Chief Executive
20 July 2016

Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 27 July 2016	**Paper No: 6.0**

Title	Performance against Strategic KPIs
Sponsoring Director	Dr. Ros Tolcher, Chief Executive
Author(s)	Rachel McDonald, Head of Performance & Analysis Samantha McLachlan, Assistant Planning Manager
Report Purpose	For information.

Key Issues for Board Focus:
Performance against all three strategic objectives and the external validation contained within the report.

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

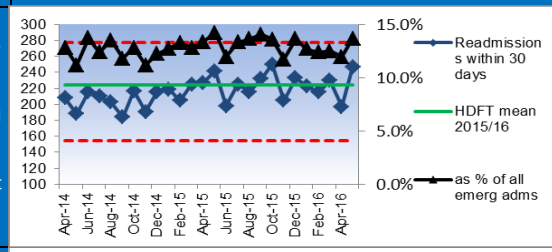
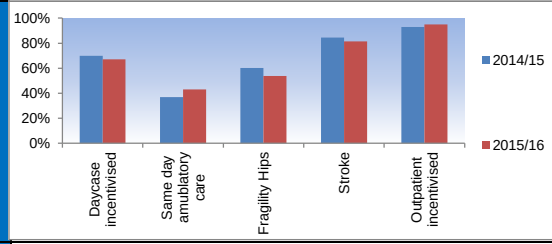
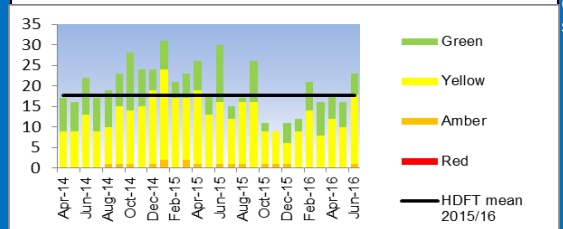
Risk and Assurance	None
Legal implications/ Regulatory Requirements	None

Action Required by the Board of Directors
To note the Strategic KPIs performance report

Harrogate and District NHS Foundation Trust

Delivering High Quality Care

Jun-16

Indicator	Description	Trend chart	Interpretation
Strategy for frail elderly in place, with milestones agreed	This narrative describes progress in relation to the development of the strategy for frail elderly and associated milestones.	The Strategy was approved at the Board in May 2016. A steering group is in the process of being established to drive the Strategy forward. Action plans are being developed for various sections of the plan and will be monitored by the Steering group.	
Reduction in avoidable emergency readmissions within 30 days	% 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.		The number of readmissions increased in May, both actual numbers and as a percentage of all emergency admissions.
Proportion of Best Practice Tariff achieved	The chart compares each key area of Best Practice Tariffs achieved/monitored from 2014/15 to 2015/16.		The achievement in Best Practice Tariff has decreased 6% in fragility hips and 3% in daycase incentivised procedures and stroke. However there have been slight increases in outpatient incentivised procedures and same day ambulatory care.
Reduction in number of complaints per 1000 contacts referencing communication	The number of complaints received by the Trust, shown by month of receipt of complaint. The criteria define the severity/grading of the complaint with green and yellow signifying less serious issues, amber signifying potentially significant issues and red for complaints related to serious adverse incidents. The data includes complaints relating to both hospital and community services.		Complaints received which referenced 'Communication' as a category within the complaint are summarised in the table below. Not all of these complaints are fully resolved/closed as yet.

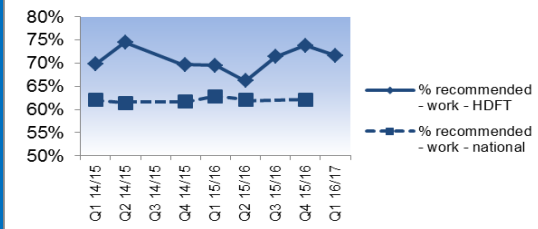
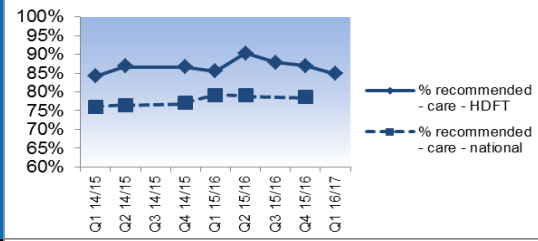
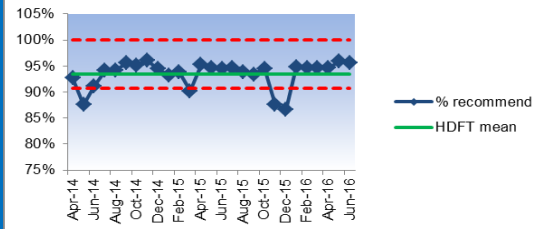
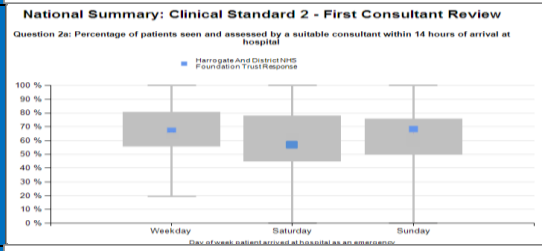
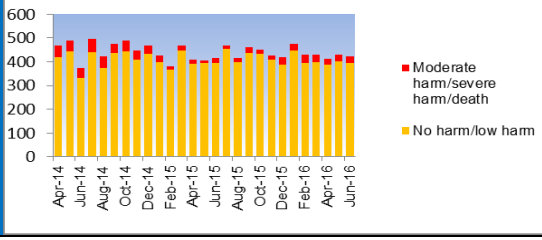
	16/17 closed	16/17 all
2016 04	11	11
2016 05	2	2
2016 06	2	6
Totals:	15	19

	15/16 all	15/16 closed
2015 04	15	15
2015 05	6	6
2015 06	14	14
2015 07	8	8
2015 08	8	8
2015 09	15	15
2015 10	4	4
2015 11	2	2
2015 12	6	6
2016 01	7	7
2016 02	8	8
2016 03	7	5
Totals:	100	98

Harrogate and District NHS
NHS Foundation Trust

Delivering High Quality Care

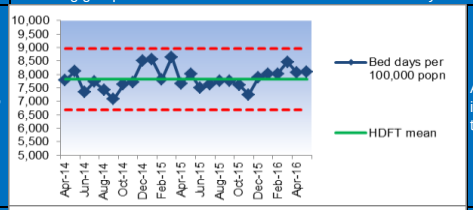
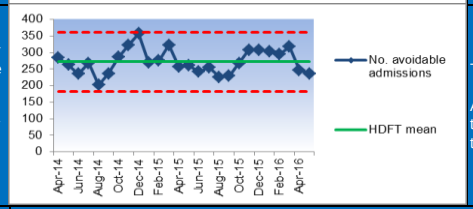
Jun-16

Indicator	Description	Trend chart	Interpretation
Friends & Family Test (FFT) - Staff - % recommend as a place to work	The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organisation they work in. 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.		In Quarter 1, 72% of HDFT staff recommended the Trust as a place to work - this compares to the latest published national average of 62%. 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.
Friends & Family Test (FFT) - Staff - % recommend as a place to receive care	The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organisation they work in. 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.		In Quarter 1, 85% of HDFT staff recommended the Trust as a place to work - this compares to the latest published national average of 79%. 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.
Friends & Family Test (FFT) - Patients	The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of hospital and community services including inpatients, day cases, outpatients, maternity services, the emergency department, some therapy services, district nursing, community podiatry and GP OOH. A high percentage is good.		Due to a technical problem with the automated phone call service, less patients than usual were surveyed in June (1,200 compared to a monthly average of around 5,000). A fix for the technical issue should be in place by late July. 95.7% of patients surveyed in June would recommend our services, above the latest published national average of 92.8%.
Senior patient reviews within 14 hours	All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours of arrival at hospital.		The Trust were approached by NHS England in February 2016 to undertake a further review of four clinical areas, including the patient review within 14 hours. There was a standard national assessment period of Wednesday 30 March until Tuesday 5 April to allow for easier direct comparison of the results between Trusts. During this period HDFT undertook a prospective case note review of 40 emergency admissions per day - a total of 280 patients across the seven day assessment period. Of the 40 reviews each day, 20 were consecutive emergency hospital admissions from 09:00, and 20 were consecutive emergency hospital admissions from 17:00. The national results are still being validated and therefore are embargoed at present but the Trust's acheivements are shown in the chart opposite.
Proportion of high/low risks. Reporting culture. Total no incidents, % that are high	The chart shows the number of incidents reported within the Trust each month. It includes all categories of incidents, including those that were categorised as "no harm". The data includes hospital and community services. A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture		There were 423 incidents reported in June. The number of incidents reported each month remains fairly static but the proportion classified as moderate harm, severe harm or death has reduced over the last 3 years. The latest published national data (for the 6 month period to end September 2015) showed that Acute Trusts reported an average ratio of 31 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 21.

Harrogate and District NHS
NHS Foundation Trust

Working with partners to deliver integrated care

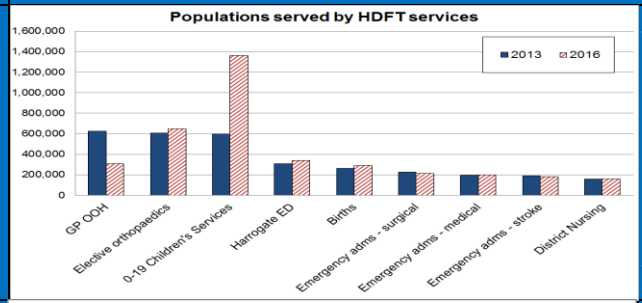
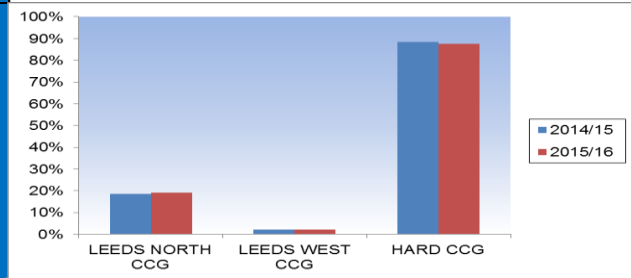
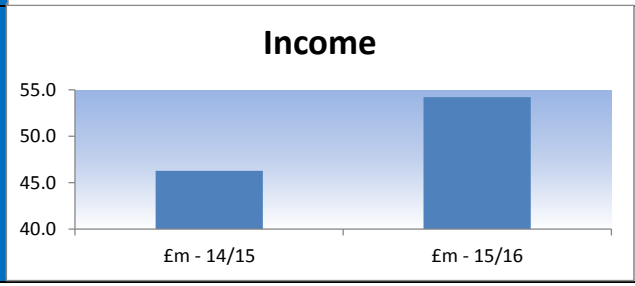
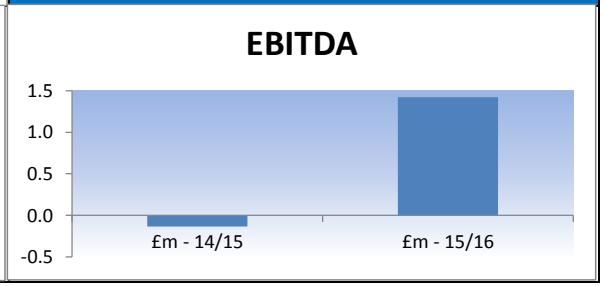
Jun-16

Indicator	Description	Trend chart	Interpretation
Agreed service model in place, milestones identified, contractual arrangements in place	The narrative describes progress in relation to the development of the joint service model and associated milestones for the New Models of Care	The first Integrated Community Care Team (ICCT) has been live since 1st February 2016 and is functioning well. Social Care and Mental Health resources are attached to the team and we have identified a number of areas of improvement within the system including: • review of some complicated referral processes which delayed care delivery; • improved access to social care assessment via direct contact; • improved access to mental health support and signposting; • feedback from GPs that unnecessary contacts have reduced; • ability to identify duplication of effort and access specialist advise via weekly MDTs; • cases of admission avoidance where services have responded jointly in the first instance. Funding for the next phase, Response and Overnight Service, is yet to be finalised but will support further enhancement of the four ICCTs once in place. In the interim, the community therapy and rehabilitation element of CFRRT is transferring into the ICCTs week commencing 11th July 2016. We are also implementing the plan to move Specialist Nurse resources into the ICCTs to provide direct support and consultation as per the agreed model. The 10 community beds are now in place and have been utilised regularly. We are now trialling the use of a number of these beds for 'step-up' as opposed to 'step-down' to establish the level of need and what will enable access for patients with higher level needs in the future. Social Care partners are supporting the initiative via ED presence to help identify people who would benefit from access to a community bed. CFRRT are also providing similar support via CATT and will signpost people to community beds where appropriate, assuming they are not able to be managed at home. A working group has been established to decide how future ways of contracting will be undertaken.	
Harrogte residents NEL bed days/1000 (over 65s) reduced	The charts shows the number of non-elective (emergency) bed days at HDFT for patients aged 18+, per 100,000 population. The chart only includes the local HARD CCG area. A lower figure is preferable.		As can be seen, the number of non-elective bed days for patients aged 18+ has remained fairly static over the last two years. Further analysis of this new indicator will be completed to look at the demograghic changes during this period and the number of admissions for this group will assist in understanding this further. This is also the focus of the New Care Models work and one of the metrics being used to evaluate this pilot.
Reduced avoidable admissions	The chart shows the number of avoidable emergency admissions to HDFT as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require admission. Conditions include pneumonia and urinary tract infections in adults and respiratory conditions in children.		There were 236 avoidable admissions in May, a decrease on last month. An admission avoidance/urgent care project group has been established and the Trust is working with HARD CCG to develop care models and pathways that support patients to stay in their own home and reduce the risk of hospital admissions. This is also the focus of the New Care Models work and one of the metrics being used to evaluate this pilot.
Joint IT strategy agreed with agreed milestones	This narrative describes the progress in relation to the development of the joint IT strategy in conjunction with our partners in the Health Community	At the end of June all partner organisations in the local health community submitted a jointly developed Local Digital Roadmap (LDR) to NHS England, reflecting the ambition for information to be shared, accessed and added to by all partner organisations. Partners involved in the Vanguard NCM IM&T work-stream were involved in the development and will continue to oversee further development and updates. The LDR reflects WebV as the Trust's integrated EPR (Electronic Patient Record) solution with the proof of concept work taking place in 2016/17 further supporting this ambition.	
Formal alliances in place	Formal alliances in place (LTHT, YHFT, AHFT) with governance arrangements and workplan agreed	LTHT - Alliance Board meetings scheduled and held regularly. A Work Plan is being developed with a number of workstreams identified. These include Cardiac Services, future use of Wharfedale Hospital, General Surgery, Paediatric Surgery, Maternity, Gynaecology, Stroke/Neurology and Paediatric Medicine. YTHT - Clinical Alliances well established. Alliance Board meetings scheduled and held regularly. Number of work programmes being taken forward across a range of specialties. Key initiatives being discussed include developing alliances in Cardiology, new pathways in Ophthalmology and potential partnership working in Gastroenterology. There are good examples of collaborative working in place with areas of best practice shared across both organisations. ATHT - Alliance Board meetings scheduled 6 monthly. Focus on sharing areas of good practice and joint learning.	
Patient satisfaction of new model of care	This narrative describes patient feedback in relation to the new models of care	Patient feedback is being collated via the FFT but does not specify the team. We are in the process of rolling out new forms which are team specific to isolate feedback from Knaresborough, Boroughbridge and Green Hammerton specifically.	

Harrogate and District NHS Foundation Trust

Clinical and Financial sustainability

Jun-16

Indicator	Description	Trend chart	Interpretation
Sustainable service strategy refreshed with milestones agreed	The narrative describes progress with regard to the sustainable service strategy and associated milestones	The Trust's 5 year strategic plan sets out the Clinical and Financial Sustainability plan, including the development of Emergency Surgery, Elderly Care, Paediatrics, Maternity and community services to deliver care closer to home. The Board set out the intention to grow the Trusts revenue by £30m over the 5 years, with the business development plan setting out how this will be achieved through a mixture of growth in elective work, demographic growth, successful tender bids and development of private patient work. This has now been achieved with the successful bid for 0-19 Childrens Services in Middlesbrough, Darlington and County Durham. The Trust has also continued to deliver increased revenue in elective work year on year. The Clinical Sustainability Review which was last undertaken in 2013, has been reviewed and the draft 2016 document is being finalised and will be shared with the Board of Directors in September.	
Sufficient catchment population for key specialites of maternity, paediatrics and emergency surgery	This narrative describes progress in relation to the development of catchment areas for the key specialities of maternity, paediatrics and emergency surgery. The chart shows populations served by HDFT services in 2013 and in 2016.		Work has progressed to develop catchment areas for Maternity, Paediatrics and Emergency Surgery, with new developments in community midwifery outreach into Leeds, development of Endoscopy services in Wharfedale and Surgical Outpatients in Yeadon, changes in provision of Paediatrics and Maternity to the north of Harrogate and development of Paediatric outpatient services into Leeds. There has been increases in population bases in 0-19 services (127% from April 16), the Emergency Department (10%), Maternity (10%) and T&O (7%). Most other services have seen little change, with the exception of GPOOH where there has been a reduction of 50% due to the transfer of contract of the York GPOOH service.
Increased share of HaRD CCG, Leeds North CCG and Leeds West CCG referrals	The chart shows the proportion of first outpatient attendances from each locality that are seen at HDFT. The data is sourced from the HED (Healthcare Evaluation Data) benchmarking system and only includes specialties for which HDFT run services.		HDFT's market share in 2015/16 was 88% in HARD CCG, 19% in Leeds North CCG and 2% in Leeds West CCG, no significant change on the previous year.
Income and EBITDA	The charts show the growth in income and EBITDA YTD last financial year vs this		

Harrogate and District NHS
NHS Foundation Trust

Clinical and Financial sustainability

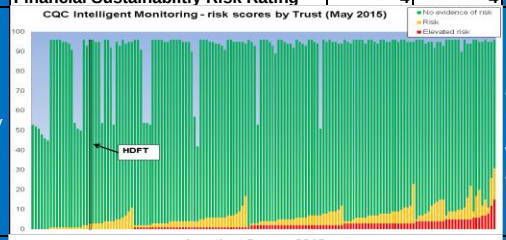
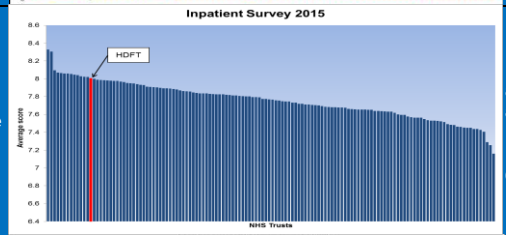
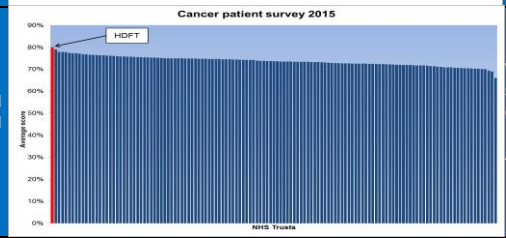
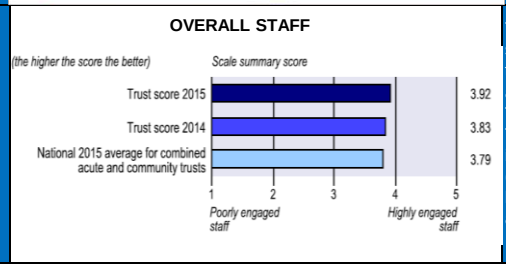
Jun-16

Indicator	Description	Trend chart	Interpretation
CCG/Commissioners survey undertaken	CCG/Commissioners survey undertaken and actions taken in response	A survey was circulated to HARD and Leeds CCGs. There has been a good response rate from HARD GPs and a limited response rate from Leeds GPs. The results of the GP survey have now been shared with the organisation and an action plan developed to take forward the key actions from the survey. This is being maintained by the Business Development Group.	

Harrogate and District NHS
NHS Foundation Trust

External Monitoring

Jun-16

Indicator	Description	Trend chart	Interpretation
NHS Improvement Financial Sustainability risk rating	The NHS Improvement Financial Sustainability risk rating includes four components, as illustrated in the table to the right. An overall rating is calculated ranging from 4 (no concerns) to 1 (significant concerns). This indicator monitors our position against plan.	**Risk Rating** / **Year to Nov** — **Plan** / **Actual** Capital Service Capacity rating: 4 / 4 Liquidity rating: 4 / 4 I&E Margin rating: 4 / 4 I&E Margin Variance rating: 3 / 4 **Financial Sustainabiltiy Risk Rating: 4 / 4**	The Trust will report a risk rating of 4 for the year to June.
CQC Intelligent Monitoring reports	CQC have now discontinued their Intelligent Monitoring Reports. The last publication was in May 2015. The reports included around 100 indicators and were used by CQC as part of the new inspection process to raise questions about the quality of care.		For the last publication, HDFT was given an overall banding of 6, the lowest risk banding. HDFT had no indicators assessed as "elevated risk" and 3 indicators assessed as "at risk", out of 96 applicable indicators. This placed HDFT joint 20th out of 155 Trusts as illustrated by the chart to the left. This is an improvement on the previous publication in December 2014, when HDFT was ranked joint 50th. We are currently awaiting the final report and rating from the CQC Inpsection of the Trust in February 2016 and should be in a position to share this with Trust board at the end of July.
Patient Survey	The national adult inpatient survey for 2015 was published in May 2016. 621 patients treated at HDFT responded in the survey this year - a local response rate of 52%, compared to 56% last year. The national response rate was 45%.		In 18 out of the 65 questions, HDFT scored significantly better than average, about the same as average for 46 questions and significantly below average for 1 question - 'Not asked to give views on quality of care' where 73% of HDFT patients agreed with this question compared to 69% national average. In terms of HDFT's overall ranking compared to other trusts, HDFT was ranked 14th out of 136 Trusts that answered all the questions in the survey. This compares to 10th out of 140 Trusts last year.
	The results of the national cancer patient survey 2015 were recently published. 455 HDFT patients were asked to take part in the survey and 317 (74%) completed and returned it. This is a greater response rate than the national average of 66%.		When taking an average of all the Trusts adjusted scores, HDFT came 3rd out of the 146 Trusts which took part in the survey achieving an average score of 80%. However, of the trusts which responded to all the questions, HDFT came top out of 131. Asked to rate their care on a scale of zero (very poor) to 10 (very good), HDFT respondents gave an average rating of 8.9.
Staff Survey (Top 20%)	The results shown are taken from the 2014 National NHS Staff Survey. The 2015 NHS Staff Survey is currently being undertaken and the results are not yet available.		The figure opposite shows how HDFT compares with other combined acute and community trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.92 was above (better than) average when compared with trusts of a similar type. This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 1, 4 and 7. These Key Findings relate to the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (Key Finding 7); their willingness to recommend the trust as a place to work or receive treatment (Key Finding 1); and the extent to which they feel motivated and engaged with their work (Key Finding 4). The table shows how HDFT compares with other combined acute and community trusts on each of the sub-dimensions of staff engagement, and whether there has been a change since the 2014 survey.

Report to the Trust Board of Directors: 27th July 2016	**Paper No: 8.0**

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

Key Issues for Board Focus:

- Performance against the A&E 4 hour standard improved and was above the required 95% level in June for both Harrogate Emergency Department and Trust overall performance.
- Whilst the Trust has delivered the Quarter 1 financial control total and will receive the first part of the S&T funding, the operational budgetary position is over £600k behind the plan to date. This significantly puts at risk achievement of future quarters' financial plan."
- The number of falls causing harm increased in June. However the number reported in the year to date is lower than in the same period last year.

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

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

Action Required by the Board of Directors
To note current performance.

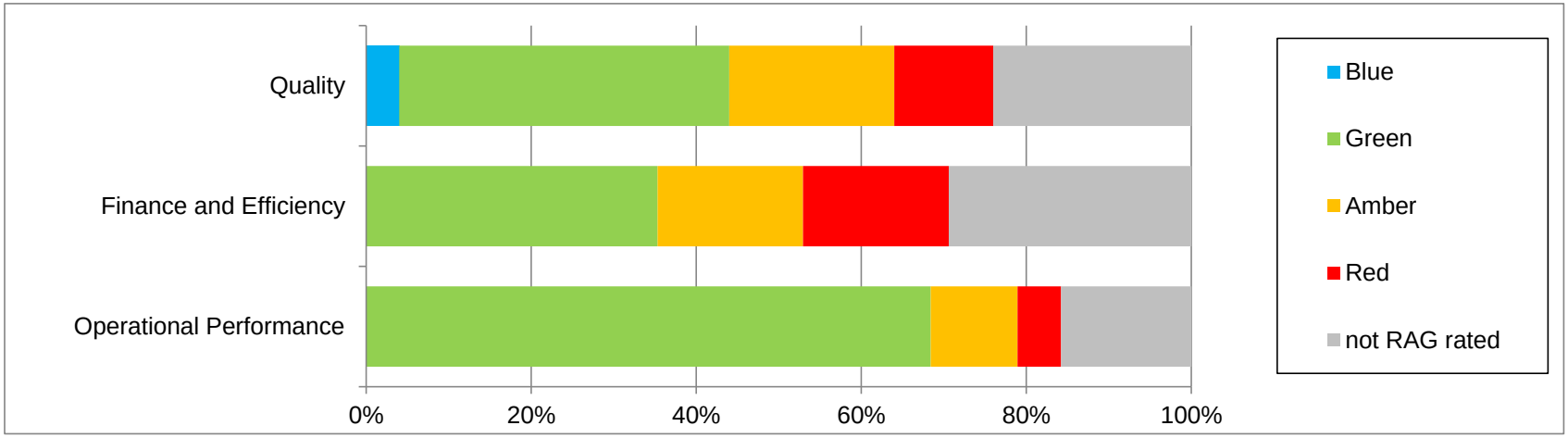
Integrated board report - June 2016

Key points this month

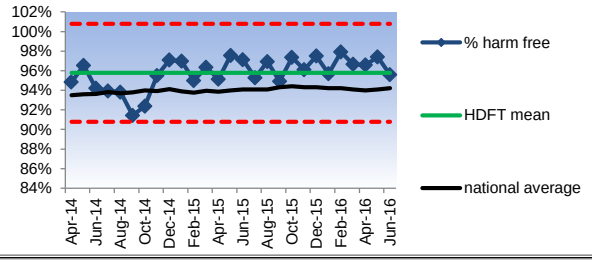
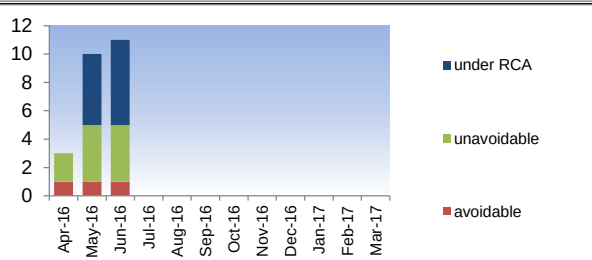
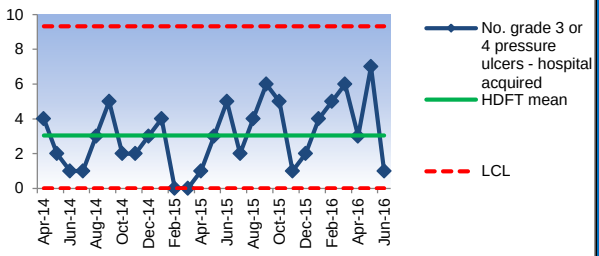
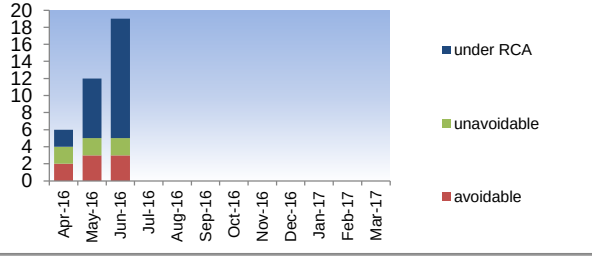
1. Performance against the A&E 4 hour standard improved and was above the required 95% level in June for both Harrogate Emergency Department and Trust overall performance.
2. Whilst the Trust has delivered the Quarter 1 financial control total and will receive the first part of the S&T funding, the operational budgetary position is over £600k behind the plan to date. This significantly puts at risk achievement of future quarters' financial plan.
3. There were 8 hospital acquired cases of C.diff reported in the year to date (to end June). Root cause analyses on 5 cases has now been completed and 2 were deemed to be due to a lapse in care.
4. The agency bill for June was 2.2% of Trust pay expenditure. Expenditure remains below the agency ceiling set by NHS Improvement but is above the benchmark the Trust has set in month.
5. The number of falls causing harm increased in June. However the number reported in the year to date is lower than in the same period last year.
6. Delivery of 18 weeks and all cancer waiting times standards were achieved for Quarter 1.
7. New metrics looking at new birth visits and 2.5 year reviews in the Darlington, Co. Durham and Middlesbrough Healthy Child Programme have been included in the report this month.

