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**The meeting of the Board of Directors held in public will take place on
 Wednesday 29 June 2016 in the Boardroom, Harrogate District Hospital, Lancaster
 Park Road, Harrogate, HG2 7SX**

Start: 9.15am Finish: 12.45pm

AGENDA			
Item No.	Item	Lead	Paper No.
9.00am Patient Story – In private			
9.15am General Business			
1.0	Welcome and Apologies for Absence <i>To receive any apologies for absence</i>	Mrs S Dodson, Chairman	
2.0	Declarations of Interest and Board of Directors Register of Interests <i>To declare any interests relevant to the agenda and to receive any changes to the register of interests</i>	Mrs S Dodson, Chairman	2.0
3.0	Minutes of the Board of Directors meeting held on 25 May 2016 <i>To review and approve the minutes</i>	Mrs S Dodson, Chairman	3.0
4.0	Review Action Log and Matters Arising <i>To provide updates on progress of actions to the Board of Directors</i>	Mrs S Dodson, Chairman	4.0
5.0	Corporate Governance Statement <i>To be considered for approval</i>	Dr R Tolcher, Chief Executive	5.0
6.0	Terms of Reference for Approval <i>6.1 To approve the Remuneration Committee terms of reference</i> <i>6.2 To approve the Quality Committee terms of reference</i>	Mrs S Dodson, Chairman/ Remuneration Committee Chair Mrs L Webster, Non-Executive Director/Quality Committee Chair	6.1 6.2
9.40am – 11.00am			
	Overview by the Chairman	Mrs S Dodson, Chairman	
7.0	Report by the Chief Executive <i>To be considered and any Board directions defined</i>	Dr R Tolcher, Chief Executive	7.0
8.0	Integrated Board Report <i>To be considered for comment</i>	Dr R Tolcher, Chief Executive	8.0
9.0	Report from the Chief Operating Officer <i>To be considered for comment</i>	Mr R Harrison, Chief Operating Officer	9.0
10.0	Report by the Finance Director <i>To be considered for comment</i>	Mr J Coulter, Deputy Chief Executive/ Finance Director	10.0

11.00am – 11.15am – Break			
11.15am – 12.30pm			
11.0	Nursing and Midwifery Strategy <i>To be considered for approval</i>	Mrs J Foster, Chief Nurse	11.0
12.0	Report from the Chief Nurse <i>To be considered for comment</i>	Mrs J Foster, Chief Nurse	12.0
13.0	Report from the Medical Director <i>To be considered for comment</i>	Dr D Scullion, Medical Director	13.0
14.0	Report by the Director of Workforce and Organisational Development <i>To be considered for comment</i>	Mr P Marshall, Director of Workforce & Organisational Development	14.0
15.0	Oral Reports from Directorates <i>15.1 Long Term and Unscheduled Care</i> <i>15.2 Planned and Surgical Care</i> <i>15.3 Children's and County Wide Community Care</i>	Mr A Alldred, Clinical Director Dr K Johnson, Clinical Director Dr N Lyth, Clinical Director	
16.0	Committee Chair Reports <i>16.1 To receive the report from the Quality Committee meeting held 1 June 2016</i> <i>16.2 To receive the report from the Finance Committee meeting held 22 June 2016</i>	Mrs L Webster, Non-Executive Director/Quality Committee Chair	16.1
		Mrs M Taylor, Non-Executive Director/ Finance Committee Chair	16.2
12.30pm – 12.45pm			
17.0	Matters relating to compliance with the Trust's Licence or other exceptional items to report, including issues reported to the Regulators <i>To receive an update on any matters of compliance</i>	Mrs S Dodson, Chairman	
18.0	Any other relevant business not included on the agenda <i>By permission of the Chairman</i>	Mrs S Dodson, Chairman	
19.0	Board Evaluation	Mrs S Dodson, Chairman	
Confidential Motion – the Chairman to move: <i>That members of the public and representatives of the press be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicly on which would be prejudicial to the public interest.</i>			

BOARD OF DIRECTORS – REGISTERED DECLARED INTERESTS

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

The register is maintained by the Foundation Trust Office.

Name	Position	Interests Declared
Mrs Sandra Dodson	Chairman	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 1. Appointed Voluntary Member of the Strategy and Resources Committee of the Methodist Church
Mr Phillip Marshall	Director of Workforce and Organisational Development	None
Mr Neil McLean	Non-Executive Director	Director of: <ul style="list-style-type: none"> - Northern Consortium UK Limited (Chairman) - Ahead Partnership (Holdings) Limited - Ahead Partnership Limited - Swinsty Fold Management Company Limited - Acumen for Enterprise Limited - Yorkshire Campaign Board Chair Maggie's Cancer Caring Centres Limited
Professor Sue Proctor	Non-Executive Director	<ol style="list-style-type: none"> 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	None

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

June 2016

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

Minutes of the Board of Directors meeting held in public on Wednesday 25 May 2016 9.20am in the Aire Room, The Pavilions, Great Yorkshire Showground, Harrogate

Present: Mrs S Dodson, Chairman
Mr J Coulter, Acting Chief Executive
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
Mr J McKie, Acting Finance Director
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 Acute and Cancer Care
Dr K Johnson, Clinical Director for Elective Care
Dr Natalie Lyth, Clinical Director for Integrated Care
Ms D Henderson, Company Secretary

1. Welcome and Apologies for Absence

Apologies for absence had been received from Dr Ros Tolcher, Chief Executive. Mrs Dodson welcomed two Governors and two members of the public to the meeting.

2. Declarations of Interest

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

3. Minutes of the meetings of the Board of Directors on 27 April 2016

The draft minutes of the meetings held 27 April 2016 were accepted as a true record, subject to the following amendments:

Paragraph 9.7 – Amend to state ‘non-children’s services are delivered county wide, and children’s services are delivered in North Yorkshire, County Durham and Darlington.

Reference was made to paragraph 11.1, and the Board requested clarity as to whether approval was granted to enter a ‘lease’ or ‘licence’ agreement. Further clarity would be provided at the June meeting of the Board to ensure accurate minutes are maintained.

Paragraph 15.10 – Remove ‘With regard to the Junior Doctors industrial action’.

4. Review of Actions Schedule and Matters Arising

Action 1 – Dr Scullion confirmed that work continued to develop a useful and informative metric which could be used to measure comparisons in historical performance relating to serious incidents requiring investigation (SIRIs) and never events. It was envisaged that the new metric would be included in the June Integrated Board Report.

Action 2 – following circulation of a detailed response via e-mail, the action was confirmed as complete.

Action 3 – Mr Coulter confirmed that the action had been addressed via the Executive Director Team and it was also confirmed that Dr Tolcher had circulated additional information to Mr McLean. As part of regular benchmarking, and as part of an iterative process in terms of progress of the smaller hospitals Acute Medical Models work, the action was confirmed as complete for the purposes of the Board of Directors meeting.

There were no other matters arising.

Overview by the Chairman

Mrs Dodson referred to the inaugural meeting of the Shadow Board which took place on 23 May. The Shadow Board formed part of the 'Inspiring Leaders Network', established to create additional learning and development opportunities for senior staff across the sector, and supported succession planning beneath Board level for clinical and non-clinical management. The Shadow Board was comprised of a cohort of senior leaders, and was chaired by Mrs Dodson.

The programme provided modular training to enable a more strategic view of the Trust, and the agenda covered a review and discussion of the Integrated Board Report, Care of the Frail Older People Strategy, and Strategic Key Performance Indicators.

Mrs Dodson confirmed that members of the Shadow Board would endeavour to attend the June Board of Directors meeting to observe Board level discussions and dynamics.

Following a request by Mr Harrison to attend a meeting of the Shadow Board as an observer, Mrs Dodson confirmed that both Executive and Non-Executive Directors of the Board would be welcome to attend any of the meetings held in June and July. Dates of the meeting would be circulated to members of the Board.

Mrs Dodson outlined the overarching themes for the meeting, as identified by the Non-Executive Directors; these were to consider the risks implicit as a Trust with regard to finance, performance, and capacity to deliver the strategy.

ACTION:

- **Circulate dates of the ILN Shadow Board meetings to members of the Board**

5. Report by the Chief Executive

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

5.1 Mr Coulter provided an update on progress with regard to agreement of the 2016/17 contract with Harrogate and Rural CCG (HaRD CCG/commissioners). It was acknowledged that

annual contract negotiations had been particularly difficult this year and contracts had yet to be agreed. A Memorandum of Understanding had been developed jointly with the commissioners as the platform on which to work toward agreeing a community contract.

5.2 Mr Coulter confirmed that the negotiations continued with regard to the community services contract, and Systems Resilience Funding. Commissioners were expected to communicate their final decision to the Trust on the services they wish to commission on the basis of the value of their offer by 31 May 2016.