8. The previous national CQUIN indicators relating to Acute Kidney Injury and Sepsis have been removed as they do not feature in the Trust's CQUIN scheme for 2016/17.

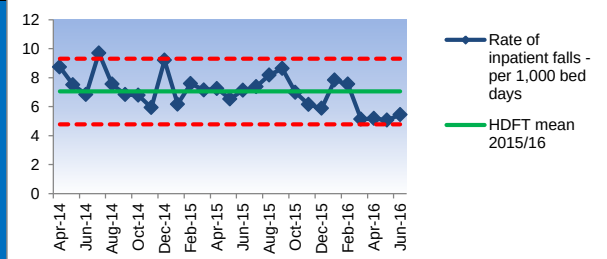
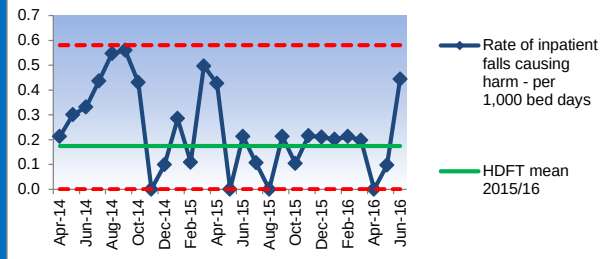
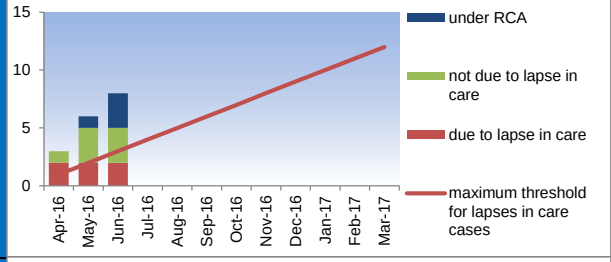
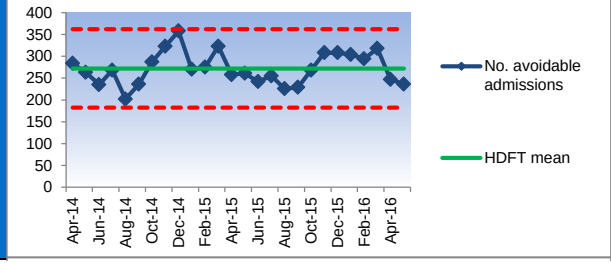
Summary of indicators



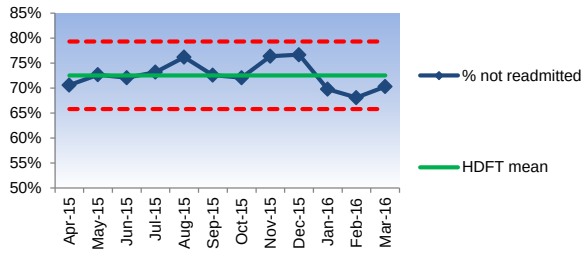
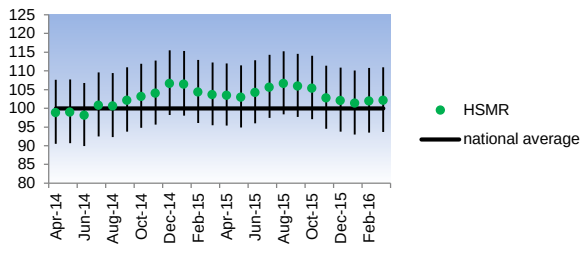
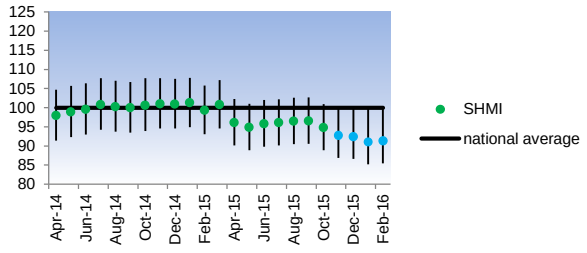
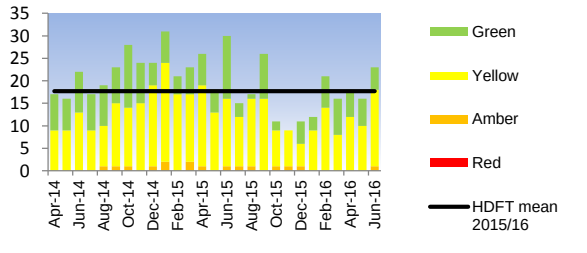
Quality - June 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Safety thermometer - harm free care	Measures the percentage of patients receiving harm free care (defined as the absence of pressure ulcers, harm from a fall, urine infection in patients with a catheter and new VTE) in the Safety Thermometer audits conducted once a month. The data includes hospital and community teams. A high score is good. Whilst there is no nationally defined target for this measure, a score of 95% or above is considered best practice.		The harm free percentage for June was 95.6%, a decrease on the previous month, but remaining above the 95% standard and above the latest national average of 94.2%.	✓
Pressure ulcers - hospital acquired	The chart shows the cumulative number of grade 3 or grade 4 hospital acquired pressure ulcers in 2016/17. The data includes hospital teams only.		There was 1 hospital acquired grade 3 or grade 4 pressure ulcer reported in June, bringing the year to date total to 11. Of the 11 cases, 1 was deemed to be avoidable, 4 unavoidable and 6 cases are still under root cause analysis (RCA). The Trust has set a local trajectory for 2016/17 of zero avoidable hospital acquired grade 3 or grade 4 pressure ulcers. A maximum trajectory of 155 cases of grade 2-4 hospital acquired pressure ulcers has been agreed via the Quality Committee.	✓
	An additional chart has been added to this month's report to illustrate the long term trend in reported grade 3 or grade 4 hospital acquired pressure ulcers. The data includes hospital teams only.		The number of hospital acquired grade 3 or grade 4 pressure ulcers reported in 2016/17 to date is 11. This compares to 17 in the same period last year.	
Pressure ulcers - community acquired	The chart shows the cumulative number of grade 3 or grade 4 community acquired pressure ulcers in 2016/17. The data includes community teams only.		There were 7 community acquired grade 3 or grade 4 pressure ulcers reported in June, bringing the year to date total to 19. Of the 19 cases, 3 were deemed to be avoidable, 2 unavoidable and 14 cases are still under root cause analysis (RCA). A maximum trajectory for the number of grade 2-4 community acquired pressure ulcers was agreed at the Quality Committee and will be based on a 20% reduction against the number of cases reported in 2015/16.	✓

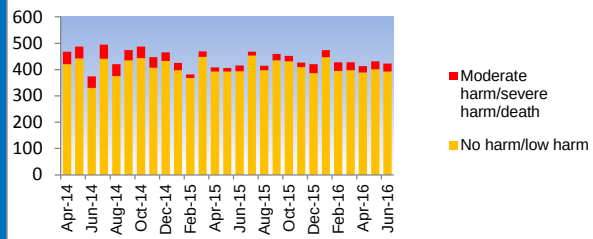
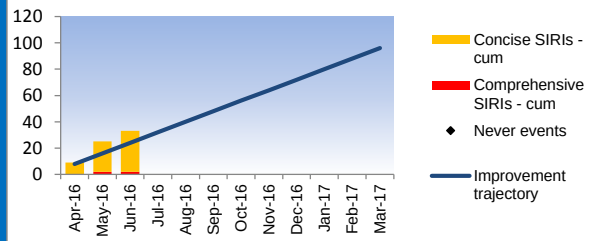
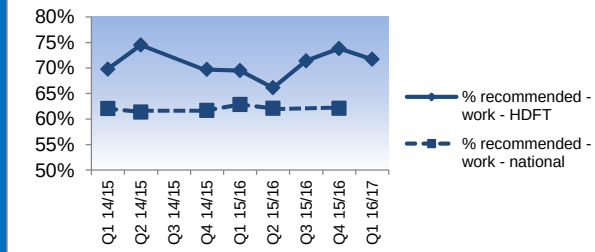
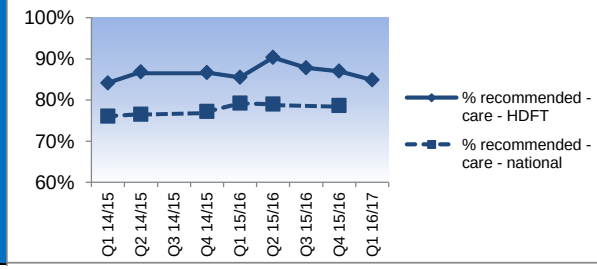
Quality - June 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Falls	The number of inpatient falls expressed as a rate per 1,000 bed days. The data includes falls causing harm and those not causing harm. A low rate is good.		The rate of inpatient falls was 5.4 per 1,000 bed days in June, a slight increase on the previous month but remaining significantly below the average HDFT rate during 2015/16. The falls sensors are now in place on Byland, Jervaulx and Farndale wards and there is a plan to roll out to the other ward areas.	✓
Falls causing harm	The number of inpatient falls causing significant harm, expressed as a rate per 1,000 bed days. The data includes falls causing moderate harm, severe harm or death. A low rate is good.		The rate of inpatient falls causing moderate harm, severe harm or death was 0.4 per 1,000 bed days in June, an increase on the previous month and above the averge HDFT rate for 2015/16. There have been 5 inpatient falls causing moderate or severe harm in 2016/17 to date, of which 1 resulted in a fracture. This compares to 6 moderate or severe harm falls in the same period last year.	✓
Infection control	The chart shows the cumulative number of hospital acquired 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.		There were 2 cases of hospital acquired C. difficile reported in June, bringing the year to date total to 8 cases. Of these, 5 have now had root cause analysis (RCA) completed and 2 have been determined to be due to a lapse in care. 3 cases are still under RCA. No cases of hospital acquired MRSA have been reported in 2016/17 to date.	✓
Avoidable admissions	The chart shows the number of avoidable emergency admissions to HDFT as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require admission. Conditions include pneumonia and urinary tract infections in adults and respiratory conditions in children.		There were 236 avoidable admissions in May, a decrease on last month. An admission avoidance/urgent care project group has been established and the Trust is working with HARD CCG to develop care models and pathways that support patients to stay in their own home and reduce the risk of hospital admissions. This is also the focus of the New Care Models work and one of the metrics being used to evaluate this pilot.	✓

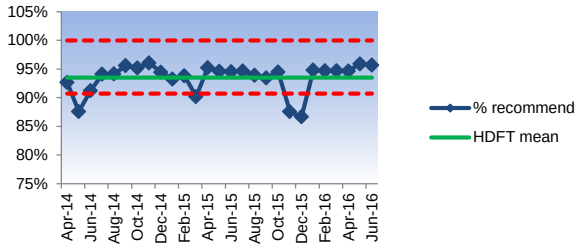
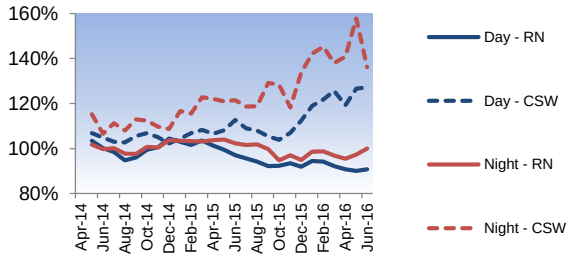
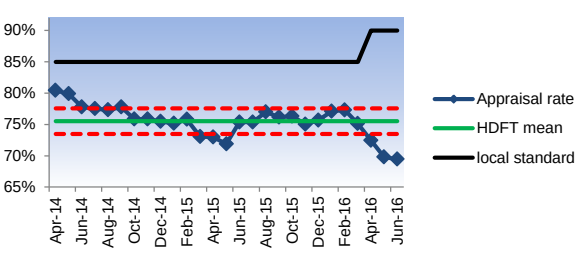
Quality - June 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Reducing readmissions in older people	The chart shows the proportion of older people aged 65+ who were still at home 91 days after discharge from hospital into rehabilitation or reablement services. A high figure is good. *This indicator is in development.*		For patients discharged in March, 70% were still in their own home at the end of June, an increase on the previous month. Following a deterioration in performance on this metric in the last few months, a case note audit of a sample of patients is being carried out to understand any themes and actions required.	
Mortality - HSMR	The Hospital Standardised Mortality Ratio (HSMR) looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care. A low figure is good.		*There is no update of this data this month.* HDFT's HSMR increased to 102.08 in March. However it remains within expected levels. At specialty level, 2 specialties (Geriatric Medicine and Gastroenterology) have a standardised mortality rate above expected levels. At site level, Ripon Hospital standardised mortality is now within expected levels.	
Mortality - SHMI	The Summary Hospital Mortality Index (SHMI) looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care. A low figure is good.		*There is no update of this data this month.* HDFT's SHMI increased to 91.36, compared to 91.07 last month. However this remains below the national average and below expected levels for the fourth consecutive month. At specialty level, 2 specialties (Geriatric Meidicine and Gastroenterology) have a standardised mortality rate above expected levels and looking at the data by site, Ripon hospital has a higher than expected mortality rate.	
Complaints	The number of complaints received by the Trust, shown by month of receipt of complaint. The criteria define the severity/grading of the complaint with green and yellow signifying less serious issues, amber signifying potentially significant issues and red for complaints related to serious adverse incidents. The data includes complaints relating to both hospital and community services.		23 complaints were received in June compared to 16 last month, with one classified as amber.	

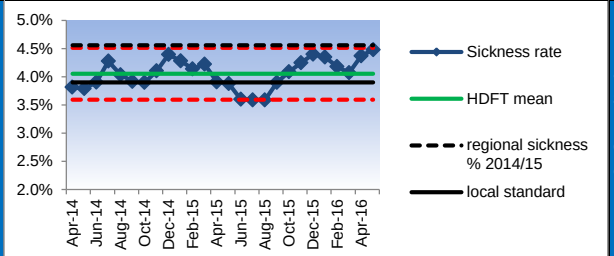
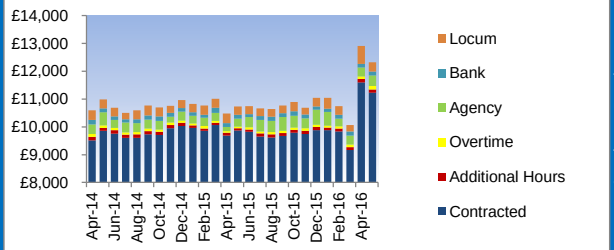
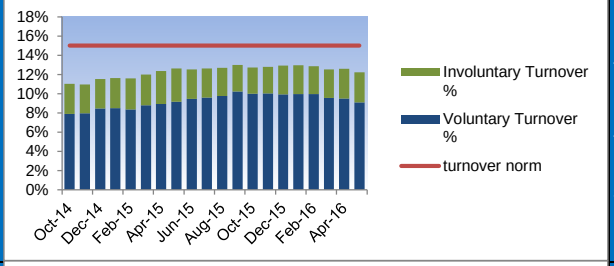
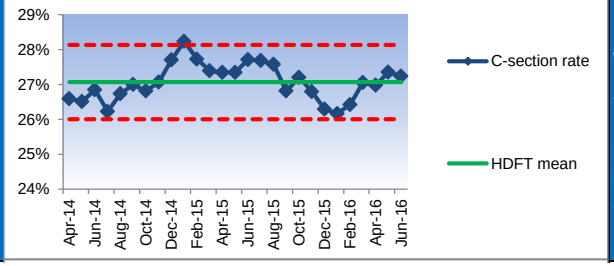
Quality - June 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Incidents - all	The chart shows the number of incidents reported within the Trust each month. It includes all categories of incidents, including those that were categorised as "no harm". The data includes hospital and community services. A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture		There were 423 incidents reported in June. The number of incidents reported each month remains fairly static but the proportion classified as moderate harm, severe harm or death has reduced over the last 3 years. The latest published national data (for the 6 month period to end September 2015) showed that Acute Trusts reported an average ratio of 31 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 21.	
Incidents - SIRIs and never events	The chart shows the number of Serious Incidents Requiring Investigation (SIRIs) and Never Events reported within the Trust each month. The data includes hospital and community services. We have changed this indicator to now include both comprehensive and concise SIRIs and have amended the presentation to show a cumulative position.		There were no never events reported in June. There have been 31 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.	
Friends & Family Test (FFT) - Staff - % recommend as a place to work	The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organisation they work in. 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.		In Quarter 1, 72% of HDFT staff recommended the Trust as a place to work - this compares to the latest published national average of 62%. 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 Q3.	
Friends & Family Test (FFT) - Staff - % recommend as a place to receive care	The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organisation they work in. 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.		In Quarter 1, 85% of HDFT staff recommended the Trust as a place to work - this compares to the latest published national average of 79%. 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 Q3.	

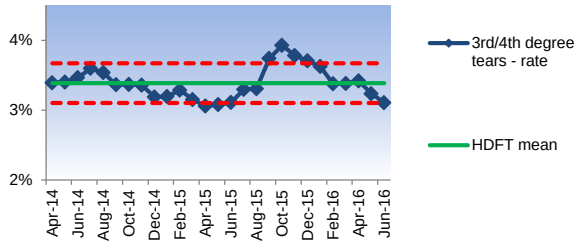
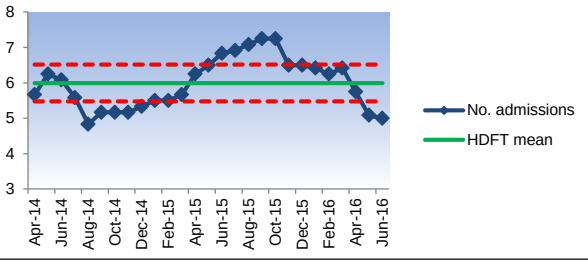
Quality - June 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Friends & Family Test (FFT) - Patients	The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of hospital and community services including inpatients, day cases, outpatients, maternity services, the emergency department, some therapy services, district nursing, community podiatry and GP OOH. A high percentage is good.		Due to a technical problem with the automated phone call service, less patients than usual were surveyed in June (1,200 compared to a monthly average of around 5,000). A fix for the technical issue should be in place by late July. 95.7% of patients surveyed in June would recommend our services, above the latest published national average of 92.8%.	✓
Safer staffing levels	Trusts are required to publish information about staffing levels for registered nurses/midwives (RN) and care support workers (CSW) for each inpatient ward. The chart shows the overall fill rate at HDFT for RN and CSW for day and night shifts. The fill rate is calculated by comparing planned staffing with actual levels achieved. A ward level breakdown of this data is published on the Trust website.		Overall staffing compared to planned was at 106%, compared to 107% last month. CSW staffing remains very high compared to plan - this is reflective of the increased need for 1-1 care for some inpatients. A significant focus is being placed on recruitment of RN staff including open events and targeted recruitment campaigns including the use of social media. A decision has been taken to pursue a further round of registered nurse recruitment in Europe.	✓
Staff appraisal rates	The chart shows the staff appraisal rate over the most recent rolling 12 months. The Trusts aims to have 90% of staff appraised. A high percentage is good. The figures from May 2016 now exclude employees currently on maternity leave, career break or suspension.		The locally reported cumulative appraisal rate for the 12 months to end June 2016 was 69.5%. Despite the overall figure, Medical & Dental appraisal rates have increased to 75.9%. Follow up emails have been sent out to areas of low compliance, requesting an action plan that will demonstrate how they will achieve at least a 90% compliance rate by December 2016. We are currently undertaking a data cleanse exercise of appraisal information for the Children's Services that TUPE transferred in to the Trust on 1st April 2016, so they are currently excluded from the appraisal rate figures.	✓
Mandatory training rates	The table shows the most recent training rates for all mandatory elements for substantive staff. A high percentage is good.	**Competence Name** / **% Completed** Equality, Diversity and Human Rights - Level 1: 83 Fire Safety Awareness: 92 Infection Prevention & Control 1: 99 Infection Prevention & Control 2: 86 Information Governance: Introduction: 89 Information Governance: The Beginners Guide: 79 Prevent Basic Awareness (December 2015): 99 Safeguarding Children & Young People Level 1 - Introduction: 95	The data shown is for end June. The overall training rate for mandatory elements for substantive staff is 90%. A workshop has been held with directorates to improve the follow up procedure for those members of staff whose mandatory and essential skills training is not up to date. The new follow up procedure will be implemented from 1st August 2016.	✓

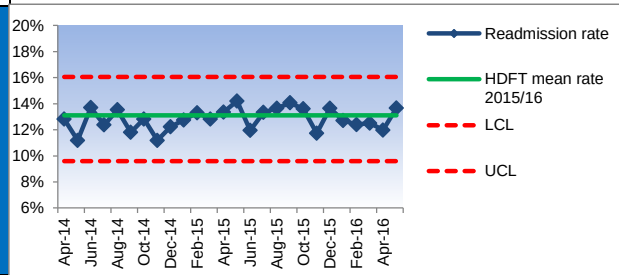
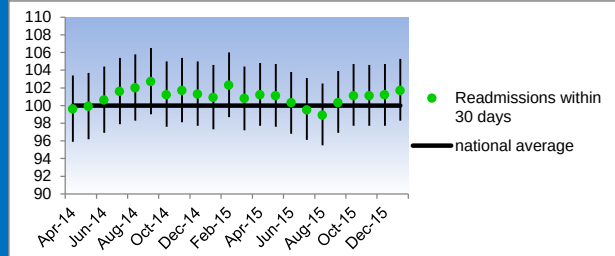
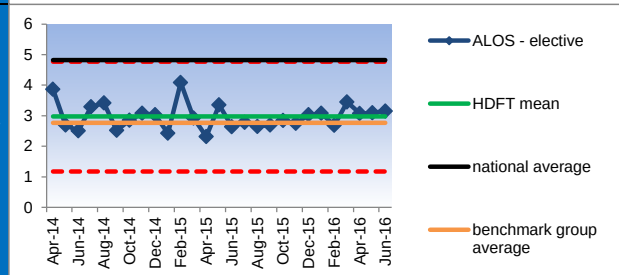
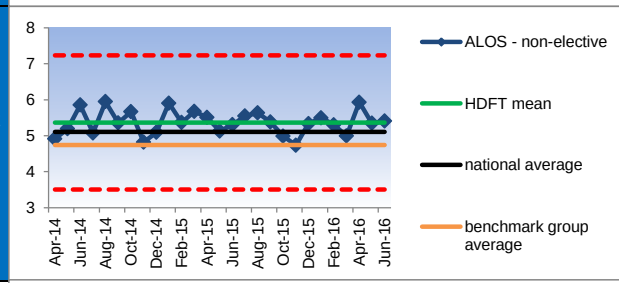
Quality - June 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Sickness rates	Staff sickness rate - includes short and long term sickness. The Trust has set a threshold of 3.9%. A low percentage is good.		HDFT's staff sickness rate was 4.48% in May. Stress, anxiety and depression related absence is now the leading cause of sickness absence again. There are a number of Trust wide interventions aimed at raising awareness and supporting staff dealing with difficulties which will help to tackle this absence cause including mental health first aid, Schwartz rounds and mentally healthy workplace training.	✓
Temporary staffing expenditure - medical/nursing /other	The chart shows staff expenditure per month, split into contracted staff, overtime and additional hours and temporary staff. Lower figures are preferable. *The traffic light criteria applied to this indicator is currently under review.*		The proportion of spend on temporary staff during April was 6.9%, compared to 7.6% during 2015/16. The significant increase in expenditure for contracted staff since April is due to the transfer of Health Visiting staff from Darlington, Durham and Middlesbrough with effect from 1st April 2016.	✓
Staff turnover rate	The chart shows the staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. The turnover figures include both voluntary and involuntary turnover. Voluntary turnover is when an employee chooses to leave the Trust and involuntary turnover is when the employee unwillingly leaves the Trust. Data from the Times Top 100 Employers indicated a turnover rate norm of 15%, i.e. the level at which organisations should be concerned.		The Trust Turnover rate for the 12 month period up to May 2016 is 12.23%. This is the lowest Trust turnover reported over the previous 12 month period and continues the downward trend being reported since January 2016.	✓
Maternity - Caesarean section rate	The caesarean section rate is determined by a number of factors including ability to provide 1-1 care in labour, previous birth experience and confidence and ability of the staff providing care in labour. The rate of caesarean section can fluctuate significantly from month to month - as a result we have amended the presentation of this indicator this month to show a 12 month rolling average position.		HDFT's C-section rate for the 12 months ending June 2016 was 27.2% of deliveries, a slight decrease on last month. The Royal College of Obstetricians and Gynaecologists recently published a paper which included a range of metrics standardised for local populations, including C-section rates. Overall HDFT was "as expected" in terms of standardised C-section rates. The report is being reviewed in detail by the maternity team to benchmark our position.	✓

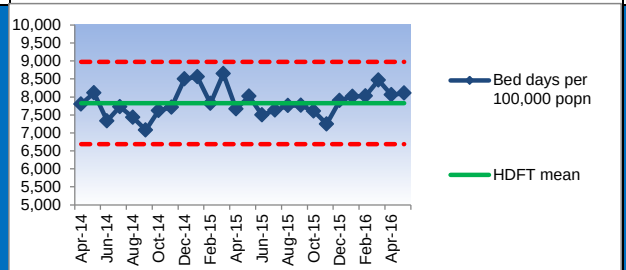
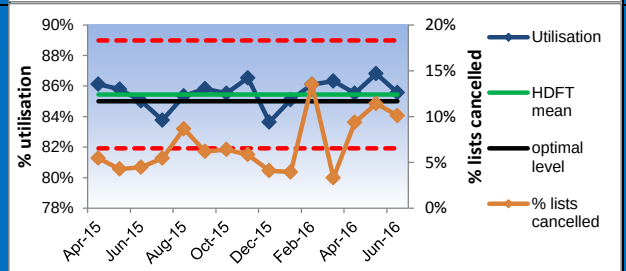
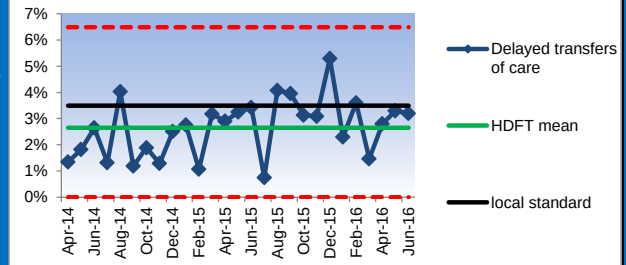
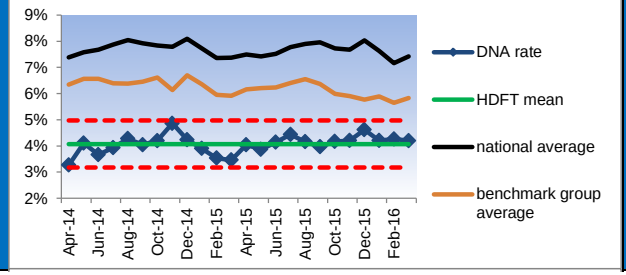
Quality - June 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Maternity - Rate of third and fourth degree tears	Third and fourth degree tears are a source of short term and long term morbidity. A previous third degree tear can increase the likelihood of a woman choosing a caesarean section in a subsequent pregnancy. 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.		The rate of 3rd/4th degree tears was 3.1% of deliveries in the 12 month period ending June 2016, a decrease on last month. The maternity team carry out a full review of all cases of 3rd/4th degree tears. Consideration is currently being made to a clinical re-audit of 3rd/4th degree tears occurring with normal deliveries.	
Maternity - Unexpected term admissions to SCBU	This indicator is a reflection of the intrapartum care provided. For example, an increase in the number of term admissions to special care might reflect issues with understanding of fetal heart rate monitoring in labour. We have amended the presentation of this indicator this month to show a 12 month rolling average position.		The chart shows the number of babies born at greater than 37 weeks gestation who were admitted to the Special Care Baby Unit (SCBU). The maternity team carry out a full review of all term admissions to SCBU. There were 5 term admissions to SCBU in June, compared to 6 in May. The average number per month over the last 12 months is 5.	