5.3 Dr Scullion referred to a Quality Impact Assessment meeting scheduled to take place on 26 May, to be attended by Dr Scullion, Mrs Foster and representatives from HaRD CCG. Dr Scullion expressed anxiety in terms of the ability to provide a view on the quality and safety impact on services as data had yet to be received. Mrs Dodson confirmed that the adequate and safe provision of community services was fundamental to the delivery of the Trust's strategic objectives, and supported Dr Scullion's comments by emphasising the importance of understanding the impact on the quality of care provided to patients.

5.4 Mrs Webster asked if a decision would be made on 26 May. Dr Scullion confirmed that the Trust would be unlikely to be in a position to take a view due to the lack of information and time to consider any proposals. Mr Coulter noted in terms of process, if an acceptable Quality Impact Assessment cannot be completed, the timeline for decision would be extended. Mr Coulter reassured members of the Board that the Trust would not compromise quality of care and patient safety in order to meet deadlines.

5.5 Mr Alldred referred to discussions with clinical specialists in all services, and anticipated that a proposed list of services would be available for the meeting on 26 May; however, Mr Alldred also advised that informed consideration would need to be given to the Quality Impact Assessment process.

5.6 Mr Thompson queried if mediation would be available if the Trust and commissioners could not agree to the proposals. Mr Coulter suggested that a request could be made to NHS Improvement and/or NHS England to support further discussions, but reminded members of the Board that both organisations had committed to resolving the contractual issues locally. The Memorandum of Understanding required a proposal to be made by the commissioners by close of play 31 May. If the proposals are accepted, the Trust would have a three month notice period, with new services being delivered from 1 September. Mr Coulter advised that a clear decision from commissioners would be required in the first instance.

5.7 Mrs Dodson confirmed that both organisations were striving to work in partnership, but the Board acknowledged that as a health economy, the Trust had a responsibility for its own financial and operational sustainability, and required clarity from the commissioners on the services they want to commission within the contract value offered.

5.8 Mr Coulter provided an update on the West Yorkshire Sustainability and Transformation Plan. A leadership group was to be established as the body with responsibility for oversight and development of the Plan, led by Rob Webster CEO of South West Yorkshire Partnership NHS Foundation Trust. Mr Coulter confirmed that the group would be comprised of CCG and provider organisations to ensure appropriate governance and decision making.

5.9 A West Yorkshire Association of Acute Trusts' session had taken place to discuss solutions to enhance sustainability of acute services. This had been attended by Mr Coulter and Mr Harrison. Mr Coulter made particular reference to the Trust's Hyper-Acute Stroke Service and noted that discussions had commenced regarding service delivery over the longer term at both a local and regional level.

5.10 Professor Proctor stated her enthusiasm that discussions had gained momentum, particular in terms of leadership and governance, and noted that further assurance would be welcomed with regard to clinical engagement between providers and commissioners. With regard to clinical engagement, Mr Coulter and Mr Alldred briefed the Board on work undertaken to compile a gap analysis with directorates including sustainability of services. Next steps would include solutions to areas for development via existing or alternative networks. It was noted that providers across West Yorkshire and Harrogate in particular already had a range of alliances and networks in place to deliver sustainable services. Mr Harrison and Mr Coulter also noted that if any formal consultation was required, formal processes were already in place and recognised that the level of public scrutiny in terms of ongoing discussions could be improved. Mr Coulter noted that the Trust had suggested the presence of a lay-member on the West Yorkshire STP Leadership Group to ensure appropriate challenge, governance, transparency and openness. Mr Harrison agreed to raise the matter further with West Yorkshire Association of Acute Trusts. Mrs Dodson also agreed to raise the issue at the next meeting of the Chairman's Forum.

5.11 Mr Ward had been encouraged by the comments regarding the collaborative approach to developing a strategic view of STP. Mr Coulter stated that although alliances across the West Yorkshire patch remained strong, further work would be required to develop alliances out-with the region.

5.12 Mr Coulter referred to challenges regarding resource allocation for transformation, which would be managed at STP level, and the potential of re-directing funding to areas experiencing increased financial challenge. A further issue was the condition of future STP funding being linked to achievement of control totals, and Mr Coulter noted that there were organisations within the area which had not committed to this. The Trust awaited further guidance in this area.

5.13 Mr Coulter referred to the recent directorate review and confirmed that the three new clinical directorates had been agreed and commenced operationally on 16 May 2016. Mr Coulter took an opportunity to thank all staff involved in the review for their professionalism and support.

5.14 The Board received an update on progress with the New Care Models Vanguard Programme and confirmed the national Value Proposition funding of £1.55m which, although less than previously hoped for, will nonetheless support the shared ambition for service transformation. The need for clarity and understanding of the community contract for 2016/17 was acknowledged, and Mr Coulter confirmed that the New Care Models Vanguard would continue to progress toward a system-wide approach to integrated care.

5.15 With regard to financial performance, Mr Coulter had been disappointed the Trust had delivered a deficit for Month 1 (April) of £162k, over £300k behind plan. Mr Coulter stated that a prudent decision had been made to assume that a proportion of the Sustainability and Transformation (S&T) funding would not be accounted for due to this performance.

5.16 In terms of S&T Funding, Mr Thompson asked if the team were clear about cash flow implications of the S&T funding, and also the risk of non-achievement of the criteria and the impact upon funding received. Mr Coulter noted that criteria on the basis of which funding would be provided or reduced depending upon performance had yet to be released. NHS Improvement had been notified of the Trust's approach to reporting on Month 1.

5.17 Mr McLean asked for clarity on the change of position for allocation of the funding, from an 'all or nothing approach' to a tapered approach depending upon achievement. Mr Harrison stated that from a performance perspective, if the S&T funding was to be reduced, then tapering in line with contract penalty threshold would be logical, however there remained uncertainty in

this area. Mrs Dodson summarised by confirming that as a system, clarity was still required from the centre, and the Trust had implemented financially prudent plans.

5.18 Mr Mckie referred to the key drivers for the current financial position as: impact of the recent Junior Doctor industrial action; cost improvement programme (CIP) delivery; and ward expenditure. It was noted that significant discussion had taken place at Senior Management Team (SMT) in order to ensure necessary action would be taken to correct the position, including implementation of recovery plans.

5.19 Accepting the implementation of corrective action, Mr McLean emphasised the current environment of exceptional pressure, and asked at what point a review of projections would be required. Mr Harrison confirmed that work had commenced at directorate level and revised activity profiles had been agreed. Mr Harrison also reassured members of the Board that some of the initiatives had already made an impact.

5.20 As Chair of the Finance Committee, Mrs Taylor suggested that there was a risk related to STP funding and the requirement to make a £2.2m surplus at the year-end and asked what the implications would be as a result of re-profiling of plans, particularly with regard to the Trust's Financial Sustainability Risk Rating and further external scrutiny from NHS Improvement. Mr Coulter reiterated that Providers still await clear guidance with regard to the criteria for STP funding.

5.21 Dr Johnson noted that the risk had been identified, acknowledged and discussed in detail at directorate level at the appropriate time. Discussions had also taken place at directorate board level with regard to activity, and emphasised the importance of understanding the reasons for the reduction in activity before plans are revised to ensure any course of action would be taken in an informed way. Mr Coulter also referred to the time taken to realise CIPs in terms of impact across the year.

5.22 Mr Coulter referred to the reference within the report relating to the Ultra-Violet Cleaning business case and confirmed that the business case process had commenced, but formal approval had not yet been given.

5.23 With regard to the Board Assurance Framework and Corporate Risk Register, Mr Coulter confirmed that further thought was being given as to the inclusion of a risk relating to Sustainability and Transformation Plans and associated funding implications. There had been two risks escalated to the Corporate Risk Register: risk CR7 which reflected a risk of failure to meet the national 4 hour A&E standard; and risk CR8 which reflected a risk of harm to ophthalmology patients due to the potential to be 'lost to follow-up'.

ACTION:

- **Issue of lay-member representatives on the West Yorkshire STP Leadership Group be raised at the WYAAT meeting and the Chairman's Forum**

6. Integrated Board Report

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

6.1 Professor Proctor expressed disappointment at the failure to achieve the 4 hour A&E waiting time target for both the month and Quarter 4 and requested further information on the corrective actions taken.

6.2 Mr Alldred provided a detailed overview of the ongoing work, which had been underpinned by significant commitment within the department and the organisation. Mr Alldred emphasised the need to analyse the issue from a system-wide perspective and confirmed that the Trust continued to perform in the top 10% nationally. Individual work-streams had been established, each with short, medium and long term action plans to achieve and sustain the 95% target. The work-streams would address issues relating to: patient flow through the department; workforce capacity; and physical capacity. Work had also commenced in terms of speciality reviews and surgical and medical assessments, as well as early discharge planning to facilitate patient flow. Mr Alldred confirmed that the new directorate structure would strengthen support to the ongoing work further as a majority of pathways resided within one directorate. The Urgent Care Reform continued as a significant component, in terms of impact on reducing admissions. Dr Tolcher had requested a report for SMT to provide a summary of the initiatives and overall impact. It was agreed to submit the paper to the Board of Directors for assurance and comment.

6.3 Professor Proctor thanked Mr Alldred for a comprehensive overview of internal initiatives and asked if any work had been undertaken to investigate whether inappropriate attendances had an impact on performance, and if there would be a role for Primary Care and Out of Hours Services to improve performance going forward. Mr Alldred confirmed that work was ongoing across the West Yorkshire region. Following an audit focussing on attendances, the number of inappropriate attendances had been relatively small, but the Trust were exploring a strategy to co-locate GP's or Primary Care Services on site, within the Emergency Department.

6.4 To provide additional context in terms of Emergency Department performance, Mr Harrison confirmed that the Trust had reported an increase in patients seen within 4 hours year on year, but confirmed that growth in attendances had exceeded the level at which patients were seen. Performance continued to improve each year, but demand continued to increase in parallel.

6.5 Mr Coulter also confirmed that Systems Resilience Funding (SRG) would not be available in 2016/17 as it had been in previous years, and would likely have a further adverse impact on performance. Challenging discussions with commissioners continued in this respect.

6.6 Mr Thompson took an opportunity to note positive areas of performance including a continued reduction in falls, pressure ulcers and staff turnover, and emphasised the need to acknowledge this in light of the challenging environment of the NHS at the current time. Mr Thompson also requested additional data with regard to health visitor number of visits and other metrics in relation to community services within the Integrated Board Report. Mr Harrison confirmed that Key Performance Indicator (KPI) Reports had been under development and required agreement by the commissioners. Headline KPIs would be included from Quarter 2.

6.7 Mr McLean referred to slow progress on the CQUIN target relating to Sepsis. Dr Scullion confirmed that the Trust continued to demonstrate strong performance on screening, and agreed that work would be required in relation to antibiotic prescribing. A case note review had been undertaken and meetings with Emergency Department consultants had taken place to implement plans for improvement.

6.8 As Chair of the Quality Committee Mrs Webster confirmed that Sepsis had been identified as one of the Trust's four quality objectives for 2016/17 and the Committee would continue to monitor performance to ensure improvement. Mrs Webster also suggested that progress updates on the quality objectives be included in the IBR going forward.

ACTION:

- **Paper on initiatives to address Emergency Department A&E 4 hour waiting time performance to be submitted to Board**
- **Progress updates on the quality objectives be included in the Integrated Board Report**

7. Report from the Chief Operating Officer

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

7.1 Mr Harrison confirmed that the Trust continued to deliver all cancer standards but April had been a challenging period across all cancer performance metrics. Mr Harrison referred to a slight reduction in performance against the 14 day standard for urgent GP referrals due to a lack of capacity in gastroenterology clinics and endoscopy. Capacity issues continued to be addressed.

7.2 Mr Harrison referred to correspondence from NHS England regarding Inter Patient Transfers (IPTs) and breach re-allocation. The Trust had been working with the local cancer network and colleagues at Leeds to develop clear IPT guidelines from secondary to tertiary care to meet the nominal 38 day IPT standard. Arrangements had been made for representatives from Leeds Teaching Hospitals to visit the Trust in July to discuss the guidance and proposals further.

7.3 Mrs Taylor referred to CQUIN schemes for 15/16 and asked what the financial implications had been of non-achievement. Mr Harrison confirmed that only element was partially achieved related to antibiotic prescribing for Sepsis to the value of £50k. Mr Harrison also confirmed that there would be no impact of this on 2016/17 schemes.

7.4 Professor Proctor requested the inclusion of narrative on the CQUIN relating to avoidable admissions in a future report.

ACTION:

- **Include narrative on avoidable admissions in the June Chief Operating Officers report**

8. Report by the Director of Finance

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

8.1 Mrs Dodson noted that an in-depth discussion on financial performance had taken place earlier in the meeting under item 5.

8.2 Mr Ward requested the inclusion of new business in future reports in terms of income and cost.

ACTION:

- **Include new business in terms of income and cost into future Finance Directors' reports**

9. 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.

9.1 Following approval of the Workforce and Organisational Development Strategy and the recommendation from the independent review against Monitor's Well Led Framework, Mr Marshall noted that the report provided an update on progress against the strategy, to ensure appropriate visibility on workforce issues at Board level.

9.2 Mr Marshall confirmed a reduction in sickness absence rates, and referred to the positive impact of resilience training and Trust's Wellness Programme.

9.3 With regard to e-rostering, Mr Marshall briefed the Board on a presentation delivered to the Executive Team by Oceans' Blue, an NHS analytics organisation, commissioned to deliver a pilot to look at time balances over the previous 18 month period. Mr Marshall stated that the next steps would include agreeing a consistent approach to addressing the time balances identified during the retrospective review process of rosters. Areas of opportunity for further efficiencies had been identified using a process called Barnacles, which would be further explored via the Rosterpro Working Group.

9.4 Mr Marshall made reference to the inaugural meeting of the Job Planning Steering Group, which had been established to ensure objectives would be built into job plans and used for pay progression purposes.

9.5 Mr Marshall noted that the Trust had published the Workforce Race Equality Scheme information on the intranet. As a result of the self-assessment against the workforce standards set out in the national Equality Delivery Scheme, an action plan would be developed to address any areas requiring improvement. Progress would be monitored via the Equality Group and the Workforce and Organisational Development Steering Group.

9.6 The report provided a comprehensive update with regard to appraisals. Mr Marshall had communicated personally with those members of staff with less than 75% compliance rates, and invited feedback as to any perceived barriers that remained to being able to achieve high appraisal completion rates. Feedback received to date suggested that issues of capacity had impacted on the ability to undertake appraisals and mid-year reviews. In terms of next steps, Mr Marshall confirmed that those individuals with a compliance rate of between 75% and 90% would be contacted for feedback.

9.7 Mr Ward referred to a discussion at the previous meeting and the suggestion that a 'zero tolerance' approach to appraisals, and suggested that further work was required. Mr McLean acknowledged the work to improve the appraisal process, and asked if the improvements also increased the complexity for completing appraisals for staff.

9.8 Dr Johnson confirmed the lowest appraisal rates had been discussed at length at Elective Care Directorate Board and there had been a view from some members of staff that the process was lengthy. Dr Lyth noted contradictory feedback from the Integrated Care Directorate, and noted that colleagues from County Durham, Darlington and Middlesbrough had been particularly impressed with the appraisal process. Mr Aldred supported this and noted feedback from the Urgent, Community and Cancer Care Directorate had also been positive.

9.9 Dr Scullion advised that appraisers and appraisees should see appraisal as a valuable tool, and suggested that this be an area which would benefit from further exploration. Mrs Taylor supported this and advised raising awareness of appraisals as an opportunity for 'discussion' as opposed to a 'process'.

9.10 With regard to the Junior Doctors contract, Mr Marshall referred to a statement by ACAS on 13 May 2016 confirming that discussions would continue. As a result, the Government had agreed to suspend any action towards the implementation of the proposed new contract and the BMA had agreed to suspend any decision on further industrial action. Providers had therefore been asked to pause while national negotiations took place. A further update would be provided within the Director of Workforce and Organisational Development Report in June.

9.11 Mr Marshall confirmed that a number of initiatives continued to be implemented to support nurse recruitment. The initiatives included regular open days, which had received positive feedback from both applicants and interview panels. The Trust continued to work in partnership with Leeds Beckett University to develop a new non-commissioned undergraduate nursing programme, with all placements being provided at the Trust with a guarantee of future employment post-qualification.

9.12 Mr Marshall referred to the inaugural meeting of the Shadow Workforce Advisory Board to take forward the work associated with the development of the Sustainability and Transformation Plan. The Trust would be hosting an event on 16 June to discuss efficiency opportunities relating to use of bank and agency staff.

9.13 Mrs Taylor referred to e-rostering and asked when the Trust would be in a position of operating effectively and efficiently. Mr Marshall confirmed that members of staff were using the system, but alongside the paper based process, which had an adverse impact on the timeliness of use. Mrs Foster advised that progress would be dependent on a significant cultural change in expectations and referred to the Internal Audit Report which had resulted in a Limited Assurance opinion. Mrs Foster advised that a firm date of efficient use could not be provided at this stage, however, further assurance could be provided via a report to the Executive Director Team on analysis of the data and options to address the issues.