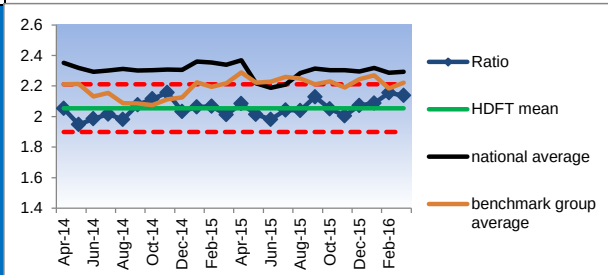
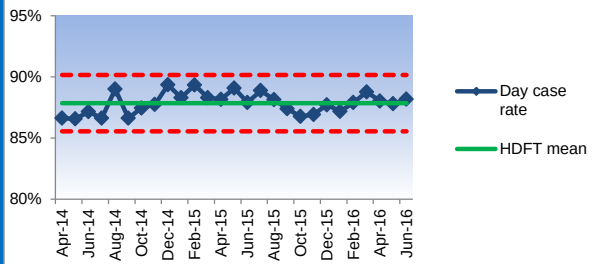
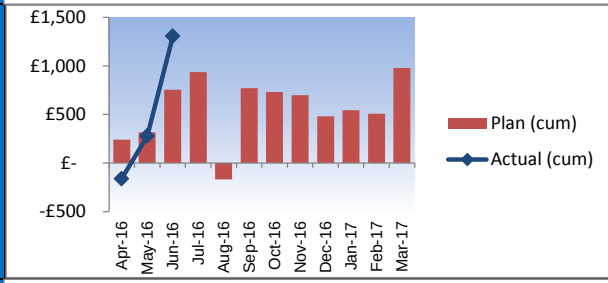
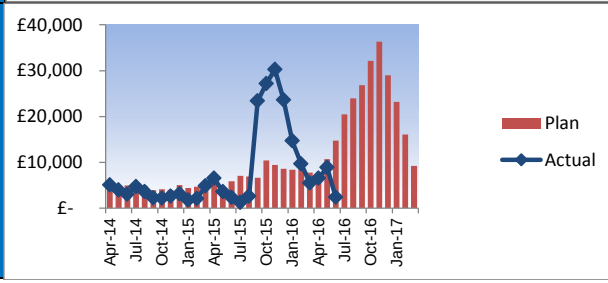
Finance and Efficiency - June 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Readmissions	% of patients readmitted to hospital as an emergency within 30 days of discharge (PbR exclusions applied). To ensure that we are not discharging patients inappropriately early and to assess our overall surgical success rates, we monitor the numbers of patients readmitted. A low number is good performance. This data is reported a month behind so that any recent readmissions are captured in the data.		The number of readmissions increased in May, both actual numbers and as a percentage of all emergency admissions. The is now slightly above the average rate for 2015/16 but remains within expected levels.	✓
Readmissions - standardised	This indicator looks at the standardised readmission rate within 30 days. The data is standardised against various criteria including age, sex, diagnosis, comorbidites etc. The standardisation enables a more like for like comparison with other organisations. The national average is set at 100. A low rate is good - rates below 100 indicate a lower than expected readmission rate and rates above 100 indicate higher than expected readmission rate.		*There is no update of this data this month.* HDFT's standardised readmission rate for the 12 month period ending January 2016 was 101.7 - above the national average but within expected levels.	✓
Length of stay - elective	Average length of stay in days for elective (waiting list) patients. The data excludes day case patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.		The average elective length of stay for June was 3.2 days, a slight increase on the previous month. A focus on sustainably reducing this through the Planned Care Transformation programme is underway, which includes reducing the number of patients admitted the day before surgery.	✓
Length of stay - non-elective	Average length of stay in days for non-elective (emergency) patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.		The average non-elective length of stay for June was 5.4 days, a slight increase on the previous month.	✓

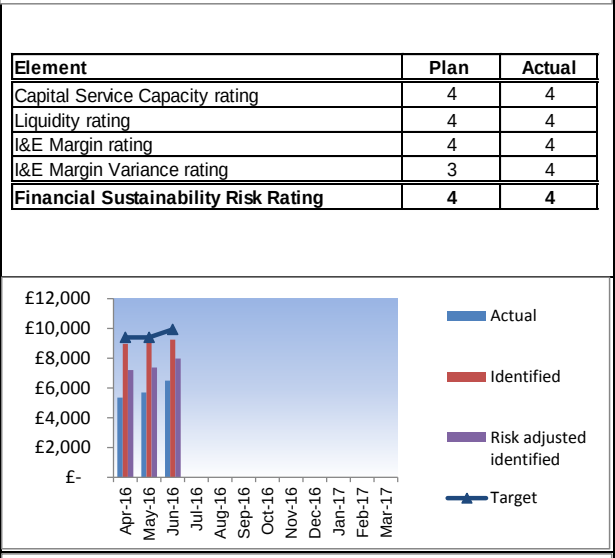
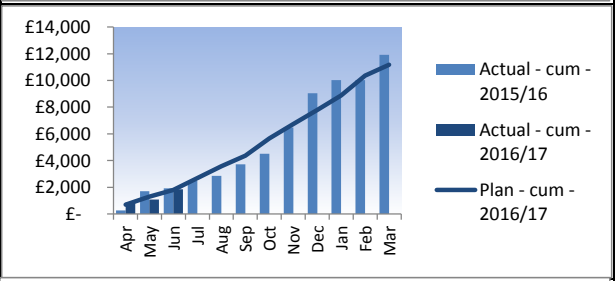
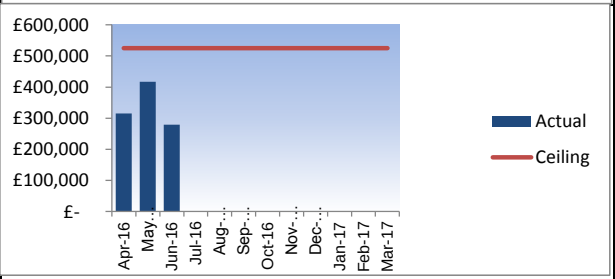
Finance and Efficiency - June 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Non-elective bed days	The charts shows the number of non-elective (emergency) bed days at HDFT for patients aged 18+, per 100,000 population. The chart only includes the local HARD CCG area. A lower figure is preferable.		As can be seen, the number of non-elective bed days for patients aged 18+ has remained fairly static over the last two years. Further analysis of this new indicator will be completed to look at the demograghic changes during this period and the number of admissions for this group will assist in understanding this further. This is also the focus of the New Care Models work and one of the metrics being used to evaluate this pilot.	
Theatre utilisation	The percentage of time utilised during elective theatre sessions (i.e. those planned in advance for waiting list patients). The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. An extra line has been added to the chart to allow monitoring of this. A higher utilisation rate is good as it demonstrates effective use of resources. A utilisation rate of around 85% is often viewed as optimal.		Theatre utilisation decreased to 85.6% in June. However the number of cancelled sessions also decreased slightly. 8 elective lists were cancelled in June due to staffing issues related to the agency cap. A number of Saturday theatre lists were also not requested by surgeons due to their concerns over the risk of not being able to cover with staff due to the agency cap. A number of elective orthopaedic theatre lists were also converted to trauma lists due to a high fluctuations in the number of trauma patients.	
Delayed transfers of care	The proportion of patients in acute hospital beds who are medically fit for discharge but are still in hospital. A low rate is preferable. A snapshot position is taken at midnight on the last Thursday of each month. The maximum threshold shown on the chart (3.5%) has been agreed with the CCG.		Delayed transfers of care decreased to 3.2% when the snapshot was taken in June. This remians below the maximum threshold of 3.5% set out in the contract.	
Outpatient DNA rate	Percentage of new outpatient attendances where the patient does not attend their appointment, without notifying the trust in advance. A low percentage is good. Patient DNAs will usually result in an unused clinic slot.		*There is no update of this data this month.* HDFT's DNA rate was 4.2% in March, a slight reduction on the previous month. As can be seen, HDFT's DNA rate is consistently significantly below that of both the benchmarked group of trusts and the national average.	

Finance and Efficiency - June 2016

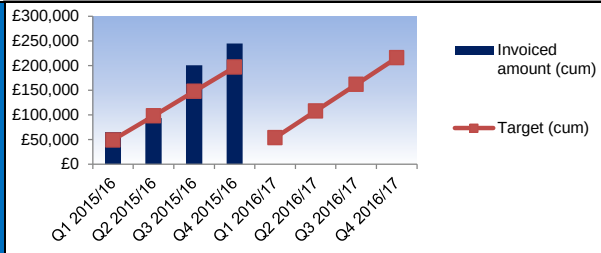
Indicator	Description	Trend chart	Interpretation	Data quality
Outpatient new to follow up ratio	The number of follow-up appointments per new appointment. A lower ratio is preferable. A high ratio could indicate that unnecessary follow ups are taking place.		*There is no update of this data this month.* The Trust is working closely with the CCG on the Elective 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. HDFT's new to follow up ratio decreased slightly in March - it is below the benchmark group average and the national average.	✓
Day case rate	The proportion of elective (waiting list) procedures carried out as a day case procedure, i.e. the patient did not stay overnight. A higher day case rate is preferable.		The Day Surgery Transformation group continues their work and are on plan.	✓
Surplus / deficit and variance to plan	Monthly Surplus/Deficit (£'000s). In some months, a deficit is planned for. This indicator reports positive or adverse variance against the planned position for the month.		The Operational Budgetary position for the year to June was a deficit of £448k, £612k behind plan. This is a significant area of risk to the Trust. The Trust has taken a year end approach to the quarterly reporting, resulting in an underlying surplus of £271k. This is above the control total requirement set by NHS Improvement. The Trust will therefore report achievement of the sustainability and transformation funding and a Quarter 1 surplus of £1,420k.	✓
Cash balance	Monthly cash balance (£'000s)		The Trust was £12,311k behind plan for cash in June with a balance of £2,429k. This is a result of the changes in profile following agreement of the acute contract with HaRD CCG.	✓

Finance and Efficiency - June 2016

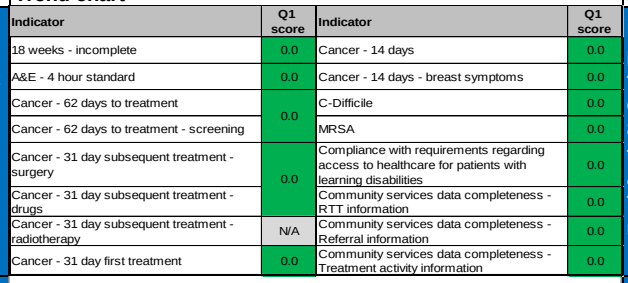
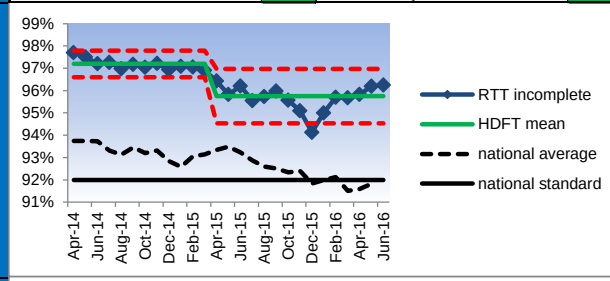
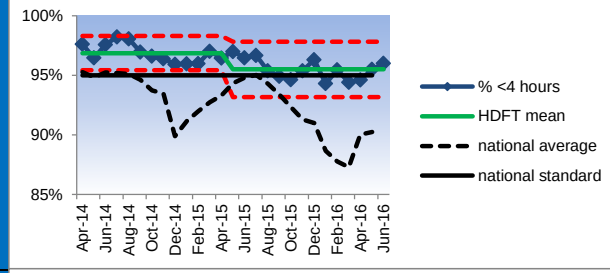
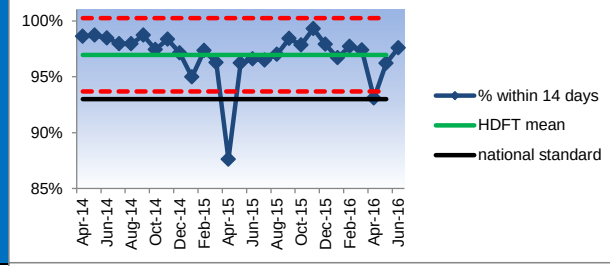
Indicator	Description	Trend chart	Interpretation	Data quality
NHS Improvement Financial Sustainability risk rating	The NHS Improvement Financial Sustainability risk rating includes four components, as illustrated in the table to the right. An overall rating is calculated ranging from 4 (no concerns) to 1 (significant concerns). This indicator monitors our position against plan.		The Trust will report a risk rating of 4 for June.	✓
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.		66% of CIP schemes have been actioned to date. Although plans are in place for 93% of the efficiency requirement, the risk adjusted total reduces to 80% (£1.9m)	✓
Capital spend	Cumulative Capital Expenditure by month (£'000s)		Capital Expenditure was £39k ahead of plan at the end of Quarter 1.	✓
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.		The agency bill for June was 2.2% of Trust pay expenditure. Expenditure remains below the agency ceiling set by NHS Improvement but is above the benchmark the Trust has set in month.	✓

Element	Plan	Actual
Capital Service Capacity rating	4	4
Liquidity rating	4	4
I&E Margin rating	4	4
I&E Margin Variance rating	3	4
Financial Sustainability Risk Rating	**4**	**4**

Finance and Efficiency - June 2016

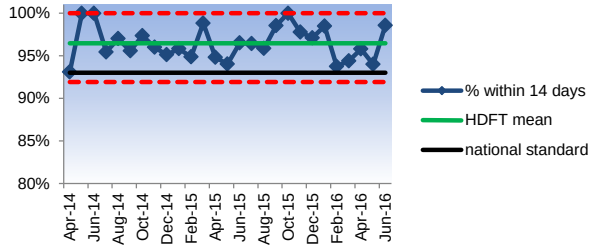
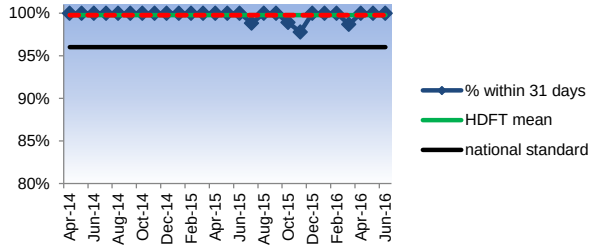
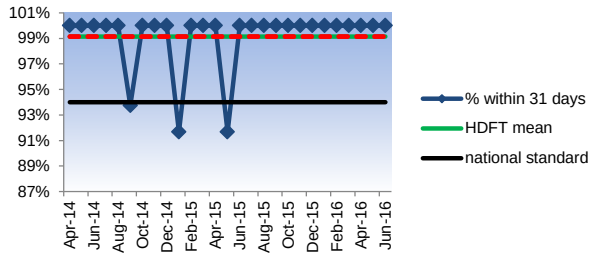
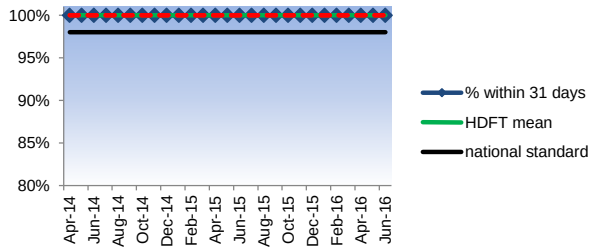
Indicator	Description	Trend chart	Interpretation	Data quality
Research - Invoiced research activity	Aspects of research studies are paid for by the study sponsor or funder.		As set out in the Research & Development strategy, the Trust intends to maintain its current income from commercial research activity and NIHR income to support research staff to 2019. Each study is unique. Last year the Trust invoiced for a total of £223k.	✓

Operational Performance - June 2016

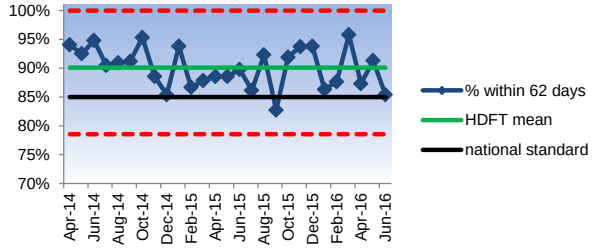
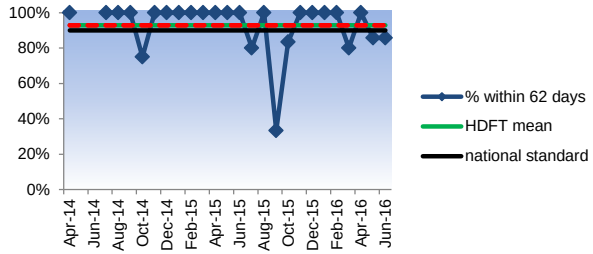
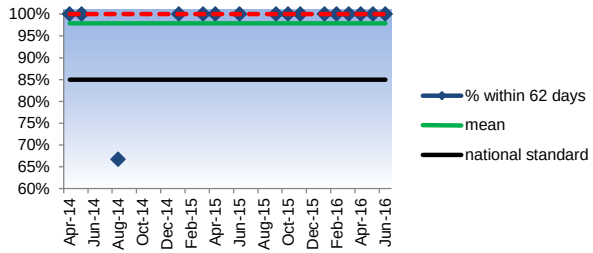
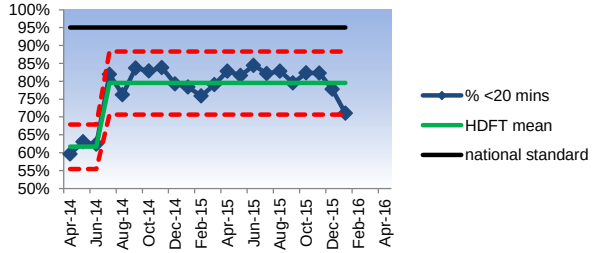
Indicator	Description	Trend chart	Interpretation	Data quality
NHS Improvement governance rating	NHS Improvement use a variety of information to assess a Trust's governance risk rating, including CQC information, access and outcomes metrics, third party reports and quality governance metrics. The table to the left shows how the Trust is performing against the national performance standards in the "access and outcomes metrics" section of the Risk Assessment Framework.		HDFT's governance rating for Q1 is Green. The Trust's performance against the A&E 4 hour standard was above 95% for Q1, but sustained delivery of this standard remains challenging. 8 cases of hospital acquired C.difficile were reported in Q1. Of these, 5 have now had root cause analysis (RCA) completed and 2 have been determined to be due to a lapse in care. The Trust's C. difficile trajectory for the full year 2016/17 is a maximum of 12 cases due to lapses in care.	✓
RTT Incomplete pathways performance	Percentage of incomplete pathways waiting less than 18 weeks. The national standard is that 92% of incomplete pathways should be waiting less than 18 weeks. A high percentage is good.		96.2% of patients were waiting 18 weeks or less at the end of June, above the required national standard of 92% and a slight increase on last month. All specialties were also above the 92% standard, including Trauma & Orthopaedics. However, concern remains about sustaining performance for this specialty, particularly in light of the new agency cap from 1st April and the impact it has on theatre staffing.	✓
A&E 4 hour standard	Percentage of patients spending less than 4 hours in Accident & Emergency (A&E). The operational standard is 95%. The data includes all A&E Departments, including Minor Injury Units (MIUs). A high percentage is good. Historical data for HDFT included both Ripon and Selby MIUs. In agreement with local CCGs, York NHSFT are reporting the activity for Selby MIU from 1st May 2015.		HDFT's Trust level performance for June 2016 was 96.0%, above the required 95% standard. This includes data for the Emergency Department at Harrogate and Ripon MIU. Performance for Harrogate ED was also above the standard at 95.2%. For Quarter 1 overall, Trust level performance was above the 95% standard at 95.4%, but performance for Harrogate Emergency Department was below the standard at 94.5%.	✓
Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%. A high percentage is good.		Delivery at expected levels.	✓

Indicator	Q1 score	Indicator	Q1 score
18 weeks - incomplete	0.0	Cancer - 14 days	0.0
A&E - 4 hour standard	0.0	Cancer - 14 days - breast symptoms	0.0
Cancer - 62 days to treatment	0.0	C-Difficile	0.0
Cancer - 62 days to treatment - screening		MRSA	0.0
Cancer - 31 day subsequent treatment - surgery	0.0	Compliance with requirements regarding access to healthcare for patients with learning disabilities	0.0
Cancer - 31 day subsequent treatment - drugs		Community services data completeness - RTT information	0.0
Cancer - 31 day subsequent treatment - radiotherapy	N/A	Community services data completeness - Referral information	0.0
Cancer - 31 day first treatment	0.0	Community services data completeness - Treatment activity information	0.0

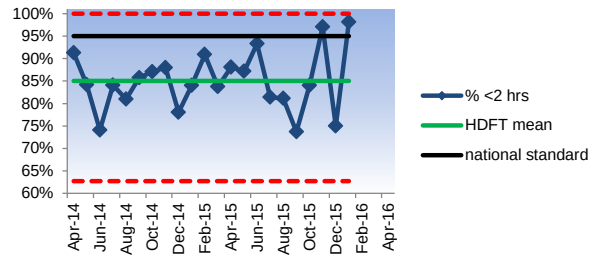
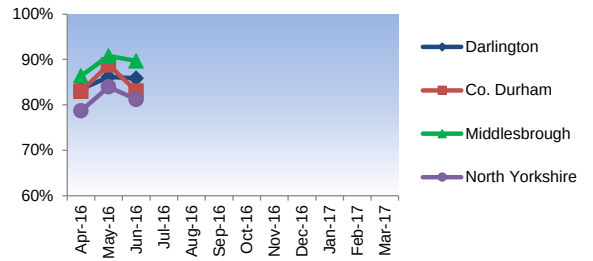
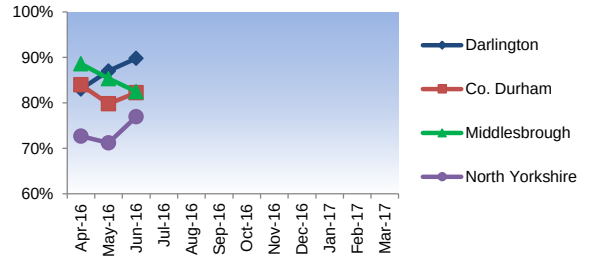
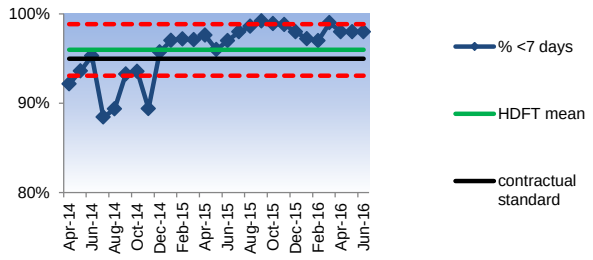
Operational Performance - June 2016