9.14 Mr Coulter noted collective frustration on e-rostering and referred to the Carter Review which highlighted challenges in terms of the behavioural change required and resistance to the benefits of it. Mrs Dodson requested an update and Mr Coulter confirmed that this would be provided in July.

9.15 Mr Thompson also reminded members of the Board that an additional meeting of the Audit Committee would be held in July to receive comprehensive updates on progress against recommendations associated with Internal Audit Reports with Limited Assurance opinions. This would include the e-rostering report.

ACTION:

- **Update on progress of e-rostering implementation to be submitted to the July Board meeting**

10. Report from the Medical Director

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

10.1 Dr Scullion informed the Board that the Trust had received a Cumulative Sum of Outcomes alert subsequent to the report being distributed. Dr Scullion had requested the completion of a structured case note review to provide further assurance. A further update would be provided within the June Medical Directors report.

10.2 Dr Scullion referred to appendix 1 which provided a high level overview of the intentions of the three sub-regional programmes regarding reconfiguration of Hyper Acute Stroke Services (HASS). The report highlighted that despite strong performance as a local unit, the regional re-design would be based on size of units. Dr Scullion emphasised the importance of ensuring the appropriate infrastructure would be in place when centralising HASS, to support patient flow and advised that the discussions were positive in terms of improving quality of care for patients. Mr Aldred supported the statement and confirmed that although the Trust demonstrated good quality of care in the service currently, it would be even better should the service be centralised and supported by an appropriate infrastructure.

10.1 National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Annual Report

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

10.1.1 Dr Scullion submitted apologies on behalf of Dr David Lavalette, Consultant Trauma and Orthopaedic Surgeon who, due to operational pressures, was unable to attend the meeting. Mrs Dodson asked that thanks be passed to Dr Lavalette on behalf of the Board for leading on the important piece of work, and the Board acknowledged the progress made.

10.1.2 Dr Scullion noted that the report provided detail on the ongoing NCEPOD reports and recommendations. Additional work had been undertaken via the Patient Safety Steering Groups, particularly around alcohol liver disease. Dr Scullion took an opportunity to thank the clinicians involved and the Patient Safety Team for their commitment.

10.2 Efficiency Programme Quality Impact Assessment Annual Report

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

10.2.1 Dr Scullion and Mrs Foster had met with the directorates and had been reassured in terms of current significant CIP schemes and the Quality Impact Assessment undertaken for each. The assessment undertaken used a scoring mechanism to address impact in terms of patient safety, effectiveness and patient experience. Dr Scullion referred to one area of concern relating to transformational aspects of the in-patient work stream regarding the potential slowdown of the recruitment of registered nurses, but overall reassurance had been given. Overall, there had been no significant quality and/or safety issues to report.

11. Report from the Chief Nurse

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

11.1 Mrs Foster referred to a reduction of 20% in complaints reported in 2015/16 from 2014/15. Mrs Foster also noted that there had not been a corresponding improvement in responses to complaints within agreed deadline, and delivery of recommendations and actions against deadline. Mrs Foster confirmed that this had been discussed at SMT and would continue to be a focus for 2016/17. A suite of metrics had been agreed as an early warning mechanism to ensure the process remained robust.

11.2 With regard to nurse recruitment, numbers of nurses being recruited continued to exceed the numbers of nurses leaving the Trust. Mrs Foster referred to a recruitment event held in May which resulted in conditional offers of employment being given to seven qualified nurses, and two student nurses. 18 Care Support Workers had also been appointed. Interviews for overseas nurses would commence at the end of May.

11.3 The report provided detail on actual versus planned staffing levels from February 2016 until April 2016 and reported a slight reduction in the total number of actual shifts filled as opposed to planned shifts. Risk analysis had been undertaken from a patient safety point of view. Indicators used to assess the mitigations in place remained strong including a continued reduction in falls and pressure ulcers.

11.4 Mrs Foster reported on the analysis of risks relating to children's safeguarding, including governance arrangements. The Trust had received an invitation to sit on the Local Children's Safeguarding Boards in County Durham and Darlington and an invitation from Middlesbrough was expected. The post of Head of Children's Safeguarding had been advertised with an interview date scheduled in June.

11.5 As chair of the Quality Committee, Mrs Webster referred to the number of complaint action plans completed to deadline, and noted that this was a continued area of focus for the committee. Mrs Webster also confirmed that the committee received a quarterly Patient Experience Report and a report on progress against performance was due to be submitted to the committee in July. Mrs Dodson requested an update as part of the Chair's report in September.

11.6 Mr Thompson expressed disappointment that deadlines are agreed not imposed, and performance still remained poor. Mrs Foster agreed and confirmed that work also continued to address recommendations from an Internal Audit Report, in line with lessons learnt following improvements made to the SRI reporting process.

11.7 Professor Proctor referred to the figures of the county's most vulnerable children, and asked how risk assessments within maternity services were considered, given the Trust does not provide maternity services in the County Durham, Darlington and Middlesbrough area. Mr Harrison referred to the process for health visitor checks and the challenges in terms of demographics and families moving in and out of the area. Mrs Foster confirmed that the referral systems ensures joined up working between maternity services and health visitors, and child protection plans would be developed.

11.8 Mr Coulter noted the significant amount of work being undertaken in terms of nurse recruitment, and acknowledged the positive benefits in the pipeline. Mrs Foster took an opportunity to thank the nursing and workforce teams for their commitment in delivering the initiatives.

ACTION:

- **Verbal update to be provided as part of the Quality Committee Chair's report in September on performance relating to complaint action plans completed against deadline**

11.1 Patient Experience Quarter 4 Report and Annual Report 2015/16

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

11.1.1 Mrs Foster referred to the work undertaken to ensure all Trust policies were up to date and noted that 96 documents had been identified as beyond their review date. Work continued to ensure all policy documents were up to date and still remained fit for purpose.

11.1.2 With regard to patient experience, Mrs Webster referred to the improvements in reporting to the Quality Committee resulting in an increase in qualitative information, and insight in terms of patient experience. The committee also highlighted the need to review the methodology used for the Friends and Family test.

11.1.3 Mr McLean noted that the Trust was seeing some concerning negative comments, but the quality of care delivered remained very high, and although the Trust remained one of the highest performing Trusts, the Board should be mindful not to dilute concerns, and continue to provide confidence to the public.

11.1.4 Professor Proctor welcomed the level of transparency in the report and noted a shift in numbers from Quarter 3 to Quarter 4 from a directorate point of view in terms of analysis of complaints by speciality, location and theme. Professor Proctor asked for a brief overview of the work undertaken to deal with some of the issues around management of complaints.

11.1.5 Mr Alldred suggested that a process of working collaboratively with carers and families had been crucial to enable earlier conversations and local resolution. The directorates had also improved their skills in terms of the investigation process to identify the root cause and key issues of complaints. The directorate triangulated information from complaints, patient stories and board reports to identify themes.

11.1.6 Dr Johnson referred to a comprehensive report which had been discussed in detail at the directorate Quality and Governance Group to ensure everyone had oversight of each complaint. Dr Johnson noted that 2015/16 had been a particularly challenging year for the Elective Care Directorate due to the significant number of complaints, but discussions continued to focus on improving the process and performance.

11.1.7 Dr Lyth supported the comments made regarding early discussions with the complainant to ensure the Trust fully understands the issues. Dr Lyth also emphasised the importance of clear feedback of the Trust's conclusions, to ensure they reflect the issues and follow through on actions and learning.

11.2 Care of Frail Older People Strategy

The strategy had been circulated in advance of the meeting and was taken a read. Dr Lyth invited Fiona Mayer, Medical Specialities Services Manager to the meeting.

11.2.1 Dr Lyth briefed the Board on the Trust's Strategy for the Holistic Care of Older People with Frailty for 2016-2021 and stated that the purpose of the strategy would be to enable the Trust to move from good to excellent. The strategy focussed on the patient's entire journey through their care, and should be considered alongside the Trust's wider Clinical Workforce Strategy.

11.2.2 Mr McLean suggested that the strategy was ambitious and asked in terms of pragmatism, how would the strategy be delivered, including measuring success and resources required. Dr Lyth stated that the strategy had been underpinned by a significant amount of data to identify the Trust's current position, and where the Trust wanted to be. This included a review of national and local audits and highlighting the gaps.

11.2.3 Mrs Dodson asked how the Board would receive assurance that the strategy was being delivered. Mr Alldred confirmed that a series of action plans had been established and specific milestones for all actions would be included. Ms Maher also confirmed that each action plan would have a sub-group to monitor delivery of the strategy. Mrs Dodson requested a further update be provided in six months to monitor progress.