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

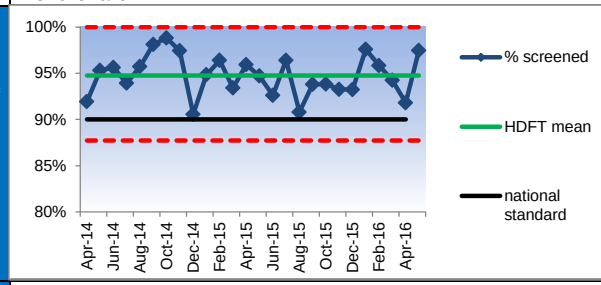
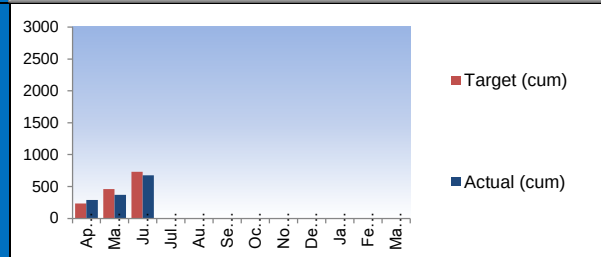
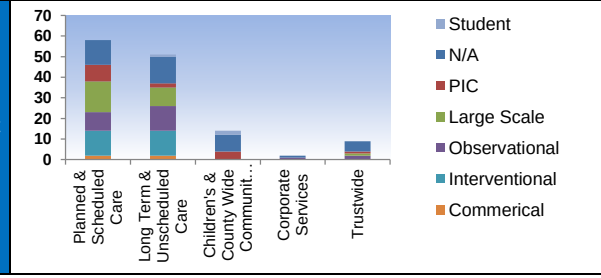
Operational Performance - June 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Cancer - 62 day wait for first treatment from urgent GP referral to treatment	Percentage of cancer patients starting first treatment within 62 days of urgent GP referral. The operational standard is 85%. A high percentage is good.		Trust total delivery at expected levels. Of the 11 cancer sites treated at HDFT, 4 had performance below 85% in June - colorectal (2.0 breaches), head & neck (0.5 breach), lung (1.0 breach) and upper gastro-intestinal (2.0 breaches). No patients waited over 104 days for treatment in June.	✓
Cancer - 62 day wait for first treatment from consultant screening service referral	Percentage of cancer patients starting first treatment within 62 days of referral from a consultant screening service. The operational standard is 90%. A high percentage is good.		Performance was below the 90% standard in June. However the latest estimated position for the full quarter is 90% performance with 1 breach and 10 reportable pathways.	✓
Cancer - 62 day wait for first treatment from consultant upgrade	Percentage of cancer patients starting first treatment within 62 days of consultant upgrade. The operational standard is 85%. A high percentage is good.		Delivery at expected levels.	✓
GP OOH - NQR 9	NQR 9 (National Quality Requirement 9) looks at the % of GP OOH telephone clinical assessments for urgent cases that are carried out within 20 minutes of call prioritisation. The data presented excludes Selby and York as these do not form part of the HDFT OOH service from April 2015. A high percentage is good.		*There is no update of this data this month.* The Trust recently changed the way that some patient groups are managed within the GP OOH service to improve efficiency and patient experience. Reports from the Adastra system no longer calculate the correct start time for these patients and as a result, the performance reported for some of the NQRs is now incorrect. We have been working with YAS to resolve this and have made some progress but are not yet confident that the data reported accurately reflects performance. The recent problems with the data have reiterated that the NQRs are out of date. We are proposing revised metrics which more comprehensively reflect both the quality and responsiveness of the GP OOH service.	▲

Operational Performance - June 2016

Indicator	Description	Trend chart	Interpretation	Data quality
GP OOH - NQR 12	NQR 12 (National Quality Requirement 12) looks at the % of GP OOH face to face consultations (home visits) started for urgent cases within 2 hours. The data presented excludes Selby and York as these do not form part of the HFT OOH service from April 2015. A high percentage is good.		*There is no update of this data this month.* The Trust recently changed the way that some patient groups are managed within the GP OOH service to improve efficiency and patient experience. Reports from the Adastra system no longer calculate the correct start time for these patients and as a result, the performance reported for some of the NQRs is now incorrect. We have been working with YAS to resolve this and have made some progress but are not yet confident that the data reported accurately reflects performance. The recent problems with the data have reiterated that the NQRs are out of date. We are proposing revised metrics which more comprehensively reflect both the quality and responsiveness of the GP OOH service.	
Children's Services - 10-14 day new birth visit	The percentage of babies who had a new birth visit by the Health Visiting team within 14 days of birth. A high percentage is good. Data shown is for the 0-5 Health Visiting Service in North Yorkshire and the Healthy Child Programme in Darlington, Co. Durham and Middlesbrough.		Data for the Healthy Child Programme in Darlington, Co. Durham and Middlesbrough is presented for the first time this month. In June, 86% of babies in Darlington, 83% of babies in Co. Durham, 90% of babies in Middlesbrough and 81% of babies in North Yorkshire were recorded on Systmone as having had a new birth visit within 14 days of birth.	
Children's Services - 2.5 year review	The percentage of children who had a 2.5 year review. A high percentage is good. Data shown is for the 0-5 Health Visiting Service in North Yorkshire and the Healthy Child Programme in Darlington, Co. Durham and Middlesbrough.		Data for the Healthy Child Programme in Darlington, Co. Durham and Middlesbrough is presented for the first time this month. In June, 90% of children in Darlington, 82% of children in Co. Durham, 83% of children in Middlesbrough and 77% of children in North Yorkshire were recorded on Systmone as having had a 2.5 year review.	
Community equipment - deliveries within 7 days	The number of standard items delivered within 7 days by the community equipment service. A high percentage is good.		Performance remains above expected levels.	

Operational Performance - June 2016

Indicator	Description	Trend chart	Interpretation	Data quality
CQUIN - dementia screening	The proportion of emergency admissions aged 75 or over who are screened for dementia within 72 hours of admission (Step 1). Of those screened positive, the proportion who went on to have an assessment and onward referral as required (Step 2 and 3). The operational standard is 90% for all 3 steps. A high percentage is good.		Recurrent achievement of this standard. Ongoing monitoring. No new actions identified.	✓
Recruitment to NIHR adopted research studies	The Trust has a recruitment target of 2,750 for 2015/16 for studies adopted onto the NIHR portfolio. This equates to 230 per month. A higher figure is good.		Recruitment in June was above plan with 305 recruited onto studies during the month. However the year to date position remains 7.8% below plan.	✓
Directorate research activity	The number of studies within each of the directorates - included in the graph is Trustwide where the study spans directorates. The Trust has no specific target set for research activity within each directorate. It is envisaged that each clinical directorate would have a balanced portfolio.		The directorate research teams are subject to studies that are available to open. The 'type of study', Commercial, Interventional, Observational, Large scale, Patient Identification Centre (PIC) or N/A influence the activity based funding received by HDFT. Each category is weighted dependant on input of staff involvement. N/A studies are those studies which are not on the NIHR portfolio. They include commercial, interventional, observational, large scale, PIC, local and student projects. They do not influence the recruitment target.	✓

Data Quality - Exception Report

Report section	Indicator	Data quality rating	Further information
Operational Performance	GP Out of Hours - National Quality Requirement 9	**Red** 	The Trust recently changed the way that some patient groups are managed within the GP OOH service to improve efficiency and patient experience. Reports from the Adastra system no longer calculate the correct start time for these patients or assign them to the most appropriate level of urgency in data reports. As a result, the performance reported for some of the NQRs is now incorrect. We have been working with YAS to resolve this and have made some progress but are not yet confident that the data reported accurately reflects performance. The recent problems with the data have reiterated that the NQRs are out of date. We are proposing revised metrics which more comprehensively reflect both the quality and responsiveness of the GP OOH service.
Operational Performance	GP Out of Hours - National Quality Requirement 12	**Red** 	
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** 	This is the first time that we have reported on this data. Caution should be exercised as further work is required to understand the completeness and quality of the data.
Operational Performance	Children's Services - 2.5 year review	**Amber** 	This is the first time that we have reported on this data. Caution should be exercised as further work is required to understand the completeness and quality of the data.

Indicator traffic light criteria

Section	Indicator	Further detail	Traffic light criteria	Rationale/source of traffic light criteria
Quality	**Safety thermometer - harm free care**	% harm free	Blue if latest month >=97%, Green if >=95% but <97%, red if latest month <95%	National best practice guidance suggests that 95% is the standard that Trusts should achieve. In addition, HDFT have set a local stretch target of 97%.
Quality	**Pressure ulcers - hospital acquired**	No. grade 3 and grade 4 avoidable hospital acquired pressure ulcers	tbc	tbc
Quality	**Pressure ulcers - community acquired**	No. grade 3 and grade 4 community acquired pressure ulcers	tbc	tbc
Quality	**Falls**	IP falls per 1,000 bed days	Blue if YTD position is a reduction of >=50% of HDFT average for 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.	
Quality	**Falls causing harm**	IP falls causing moderate harm, sever harm or death, per 1,000 bed days		Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Quality	**Infection control**	No. hospital acquired C.diff cases	Green if below trajectory YTD, Amber if above trajectory YTD, Red if above trajectory at end year or more than 10% above trajectory in year.	NHS England, NHS Improvement and contractual requirement
Quality	**Avoidable admissions**	The number of avoidable emergency admissions to HDFT as per the national definition.	tbc	tbc
Quality	**Reducing readmissions in older people**	The proportion of older people 65+ who were still at home 91 days after discharge from hospital into rehabilitation or reablement services.	tbc	tbc
Quality	**Mortality - HSMR**	Hospital Standardised Mortality Ratio (HSMR)	Blue = better than expected (95% confidence interval), Green = as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval).	
Quality	**Mortality - SHMI**	Summary Hospital Mortality Index (SHMI)		Comparison with national average performance.
Quality	**Complaints**	No. complaints, split by criteria	Blue if no. complaints in latest month is below LCL, Green if below HDFT average for 2015/16, Amber if 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	**Incidents - all**	Incidents split by grade (hosp and community)	Blue if latest month ratio places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%	Comparison of HDFT performance against most recently published national average ratio of low to high incidents.
Quality	**Incidents - SIRIs (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.	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	**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%.	
Quality	**Friends & Family Test (FFT) - Staff**	% staff who would recommend HDFT as a place to receive care		Comparison with performance of other acute trusts.
Quality	**Friends & Family Test (FFT) - Patients**	% recommend, % not recommend - combined score for all services currently doing patient FFT	Green if latest month >= latest published national average, Red if < latest published national average.	Comparison with national average performance.
Quality	**Safer staffing levels**	RN and CSW - day and night overall fill rates at trust level	Green if latest month overall staffing >=100%, amber if between 95% and 100%, red if below 95%.	The Trusts aims for 100% staffing overall.
Quality	**Staff appraisal rate**	Latest position on no. staff who had an appraisal within the last 12 months	Annual rolling total - 90% green. Amber between 70% and 90%, red<70%.	Locally agreed target level based on historic local and NHS performance
Quality	**Mandatory training rate**	Latest position on the % staff trained for each mandatory training requirement	Blue if latest month >=95%; Green if latest month 75%-95% overall, amber if between 50% and 75%, red if below 50%.	Locally agreed target level - no national comparative information available until February 2016
Quality	**Staff sickness rate**	Staff sickness rate	Green if <3.9% , amber if between 3.9% and regional average, Red if > regional average.	HDFT Employment Policy requirement. Rates compared at a regional level also
Quality	**Temporary staffing expenditure - medical/nursing/other**	Expenditure per month on staff types.	tbc	tbc
Quality	**Staff turnover**	Staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts.	Green if remaining static or decreasing, amber if increasing but below 15%, red if above 15%.	Based on evidence from Times Top 100 Employers
Quality	**Maternity - Caesarean section rate**	Caesarean section rate as a % of all deliveries	Green if <25% of deliveries, amber if between 25% and 30%, red if above 30%.	tbc
Quality	**Maternity - Rate of third and fourth degree tears**	No. third or fourth degree tears as a % of all deliveries	Green if <3% of deliveries, amber if between 3% and 6%, red if above 6%.	tbc
Quality	**Maternity - Unexpected term admissions to SCBU**	Admissions to SCBU for babies born at 37 weeks gestation or over.	tbc	tbc
Finance and efficiency	**Readmissions**	No. emergency readmissions (following elective or non-elective admission) within 30 days.	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%	

Section	Indicator	Further detail	Traffic light criteria	Rationale/source of traffic light criteria
Finance and efficiency	Length of stay - non-elective	Average LOS for non-elective patients	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	Non-elective bed days for patients aged 18+	Non-elective bed days at HDFT for HARD CCG patients aged 18+, per 100,000 population	Improvement trajectory to be agreed.	Improvement trajectory to be agreed.
Finance and efficiency	Theatre utilisation	% of theatre time utilised for elective operating sessions	Green = >=85%, Amber = between 75% and 85%, Red = <75%	A utilisation rate of around 85% is often viewed as optimal.
Finance and efficiency	Delayed transfers of care	% acute beds occupied by patients whose transfer is delayed - snapshot on last Thursday of the month.	Red if latest month >3.5%, Green <=3.5%	Contractual requirement
Finance and efficiency	Outpatient DNA rate	% first OP appointments DNA'd		
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%.	
Finance and efficiency	Day case rate	% elective admissions that are day case		Comparison with performance of other acute trusts.
Finance and efficiency	Surplus / deficit and variance to plan	Monthly Surplus/Deficit (£'000s)	Green if on plan, amber <1% behind plan, red >1% behind plan	Locally agreed targets.
Finance and efficiency	Cash balance	Monthly cash balance (£'000s)	Green if on plan, amber <10% behind plan, red >10% behind plan	Locally agreed targets.
Finance and efficiency	NHS Improvement continuity of services risk rating	An overall rating is calculated ranging from 4 (no concerns) to 1 (significant concerns). This indicator monitors our position against plan.	Green if rating =4 or 3 and in line with our planned rating, amber if rating = 3, 2 or 1 and not in line with our planned rating.	as defined by NHS Improvement
Finance and efficiency	CIP achievement	Cost Improvement Programme performance	Green if achieving stretch CIP target, amber if achieving standard CIP target, red if not achieving standard CIP target.	Locally agreed targets.
Finance and efficiency	Capital spend	Cumulative capital expenditure	Green if on plan or <10% below, amber if between 10% and 25% below plan, red if >25% below plan	Locally agreed targets.
Finance and efficiency	Agency spend in relation to pay spend	Expenditure in relation to Agency staff on a monthly basis (£'s).	Green if <1% of pay bill, amber if between 1% and 3% of pay bill, red if >3% of pay bill.	Locally agreed targets.
Finance and efficiency	Research - Invoiced research activity		to be agreed	
Operational Performance	NHS Improvement governance rating	Trust performance on Monitor's risk assessment framework.	As per defined governance rating	as defined by NHS Improvement
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%	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

Report to the Trust Board of Directors: 27th July 2016	Paper No: 9.0

Title	Report from Chief Operating Officer
Sponsoring Director	Robert Harrison, Chief Operating Officer
Author(s)	Rachel McDonald, Head of Performance & Analysis Jonathan Green, Information Analyst Specialist
Report Purpose	For information

Key Issues for Board Focus:

1. HDFT was ranked first out of the 131 Trusts who participated in all sections of the National Cancer Patient Experience Survey 2015.

2. Performance against the 4 hour A&E waiting times target was above the required 95% for June and Quarter 1 overall.

3. Provisional data suggests that the Trust will achieve all Cancer Waiting Times and 18 week targets for Quarter 1.

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

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

Action Required by the Board of Directors

That the Board of Directors note the information provided in the report and approve the Information Governance Toolkit baseline submission and submission of the NHS Improvement RAF Governance compliance for Quarter 1.

1.0 NATIONAL CANCER PATIENT EXPERIENCE SURVEY

The National Cancer Patient Experience Survey 2015 is the fifth iteration of the survey first undertaken in 2010. It has been designed to monitor national progress on cancer care; to provide information to drive local quality improvements; to assist commissioners and providers of cancer care; and to inform the work of the various charities and stakeholder groups supporting cancer patients.

455 HDFT patients were asked to take part in the survey and 317 (74%) completed and returned it. This is a greater response rate than the national average of 66%.

When taking an average of all the Trusts adjusted scores, HDFT came 3rd out of the 146 Trusts which took part in the survey achieving an average score of 80%. However, of the trusts which responded to all the questions HDFT came top out of 131.

Asked to rate their care on a scale of zero (very poor) to 10 (very good), HDFT respondents gave an average rating of 8.9.

In the NHS England Summary Report, Harrogate and District NHS Foundation Trust scored better than the national average in all 29 questions used to grade the trust by.

2.0 REDUCING READMISSIONS IN OLDER PEOPLE

The integrated board report includes a metric looking at the proportion of older people aged 65+ who were still at home 91 days after discharge from hospital into rehabilitation or re-ablement services. This metric is also monitored as part of the New Care Models evaluation. For patients discharged in March, 70% were still in their own home at the end of June - an increase on the previous month. The construction of this metric is quite complex as it requires linking data from different systems which may include multiple referrals, contacts and admissions for the same patient. Therefore a data quality rating of amber has been applied to this metric in the integrated board report to reflect this.

Following two successive months reduction in performance in this metric, a case note audit of a sample of patients who were readmitted within 91 days of a discharge in January or February 2016 is being carried out to understand any themes and actions required. The results of this audit will be reported back to Trust Board in September once completed by the Team in Long Term and Unscheduled Care Directorate.

3.0 SAFEGUARDING CHILDREN

As part of the transfer of children's services from County Durham and Darlington NHS Foundation Trust (CDDFT) to Harrogate, agreement had been reached that an individual would transfer on the 18th July 2016 to the position of Named Nurse Child Protection for HDFT in that locality. Unfortunately this will position has changed and the individual will not transfer as expected. The directorate and the safeguarding children's team are therefore working on contingency plans until an appointment can be made into the post. This includes utilising Named nurses from other localities to ensure the appropriate activities are being completed in the interim.

4.0 INFORMATION GOVERNANCE BASELINE SUBMISSION – JULY 2016

The Information Governance Toolkit is a Department of Health (DH) Policy delivery vehicle that the Health and Social Care Information Centre (HSCIC) is commissioned to develop and maintain. The IG Toolkit is separated into six categories:

- Information Governance Management
- Confidentiality and Data Protection Assurance
- Information Security Assurance
- Clinical Information Assurance
- Secondary Use Services Assurance
- Corporate Information Assurance

The Trust is required to carry out self-assessments of their compliance against the IG requirements. The purpose of the assessment is to enable organisations to measure their compliance against the law and central guidance and to see whether information is handled correctly and protected from unauthorised access, loss, damage and destruction.

The Trust's 2016/17 baseline submission scores are shown in the table overleaf and are unchanged from the 2015/16 final submission.

Information Governance Toolkit	2015/16 Final Submission	2016/17 July Baseline Submission
1. Information Governance Management	86%	86%
2. Confidentiality and Data Protection Assurance	87%	87%
3. Information Security Assurance	73%	73%
4. Clinical Information Assurance	100%	100%
5. Secondary Uses Assurance	91%	91%
6. Corporate Information Assurance	77%	77%
Total	**84%**	**84%**

Level 0	Level 1	Level 2	Level 3	Not Relevant
0	0	21	23	1

Notable Changes

There have been some changes to the Secondary Uses Assurance standards to ensure that actions have been taken following data quality checks and audits by developing and implementing improvement plans. However these changes have not impacted on the Trust's scores for these standards.

5.0 COMMON PURPOSE EVENT

On the 13th and 14th July a collaborative innovation event was held in Leeds, bringing together teams from all the WYAAT Trusts, the Association of British Industries, the Yorkshire and Humber Academic Health Science Network and PWC. The focus of the event was to find new innovative solutions to delayed discharges in partnership with the technology industry. The Chief Operating Officer is the Executive lead for this work on behalf of WYAAT and is part of the steering group which organised the event and will be taking forward the ideas generated during the two days. This is an exciting opportunity working across West Yorkshire, to create a new test bed for healthcare technologies and the work has been referenced to NHSE and NHSI as part of the STP planning process. An initial collaboration has already commenced with a joint bid for funding to develop a communication tool to support patients and families during discharge between HDFT and one of the Software companies present.

6.0 ELECTIVE CARE RAPID TESTING PROGRAMME

HDFT is working in collaboration with HARD CCG as one of two local health communities participating in the national Elective Care Rapid Testing Programme being run by NHS England.

As one of a number of measures to improve the relationship between primary and secondary care, the programme will systematically trial:

- how better support for primary care can improve referral accuracy, reducing the potential for patients to have multiple hospital appointments before finding the right service;
- how better use of technology and putting patients in the driving seat can reduce the need for people to attend unnecessary outpatient appointments, and;
- how increasing the use of shared decision-making (where professionals and patients discuss options and preferences for different treatments and providers) can improve patient experience, choice and outcomes.

The local team is working on a 100 day challenge during which innovative approaches will be trialled and evaluated. Learning from the project will then be codified, enabling other NHS commissioners and providers to adopt and adapt lessons from these initial sites.

The three specific challenges chosen by the Harrogate and District area team are:

- Dermatology – significantly reduce the number of referrals made into secondary care by increasing the opportunities to safely, diagnose, treat and follow up cases in primary care and/or the community.
- Gastroenterology – increase options for patients and clinicians in a way that reduced demand on the need for face to face consultations without compromising on the quality of care.
- Osteoarthritis in the hip and knee – transform the care pathway in ways that increase shared decision making and reduce demand on secondary care.

A launch event took place in June involving clinical and non-clinical staff. Each work stream has a designated lead who is now taking forward specific actions for their specialty.

7.0 CARBON AND ENERGY FUND

Work in the satellite plantrooms across the site is progressing well in advance of the plans to change over from steam as the primary heat source to medium temperature hot water which is generated by the CHP unit as part of the by-product of the electrical generation. The design is such that during the summer months all the domestic hot water will be generated by this waste heat. Work to install the underfloor heating in the car park is well underway; this uses the low grade waste heat from the CHP in the winter to prevent icing.

The final testing of the new electrical standby generator in Strayside wing has been completed and approved by the network operator. This now completes all the elements of the electrical upgrade.

8.0 SERVICE ACTIVITY

Variances above or below 3% are as follows – At the end of June, new outpatient activity was 6.8% below plan, follow-up outpatient activity was 5.0% below plan, elective admissions were 8.0% below plan, and ED attendances were 4.0% above plan.

For Leeds North CCG, new outpatient appointments were 16.8% above plan, elective admissions were 13.4% below plan, and non-elective admissions were 8.2% below plan.

9.0 CHILDREN'S SERVICES PERFORMANCE METRICS

Data for the Healthy Child Programme in Darlington, Co. Durham and Middlesbrough has been included in the Integrated Board Report for the first time this month. Performance is presented for two contractual requirements:

- 10-14 day new birth visit - % babies who had a new birth visit within 14 days
- 2.5 year review - % children who had a 2.5 year review

Data for the 0-5 Health Visiting Service in North Yorkshire is also shown.

On an annual basis, performance will also be reported in this report on the National Child Measurement Programme and HPV immunisations.

10.0 FOR APPROVAL

The Board is asked to approve the Information Governance Toolkit baseline July update submission.

The Board is asked to approve the Quarter 1 Governance section of the Risk Assessment Framework as **Green** for submission to NHS Improvement as detailed in the Integrated Board Report.

Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 27th July 2016	**Paper No: 10.0**

Title	Financial Position
Sponsoring Director	Mr J Coulter, Deputy Chief Executive/ Finance Director
Author(s)	Mr J McKie, Deputy Finance Director
Report Purpose	Review of the Trusts financial position

Key Issues for Board Focus:

1. Whilst the Trust has delivered the Q1 financial control total and will receive the first part of the S&T funding, the operational budgetary position is over £600k behind the plan to date.

2. Plans are in place for 93% of the £9.4m Cost Improvement target; however, this reduces to 80% following risk adjustment. 65% of plans have been actioned to date.

3. The Trust cash balance at the end of June was £2,429k. Following contract agreement the annual plan for cash will be re-profiled.

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

Risk and Assurance	There is a risk to delivery of the 2016/17 financial plan if budgetary control is not improved. Mitigation is in place through regular monthly monitoring, and discussions on improving this process are ongoing.
Legal implications/ Regulatory Requirements	

Action Required by the Board of Directors

The Board is asked to note the contents of this report.

The Board is asked to approve the submission of the quarter one governance return to NHS Improvement.

June 2016 Financial Position

Financial Performance

- Whilst the Trust has delivered the Q1 financial control total and will receive the first part of the S&T funding, the operational budgetary position is over £600k behind the plan to date. This significantly puts at risk achievement of future quarters' financial plan.

- There is an underlying adverse income variance of £936k to date. There has been an impact on elective activity levels as a result of the agency cap and junior doctor strike. There is, however, further work being undertaken to maximise utilisation of theatre lists and ensuring the impact of the agency cap is minimised.

- Pay expenditure is reported as a £621k favourable variance to date. Ward nursing continues to be the major adverse variance at £277k. Although the wards are experiencing pressure as a result of vacancies and 1 to 1 care requirements, actions are in place to bring this area of overspend under control.

- Wheelchair services continues to be an area of overspend for non pay. The adverse variance stands at £130k to date. The service are putting controls in place to manage this back to budget following discussions with commissioners regarding available funding. The risks associated with this are being carefully managed and local CCGs are being made aware of the impact to waiting lists.

- The cost improvement programme is discussed in more detail later in this report. There is an adverse variance of £535k to date as a result of plans which have not been actioned. This is a key area of focus for directorates, with a need to action current plans, establish any delays and mitigate the current gap.

- The Trust was £12,311k behind plan for cash in June with a balance of £2,429k. This is predominantly the result of the changes in profile following agreement of the acute contract with HaRD CCG. As a result of the contract agreement the planned cash profile will be revised for July reporting. Further information can be found on page 10.

- Achievement of S&T funding in quarter 1 is a really positive position, both financially and operationally. The operational budgetary position, however, highlights the risk associated with the Trusts current financial performance and therefore it is important that directorates continue to resolve the above issues. Discussions with the directorate teams will focus on these areas, identifying blocks to achieving further efficiencies and moving forward schemes to recover the position.

June 2016 Financial Position

NHSI Financial Sustainability Risk Rating (FSRR)

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

• The table to the right outlines the Trusts FSRR for June.

• Performance in June has resulted in a FSRR of 4.

• It is anticipated that the Trust will maintain a FSRR of at least 3 over the next 12 months.

• The Board is asked to approve the submission of the quarter one governance return to NHS Improvement.

Sustainability and Transformation Fund

• The following criteria for accessing the Sustainability and Transformation fund has been outlined by NHS Improvement –

1. Financial Performance – The financial control totals are a binary on/off switch to secure STF funding – i.e. having achieved the year-to-date control total in a quarter, the organisation becomes eligible for funding, the size of which is determined by the level of success with the other criteria. There will be zero tolerance in relation to the financial element. Achievement of the year-to-date financial control total for the quarter is weighted at a minimum of 70% dependant on the range of agreed performance trajectories;

2. Access Standards – Performance against agreed trajectories is weighted at 30%, with RTT and accident and emergency accounting for 12.5% each, Cancer 62 days at 5%. Diagnostics has also been included as improvement trajectories were collected but will carry a 0% weighting. There will be a 1% tolerance for Q2, 0.5% in Q3 and 0% in Q4.

• The finance aspect of the STF will operate on a cumulative basis so that if a provider misses the year-to-date control total in a quarter but achieves the control total in a subsequent quarter it could receive the full amount of funding.

• Based on Q1 performance the Trust achieved all requirements for the fund and will therefore receive the Q1 allocation of £1,150k.

June 2016 Financial Position

Summary Income & Expenditure 2016/17

For the month ending 30th June 2016

	Budget		Actual	Cumulative	June
	Annual Budget £000	Proportion To Date £000	To Date £000	Variance £000	Actuals £'000
INCOME					
NHS Clinical Income (Commissioners)					
NHS Clinical Income - Acute	141,398	35,239	34,615	(624)	11,736
NHS Clinical Income - Community	56,595	14,244	14,035	(209)	4,716
System Resilience & Better Care Funding	561	140	140	(0)	47
Non NHS Clinical Income					
Private Patient & Amenity Bed Income	1,888	478	335	(143)	99
Other Non-Protected Clinical Income (RTA)	523	131	181	51	131
Other Income					
Non Clinical Income	13,651	3,481	3,469	(12)	1,193
Hosted Services	2	0	2	2	2
TOTAL INCOME	**214,618**	**53,713**	**52,777**	**(936)**	**17,924**
EXPENSES					
Pay					
Pay Expenditure	(146,773)	(38,278)	(37,657)	621	(12,463)
Non Pay					
Drugs	(5,941)	(3,593)	(3,626)	(32)	(1,273)
Clinical Services & Supplies	(16,719)	(4,587)	(4,799)	(212)	(1,781)
Other Costs	(15,941)	(4,110)	(4,949)	(839)	(1,718)
Reserves : Pay	(2,781)	0	0	0	0
Pay savings targets	0	0	0	0	0
Other Reserves	(8,438)	(915)	0	915	0
High Cost Drugs	(6,981)	0	0	0	0
Non Pay savings targets	(341)	0	0	0	0
Other Finance Costs	(18)	(4)	(8)	(3)	0
Hosted Services	(708)	(156)	(163)	(7)	(51)
TOTAL COSTS	(204,641)	(51,643)	(51,201)	442	**(17,286)**
EBITDA	**9,976**	**2,070**	**1,576**	**(494)**	**637**
Profit / (Loss) on disposal of assets	0	0	0	0	0
Depreciation	(5,081)	(1,270)	(1,333)	(62)	(456)
Interest Payable	(90)	(23)	(51)	(28)	(18)
Interest Receivable	41	10	7	(3)	4
Dividend Payable	(2,646)	(662)	(687)	(26)	(229)
Net Surplus/(Deficit) before donations and impairment	**2,200**	**126**	**(487)**	**(613)**	**(62)**
Donated Asset Income	0	0	39	39	13
Impairments re Donated assets	0	0	0	0	0
Impairments re PCT assets	0	0	0	0	0
Operational Budgetary Position	**2,200**	**126**	**(449)**	**(575)**	**(49)**
Non Operational Expenses	0	0	719	719	719
Sustainability and Transformation Fund	4,600	1,150	1,150	0	639
Total and Consolidated Net Surplus/(Deficit)	**6,800**	**1,276**	**1,420**	**144**	**1,309**

Negative sign under variance indicates an UNDER-recovery of forecast income, or an OVER-spending against budget

June 2016 Financial Position

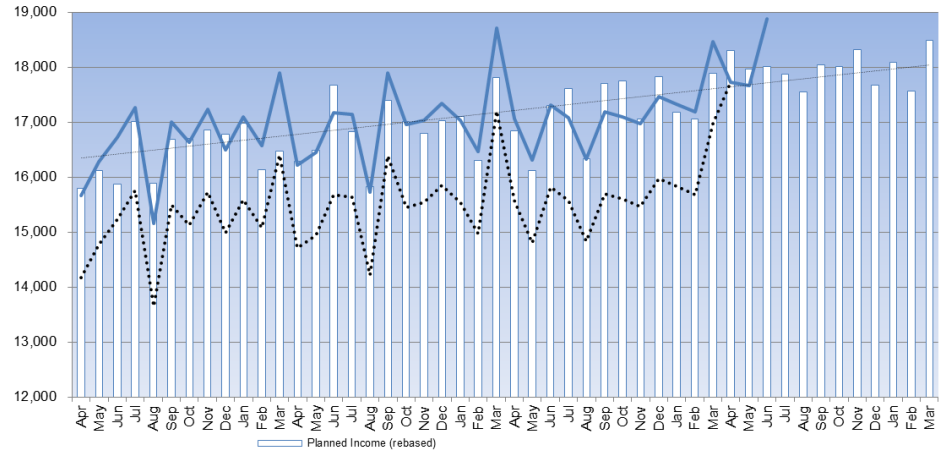
Net Income & Expenditure Position

For the month ending 30th June 2016

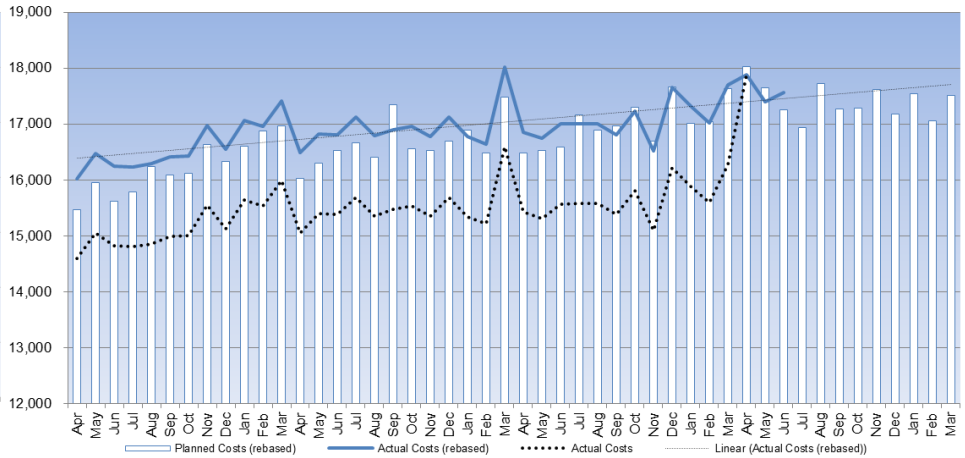
2014/15 Actual £000	Opening Budget £000		Annual Budget £000	Workforce Budget wte	Workforce Contracted wte	Workforce Actual wte	In Month Budget £000	In Month Actual £000	In Month Variance £000	Cumulative Budget £000	Cumulative Actual £000	Variance (o.s)/u.s £000
2,169	1,274	Non-Comissioner Income	1,721				245	218	(27)	668	659	(9)
(36,721)	(34,989)	Pay	(36,400)	971.92	912.35	896.61	(3,122)	(2,993)	129	(9,346)	(9,005)	341
(9,172)	(2,947)	Non-Pay	(4,344)				(462)	(563)	(101)	(1,180)	(1,486)	(306)
(43,724)	**(36,662)**	**Total Childrens & County Wide Community Care D**	**(39,024)**	**971.92**	**912.35**	**896.61**	**(3,339)**	**(3,338)**	**1**	**(9,857)**	**(9,832)**	**25**
3,180	1,764	Non-Comissioner Income	2,997				281	253	(27)	794	728	(66)
(29,388)	(28,642)	Pay	(48,475)	1129.03	1030.25	1020.44	(4,290)	(4,190)	100	(12,788)	(12,763)	25
(12,671)	(7,202)	Non-Pay	(7,452)				(1,054)	(1,179)	(125)	(2,858)	(3,256)	(398)
(38,879)	**(34,080)**	**Total Long Term & Unscheduled Care Directorate**	**(52,930)**	**1129.03**	**1030.25**	**1020.44**	**(5,063)**	**(5,116)**	**(53)**	**(14,852)**	**(15,291)**	**(438)**
1,360	1,457	Non-Comissioner Income	1,573				121	83	(38)	392	295	(97)
(43,027)	(40,216)	Pay	(42,342)	893.14	848.41	825.19	(3,717)	(3,667)	49	(11,290)	(11,104)	187
(13,347)	(9,307)	Non-Pay	(14,061)				(1,794)	(1,842)	(48)	(5,017)	(5,170)	(153)
(55,014)	**(48,066)**	**Total Planned & Surgical Care Directorate**	**(54,830)**	**893.14**	**848.41**	**825.19**	**(5,390)**	**(5,426)**	**(36)**	**(15,915)**	**(15,979)**	**(63)**
(19,852)	**(18,471)**	**Corporate (Clinical)**	**(16,573)**	**454.44**	**432.37**	**444.19**	(1,404)	(1,442)	(37)	(4,139)	(4,148)	(9)
(157,469)	(137,279)	**Total Clinical Spend**	(163,357)	3448.53	3223.38	3186.43	(15,197)	(15,322)	(125)	(44,764)	(45,250)	(486)
(7,626)	**(7,802)**	**Corporate (inc. CNST)**	(13,173)	**162.93**	**155.44**	**156.27**	(1,092)	(997)	96	(3,287)	(3,290)	(3)
(27,478)	**(26,273)**	**Total Corporate Position**	**(29,746)**	**617.37**	**587.81**	**600.46**	**(2,497)**	**(2,438)**	**59**	**(7,426)**	**(7,438)**	**(12)**
165,503	165,941	**Commissioner Income**	202,456				17,060	17,427	366	50,739	50,206	(534)
(388)	(19,158)	**Central**	(19,126)	2.91	(23.71)	(24.91)	(125)	188	313	(1,414)	(285)	1,129
21	**1,702**	**Total before donations & impairments**	**6,800**	**3,614.37**	**3,355.11**	**3,317.79**	**646**	**1,296**	**650**	**1,275**	**1,382**	**106**
5,297	0	**Donations for Capital Expenditure**	0					13	13	0	39	39
(3,340)	0	**Impairments on Donated assets**	0						0	0	0	0
(1,305)		**Impairments on PCT assets**	0						0	0	0	0
672	**1,702**	**Trust reporting position**	**6,800**	**3,614.37**	**3,355.11**	**3,317.79**	**646**	**1,309**	**663**	**1,275**	**1,420**	**145**
457		**Charitable funds consolidation**	0					0	0	0	0	0
1,129	**1,702**	**Total Trust reported position**	**6,800**	**3,614.37**	**3,355.11**	**3,317.79**	**646**	**1,309**	**663**	**1,275**	**1,420**	**145**

June 2016 Financial Position

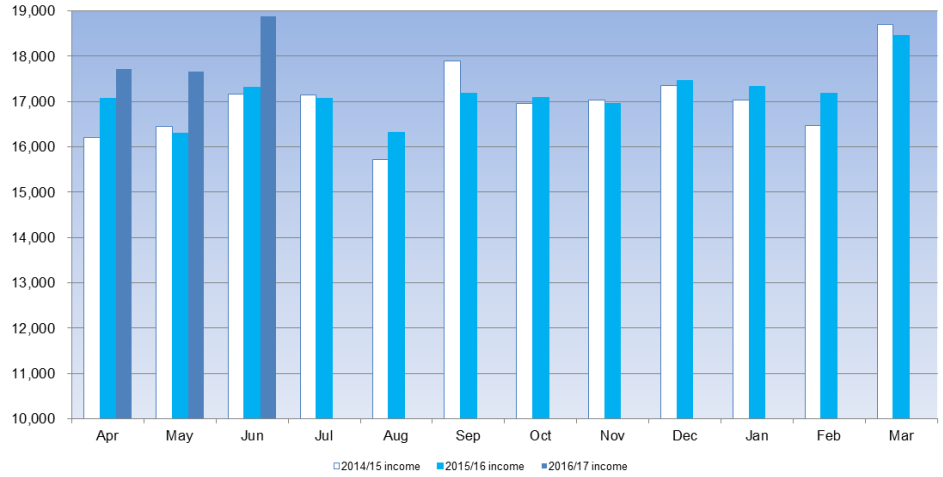
Planned and Actual Income Apr 2013 - Mar 2017 (rebased for new contracts)



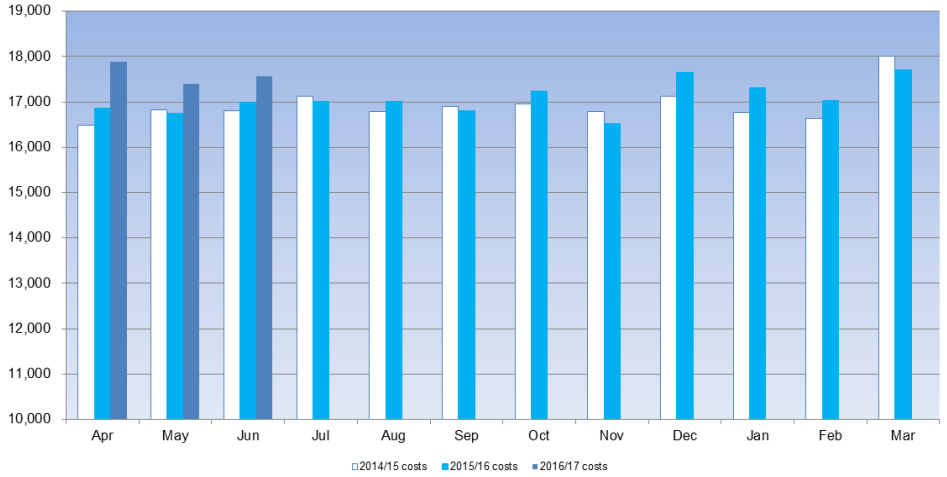
Planned and Actual Costs Apr 2013 - Mar 2017 (rebased for new contracts)



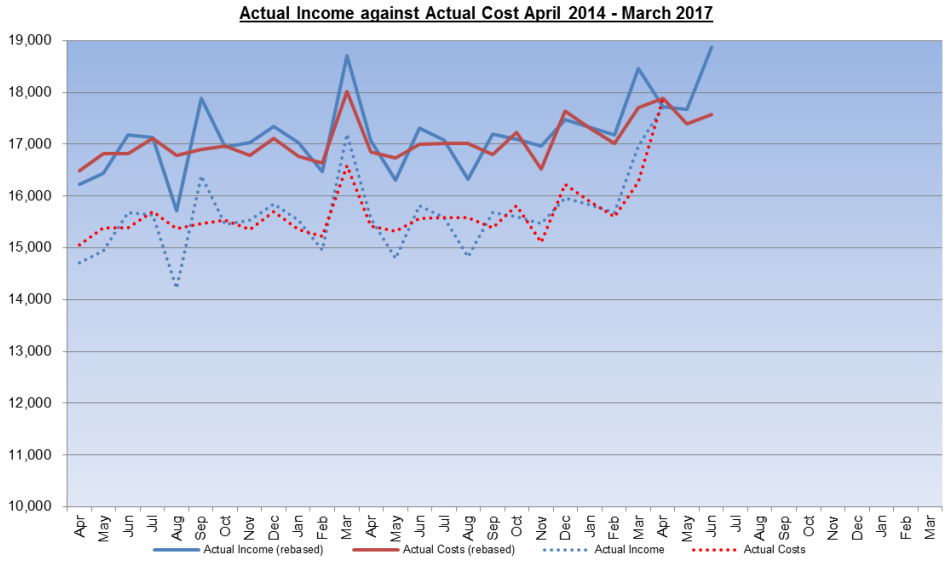
Actual Income (rebased) 2014/15, 2015/16 & 2016/17

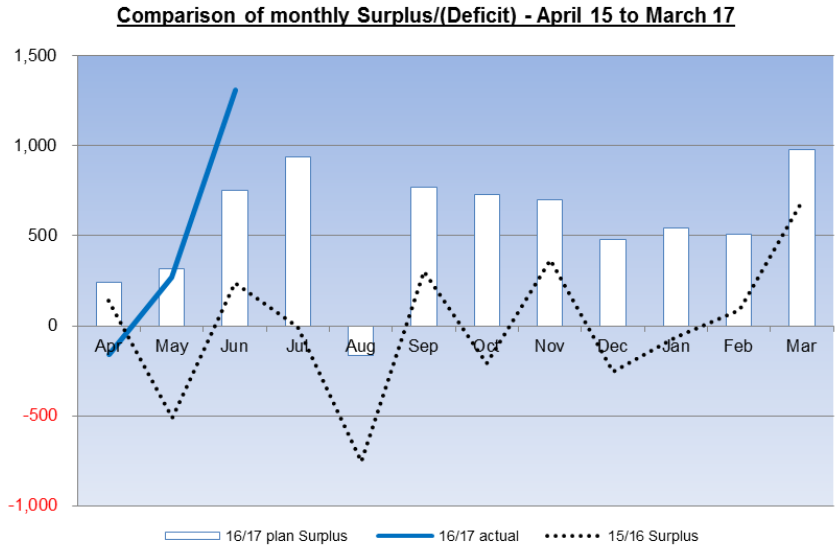


Actual costs (rebased) 2014/15, 2015/16 & 2016/17



June 2016 Financial Position



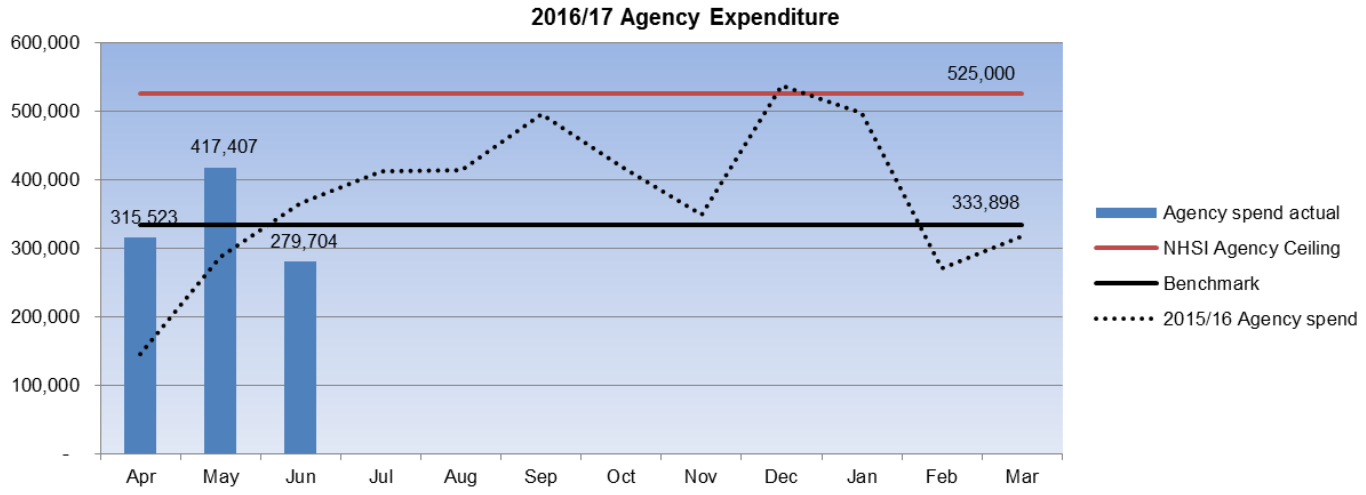


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15 income	14,717	14,945	15,674	15,637	14,221	16,388	15,451	15,533	15,845	15,539	14,967	17,201
2015/16 income	15,564	14,802	15,810	15,578	14,826	15,689	15,595	15,467	15,968	15,828	15,686	16,967
2016/17 income	17,725	17,665	18,876									
2014/15 costs	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									
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									

June 2016 Financial Position

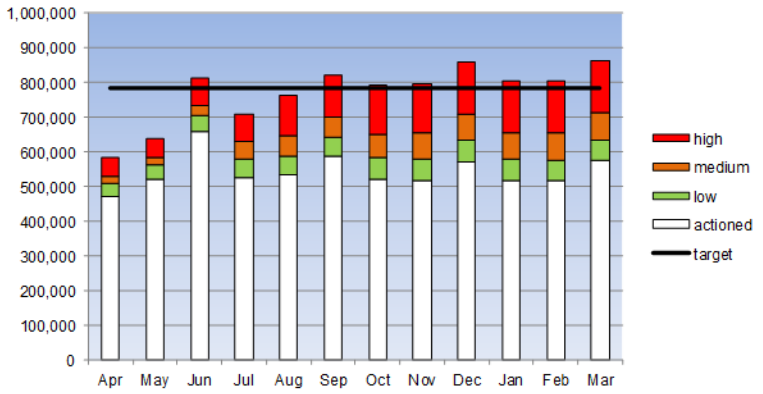
Agency Expenditure

- 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

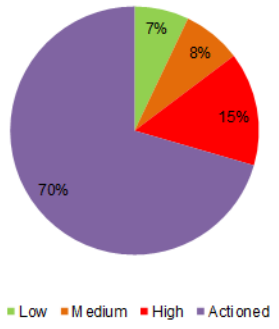


Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Trustwide	9,929,400	6,521,700	655,275	706,045	1,368,922	9,251,941	93%	7,982,831	80%
		% age of target	7%	7%	14%				

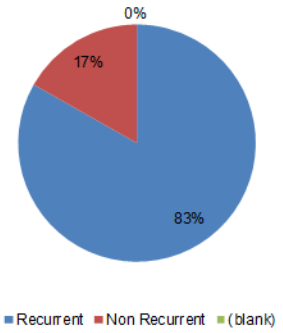
Top 10 schemes Top 10 as % of schemes - 27%

No.	Scheme	Value	Risk
1	Cardiology and Respiratory Outpatient Review	486,200	Actioned
2	Business Development 1	450,000	Actioned
3	Maternity Review	400,000	Actioned
4	Business Development 2	200,000	Actioned
5	Business Development 3	200,000	Actioned
6	Drug Savings	160,000	Actioned
7	Drug Savings - Actioned	149,600	Actioned
8	1st Managed Contract additional 2nd year savings	145,000	Actioned
9	Business Development 4	143,800	High
10	Overhead funding review	135,400	Actioned

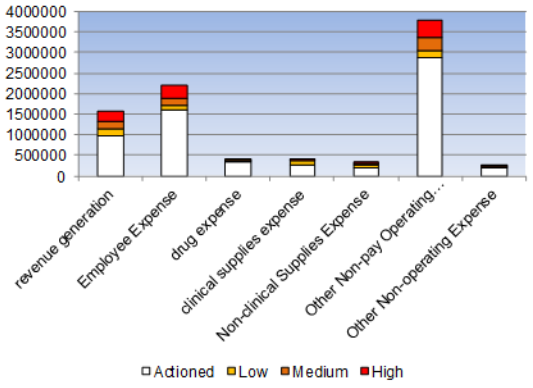
CIP schemes by Risk



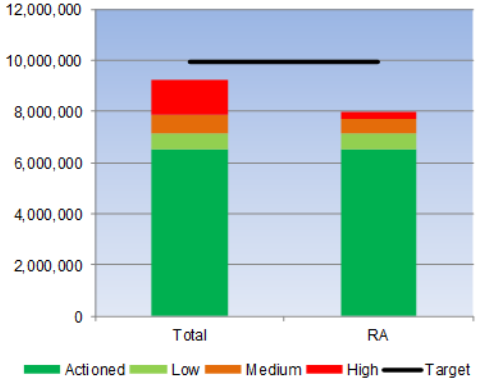
Recurrent V Non Recurrent Plans



Efficiency Category



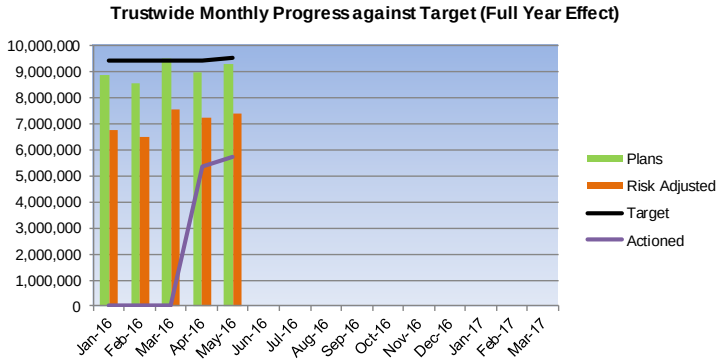
Risk Profile



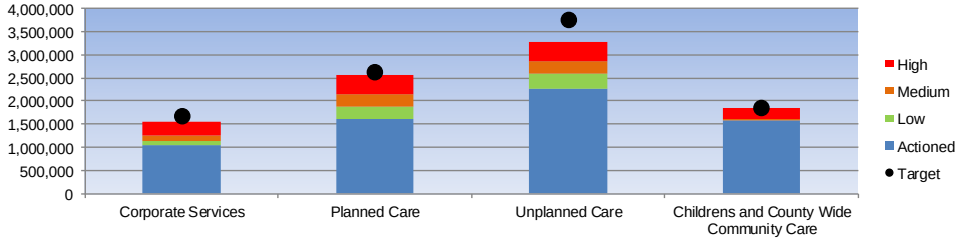
- As outlined above, £6,521,700 full year effect of cost improvement schemes have been actioned to date. This equates to 65% of the target.
- Of the high value schemes, three are rated as high risk. These are currently being reviewed with the directorates.
- Of the total above, £1.6m of schemes are linked to transformational work. 15% of these have been actioned, therefore the clinical transformation board is focusing on ensuring blocks to this positive area of work are removed.