11.2.4 Professor Proctor suggested a member of the Non-Executive Director cohort be identified as Non-Executive Director Lead for Older People. Mrs Dodson agreed to discuss with Dr Ros Tolcher, Chief Executive.

ACTION:

- **A further update on the Care of Frail Older People Strategy be submitted to the November meeting of the Board**
- **Confirm a Non-Executive Director Lead for Older People**

12. Oral Reports from Directorates

Urgent, Community and Cancer Care

12.1 Mr Alldred referred to the implementation of the new directorate structure and the work ongoing to ensure a smooth transition and handover. Teams continued to work well together and gain momentum, and Mr Alldred confirmed that all General Manager posts had been appointed to on an interim basis, and adverts had been placed for substantive posts. Line Management structures were also being worked through.

12.2 Mr Alldred referred to the challenging period of negotiations relating to the Community Services contract. The Directorate Management Team and Clinical Leads had been engaged and Mr Alldred commended the teams for their professionalism and support throughout the process.

12.3 There had been an increased focus on infection prevention and control, and root cause analyses continued to identify issues to be addressed.

12.4 Mr Alldred referred to a number of consultant appointments and the business cases for Diabetes and Respiratory. From a Directorate point of view, Mr Alldred stated that the directorate remained busy in terms of transformation work and ensuring the Trust continued to achieve performance targets.

Elective Care

12.5 Dr Johnson referred to the time out session planned to take place in June. 40 members of staff would be attending and Dr Sylvia Wood, Deputy Director of Governance, would be in attendance to advise on directorate governance arrangements.

12.6 Dr Johnson briefed the Board on challenges regarding middle grade appointments across a number of specialities. A meeting had been arranged with clinical leads to discuss opportunities and risks.

12.7 Mrs Barron, Operational Director would be commencing maternity leave in a few months' time and consideration was being given into supporting Mrs Barron to maintain a strategic overview of the Directorate whilst on maternity leave via 'keeping in touch days'.

12.8 Dr Johnson expressed concern following the failure to appoint to the Consultant Elderly Care post and the impact on workload of the Consultant currently covering the service. Mrs Dodson requested a further update on options related to the appointment as part of the directorate update at the June meeting of the Board.

Integrated Care

12.9 Dr Lyth referred to the first governance meeting under the new directorate structure and noted positive synergy within the service. Acknowledgement had also been given to members of staff who work off-site in terms of ensuring appropriate dialogue and support.

12.10 Dr Lyth referred to challenges regarding staffing in acute paediatrics due to maternity leave and vacancies. Robust action plans had been implemented to mitigate the associated risks. Dr Lyth also referred to gaps of middle grade staff.

ACTION:

- **Further update on progress to appoint to the Consultant Elderly Care post to be provided by Dr Johnson at the June meeting of the Board**

13. Committee Chair Reports

Report from the Quality Committee held 4 May 2016

Mrs Webster's report had been circulated in advance of the meeting, alongside the Quality Committee Annual Report 2015/16 and Forward Plan for 2016/17. All documents were taken as read.

13.1 Mrs Webster requested formal endorsement from the Board on the forward plan for the Quality Committee for 2016/17. Mr Harrison referred to the forward plan and noted the Director for Infection Prevention and Control as Jenny Childs.

13.2 Mrs Webster referred to the Quality Committee Annual Report and the outstanding work in relation to the Caldicott report. Mrs Webster confirmed that this was no longer required as the committee had been satisfied that the report would be addressed within the existing governance structure.

APPROVED:

- **The Board of Directors endorsed the forward plan for the Quality Committee for 2016/17 subject to the amendments highlighted in the minutes**

Report from the Audit Committee meetings held 5 May and 19 May 2016

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

14. Council of Governors' minutes of the Meeting held 6 February 2016

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

15. Matters relating to compliance with the Trust's Licence or other exceptional items to report, including issues reported to the Regulators

15.1 Mrs Dodson confirmed that the Trust's Annual Report and Accounts 2015/16, including the Quality Account and associated statutory documents had been approved in the meeting held in private earlier on 25 May, and would be submitted to NHS Improvement by the deadline of 27 May 2016.

15.2 Following the formal Care Quality Inspection undertaken at the Trust in February, Mr Coulter noted that correspondence had been received from the CQC confirming that a draft report would be provided to the Trust in Mid-June.

16. Any other relevant business not included on the agenda

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

17. Board Evaluation

Mr Thompson stated that some highly important issues had been discussed with work being carried forward, but acknowledged that this had been wholly appropriate in order to receive the necessary level of assurance.

Mr Harrison referred to comments made by Mr McLean in terms of ensuring the Trust remembers the context in which staff are working, and the importance of acknowledging the Trust's successes, as well as not losing focus on areas for improvement.

Mr McLean asked if the Trust were confident in its capacity and capability to deliver its ambition, given the challenging context in which the NHS continued to operate. Professor Proctor supported Mr McLean's question and referred to issues highlighted by Non-Executive Directors used to frame the meeting. Professor Proctor suggested that issues relating to risk associated with finance and performance had been discussed, but there had been less discussion on risk associated with capacity.

Mrs Foster suggested the effort relating to the ongoing contractual discussions and the directorate review had perhaps taken up a significant amount of time recently.

18. Confidential Motion

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

The Board agreed the motion unanimously.

The meeting closed at 12.30pm

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HDFT Board of Directors Actions Schedule – June 2016
Completed Actions

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

Item Description	Director/ Manager Responsible	Date of completion/ progress update	Confirm action Complete
An extraordinary Board meeting to be arranged to formally approve the operating plan prior to Monitor submission on Monday 11th April	Ms D Henderson, Company Secretary	April 2016	Complete
A discussion to take place at the Quality Committee on processes for ensuring oversight of quality priorities from the current year as well as 2016/17 priorities (13.6)	Mrs L Webster, Chairman of the Quality Committee and Mrs Jill Foster, Chief Nurse	April 2016	Complete
Include details of the status and reasoning for new Consultant appointments in future reports (5.16)	Dr R Tolcher, Chief Executive	April 2016	Complete
Prepare report for Board on debtors through Finance Committee (7.6 – Jan 16)	Mr J Coulter, Director of Finance	April 2016	Complete
Risks around junior doctor industrial action to be reflected on Directorate Risk Registers (5.7 – Feb 16)	Clinical Directors	April 2016	Complete
Identify measures to improve patient choice of meals and process for meal following patient if latter moved (12.8 – Feb 16)	Mr R Harrison, Chief Operating Officer	April 2016	Complete
Inclusion of an additional metric in the IBR to reflect the proportion of available theatre sessions used and not used (6.12 – March 16)	Mr R Harrison, Chief Operating Officer	April 2016	Complete
Seek clarity on the target compliance rates for appraisal completion (6.9 – March 16)	Mr P Marshall, Director of Workforce & Organisational Development	April 2016	Complete
A letter of thanks and acknowledgement to be sent in response to the patient letter on behalf of the Board (March 16)	Mrs S Dodson, Chairman	April 2016	Complete
Bring report to Board through Quality Committee to demonstrate that GP OOH service is safe for patients (6.8 – January 16)	Mr A Alldred – Clinical Director, Urgent Community and Cancer Care	April 2016	Complete
Reflect trend in recruitment processes over last 12 months in routine Report (11.4 – January 16)	Mrs J Foster, Chief Nurse	April 2016	Complete
Actual nurse staffing numbers overall at directorate level, and month on month comparisons to be included in future reports including (13.4 – March 16)	Mrs J Foster, Chief Nurse	April 2016	Complete
The Patient Safety Visit Programme to be circulated to Board members (13.1 – March 16)	Mrs J Foster, Chief Nurse	April 2016	Complete

Item Description	Director/ Manager Responsible	Date of completion/ progress update	Confirm action Complete
Circulate STP correspondence/ objectives to Board members (5.3 – March 16)	Dr R Tolcher, Chief Executive	April 2016	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

HDFT Board of Directors Actions Schedule – Outstanding Actions **June 2016**

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

Ref	Meeting Date	Item Description	Director/Manager Responsible	Completion date	Detail of progress
1	May 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	June 2016	
2	May 2016	Progress updates on Quality Objectives to be included in the IBR (6.8)	Mrs J Foster, Chief Nurse	July 2016	
3	March 2016	Submission of a Research and Development Strategy for Board approval	Dr A Layton - Associate Medical Director for Research	July 2016	
4	January 2016	Update Board on progress with EDS2 action plan (11.10)	Mrs J Foster – Chief Nurse	July 2016	
5	April 2016	Undertake a refresh of the Trust's approach to raising the profile of appraisals (7.23)	Mr P Marshall, Director of Workforce & Organisational Development	July 2016	
6	May 2016	Paper on progress of e-rostering implementation (9.13)	Mrs J Foster, Chief Nurse	July 2016	
7	May 2016	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	
8	January 2016	Review and revise questions in annual Audit Committee survey (14.1.3)	Mr C Thompson – Chair Audit Committee – Non-Executive Director	November 2016	
9	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	
10	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	