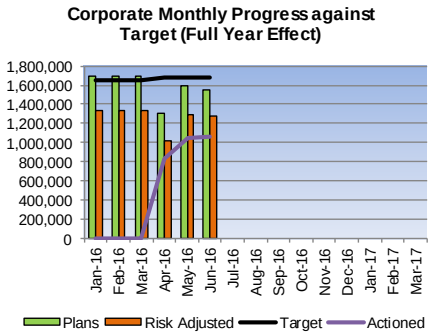
2016/17 Efficiency Update

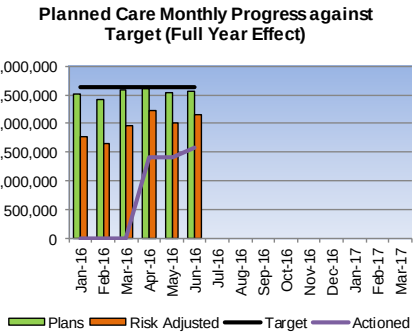
Trustwide Cost Improvement Programme 2016/17

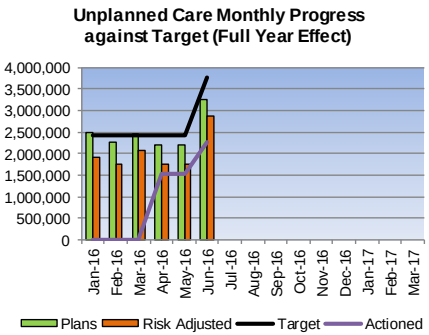


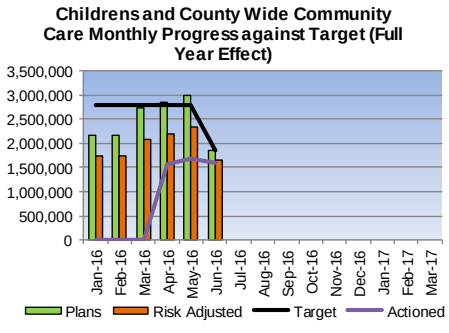
Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Corporate Services	1,675,100	1,055,900	69,200	127,915	302,500	1,555,515	93%	1,284,472	77%
Planned Care	2,632,600	1,619,300	249,925	281,367	417,319	2,567,910	98%	2,165,286	82%
Unplanned Care	3,761,800	2,258,300	336,150	279,300	390,400	3,264,150	87%	2,879,163	77%
Childrens and County	1,859,900	1,588,200	0	17,463	258,703	1,864,366	100%	1,653,911	89%

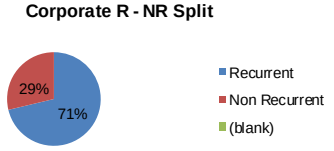


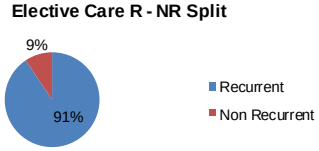


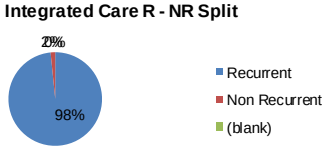


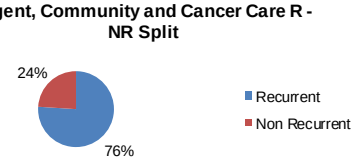












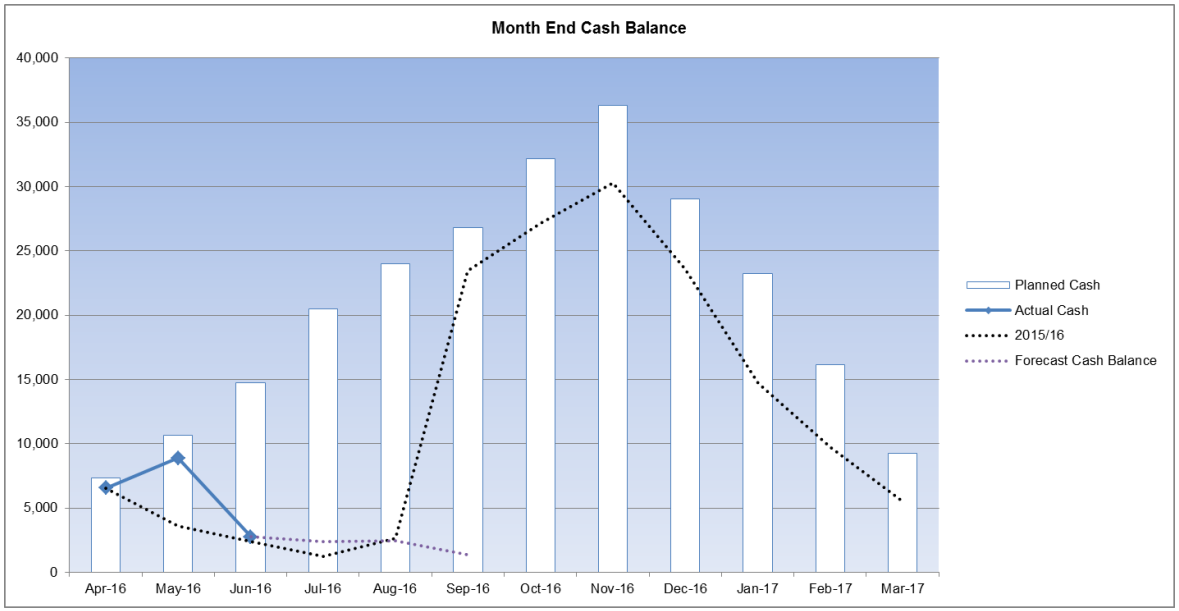
- The above highlights directorate level performance. The significant changes to planned target relate to the directorate restructure.

Cash Management

Outstanding Accounts Receivable Debts - JUNE 2016

	0 to 30 Days £000	31 to 60 Days £000	61 to 90 Days £000	Over 91 Days £000	Total £000
NHS/WGA Debts	1,090	621	2,346	4,750	8,807
Insurance Companies	43	65	22	32	162
Other	1,138	128	16	138	1,420
Totals	2,271	814	2,384	4,920	10,389

Top 5 Receivables - June 16	£
NHS HARROGATE AND RURAL DISTRICT CCG	2,338,325.29
DURHAM COUNTY COUNCIL	937,500.00
NHS HAMBLETON, RICHMONDSHIRE AND WHITBY CCG	870,215.50
YORK TEACHING HOSPITALS NHS FOUNDATION TRUST	845,233.40
DARLINGTON BOROUGH COUNCIL	685,380.00
Total	**5,676,654.19**



Report to the Trust Board of Directors: 27 July 2016	Paper No: 11.0

Title	Chief Nurse Report
Sponsoring Director	Mrs J Foster, Chief Nurse
Author(s)	Mrs J Foster, Chief Nurse
Report Purpose	To receive, note and approve the contents of the report

Key Issues for Board Focus:

1. To **note** the results of Director Inspection Visits
2. To **note** the number of complaints received by the Trust in June 2016.
3. To **understand** the steps being undertaken to maintain safe staffing levels including robust registered nurse recruitment
4. To be **informed** of how the Board will be updated on the progress of the Trust's Quality Objectives
5. To **acknowledge** the effectiveness of the Trust's processes to support nurse revalidation.

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

Risk and Assurance	
Legal implications/ Regulatory Requirements	No additional Risks

Action Required by the Board of Directors

The Board of Directors are asked to:

- To **note** the outcome of the Director Inspection Visits
- To **note** the number of complaints received by the Trust in June 2016
- To **understand** the actions being undertaken to ensure safe nurse staffing levels including robust registered nurse
- To **understand** how the Board will be updated on the progress of the Trust's Quality Objectives
- To **acknowledge** the effectiveness of the Trust's processes to support nurse revalidation.

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.	14/06/2016		
06/06/2016	Medical Day Unit	Amber	Largely relating to the non-compliant chairs in the treatment room and waiting room. The Unit Manager has found a supplier and got a quote – however it was evident that this has not been signed off by Senior Management. Ros Tolcher and Sandra Dodson plan to take this forward.			
16/06/2016	Pannal (follow up visit)	Red	Further review to be undertaken (Lack of cannula VIP scores)			
24/06/2016	Harlow	Red	Lack of cannula VIP scores			

Patient Safety Visits

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

Date	Area
08/06/16	The Equipment Library
14/06/16	Ripon Community Hospital
28/06/16	Scarborough Wheelchair Service

Complaints Update

The number of complaints received in June is 23.

Of the 23 complaints received in June 2016, one was graded amber, 17 Yellow and five 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**
2016/17	18	16	23										
2015/16	26	18	30	15	17	26	11	9	12	12	21	16	**213**

Nurse Recruitment

Last month I reported the nurse recruitment campaign continues to be successful in that the number of registered nurses being recruited is exceeding the number of registered nurses leaving. This has continued for June moving into July.

Local recruitment continues with an event being held on Thursday 21 July 2016. The next event is planned for September to coincide with the Trust Open day.

Approximately 30 student nurses qualifying in September/October have committed their future to the organisation, a 'keeping in touch' event was held in June and 17 students attended.

We have had a small success recruiting from the EU.

Actual versus Planned Nurse Staffing - Inpatient areas

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

This is the second month that 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 June is 8.5 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.

	Jun-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	93%	112%	99%	142%	4.40	2.81	7.21
Byland	83%	146%	97%	154%	2.88	3.91	6.79
CATT	90%	131%	123%	117%	5.45	3.35	8.80
Farndale	80%	155%	100%	172%	2.93	5.19	8.12
Granby	78%	178%	100%	250%	3.47	5.21	8.68
Harlow	107%	103%	100%	-	7.04	2.02	9.07
ITU/HDU	97%	-	96%	-	25.30	1.67	26.97
Jervaulx	90%	156%	110%	129%	3.39	5.13	8.53
Lascelles	93%	99%	100%	100%	5.48	4.99	10.47
Littondale	96%	117%	101%	160%	3.49	2.28	5.78
Maternity Wards	85%	82%	95%	93%	11.42	3.15	14.57
Nidderdale	97%	128%	97%	133%	3.78	2.94	6.71
Oakdale	96%	119%	98%	185%	4.63	3.69	8.32
SCBU	91%	85%	102%	-	17.58	3.79	21.38
Trinity	83%	130%	100%	97%	3.68	3.31	6.99
Wensleydale	90%	101%	100%	100%	3.60	2.37	5.97
Woodlands	99%	100%	96%	103%	9.42	3.26	12.67
Trust total	**91%**	**127%**	**100%**	**136%**	**4.98**	**3.52**	**8.50**

ED staffing	89%	71%	99%	103%

Further information on this month's data

On the medical wards Jervaulx, Byland, AMU and CATT where the Registered Nurse fill rate was less than 100% against planned; this reflected current band 5 Registered Nurse vacancies and is reflective of the local and national position in particular regarding the challenges in recruiting Registered Nurses. The Trust is engaged in an extensive recruitment plan in response to this. Extra care staff were deployed to support the wards during this period and this is shown in the enhanced care staff, day and night time hours. 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 remain adjusted to reflect the closure of beds in these areas

in response to Registered Nurse vacancies and activity levels.

On Farndale ward, although the daytime RN hours in June were less than planned due to staff sickness and vacancies, an assessment was undertaken on a shift by shift basis to ensure that the planned staffing matched the needs of the patients.

On Granby ward, although the daytime RN hours were less than planned due to vacancies, an assessment was undertaken on a shift by shift basis to ensure that the planned staffing matched the needs of the patients. In addition further care staff hours were required at times in this area to provide intensive 1:1 patient support.

On the ITU / HDU the 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.

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 and care staff gaps in June were due to staff sickness; 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 June this is reflected on the wards; Acute Medical Unit (AMU), Byland, CATT, Granby, Farndale, Oakdale, Nidderdale and Littondale.

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.

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

The staffing complement for the children's ward, Woodlands, is designed to reflect varying levels of occupancy. Although the day and night time RN staffing levels are less than 100% in June, 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.

On Trinity ward, although the daytime RN hours were less than planned due to vacancies, staffing levels were adjusted to reflect bed occupancy levels in June.

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 of Byland and Jervaulx. For the majority of June, eight8 beds have been closed on both Byland and Jervaulx. Conversations with staff at ward level continue to be about feeling under increased pressure. Farndale staffing continues to be a concern and is being carefully monitored. In other wards and department areas the concerns being raised are the movement of staff to support these areas.

On balance I believe we continue to provide safe and effective care to patients. This view is supported by our metrics related to safe and effective care such as the reductions in pressure ulcers, falls and complaints. However the risk to patient safety, increased by the current vacancy level, should continue to be noted.

Monitoring the Quality Objectives for 2016/17

The Board is aware the Quality Objectives for 2016/17 are

- Improvement in Sepsis Care
- Safer use of insulin in Diabetes
- Improving Stroke Care
- Improving the Care of People with Learning Disabilities

I was asked to consider if each objective could be included monthly as a metric in the Integrated Board Report. Detailed progress against each of these objectives is monitored through the Quality Committee, therefore, following careful consideration a summary of progress will be periodically provided within the appropriate Director reports.

- Improvement in Sepsis Care - Medical Director
- Safer use of Insulin in Diabetes - Medical Director
- Improving Stroke Care – Chief Operating Officer
- Improving the Care of People with Learning Disabilities – Chief Nurse

Nurse Revalidation

Last month I informed the Board the Trust is meeting the requirements for Nursing and Midwifery Revalidation which commenced in April 2016.

Nurse Revalidation is a cyclic programme with nurses and midwives required to revalidate every three years.

Our current head count for registered nurses and midwives is approximately 1,400 including Middlesbrough, County Durham and Darlington, which translates into 470 nurses and midwives revalidating every year.

15 – 30 registrants revalidate every month with the exception of September when the numbers increase as this is when newly qualified nurses now graduate. This September the number of our nurses and midwives revalidating is 83.

I am happy to report since 1 April 2016 our nurses have been supported through the revalidation process without difficulty.

Jill Foster
Chief Nurse
July 2016

Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 27 July 2016	**Paper No: 11.1**

Title	**Infection Prevention and Control Annual Report 2015/16**
Sponsoring Director	Mrs J Foster, Chief Nurse
Author(s)	Mrs J Child, Director of Infection Prevention and Control
Report Purpose	Information Prevention and Control Annual Report 2015/16

Key Issues for Board Focus:

The Board are required to receive the Infection Prevention and Control Annual Report for 2015/16.

There are no areas of significant risk during the period.

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

Risk and Assurance	N/A
Legal implications/ Regulatory Requirements	N/A

Action Required by the Board of Directors

The Board are asked to receive the Annual Report for comment

Harrogate and District NHS
NHS Foundation Trust

INFECTION PREVENTION & CONTROL REPORT TO TRUST BOARD HDFT 2015 2016

Contents

Introduction

2015/2016 has been a tough year in many respects , and seen a lot of changes.
The activities of the IPCT are covered in the HCAI Steering Group annual report, available on the intranet, and will not be duplicated here.

The most important thing to remember is that effective infection prevention and control is that it's about everyone. Together, we will make great strides.

1. Mandatory reporting

The final numbers for 2015/2016 are shown in Table 1.

Table 1

Summary, Mandatory reporting, HDFT 2015/2016

MRSA bacteraemia		MSSA bacteraemia		*Clostridium difficile* (CDI)		CDI in the community[b]	*E. coli* bacteraemia
HAI	CAI	HAI	CAI	HAI	CAI[a]		
0	0	7	26	34	30	10	144

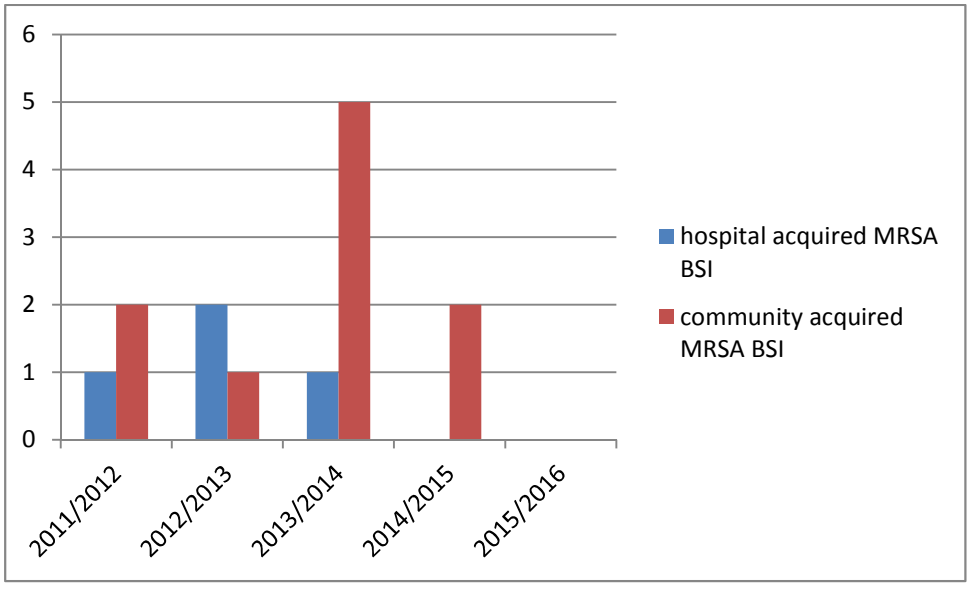
The number of CDI cases deemed to have been caused by a lapse in care at HDFT is ten*.
(*) provisional figure at the time of writing- please refer to p8 for further explanation.
[a]- cases of *C. difficile* infection diagnosed within 72h of admission to hospital. Thought to have been acquired in the community.
[b]- cases of *C. difficile* infection diagnosed in the community.

2. MRSA bacteraemia (MRSA BSI)

There was no hospital-acquired MRSA BSI for the second year in a row.
The last MRSA bacteraemia at HDFT was identified in September 2013.

Figure 1

Hospital – and community- acquired MRSA BSI, April 2011-March 2016

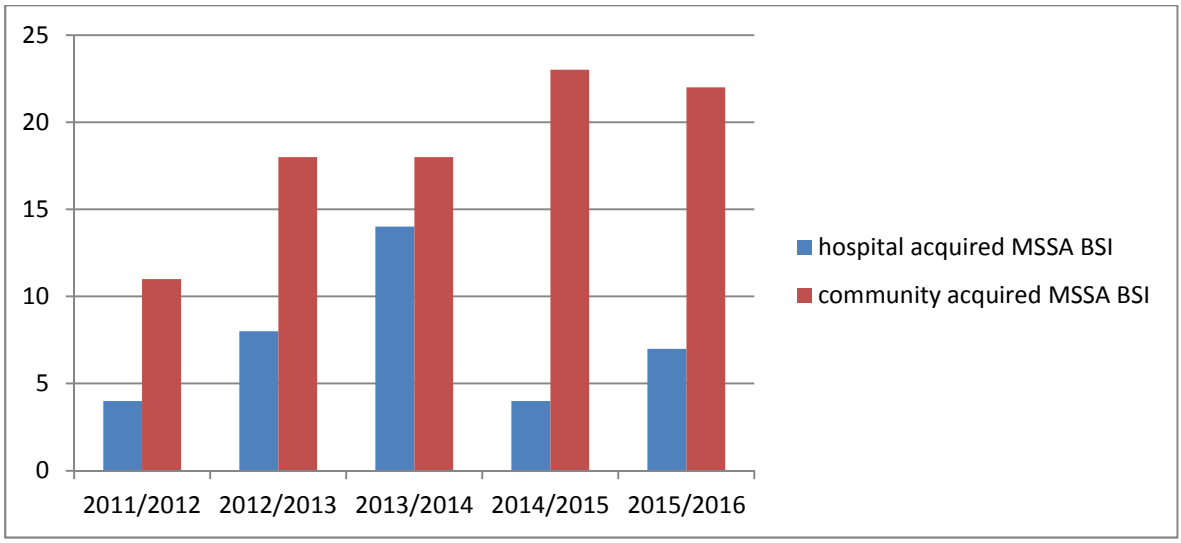


3. MSSA bacteraemias

There were 33 patients identified as having MSSA bacteraemia in 2015/2016, of which seven were hospital-acquired, including a SROMC patient who was not an inpatient at the time the blood-culture was taken. Three of the seven were thought most likely to be secondary to IV line infections (two PICC lines, one PVC) although this is not away as clear-cut as we would like it to be. One was possibly due to a septic shoulder present on admission, but the blood-cultures were not taken until three days after admission.

The factors involved in MSSA bacteraemias, in particular, IV line associated bacteraemia, are no different for MRSA. The number of MSSA bacteraemias must be seen as a "shot across the bows". Every MSSA bacteraemia is a dress rehearsal for a MRSA bacteraemia.

Figure 2 Hospital- and community-acquired MSSA BSI April 2011-March 2016



4. *E. coli* bacteraemias

There were 144 patients with *E. coli* bacteraemias in 2015/2016. The vast majority of these came in with their bacteraemias, which were identified within 48h of admission (124 cases, 86%). Although these are reportable under the national mandatory reporting scheme, there are currently no DoH objectives or ceilings set.

5. *Clostridium difficile* infection (CDI)

The final number of CDI attributed to the Trust was 34, an almost three-fold increase on the number reported in the previous year. The number of positive stools in the community (ie sent in by a GP to the microbiology laboratory at HDFT) showed a similar increase from just three in 2014/2015 to ten in 2015/2016. The figures for the community patch covered by the HDFT Community Infection Control Team as a whole are shown on p15.

Part of the reason for the increase in hospital diagnosed cases has undoubtedly been an increase in ascertainment. In August/September 2015, the laboratory changed its method of testing for *C. difficile* toxin (CdT) in stools, which may have increased the pick-up rate

Figure 3

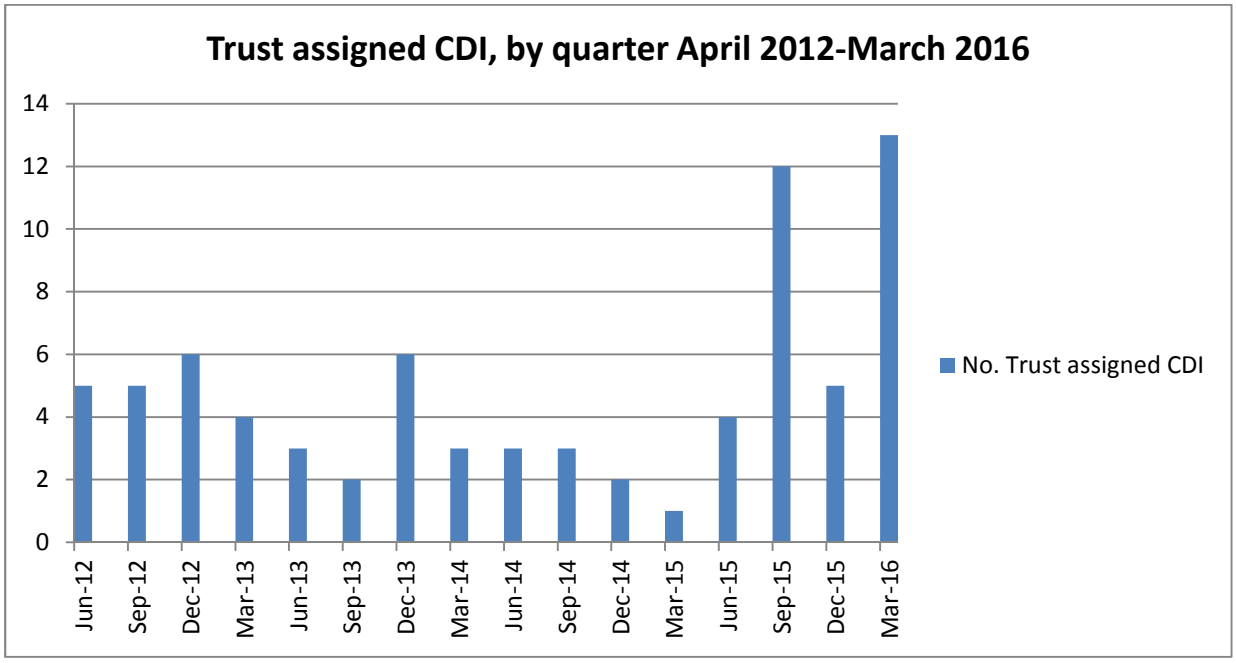
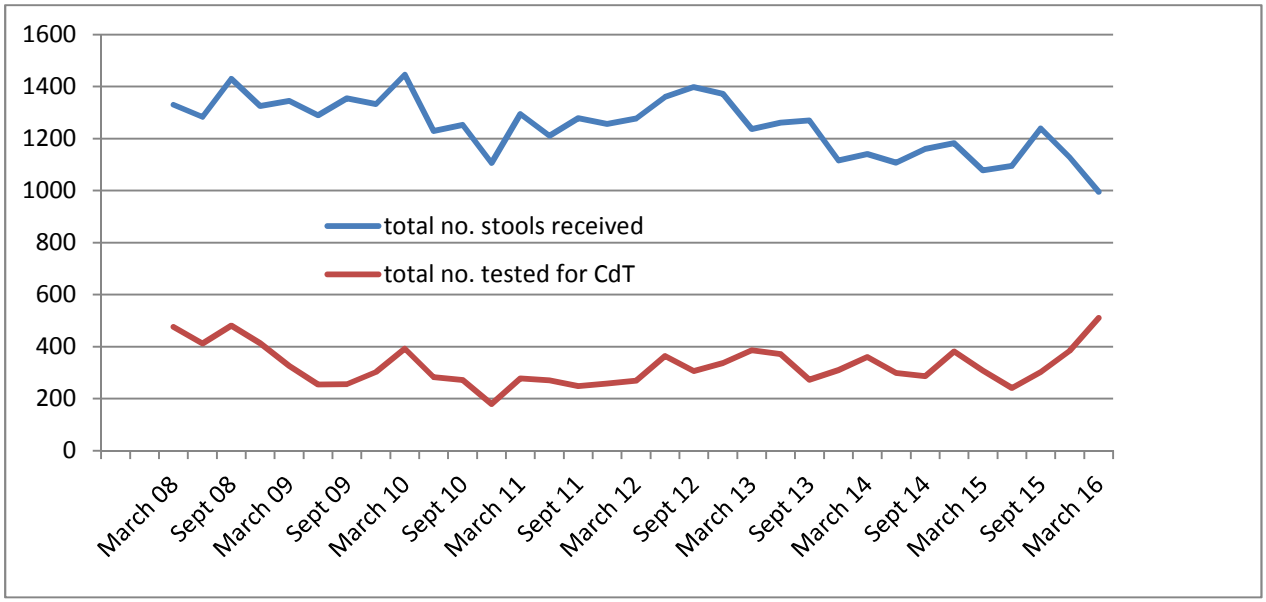


Figure 4
Quarterly numbers of total stool samples received in the laboratory from both the hospital and community and number of those being tested for CdT, June'08 qtr- March 16 qtr.



Source: Microbiology Dept, HDFT

The percentage of stools received in the laboratory which are being tested for CdT has also risen significantly over the last year (Figure 5).

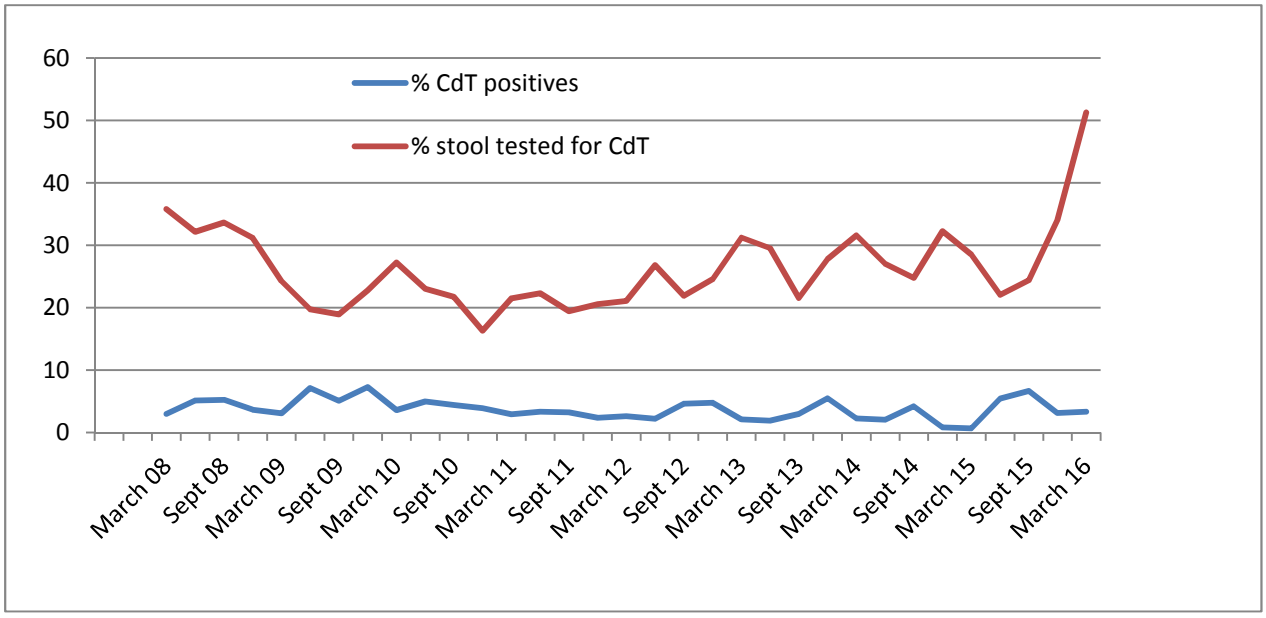
In the second half of 2015, wards were encouraged to send stools of Bristol Stool Type 5,6 or 7 for CdT testing (Figure 6). Prior to this, only stools which took up the shape of the container (ie type 7 and some type 6 only) would have been tested. The national guidelines are not consistent on this point, mentioning testing type 5 stools for CdT, but restricting the sampling to stools which take up the shape of the container. Type 5 is a loose, but not liquid stool, which would not necessarily fulfil the second criterion.

The greatest change has been the numbers tested, rather than a dramatic change in the positivity rate. We are finding more partly because we are looking harder. Why would we do this?

As patients who are *C. difficile* carriers, whether symptomatic or asymptomatic, will be shedding vast quantities of spores into the environment, it is in everyone's interests to identify carriers at the earliest possible opportunity. The number of positives has increased with the number of stools tested. Unfortunately, the Department of Health sets the annual CDI objective for Trusts and CCGs based on previous years' numbers.

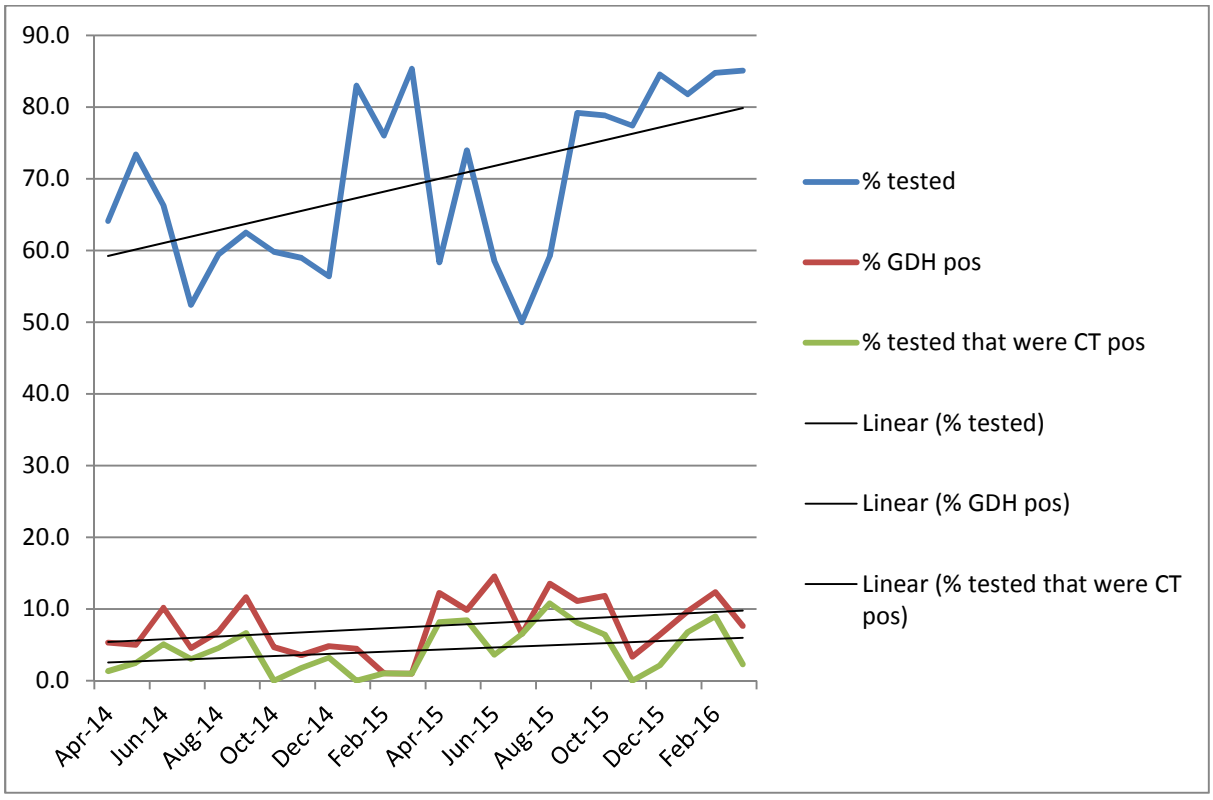
Figure 5

The percentage of stool samples which are tested for CdT & the percentage of CdT tests which are positive (hospital and community patients, March 2008-March 2016)



Source: Microbiology Dept, HDFT

Figure 6 Testing of stool samples from hospital inpatients only, April 2014-March 2016



Not only are we now using what we believe to be a better diagnostic testing regime, but the number of patients from both the acute unit and community actually tested for CdT has also risen sharply.

We are currently screening samples with GDH (glutamine dehydrogenase; Techlab UK) according to national guidelines. Positive samples are then tested by PCR (Ceheid, GeneXpert *C. difficile*), and if positive, by a cytotoxin assay (Diagnostic Hybrids Inc). Only those which are cytotoxin positive are reportable under the national mandatory data capture scheme.

5.1 Oakdale outbreak- February/March 2016

An outbreak is defined as two or more cases with the same disease / symptoms / organisms that are linked in time and location. A fuller account of the outbreak has been written separately, but is summarised below.

Between April 2015 and February 2016 there have been eight patients infected with *C difficile* on Oakdale Ward and two patients colonised with *C difficile*. This would suggest there is a burden of *C difficile* in that environment. Prior to this recent cluster of cases, the last reportable case on Oakdale was October 2015.

In a ten day window between the 10th and 21st February 2016, we identified three patients on Oakdale with toxigenic *C. difficile* in their stools. All had had dense strokes, and were heavily dependent and receiving enteral feeds. Two had been inpatients on the ward since December 2015. Molecular typing (ribotype and MVLA) done at Leeds confirmed that the isolates from the three patients were of an identical strain (which meant direct or indirect patient to patient transmission. This was different to earlier clusters (e.g. on Jervaulx and Nidderdale), which involved different ribotypes.

The ward was closed to admissions, and all remaining patients moved to Granby ward. The Granby patients were moved to Swaledale. Once emptied, Oakdale was systematically de-cluttered, deep cleaned and decontaminated with hydrogen peroxide vapour (HPV, Bioquell) before moving the patients back. Oakdale was re-opened on the 28th March. Since re-opening, there have been two further cases, although neither are believed to be part of the original outbreak.

5.2 Lapses in Care

The term "lapse in care" pertaining to CDI is defined in the NHSE 2016/2017 guidelines for commissioners (*Clostridium difficile* infection objectives for NHS organisations in 2016/17 and guidance on sanction implementation) . They make a distinction between contributing and non-contributing lapses in care:

"**Annex B, 9.0 Preventability**
9.1 State whether you have identified any 'lapses in care' that could have contributed to the development of this CDI case.
9.2 In order to facilitate learning and optimisation of patient care, please identify any other lapses in care i.e. that did not contribute to the development of this CDI case.
9.3 If you consider this CDI case occurred despite no lapses in care (and so was deemed not to be 'preventable'), outline your reason(s) why".

.At the time of writing (mid-June 2016) we are still awaiting a decision from North Leeds CCG on three cases. The number of contributing lapses in care so far agreed, is nine, which included the three outbreak cases on Oakdale.

Five contributing lapses in care have been associated with poor antimicrobial prescribing: overuse of antibiotics, not following the Trust guidelines, broader spectrum than actually required by the clinical situation, and prolonged courses of antimicrobials with no clear clinical justification.

In one case, North Leeds CCG has decided that incomplete documentation and a delay in sending a sample, which while not causing that patient's relapse, was a lapse in care nonetheless.

5.3 Key themes from the RCAs on Trust-attributable CDI, HDFT, 2015/2016

A root cause analysis is carried out on every case of hospital-acquired CDI, and the findings discussed with the relevant CCG. I am grateful to Dr Jessica Martin (ST4/ACF in Microbiology) for going through them all, and drawing out the key themes.

Between 1/4/15 and 31/3/16, 34 cases of Trust-attributable CDI occurred in 31 patients at Harrogate District Hospital (HDH).

Admission diagnosis was infection related in 13 (38%) (e.g. community acquired pneumonia, urinary tract infection), diarrhoea in 2 (6%), medical (non-infective) in 14 (41%) and surgical (non-infective) in 5 (15%). Median age at diagnosis was 82 years (range 26 to 97). Twenty CDIs (59%) occurred in females.

It is not possible to ascertain where strain acquisition actually occurred in most CDIs. The ward of diagnosis was elderly medicine in 10 (29%) cases, surgical/orthopaedic in 9 (26%), stroke unit in 6 (18%), acute medicine in 4 (12%), medicine in 1 (3%) and other wards in 4 (12%) cases.

The median number of days between admission and *C. difficile* positive stool sample was 10 (interquartile range [IQR] 5-26, range 2-82). Eighteen (53%) cases had been admitted to hospital in the three months prior to infection. If all prior inpatient days <3 months are accounted for, the number of days pre-diagnosis rises to 16 (IQR 8-43, range 3-86). There was evidence of admission to a neighbouring NHS trust in one patient.

The duration spent as an inpatient prior to diagnosis would suggest hospital acquisition in about half of cases (most strains are acquired within a fortnight of diagnosis) but this is only an estimate.

5.3.1 Risk factors for CDI.
Five CDI cases were previous NH residents (this data was only recorded in 25). Other recognised risk factors included enteral feeding (6, 18%), pre-existing bowel disease (2, 6%), laxative use (15, 44%), proton pump inhibitor use (19, 56%) and chemotherapy/immunosuppression (6, 18%). Data on co-morbidity (e.g. Charlson index) was not collected.
All cases were reviewed by the microbiology team.

5.3.2 Severity.
Mean white cell count (WCC) at diagnosis was 11.7. 11 (32%) cases had a WCC ≥15. If this is combined with other severity markers, severe infection occurred in 13 (38%) cases, 20 (59%) had mild CDI (1 (3%) unknown).

***5.3.3 C. difficile* treatment**.
Thirteen (38%) were treated for severe infection with vancomycin, 13 (38% were treated for mild infection with metronidazole and seven (21%) cases were not treated as symptoms did not indicate treatment was required. Current national guidance (PHE 2013) recommends that 'patients with mild CDI may not require specific CDI treatment'. The proportion of cases in this review that did not require treatment was high, this suggests sensitive case ascertainment but comparator data using the same diagnostic strategy is not available (i.e. the proportion of other populations who are not treated for *C. difficile* following positive cytotoxicity testing). All patients who were treated had appropriate CDI therapy as per HDH guidance.

5.3.4 Recurrent *C. difficile* infection
Eight patients had previously had CDI colonisation or infection. Five patients were documented in the RCA as having recurrent CDI (Two first episodes pre-dated this review period). Therefore, of 31 first episodes, the recurrence rate was 3/31 (9.6%) which is lower than published data on CDI first recurrence (~20%). However, this rate is probably typical of the 'post-ribotype-027 era' of CDI. Four of the five patients with recurrence had received antibiotics between first and second episodes of infection (the fifth patient had received CDI treatment only). This treatment was in agreement with antibiotic guidance in all but one case.

5.3.5 Mortality.
The all cause 30-day mortality rate was 14.7% (Five deaths) which is slightly lower than the national average for CDI (~16-18%) but again may reflect the national picture of CDI with low prevalence of ribotype 027. CDI was mentioned on death certificates in four of the five cases that died.

***5.3.6 C. difficile* typing results**
Ribotyping was used to differentiate *C. difficile* strains (Table 2). In a small number of cases, multi-locus variable number tandem repeat analysis (MLVA) was used to differentiate cases with the same ribotype who had an epidemiological link (highlighted red in Table 2).

Eight (23%) cases had a unique ribotype indicating they had not acquired *C. difficile* from a symptomatic donor during the review period (linkage with the previous year has not been sought). Of the other ribotypes with multiple cases, most represent common UK strains (e.g. 002, 020, 014, 015). Epidemiological linkage between these cases is difficult to ascertain from the RCA data as the journey between wards before and after diagnosis is not always comprehensive.

Linkage between three cases with ribotype 078 was demonstrated by MLVA as part of an outbreak on Oakdale ward. However, a community acquired 078 case, also identified in February 2016 but on a different ward, was found to be distinct. Two cases of ribotype 014 underwent MLVA but were found to be distinct.

Table 2: *C. difficile* typing results for HDH 2015-16.

Ribotype	Frequency
001	1
002	2
003	1
005	4
011	1
014	2
015	5
020	2
023	2
042	2
056	1
076	1
078	3
159	1
249	1
658	1
No growth	3
Not repeated	1

5.3.7 'SIGHT' criteria for sampling and source isolation.

The following criteria are recommended for all suspected CDI cases for UK NHS providers (PHE guidance, 2013), and feature prominently on the new HDFT Diarrhoea Algorithm.

S – symptoms monitored with Bristol stool chart immediately symptoms begin
I – isolate within 2 hours
G – gloves and apron worn for patient contact
H – hand washing with soap and water
T – test for CDI immediately

Table 3 below indicates the number (and percentage) of cases meeting these criteria in the first and second half of the 2015-16 period. Gloves and apron use along with hand washing were performed in a high proportion of cases. It would be helpful to know how this is evidenced in individual cases.

Table3 – adherence to SIGHT criteria at HDH 1/4/15 to 31/3/16.

		Total	S	I	G	H	T
1/4/15-31/10/15	Frequency	16	15	7	15	15	8
1/11/15-31/3/16		18	12	9	17	18	9
	Total		27	16	32	33	17
1/4/15-31/10/15	%	100	94	44	94	94	50
1/11/15-31/3/16		100	67	50	94	100	50

5.3.8 Stool sampling

Bowel habit on admission was recorded in 27 (79%) cases. 12 (35%) cases were sampled on the first day diarrhoeal symptoms occurred, the remainder were sampled a median 2.5 days after symptom onset (IQR 0-6, range 0-62). Not all delays in sampling represented lapses in care; from the RCA meetings, it emerged that 15 (44%) cases were deemed to have a sampling delay.

The number of cases with delayed sampling was the same in the first and second half of the year (see Table 3. Given the low number of apparent transmission events, the impact of these delays is likely to be minimal. However, the impact of transmission from asymptomatic carriers is unknown, but thought to be significant.

During this period, a 'Loose Stool Decision Tool' was introduced to improve the time between symptom onset and sampling. Laboratory criteria were also changed; type 5 stools (using the Bristol Stool Chart criteria) and requests labelled as 'type 5-7 stool' were processed rather than only stools taking the shape of the container. Feedback from clinical teams indicated that the 'Loose Stool Decision Tool' was difficult to use. For this reason, a new algorithm to support decision making on the wards was introduced in April 2016. The new algorithm requests that patients be isolated and tested as soon as they develop loose stool. This goes over and above what is suggested in the current national guidelines; it was introduced as a consequence of several delayed diagnoses in which the loose stool was assumed to have been due to other causes.

5.3.9 Source isolation

Only 16 (47%) patients were source isolated within two hours of symptom onset. The proportion of cases isolated appropriately was similar in the first and second half of the review period.

5.3.10 Communicating with patients and families about *C. difficile*

Of 34 CDI cases; 16 lacked capacity, 5 patients were at home at the time of RCA, one patient was deaf and one died prior to the RCA process. These factors limited the ability of clinicians to communicate with patients about CDI. However, 22 (65%) patients were able to understand the diagnosis. Information for carers and relatives was provided in all cases. Information on patient feedback is limited. For those that were able to communicate, the feedback was positive overall with no areas of concern highlighted by patients or their carers.

5.3.11 Antimicrobial prescribing

There was evidence of antibiotic use in the three months prior to CDI diagnosis in 30 (88%) CDI cases. Therefore, four cases had no evidence of antibiotic use (though GP prescribing may not always have been accounted for). The median number of antibiotic agents prior to diagnosis was 3 (range 0-10). 17 (50%) cases had received piperacillin-tazobactam, 10 (29%) co-amoxiclav, 4 (12%) fluoroquinolones, 2 (6%) cephalosporins and 1 (3%) had meropenem. No patient had received clindamycin. Overall, 20 (59%) of cases had received co-amoxiclav and/or piperacillin-tazobactam. The RCA process demonstrated that five patients had inappropriate antibiotic prescribing and there were five instances of incorrect ePMA use in terms of dose, duration, indication or stop date. Two cases demonstrated failure of antibiotics to be tailored in response to microbiology results.

5.3.12 Environmental and organisational issues

Mandatory training was up to date for all ward staff in all 34 RCAs. Areas for improved clinical communication were apparent in 9 (26%) cases. Adherence of staffing level/mix to local agreements was inadequate in 12 cases (but this data was not collected for all RCAs). Failure to comply with local policies about suspected infectious diarrhoea monitoring and management was demonstrated in 9 (26%) cases. 8 cases reported a recent increase in diarrhoea and this related to previous CDI cases in all but one. PII investigations and HPV were documented as a response to this.

Later RCAs include a section on estate jobs pending or staff concerns regarding integrity of the environment. Flooring and holes in the walls were mentioned in a handful of RCAs but as this data is missing from the majority, summary data is not possible.

Commode cleaning was 100% or documented as ‘good’ in all recorded instances. Cleaning compliance was variably documented making a summary difficult. Many clinical areas were treated with HPV (Bioquell) but details of this are probably better documented elsewhere. Staff hand hygiene scores mostly 100% but rates were lower in patients (80-100%) and it was not always documented whether results belonged to staff or patients so it was not easy to summarise this data.

Dr Jessica Martin (ST4/ACF microbiology).

5.4 Summary of actions & improvements following CDI RCAs

Report Compiled by Jennifer Featherstone HIPC Team Lead

5.4.1 Background

All acute apportioned CDI cases are subject to RCA review. This review process involves the collection and analysis of information relating to the patient care and patient journey. The RCA process involves subsequent identification of potential contributing factors for *Clostridium difficile* acquisition, and explores preventability of each case. HDFT need to be able to demonstrate that organisationally, that there are no noted lapses in care.

Within each Directorate, the Quality Lead in conjunction with Risk Management will monitor the completion of the CDI RCA action plans, Datix case will remain open until actions have been achieved and escalated via CORM.

In addition, CDI RCA is undertaken in situations where the episode of infection is identified as part of period of increase incidence (PII); potential CDI outbreak and when CDI is a contributing factor in the death of the patient or when the patient is identified within an in-patient ward area.

5.4.2 Introduction

This paper provides insight and describes the specific Infection Prevention and Control (IPC) service improvements identified from *Clostridium difficile* infection (CDI) root cause analyses (RCAs). These actions are a direct action aimed at improving clinical practice, patient safety and reduce the burden linked to Clostridium difficile infection (CDI) within HDFT.

5.4.3 Antimicrobial prescribing

- Antimicrobial usage prior to onset of CDI remains a potential contributing factor for infection. Education and training for Junior Clinicians has been facilitated by a Consultant Microbiologists, focusing upon antimicrobial stewardship and preventing harm.
- Facilitated antimicrobial Stewardship Awareness Campaign Further work is planned to review the medical documentation 'CDI Rapid Assessment' in the medical records.
- Medicine management and Consultant Microbiologist plan to review if it would be possible to improve ePMA alerts.
- Twice weekly Antimicrobial Wards rounds are undertaken by the duty microbiologist, an infection prevention and control nurse, and the antimicrobial pharmacist.

5.4.4 Isolation

- The RCA has identified that patients are not always being isolated within two hours, as set out in the HDFT Isolation Policy, in turn based on the national standard.
- The lack of side rooms is on the HDFT risk register.
- Further work facilitated to encourage staff to file a Datix report when isolation has not been achieved - under the new section 'inability to isolate'. Dissemination of awareness posters cascaded by IPC.
- Side-room status form developed in line with risk assessment in IPC bed management policy, to be inserted into Appendix. Jervaulx ward has successfully demonstrated the benefits of using the tool, which has now been shared with all wards.

5.4.5 Greater need for prompt sampling

- Delay in submitting a stool sample beyond 72 hours of admission may result in attribution as a HDFT acquired case.
- Documented explanation required if prompt sampling has not be achieved.
- A simplified Diarrhoea Flow Chart replaced Loose Stool decision tool in April 2016.
- Loose stool chart must be commenced at onset of symptoms.
- Loose stool charts must be commenced for all patients with a history of CDI and or diarrhoea and reviewed daily - regular audit undertaken.

5.4.6 Cleaning

- The cleaning issues have been incorporated into the 'CDI Surge Plan'.
- Action plan to consider business case for a rolling HPV planned programme.
- DIPC Jenny Child submitted bid proposal for a decontamination UVC system.
- To increase cleaning activity during frequently used periods on the Wards.
- To consider business case for 24 hour cleaning service
- Sluice rules produced

5.4.7 Education

- Aim to increase staff CDI knowledge and awareness, IPC facilitated CDI Roadshows to all wards.
- Infection Prevention and Control nurses attended ward managers' meetings to share learning from RCAs.
- Infection Prevention and Control -Learning for Patient Memo circulated to all Updates of CDI situation on Daily Bulletin and via Team Brief
- SIGHT screen saver revised and uploaded.

5.4.8 Environmental factors

- Removal of the carpet flooring on Harlow Suite and impervious flooring laid.
- Holes in walls filled on general medical wards
- Director inspection now undertaken with a representative from the Estates Department.

5.4.9 Documentation review

- Review of nursing Fundamental Care Plan undertaken.
- For infection prevention purposes the documentation now reads Bristol stool types 5, 6 and 7 for both the Fundamental Care Plan and the Bristol Stool Chart documentation.
- Bristol Stool Chart now on patient track.
- RCA documentation reviewed and process established.
- IPC clinical review documentation reviewed and updated.
- To trial the use of new Frontline IPC assurance audit with a view to obtain more meaningful data.
- IPC policies are now up to-date.

5.4.10 Hand hygiene

- All Wards to ensure staff complete hand hygiene and PPE competency for isolation. Jervaulx Ward the first to trial and completed this within one month.
- IPC facilitated Global hand hygiene campaign for staff and visitors
- Patient hand hygiene task and finish group undertaken.
- Revise and develop face-to-face hand hygiene education session at ward level throughout 2016, focusing on the WHO 5 Moments for Hand Hygiene.

5.5 CDI cases in the community

The patch covered by the HDFT community team extends out far beyond the Harrogate area, and many of these cases will have been diagnosed at other laboratories in the region. Overall, during the year, the number of cases in the community has not increased, if anything, the number of community cases decreased in the second half of the year (Figure 7). The increase in the number of hospital cases is therefore probably not just a reflection of more cases in the region generally, as we often see with norovirus, for example.

Table 4 *C. difficile* in the community

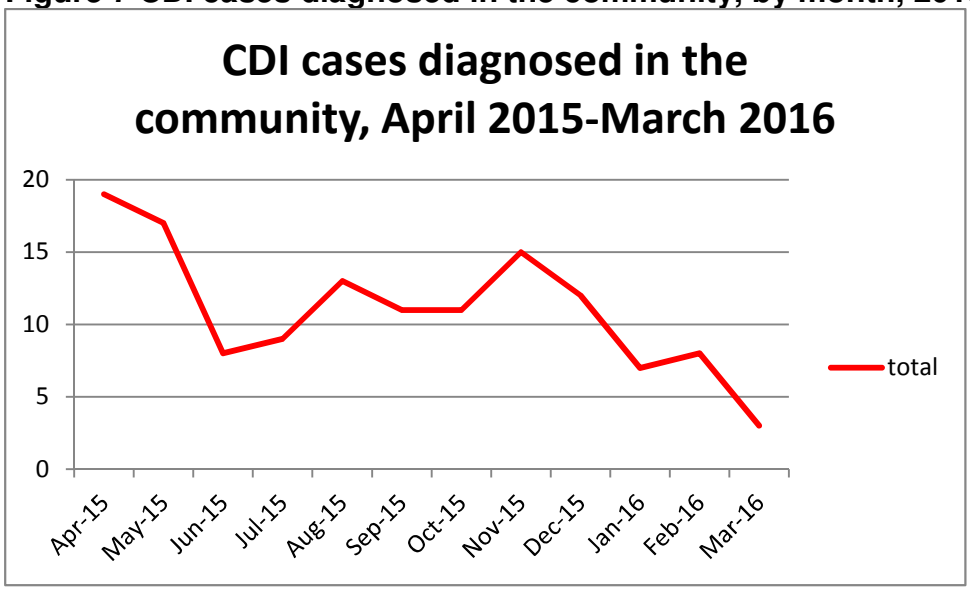
	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Total [a]	2015/16 objectv
HRW CCG	4	7	2	3	5	3	3	6	3	0	2	1	39	45
HaRD CCG	5	3	0	1	1	3	5	1	0	2	1	0	22	34
S&R CCG	2	1	0	3	4	1	0	2	2	2	1	1	19	31
VoY CCG	8	6	5	2	3	4	3	5	6	3	4	1	50	78
ACW CCG	0	0	1	0	0	0	0	1	1	0	0	0	3	36
total	**19**	**17**	**8**	**9**	**13**	**11**	**11**	**15**	**12**	**7**	**8**	**3**	**133**	

Figures supplied by the Community IPCT.