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Report to the Trust Board of Directors: 29 June 2016	Paper No: 5.0
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Title	Corporate Governance Statement	
Sponsoring Director	Dr Ros Tolcher, Chief Executive	
Author(s)	Ms Debbie Henderson, Company Secretary	
Report Purpose	To provide assurance to the Board of Directors of the systems and processes in place to support Board approval of the Corporate Governance Statement submission to NHS Improvement.	
Key Issues for Board Focus:		
<p>The paper provides a summary following a table top exercise providing evidence relating to each of the component parts of the Corporate Governance Statement to support the Board's assessment of its ongoing compliance with the Governance Condition of the NHS Provider Licence.</p> <p>In accordance with the Monitor's Risk Assessment Framework, to comply with the governance conditions of their Licence, NHS Foundation Trusts are required to provide a statement – 'The Corporate Governance Statement' setting out any risks to compliance with the governance condition; and actions taken, or being taken, to maintain future compliance.</p> <p>There are no risks to ongoing compliance with the Governance Condition of the NHS Provider Licence.</p>		
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		
<ul style="list-style-type: none">The Board is asked to approve the declaration of 'Confirmed' for the following statutory statements for submission to NHS Improvement:<ul style="list-style-type: none">Corporate Governance StatementTraining for Governors Statement		

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Harrogate and District NHS Foundation Trust
Corporate Governance Statement – Board Self-Certification
29 June 2016

1. Context

The Monitor Risk Assessment Framework (RAF) requires Foundation Trusts to submit a one-year Operational Plan to NHS Improvement (formally Monitor), as part of the Trust's planning process. NHS Improvement uses the information provided to assess the risk of an NHS Foundation Trust breaching its Licence in relation to finance and governance. Part of this annual planning process is the submission of self-certification Board Statements as follows:

- **Corporate Governance Statement** – confirming compliance with Condition FT (4) of the Provider Licence;
- **Certification for Academic Health Science Centres (AHSC)** – only required for Trust's that are part of a joint venture or AHSC, therefore not applicable for Harrogate and District NHS Foundation Trust; and
- **Training for Governors Statement** – as required by Section 151(5) of the 2012 Act (relating to the requirements for Foundation Trust's to ensure that Governors are equipped with the skills and knowledge they require to undertake their role.

2. Overview

In accordance with the RAF, to comply with the governance conditions of their Licence, NHS Foundation Trusts are required to provide a statement '*The Corporate Governance Statement*' setting out:

- Any risks to compliance with the governance condition; and
- Actions taken, or being taken, to maintain future compliance.

Where facts come to light that could call into question information in the Corporate Governance Statement, or indicate that a Foundation Trust may not have carried out planned actions, NHS Improvement may seek additional information. The Trust is expected to submit its declaration to NHS Improvement on 30 June 2016 immediately following the Board meeting on 29 June 2016.

3. Self-Certification Process

A table top exercise has been undertaken with the aim of providing evidence relating to each of the component parts of the Corporate Governance Statement to support the Board's assessment of its compliance with each of the key questions, the identification of any risks and mitigation and completion of the overall statement. The proposed sources of

evidence to substantiate the statements in the Board's declaration are detailed in this report.

In the event that the Trust is unable to self-certify, it must provide NHS Improvement with commentary explaining the reasons for the absence of a full self-certification and the action it proposes to take to address the issues.

4. Recommendations

The Board is asked to:

- **Approve** the statements as 'confirmed' for submission to NHS Improvement on 30 June 2016.

Dr Ros Tolcher
Chief Executive
15 June 2016

Corporate Governance Statement 2016/17

Corporate Governance Statement Reference	Evidence for self-certification as 'confirmed'	Risks and mitigating actions for 2016/17
<p>1. The Board is satisfied that Harrogate and District NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of healthcare services to the NHS.</p>	<ul style="list-style-type: none"> • Annual Report on compliance with the Code of Governance (AC) • Annual review of the Trust's Constitution (BoD/CoG) • Annual Governance Statement (AC/BoD) • ISA 260/External Audit Opinion on the Trust's Accounts/Quality Report and audit of Quality Indicators (AC/BoD) • Head of Internal Audit Opinion (AC/BoD) • Approved Internal Audit Plan (AC) • Internal/External Audits with appropriate system for implementation of recommendations (AC/ BoD) • Trust Board governance structure (BoD) • Board effectiveness – Well Led Framework independent assessment (BoD/SMT) • Submission of Operational Plan 2016/17 (BoD/SMT) • Progress reports on Quality Objectives (QC) • Monthly, Quarterly and Annual declarations (BoD/AC/QC/FC/SMT) • Monthly finance and performance reporting (BoD/AC/QC/FC/SMT) • Risk Management Framework at both strategic, corporate, directorate and operational level (BoD/AC/QC/FC/SMT/CRRG, DBMs) • Annual IG Toolkit Certification (BoD) • Compliance with Code of Conduct (BoD/CoG and all staff) • SFIs, Scheme of Delegation and Standing Orders (BoD/FC) • Patient Safety visits and Director inspections (BoD/QC) 	<p>There are no risks to compliance with the governance condition for 2016/17</p> <p>'Confirmed' as compliant</p>

Corporate Governance Statement Reference	Evidence for self-certification as 'confirmed'	Risks and mitigating actions for 2016/17
2. The Board has regard to such guidance on good corporate governance as may be issued by Monitor/NHS I from time to time.	Evidence as per requirement 1 above; and <ul style="list-style-type: none"> • New and updated regulatory guidance implemented on an ongoing basis • External Auditor Technical Updates including forthcoming changes to legislation and regulation affecting the health sector (AC) 	There are no risks to compliance with this governance condition 'Confirmed' as compliant
3. The Board is satisfied that Harrogate and District NHS Foundation Trust implements: (a) Effective Board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation	Evidence as per requirement 1 and 2 above; and <ul style="list-style-type: none"> • Board committee and governance framework • Minutes and reports to Board and committees • Review of the terms of reference and effectiveness of the Board and committees, and other decision making forums • Board development programme and strategy away days • Internal Audit reports on governance related matters • Cross committee Non-Executive Director membership and reporting lines • Executive and Non-Executive Director appraisal process • Objectives and personal development plans for individual Board members • Risk Management Framework and associated accountability and responsibilities • Statutory disclosure of Director's responsibilities in the Annual Report 	There are no risks to compliance with the governance condition No risks identified for 2016/17 'Confirmed' as compliant

Corporate Governance Statement Reference	Evidence for self-certification as 'confirmed'	Risks and mitigating actions for 2016/17
	<ul style="list-style-type: none"> • Directorate structure 	
<p>4. The Board is satisfied that Harrogate and District NHS Foundation Trust effectively implements systems and/or processes:</p> <p>(a) to ensure compliance with the Licence holder's duty to operate economically, efficiently and effectively;</p> <p>(b) For timely and effective scrutiny and oversight by the Board of the licence holder's operations;</p> <p>(c) To ensure compliance with healthcare standards binding on the Licence holder including, but not restricted to, standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of healthcare professions;</p> <p>(d) For effective financial decision-making, management and control including, but not restricted to, appropriate systems and/or processes to ensure the Licence holder's ability to continue as a going concern;</p> <p>(e) To obtain and disseminate accurate, comprehensive, timely and up-to-date</p>	<p>Evidence as per requirement 1, 2 and 3 above; and</p> <ul style="list-style-type: none"> • Monthly performance data reviewed in respect of targets and standards in line with requirements of the RAF (BoD) • Monthly financial reporting (BoD/FC) • Quarterly reporting on achievement (BoD/FC) against the Cost Improvement Programme • Quarterly consideration of the Financial Sustainability Risk Rating and Governance Risk Rating (BoD) • Monthly CEO report (BoD) • Annual planning process (SMT/BoD) • Scrutiny and challenge of KPIs/metrics (BoD/all committees) • Complaints and Patient experience reporting (BoD/QC) • Triangulation of reporting across committee structure (all committees) • Divisional performance monitoring (DBM) • Review of progress against the key elements and actions in-year to achieve the overall strategy (BoD) • Reporting in compliance with CQC fundamental standards (QC) • The Trust's going concern review (BoD/AC) • Clinical Audit Planning (QC) • Patient and staff surveys (QC/BoD/SMT) • Review of Serious Incidents Requiring Review (SIRIs), Never Events (NEs) and associated Root Cause Analysis (RCAs) to demonstrate wider learning (BoD/QC) 	<p>No risks identified for 2016/17</p> <p>'Confirmed' as compliant</p>