HRW Hambleton, Richmondshire and Whitby CCG
HaRD Harroagate and Rural District CCG
S&R Scarborough and Ryedale CCG
VoY Vale of York CCG
ACW Airdale, Craven & Wharfedale CCG (figures for Craven only)

a- Column shows the total of community cases (excluding hospital cases)
b- 2015/2016 DoH objective (total of hospital and community cases)

Figure 7 CDI cases diagnosed in the community, by month, 2015/2016



5.6 Comment on *C. difficile* numbers

On the face of it, HDFT saw a trebling of CdT positive stool samples reported in the year 2015/2016 in comparison with previous years. Some of this is undoubtedly due to an increase in ascertainment.

The change of testing regime to what we believed to be a better one does not seem to have resulted in an increased proportion of positive tests (Figure 5), but from the Autumn of 2015 onwards, a far greater number of stools were tested for *C difficile*. Carriage rates in the general population are greater than previously thought. Some of the cases picked up, eg after laxatives or with the testing of stool that was diarrhoeal for other causes would have been incidental findings, but under current reporting rules, we are still obliged to report them. Many of these would have been missed in previous years.

At HDFT, our first consideration is to patient safety, and we believe that it is in the interests of individual patients and the patient population as a whole to identify carriers early.

In response to reports of confusion about which patients need to be tested for *C. difficile*- we have attempted to simplify local testing guidelines. We are now asking the wards to isolate any patient with loose stool and to send a sample for *C difficile* testing, irrespective of what the cause is believed to be. This is actually more stringent than is required by the current national guidelines, published by the Department of Health with Public Health England in March 2012 which state:

"*If a patient has diarrhoea (Bristol Stool Chart types 5-7) that is not clearly attributable to an underlying condition (e.g. inflammatory colitis, overflow) or therapy (e.g. laxatives, enteral feeding) then it is necessary to determine if this is due to CDI."*
(Updated guidance on the diagnosis and reporting of *Clostridium difficile,* PHE 2012, page 11)

We believe strongly that testing of loose stools at the earliest available opportunity is the right thing to do, as patients who are *C difficile* carriers, whether infected or not, need to be careful about taking antimicrobials which could precipitate a relapse of CDI. However mild the infection, they will still be spreading spores in the ward environment, and so being able to deal with the situation earlier rather than later is in everyone's interests. This is surely more in the spirit of the Health and Social Care Act 2008 which includes a clause about early diagnosis of infectious disease in order to prevent spread to other patients. It is, nonetheless, a far more rigorous approach than many Trusts are believed to adopt, and which the national guidelines suggest.

The change of approach means that it is difficult to compare the CDI numbers at HDFT in 2015/2016 with previous years, as in all probability, there would have been cases missed in the past which would now be picked up. The change in ascertainment is undoubtedly part of the explanation, but not the whole.

The Oakdale outbreak involved transmission of a single strain between three patients with severe stroke within a ten day period. We have also had clusters of cases on Nidderdale and Jervaulx in particular which were clearly linked in time and place, and in the latter case, involved a single bay. Ribotyping showed them to be different strains, which suggests that direct patient to patient transmission was not an issue, but does not rule out the role of an environment heavily contaminated with spores. Jessica Martin's analysis of the RCA findings suggested that half of our Trust-assigned cases in all probability acquired their strain of *C. difficile* during their hospital admission. There is an overwhelming body of published literature now implicating environmental contamination in *C difficile* acquisition.

The evidence for a contaminated environment playing a part in the transmission of HCAI including CDI is now overwhelming. As part of the strategy to reduce the numbers, we are going to re-evaluate our cleaning strategy, and are considering the way in which we decontaminate patient bed-spaces and bays.

6. Changes within the Infection Team

Review of the IPC service establishment is an ongoing process and there have been several changes in personnel, structure and function since April 2015. Within the hospital-based section of the Team Kath Jones, Team Lead retired and was succeeded by Jen Featherstone. The IPC Support Officer post was recently vacated by Owen Davis and taken up by Karina Hess.

Within the TB/New Entrant Assessment Team Jane Horton, TB Nurse was succeeded by Karina Coxhead and Samuel Nganga now provides administerial support for the service. Within the community-based section of the IPC Team Jane Cozens was appointed in the Band 6 nurse vacancy and the administrative support team has been reviewed and reorganised with Cailean Owens appointed to provide additional support.

Consultant Microbiologist Jenny Child joined the Trust in January 2016, and took over from Richard Hobson as DIPC at the end of March. On the 28th November, Professor Kevin Kerr, former DIPC at HDFT, and highly regarded colleague, both at HDFT and to Jenny on the *Journal of Hospital Infection*, died peacefully at home in Scotland.

Progress with the 2015/2016 Infection Control plan

The 2015/2016 Annual Report of the HCAI Steering Group has already been published, and is available on the intranet.

http://nww.hdft.nhs.uk/long-term-and-unscheduled-care/infection-prevention-control-tb-new-entrant-assessment-team/hospital-resources/infection-prevention-and-control-annual-report-and-plan/

6. HCAI Annual Plan 2016/2017

- Development of a monthly HCAI dashboard for imparting information to the Directorates, SMT, the Improving Fundamental Care group etc
- Development of monthly Directorate reports
- Development of a new Infection Control Committee Structure, to replace the current HCAI steering and organisational groups.
- Development and implementation of a new mandatory education programme for nurses and cleaners. This will have to be delivered in several, accessible bite-sized chunks and in a format that can be delivered on a ward, or in the workplace.
- Re-evaluating hand-hygiene audits, including assessment of different tools, eg the WHO5M, to give us more meaningful data
- Launch of a patient hand-hygiene campaign and development of a patient hand hygiene audit tool
- Revaluating cleaning programme for the acute hospital, this would include a plan of who is expected to clean what, cleaning schedules, monitoring and audit of cleaning (eg with UV, ATP, microbiological monitoring), increasing the use of automated decontamination,
- Introducing legionella water testing as per national guidelines

Dr J A Child MBBs MD FRCPath
Consultant Microbiologist/Director of Infection Prevention and Control
June 2016

Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 27 July 2016	Paper No: 12.0
Title	**Report by the Medical Director**
Sponsoring Director	Medical Director – Dr David Scullion
Author(s)	Medical Director – Dr David Scullion
Report Purpose	To update the Board on current clinical issues

Key Issues for Board Focus:

- There are no published mortality indices this month.
- The Trust level SHMI for septicaemia for the period January 2015 – December 2015 is as expected.
- Correspondence on 7-day services from NHS Improvement.
- An overall improvement in National Emergency Laparotomy performance following this year's Audit.

There are no high risks to note for the period.

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

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

Action Required by the Board of Directors

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

Report by the Medical Director - July 2016

1 Mortality

There are no published mortality indices this month. Recent training for the structured case note review programme took place in York. This was a combined event between York and Harrogate. There were eight attendees from Harrogate. It has now been confirmed that the structured case note review process already in place in Yorkshire and Humber will be rolled out in England and Scotland.

A national lead for mortality has been appointed and has made contact to arrange a further discussion regarding the national rollout programme. I will be meeting with colleagues within the Trust in order to determine the most efficient way of rolling out the mortality programme locality

2 Revalidation Update

Following the appointment of Dr Gray as Guardian for Safe Working, and the intended implementation of the junior doctor contract, Dr Gray will be relinquishing his role as responsible officer for the organisation. It is expected that his current Deputy, Mr David Lavallette will step into the role as Responsible Officer. A separate paper is provided for Board approval of this position.

3 Sepsis Update

The Health and Social Care Information Centre (HSCIC) has recently produced Trust level sepsis mortality data using the Standardised Hospital Mortality Indicator (SHMI). The usefulness of this data is currently subject to consultation. The Trust level SHMI for septicaemia for the period January 2015 – December 2015 is as expected at 0.939 (921 observed vs 980 expected).

4 7-Day Services Update

I have received a letter from the Medical Director of NHS Improvement. Following the previous 7 day acute admission survey, further dates have been circulated for information. Previous feedback from provider Trusts had indicated more notice would be useful. Future surveys will have an option for retrospective audits within a defined time period. Sample size will vary according to numbers of admissions. It is anticipated the 7 day self-assessment tool will be repeated at 6 monthly intervals until 2020/21.

5 National Emergency Laparotomy Audit (round 2):

There has been an overall improvement in performance since the first round audit last year

- Green on 7/10 (4/11), amber on 2/10 (4/11) and red on 1/10 (3/11)
- Dr Earl will be leading the review of data and relevant action plans. The red rating pertains to medical care of the elderly input to acute surgical services.

6 New Consultant appointments

The interviews for an additional Histopathologist took place on Thursday 21st July. I will update Board on the outcome in due course.

Dr David Scullion, Medical Director
20 July 2016

Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 27 July 2016	Paper No: 12.1
Title	**Appointment of Responsible Officer**
Sponsoring Director	Dr David Scullion, Medical Director
Author(s)	Mr Andrew Forsyth, Compliance and Revalidation Manager
Report Purpose	To approve the appointment of a Responsible Officer

Key Issues for Board Focus:

- Dr Gray has resigned as Responsible Officer consequent on his appointment as Guardian of Safe Working Hours under the Terms and Conditions for Doctors in Training 2016
- The statutory role of Responsible Officer is a Board appointment which must be recorded and reported to NHS England and the General Medical Council
- The proposed candidate is Mr David Lavalette, Consultant Orthopaedic Surgeon

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

Risk and Assurance	The Trust must have a Responsible Officer to provide a mechanism for compliance with the General Medical Council requirement for revalidation recommendations
Legal implications/ Regulatory Requirements	Statutory post required by Medical Profession (Responsible Officers) Regulations 2010 (as amended 2013)

Action Required by the Board of Directors

The Board of Directors is requested to **approve** the appointment of Mr David Lavalette as Responsible Officer for Harrogate and District NHS Foundation Trust

APPOINTMENT OF A RESPONSIBLE OFFICER

Background

1. The statutory role of Responsible Officer was established in law by the Medical Profession (Responsible Officers) Regulations 2010 (as amended 2013). All bodies designated under the Medical Act 1983 as amended by the Health and Social Care Act 2008) are required to appoint a Responsible Officer.

2. Responsible Officers are regarded as integral to improving the quality of care and ensuring a focus on the three core components of quality: patient safety, effectiveness of care and patient experience. The development of the role was part of the programme of reform set out in the White Paper '*Trust, Assurance and Safety' (February 2007).*

3. The Responsible Officer is tasked with ensuring that those doctors who provide care continue to be safe, that doctors are properly supported and managed in sustaining and improving their professional standards, that there are effective mechanisms to provide remedial, performance or regulatory action to safeguard patients where doctors fall short of high professional standards and increase public and professional confidence in the regulation of doctors.

4. The Responsible Officer plays a crucial role in the process of medical revalidation. Recommendations on a doctor's fitness to practise are made to the General Medical Council (GMC), on a periodic basis, by the Responsible Officer on all those doctors who have a 'prescribed connection' with the registered healthcare body.

Current Position

5. At its meeting on 24 November 2010, the Trust Board appointed Dr Carl Gray, Consultant Histopathologist, as the first Responsible Officer under these Regulations. The Responsible Officer reports to the Board through the Medical Director.

6. As the result of the implementation of the Terms of Reference for Doctors and Dentists in Training 2016, the Trust has appointed a Guardian of Safe Working Hours (GSWH), a senior appointment whose role is to ensure that issues of compliance with safe working hours are addressed as appropriate, and to provide assurance to the Board, through the Medical Director, that doctors' working hours are safe. The GSWH must not simultaneously hold any other role within the management structure of the organisation.

7. Dr Gray was successful in his application for the role of GSWH and consequently he must relinquish the role of Responsible Officer. He has agreed to resign from the Responsible Officer post on the appointment of a replacement.

8. In 2014 the Trust appointed Mr David Lavalette as Assistant Responsible Officer, an informal, unremunerated post with a view to him moving to the position of Responsible Officer, as part of succession planning, when it eventually fell vacant. On this basis, and as Mr Lavalette has been trained and has attended a number of events *in lieu* of Dr Gray, it is not proposed to advertise the post of Responsible Officer.

Proposed Responsible Officer

9. Mr Lavelette has now agreed to move into the post of Responsible Officer to relieve Dr Gray. A new Assistant Responsible Officer will be recruited in due course.

10. At its meeting on 23 May 2012 the Trust Board approved two specific additional arrangements for the Trust's Responsible Officer. These were for the Trust's Responsible Officer to act as Responsible Officer for St Michael's Hospice, Harrogate and, as a reciprocal arrangement, to cover any conflicts of interest encountered by the Responsible Officer at Airedale NHS Foundation Trust. It is proposed that these arrangements continue with the appointment of Mr Lavalette.

11. The Board is requested to **approve** the appointment of Mr Lavalette to date 27 July 2016. The GMC, NHS England, Airedale NHS Foundation Trust and St Michael's Hospice will be informed as appropriate.

Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 27 July 2016	**Paper No: 13.0**
Title	**Workforce and Organisational Development Update**
Sponsoring Director	Mr Phillip Marshall, Director of Workforce and Organisational Development
Author(s)	Mr Phillip Marshall, Director of Workforce and Organisational Development
Report Purpose	To provide a summary of performance against key workforce matters

Key Issues for Board Focus:

This report provides information on the following areas:

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

Related Trust Objectives	
a) To deliver high quality care	Through the pro-active management of workforce matters, including recruitment, retention and staff engagement.
b) To work with partners to deliver integrated care	To work with external organisations such as Health Education England and others to commission our future workforce and develop the existing workforce.
c) To ensure clinical and financial sustainability	By seeking to recruit and retain our workforce to full establishment and minimise our use of agency staff.

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

Action Required by the Board of Directors

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

Key Messages for July 2016

Please note that this report now reflects the new Directorate structure.

The Workforce and Organisational Development Strategy Group determine the content of the Workforce Performance paper for Senior Management Team and Board of Directors' meetings. The intention is to report on exceptions only.

a) Summer Fair

The Summer Fair was a fantastic day for all our staff and families. The sun shone and everyone had a great day. Activities were included in the small ticket price and included; face painting, barrel train (very popular with children and adults alike), bouncy castle, archery, coconut shy, hook a duck and garden games. There were also some excellent 'rock up and race' activities and stalls from our sponsors.

Feedback has been fantastic, with it being described as a relaxed and enjoyable day for everyone and we are already looking forward to next year's event.

The event also gave an opportunity to celebrate staff who had achieved 25, 35 and 40 years' service and awards were given on the day. The Celebrating Success awards were also presented, after another successful 'Dragon's Den' process.

b) Quality Charter

The overall aims of the Quality Charter are to have an ambition for Quality and Safety, promote staff engagement, provide assurance on care quality and support a positive culture.

The Deputy Director of Partnerships and Innovation is working on communications to engage all staff on each of the different streams of work within the Quality Charter. A dedicated Quality Charter section, accessed via the Partnerships and Innovation page on the HDFT intranet site, has been established and information will be added over the upcoming weeks.

The Quality of Care Champions scheme is one of the key work streams and this scheme has been developed to recognise and reward those staff who undertake training and deliver quality improvement work. The development of this scheme is in the very early stages and further consultation will take place with Directorate colleagues as the scheme progresses.

The 'Making a Difference Awards' are now up and running and some further information about the awards will be shared throughout the Trust during July.

c) Appraisal

There has been a focus on appraisal compliance for a number of months now and also the Trust has introduced the new values based appraisal. There will shortly be an email going to managers with departments who have achieved less than 90 per cent compliance for the last rolling 12 months. Managers will be

requested to develop and present an action plan to their Operational Director or Head of Service, which should include forward appraisal dates for all staff to achieve by December 2016 the 90 per cent appraisal compliance.

d) Love our EU staff

The recent referendum decision to leave the European Union clearly has implications for the NHS and the workforce at Harrogate and District NHS Foundation Trust. The Trust is very proud to say that EU colleagues are vital and valued members of our team and recognises the significant contribution which they make as part of our team - and we want them to stay.

The NHS has always needed to supplement UK-trained staff with staff from across the globe and this is very unlikely to change. There will be questions about how the referendum decision affects EU colleagues, and working life in general. There is a range of employment and regulatory agreements that exist within the EU that impact on the people working in the NHS, and nationally NHS Employers will be consulting with its members about these and will work with trade union and European Office colleagues to help the Government and regulators ensure that there is a careful settlement of these issues over the next two years at least.

Staff will be kept informed about developments as information becomes available from key organisations, such as NHS England and NHS Employers, and affected staff will have the support and information they need throughout this process.

The Health Service Journal (HSJ) has created a new award which seeks to recognise and celebrate the work of staff that have left their home in another EU country and now work in the NHS. The award is open to clinical, support and managerial staff and entries will take the form of nominations from colleagues. The award will be presented in November alongside the other 23 categories of the HSJ Awards, the UK's largest celebration of healthcare excellence. Trust staff are being encouraged to nominate a colleague for this award and entries must be received by Friday 29 July.

e) Global Health Exchange Scheme

On Monday 18 July I travel to Hyderabad, India, with Annie McCluskey, Matron, Jonathan Brown, Chief Operating Officer, Global Health Exchange Scheme (Health Education England) and other NHS representatives. Colleagues will be aware that I have lobbied Health Education England to change the focus of some of its work towards delivering an existing NHS registered nursing workforce as well as commissioning the future NHS workforce. Health Education England has recently agreed to establish a £250,000 budget to establish an international education exchange scheme with the Apollo Group in India, and the University of Salford. The ambition of this educational exchange programme will be to recruit up to 3000 registered nurses from India to work in England and develop their nurse education and skills. Upon completion of the programme, the registered nurses will return to India in order to utilise their skills and further develop the Indian health economy.

The purpose of the visit will be to confirm all the contractual arrangements associated with the programme, to meet many of the registered nurses and tour the educational facilities in Hyderabad.

Following the visit a process will then take place to allocate registered nurses to vacancies across England. Health Education England will be funding the whole programme, including travel arrangements. Employers will be required to contribute towards the programme and the costs of employing the nurses concerned.

f) Doctors in Training - New Contract

The ballot of BMA Junior Doctors and final year medical students closed on 1 July and the result was promulgated on 5 July. Of the 68% who voted, 58% voted not to accept the final revised Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (TCS 16) published on 27 May 2016.

On 6 July 2016 the Secretary of State announced in the House of Commons that he would proceed to impose TCS 16 from 5 October 2016. Following the resignation of the previous Chairman of the Junior Doctors' Committee of the BMA, who had endorsed the proposed TCS 16, the new Chairman, Dr Ellen McCourt, is taking soundings from some of the 58% of Junior Doctors who voted against acceptance in the ballot and has reserved her position on the possibility of further action until she has completed this exercise, the timeframe for which is currently unknown.

TCS 16 will first be introduced for ST3 doctors in Obstetrics and Gynaecology in October 2016 and then for F1 doctors (and any F2 doctors on F1 rotas) in December 2016. The new cohort of F1 doctors who commence work in the Trust on Wednesday 3 August will therefore do so on the existing (2002) Terms and Conditions of Service and be offered TCS 16 (without an alternative) as from December. Thereafter TCS 16 will be progressively implemented, with the aim that all Doctors in Training will be on TCS 16 by December 2017.

Work has now restarted on defining the individual work schedules and ensuring that staffing rotas are compliant with TCS 16, following the mandatory 'pause' whilst the negotiations and ballot took place.

g) Guardian of Safe Working Hours

As part of the implementation of TCS 16 the Trust has to appoint a Guardian of Safe Working Hours. The Trust undertook a recruitment exercise and interviewed an applicant on 22 June 2016. The interview panel included the Director of Workforce and Organisational Development, one of the Joint Deputy Medical Directors and two Doctors in Training and agreed unanimously to appoint Dr Carl Gray as the Guardian of Safe Working Hours. Since it is mandated that the Guardian must not hold a managerial post in the Trust at the same time as the role of Guardian, Dr Gray will step down from the post of Responsible Officer and arrangements are in hand to fill this post as soon as possible. Dr Gray took up the post on 11 July 2016, initially until the end of December 2017, and will attend a national conference for Guardians of Safe Working Hours in London on 26 July.

h) Job Planning

Below are the latest job planning figures for Consultants and Specialty Doctor and Associate Specialist grades as at 30 June 2016. In future it is intended to reflect progress on compliance month on month but, following the implementation of the restructured Directorates, no comparison is available this month.

JULY 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**
C & CWCC	9	4	44.44%	1	11.11%	4	44.44%	
LT & UC	51	48	94.12%	2	3.92%	1	1.96%	
P & SC	61	50	81.97%	5	8.20%	6	9.84%	1
Total	**121**	**102**	**84.30%**	**8**	**6.61%**	**11**	**9.09%**	1

JULY 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**
C & CWCC	7	6	85.71%	0	0.00%	1	14.29%	
LT & UC	6	4	66.67%	0	0.00%	2	33.33%	
P & SC	34	12	35.30%	3	8.82%	19	55.88%	7
Total	**47**	**22**	**46.81%**	**3**	**6.38%**	**22**	**46.81%**	7

The Trust's Job Planning Steering Group met on 21 June and 19 July and continues to progress a number of initiatives which are designed to improve the quality and timeliness of medical Job Plans throughout the Trust, as well as overall levels of compliance.

i) Leadership

A meeting of the Trust's Leadership Group, which has now been expanded to include all consultants, took place on Friday 24th June.

The agenda included debate about improving discharge arrangements, briefings from the Executive Directors on changes in operating context, and a spotlight on 'live' quality improvement activities.

j) Disclosure and Barring Service Checks

The Trust employs 3955 staff, of which 3353 have been subject to a criminal records check at a start of their employment; there are a further 450 employees who joined the Trust on 1st April 2016 which are still to be reviewed as part of the transition work.

Currently the Trust does not routinely re-check all employees during their employment. This raises the concern that there is a lack of overall assurance in terms of safeguarding the organisation, patients and staff. The only employees that are now re-checked routinely are School and District Nurses due to external requirements by schools and social care settings; the costs are currently funded by the Trust.

The Trust does undertake a DBS check of existing employees if they move posts internally as part of the pre-employment checks for the new post and the cost is picked up by the employee through salary deduction, as is the case with all new starters to the Trust.
In June 2015 the Director Team confirmed that it was supportive of the following recommendations:

- DBS checks only to be undertaken on individuals who work in a regulated role.
- A 3-yearly check be undertaken across the Trust and consideration be given to the utility of the DBS Update Service, subject to resource implications.
- Staff who require a current DBS clearance for their posts, eg School Nurses, should sign up to the Update Service and the Trust should consider covering this annual subscription (currently standing at £13 per person).
- A Band 2 DBS project assistant will need to be recruited to administer this project.

The Director Team has now considered four options to improve assurance. It was agreed that the 3-yearly check for all those in regulated roles would not necessarily increase assurance and was unaffordable; the Directors have commissioned further work on the potential to extend the requirement for all staff to undertake a DBS check and subscribe to the Update Service. The Trust is currently compliant with the legislation; the Director Team will consider further options during August 2016.

k) Mandatory Training

The Learning and Organisational Development team held a focus group with line managers to understand their views and feedback on the current processes around mandatory training. As a result the Trust will pilot a new process from 1 August 2016, for six months, which will include mandatory training leads identifying areas where training compliance is below 95%. Where this is the case then the relevant line managers will be contacted and required to address this within 30 days, advising how they intend to improve compliance. If training compliance has not improved by 1% after the 30-day period, a report listing all defaulting line managers will be escalated to the HR Business Partner and raised at the Directorate Board. The Directorate will be responsible for managing poor compliance. Both the process and training compliance levels will be reviewed at the end of the pilot period in January 2017.

l) Agency Wage Cap

The Trust is already operating in accordance with the agency price cap directions from NHS Improvement. From 1 July an additional 'wage cap' has been introduced, against which weekly reports are required (from 13 July).

The wage cap is designed to try to ensure that the individual temporary employee is not paid more than the rate for a substantive employee in that role. The agency rate charged must now show the wage paid to the worker (inclusive of a holiday pay element) separately from the commission charged by the agency and from the on-costs (pension, NI) and any framework management fees which might be applicable.

The Trust is taking the opportunity to move towards a preferred supplier list and has written to all those agencies currently supplying temporary staff to ensure that these costs are shown separately on their rate cards. It has also contacted Comensura, the Trust's neutral vendor, to request that it undertakes a similar exercise.

It is intended to hold a meeting in early August with each of those framework agencies who wish to be either on the preferred list or a 'break glass' list which can only be used once the escalation process has been agreed (on the grounds of patient safety) , to ensure that they are fully compliant.

m) National Freedom to Speak Up Guardian appointment

Following the acceptance by the Secretary of State of the recommendations of Sir Robert Francis QC in his report into 'whistleblowing', published in February 2015, the Care Quality Commission (CQC) has appointed a new National Guardian for speaking up freely and safely within the NHS. Dr Henrietta Hughes, Medical Director for NHS England's North, Central and East London region and a practising GP, has been appointed by a panel consisting of representatives of the CQC, NHS England, NHS Improvement, the Patients' Association and Sir Robert Francis himself.

As National Guardian, Dr Hughes will help to lead a cultural change within NHS Trusts and NHS Foundation Trusts, so that healthcare staff feel confident and supported to raise concerns about patient care at all times.

Harrogate and District NHS
NHS Foundation Trust

15.1

Board Committee report to the Board of Directors

Committee Name:	Quality Committee
Committee Chair:	Mrs L.A Webster, Non-Executive Director/ Quality Committee Chair
Date of last meeting:	06/07/2016
Date of Board meeting for which this report is prepared	27/07/2016

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

1. **Timely Completion of Action Plans relating to Complaints –** The Committee received an update and confirmed that the Directorates are now very focussed on completing plans within agreed timescales and an emphasis on setting appropriate and realistic objectives will support this. From August the Learning from Patient Experience Group will track progress on a quarterly basis.

2. **GP Out of Hours Service –** Verbal update received which provided a positive report with progress in the quality of metrics to measure delivery of care for urgent patients. A written report will be submitted to the Committee in August.

3. **Quality Priorities –** a verbal update was provided relating to the Trust's quality priority to **'**Provide high quality Stroke Care' following the Committee's request to provide more ambitious objectives which highlighted that a broader view of stroke care should be being considered under this priority. The Committee will receive a further update in August

4. **Safeguarding Children Annual Report –** the report was deferred until August but a verbal update was received to provide interim assurance of progress received.

5. **2015/2016 Annual Report of Directorate Governance -** received very clear reports from two Directorates, with the final report to be presented in August.

6. **Target for reduction in avoidable pressure sores in the Community Set –** the base line for beginning to measure the reduction in avoidable Pressure sores in the community setting has been confirmed and a stretch target was set of reducing this by 20% for patients who are wholly receiving care from the community team. This will be reported via the Integrated Board Report.

Are there any significant risks for noting by Board? (list if appropriate)
• A lack of assurance to be noted in relation to record keeping by junior doctors in respect to key areas of care (TACCORD / CAT mnemonic). • A lack of assurance in respect of record keeping in general to be noted
Matters for decision
• **None**

Action Required by Board of Directors:
• Report to be noted