Corporate Governance Statement Reference	Evidence for self-certification as 'confirmed'	Risks and mitigating actions for 2016/17
<p>information for Board and committee decision-making;</p> <p>(f) To identify and manage (with, but not restricted to, forward plans) material risks to compliance with the conditions of its Licence;</p> <p>(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and</p> <p>(h) To ensure compliance with all applicable legal requirements.</p>		
<p>5. The Board is satisfied:</p> <p>(a) There is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;</p> <p>(b) The Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;</p> <p>(c) Accurate, comprehensive, timely and up-to-date information on quality of care is collected;</p>	<p>Evidence as per requirement 1, 2, 3 and 4 above; and</p> <ul style="list-style-type: none"> • Appraisal compliance and outcomes (BoD/SMT) • Terms of reference for Non-Executive Directors' Remuneration and Nomination Committees (BoD) and Governors' Remuneration and Nomination Committee (CoG) • Board induction programme (NC) • Register of Interests and ongoing declaration (BoD/all committees) • Standards of Business Conduct Policy and Register of Gifts and Hospitality (AC) • Recruitment process (including Fit and Proper Persons Test) • Annual Quality Account, and external assurance (BoD/QC) • Patient stories (BoD) 	<p>No risks identified for 2016/17</p> <p>'Confirmed' as compliant</p>

Corporate Governance Statement Reference	Evidence for self-certification as 'confirmed'	Risks and mitigating actions for 2016/17
<p>(d) It receives and takes into account the accurate, comprehensive, timely and up-to-date information on quality of care;</p> <p>(e) Harrogate and District NHS Foundation Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders, and takes into account as appropriate views and information from these sources; and</p> <p>(f) There is clear accountability for quality of care throughout Harrogate and District NHS Foundation Trust, including but not restricted to, systems and/or processes for escalating and resolving quality issues, including escalating them to the Board where appropriate.</p>	<ul style="list-style-type: none"> • CQC Assessment (BoD/QC) • Quality Impact Assessments (BoD/QC) • Data quality (validation, internal audits, coding and policies) • Council of Governor sub-committees, Patient Voice Group, and Learning from Patient Experience Group (CoG/BoD/QC) • PLACE visits • Job descriptions for CEO, Chairman, Executive and Non-Executive Directors (RC/NC) 	
<p>6. The Board effectively implements systems to ensure it has personnel on the Board, reporting to the Board and within the rest of the Licence holder's organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of this Licence.</p>	<p>Evidence as per requirements 1, 2, 3, 4 and 5 above; and</p> <ul style="list-style-type: none"> • Formal, rigorous and transparent procedure for the appointment of new Directors of the Board (RC/NC) • Annual Constitutional review (BoD/CoG) • HDFT Board includes appropriately qualified Finance Director, Medical Director and Chief Nurse • Recruitment process • Annual appraisal processes (RC/NC) • Minutes of papers of RC/NC 	<p>No risks identified for 2016/17</p> <p>'Confirmed' as compliant</p>

Corporate Governance Statement Reference	Evidence for self-certification as 'confirmed'	Risks and mitigating actions for 2016/17
<p>TRAINING FOR GOVERNORS SELF-CERTIFICATION</p> <p>The Board is satisfied that during 2015/16, the Trust has provided the necessary training to its Governors as required by S151(5) of the Health and Social Care Act 2012, to ensure they are equipped with the skill and knowledge they need to undertake their role.</p>	<p>Through the Council of Governors governance framework, Governors are provided with the necessary skill and knowledge to perform their statutory duties effectively, and discharge their responsibilities enhanced level of insight via:</p> <ul style="list-style-type: none"> • Governors General meetings • Governor informal meetings • Governor/Non-Executive Director meetings • Council of Governor and Board of Directors 'Board to Board' meetings • Governors' Volunteers and Education Working Group • Governors' Membership and Communications Working Group • Governors attendance on the Board sub-committees as observers • Governor involvement in operational working groups across the Trust • Staff Governor meetings with CEO and Chairman • One-to-one meetings with Chairman and individual governors • Governor attendance at Board of Directors meetings • Governors attendance at NHS Providers Governwell events • Governor induction programme 	<p>No risks identified for 2016/17</p> <p>'Confirmed' as compliant</p>

Key:

BoD Board of Directors
CoG Council of Governors
AC Audit Committee
QC Quality Committee
NC Nomination Committee

FC Finance Committee
SMT Senior Management Team
CRRG Corporate Risk Review Group
DBM Directorate Board/Governance Meetings
RC Remuneration Committee



Self-Certification Template

FT Name: Harrogate and District NHS Foundation Trust

NHS Foundation Trusts are required to make the following declarations to NHS Improvement:

- 1 & 2 *Systems for compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence*
- 3 *Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence*
- 4 *Corporate Governance Statement - in accordance with the Risk Assessment Framework*
- 5 *Certification on AHSCs and governance - in accordance with Appendix E of the Risk Assessment Framework*
- 6 *Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act*

Declarations 1 and 2 above are set out in a separate template, which is required to be returned to NHS Improvement by 31 May 2016.

Declaration 3 is included in the APR 2015/16 Final Financial Template, which is required to be returned to NHS Improvement per communications on final operational plan submissions.

Declarations 4, 5 and 6 above are set out in this template, which is required to be returned to NHS Improvement by 30 June 2016.

Templates should be returned via the Trust portal, marked as a Trust Return with the activity type set to Annual Plan Review.

How to use this template

- 1) Copy this file to your Local Network or Computer.
- 2) Select the name of your organisation from the drop-down box at the top of this worksheet.
- 3) In the Corporate Governance Statement and Other Certifications worksheets, enter responses and information into the yellow data-entry cells as appropriate.
- 4) Once the data has been entered, add signatures to the document, as described below.
- 5) Use the Save File button at the top of this worksheet to save the file to your Network or Computer - note that the name of the saved file is set automatically - please do not change this name.
- 6) Copy the saved file to your outbox in your NHS Improvement Portal.

Notes: *NHS Improvement will accept either:*

- 1) electronic signatures inserted into this worksheet (save signature file locally and use 'Insert - Picture' from the toolbar/ribbon to do this) or*
- 2) hand written signatures on a paper printout of this declaration posted to NHS Improvement to arrive by the submission deadline.*

In the event that an NHS foundation trust is unable to fully self certify, it should NOT select 'Confirmed' in the relevant box. It must provide commentary (using the section provided at the end of this declaration) explaining the reasons for the absence of a full self certification and the action it proposes to take to address it.

Worksheet "Corporate Governance Statement"

Corporate Governance Statement

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

4	Corporate Governance Statement	Response	Risks and mitigating actions
1	The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	There are no risks to compliance for 2016/17
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	There are no risks to compliance for 2016/17
3	The Board is satisfied that the Trust implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	There are no risks to compliance for 2016/17
4	The Board is satisfied that the Trust effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	There are no risks to compliance for 2016/17
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	There are no risks to compliance for 2016/17
6	The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	There are no risks to compliance for 2016/17

Signed on behalf of the board of directors, and having regard to the views of the governors

Signature

Signature

Name Dr Ros Tolcher, Chief Executive

Name Mrs Sandra Dodson, Chairman

The board are unable make one of more of the above confirmations and accordingly declare:

A

B

C

Worksheet "Other declarations"

Certification on AHSCs and governance and training of governors

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

5 Certification on AHSCs and governance

Response

For NHS foundation trusts:

- that are part of a major Joint Venture or Academic Health Science Centre (AHSC); or
- whose Boards are considering entering into either a major Joint Venture or an AHSC.

The Board is satisfied it has or continues to:

- ensure that the partnership will not inhibit the trust from remaining at all times compliant with the conditions of its licence;
- have appropriate governance structures in place to maintain the decision making autonomy of the trust;
- conduct an appropriate level of due diligence relating to the partners when required;
- consider implications of the partnership on the trust's financial risk rating having taken full account of any contingent liabilities arising and reasonable downside sensitivities;
- consider implications of the partnership on the trust's governance processes;
- conduct appropriate inquiry about the nature of services provided by the partnership, especially clinical, research and education services, and consider reputational risk;
- comply with any consultation requirements;
- have in place the organisational and management capacity to deliver the benefits of the partnership;
- involve senior clinicians at appropriate levels in the decision-making process and receive assurance from them that there are no material concerns in relation to the partnership, including consideration of any re-configuration of clinical, research or education services;
- address any relevant legal and regulatory issues (including any relevant to staff, intellectual property and compliance of the partners with their own regulatory and legal framework);
- ensure appropriate commercial risks are reviewed;
- maintain the register of interests and no residual material conflicts identified; and
- engage the governors of the trust in the development of plans and give them an opportunity to express a view on these plans.

N/A

6 Training of Governors

The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

Confirmed

Signed on behalf of the Board of directors, and having regard to the views of the governors

Signature

Signature

Name: Dr Ros Tolcher

Name: Mrs Sandra Dodson

Capacity: Chief Executive

Capacity: Chairman

Date: 29 June 2016

Date: 26 June 2016

Where boards are unable to self-certify, they should make an alternative declaration by amending the self-certification as necessary, and including any significant prospective risks and concerns the foundation trust has in respect of delivering quality services and effective quality governance

The Board are unable make one of more of the confirmations on the preceding page and accordingly declare:

A

B

C

Report to the Trust Board of Directors: 29 June 2016	Paper No: 6.1
Title	Remuneration Committee Terms of Reference
Sponsoring Director	Mrs Sandra Dodson, Chairman/ Remuneration Committee Chair
Author(s)	Mrs Sandra Dodson, Chairman/ Remuneration Committee Chair
Report Purpose	To conduct the annual review of the Quality Committee Terms of Reference
Key Issues for Board Focus: The Remuneration Committee is required to undertake an annual review of its Terms of Reference to ensure that it is conducting its business appropriately and in accordance with them. An annual review also ensures that the Committee remains up to date with current best practice and reflects the changing needs of the Trust.	

Related Trust Objectives	
1. To deliver high quality care	Yes. Provision of robust governance processes and oversight to support the Board in fulfilling its role to provide leadership, and ensure the achievement of the overall Trust's strategic objectives.
2. To work with partners to deliver integrated care	
3. To ensure clinical and financial sustainability	

Risk and Assurance	The Terms of Reference provide assurance that the Committee has clarity on its role and delegated responsibilities.
Legal implications/ Regulatory Requirements	This review complies with the requirement to examine the Terms of Reference on an annual basis.

Action Required by the Board of Directors The Board of Directors are asked to review and approve the Remuneration Committee Terms of Reference.
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REMUNERATION COMMITTEE

COMPOSITION AND TERMS OF REFERENCE

1. Composition

- 1.1 The Committee shall comprise of the Trust's Chairman and all Non-Executive Directors. No business shall be transacted at a meeting unless the Chairman of the Board (or Vice Chairman) and three Non-Executive Directors are present for the whole meeting. Membership of the Committee will be reviewed annually.

The membership of the Committee and other mandatory information will be published in the Annual Report as determined by the Board of Directors.

- 1.2 The Chief Executive will be invited to attend the Committee in an advisory capacity but he/she will be required to withdraw when a matter concerning his/her remuneration package or other matter of individual confidentiality is being discussed or documented.
- 1.3 The Director of Workforce and Organisational Development will also attend the Committee as an adviser but he/she will be required to withdraw when a matter concerning his/her remuneration package or other matter of individual confidentiality is being discussed or documented.
- 1.4 The Director of Workforce and Organisational Development will be responsible for providing comparative pay information and for minuting the meetings. The minutes shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be agreed by those attending.

2. Conduct of the Committee

- 2.1 The Chairman will make reference to Remuneration Committee meetings at the Board of Directors' meeting.
- 2.2 All meetings of the Committee will be minuted.

3. Frequency

- 3.1 The Committee will meet as and when necessary and not less than once a year, or at the request of three Non-Executive Directors of the Trust. The Chief Executive and the Director of Workforce and

Organisational Development also have the right to request a meeting of the Committee. The Committee will usually meet in March each year to determine remuneration levels for Executive Directors effective from 1 April each year.

3.2 Meetings will be subject to 7 days' notice.

4. Authority

4.1 The powers of the Committee shall be such as may be delegated to it by the Board of Directors on all matters relating to remuneration.

5. Aims and Objectives

5.1 To make such recommendations to the Board of Directors on remuneration, allowances and terms of service to ensure that Directors are fairly rewarded for their individual contribution to the organisation, having proper regard to the organisation's circumstances and performance and to the provisions of any national agreements where appropriate.

5.2 To monitor and evaluate the performance and development of the Chief Executive and all Executive Directors.

5.3 To advise on and oversee appropriate contractual arrangements for the Chief Executive and all Executive Directors including:

5.3.1 The proper calculation and scrutiny of termination payments in the light of appropriate guidance as is appropriate.

5.3.2 All aspects of salary.

5.3.3 Provisions for other benefits, including removal expenses, pensions and lease cars.

5.4 To advise the Board of Directors on pay policy and other contractual matters for the Chief Executive and all Executive Directors.

6. Duties

The duties of the Committee shall be to determine, on behalf of the Board of Directors, the following:

Pay & Conditions

6.1 The pay and conditions of the Chief Executive and Executive Directors.

6.2 Individual Directors performance against objectives.

6.3 Termination packages, including overseeing appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments; taking account of such national guidance as is appropriate.

6.4 To seek advice from whatever source it deems to be appropriate.

7. Policy Determination and Good Practice

In undertaking its duties and functions, the Committee shall give proper regard to the following matters:

7.1 Adopting policies on:

7.1.1 Pay.

7.1.2 The position of salaries in the market place.

7.1.3 Remuneration packages to enable people of appropriately high ability to be recruited, retained and motivated, within levels of affordability.

7.2 Internal and external information to be made available on:

7.2.1 The performance of the Chief Executive and other Directors.

7.2.2 Trends in pay and conditions elsewhere.

7.2.3 The levels of remuneration offered by similar organisations.

7.2.4 Consideration of the environment in which the organisation is operating with regard to such factors as:

- The local labour market.
- The competitiveness of the market place in which the organisation operates.
- The effectiveness of various human resource policies and practices.
- Sources of external information, provided by external agencies such as CAPITA, NHS Providers or Incomes Data Services.

8. Reporting

- 8.1 The Chairman will make reference to Remuneration Committee meetings at the Board of Directors' meeting.
- 8.2 The minutes of the Committee meetings shall be recorded and only discussed within the confidential Board of Directors' meeting agenda, and submitted to members of the Committee, given the confidential nature of the business transacted.

9. Review Date

- 9.1 The terms of reference of the Committee will be reviewed annually for approval by the Board of Directors.

April 2016

Report to the Trust Board of Directors: 29 June 2016	Paper No: 6.2a
Title	Quality Committee Terms of Reference
Sponsoring Director	Mrs Lesley Webster, Non-Executive Director/ Quality Committee Chair
Author(s)	Mrs Lesley Webster, Non-Executive Director/ Quality Committee Chair Dr Sylvia Wood, Deputy Director of Governance
Report Purpose	To conduct the annual review of the Quality Committee Terms of Reference
Key Issues for Board Focus: The Quality Committee is required to undertake an annual review of its Terms of Reference to ensure that it is conducting its business appropriately and in accordance with them. An annual review also ensures that the Committee remains up to date with the current best practice and reflects the changing needs of the Trust.	

Related Trust Objectives	
1. To deliver high quality care	Yes. Provision of robust governance processes and oversight to support the Board in fulfilling its role to provide leadership, and ensure the achievement of the overall Trust's strategic objectives.
2. To work with partners to deliver integrated care	
3. To ensure clinical and financial sustainability	

Risk and Assurance	The Terms of Reference provide assurance that the Committee has clarity on its role and delegated responsibilities.
Legal implications/ Regulatory Requirements	This review complies with the requirement to examine the Terms of Reference on an annual basis.

Action Required by the Board of Directors The Board of Directors are asked to review and approve the Quality Committee Terms of Reference.

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Terms of Reference

Quality Committee

1. Accountable to Board of Directors

The Quality Committee is a committee of the Board of Directors. As such it will, on behalf of the board contribute to setting strategy as this relates to quality; oversee arrangements for quality governance and seek assurances on the delivery of high quality care and regulatory compliance.

2. Purpose of the Committee

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

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

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

3. Responsibilities

The key responsibilities of the group are to:

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

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

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

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

4. Membership

The core membership comprises:

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

Clinical Director Children's and County Wide Community Care directorate	Operational Director Children's and County Wide Community Care directorate	
Clinical Director Long Term and Unscheduled Care directorate	Deputy Clinical Director Long Term and Unscheduled Care directorate	
Clinical Director Planned and Surgical Care directorate	Deputy Clinical Director Planned and Surgical Care directorate	

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

5. Quorum

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

6. Administrative support

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

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

7. Frequency of meetings

The meeting will be timetabled to take place monthly.

8. Communication

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

9. Reporting

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

10. Review

The terms of reference will be reviewed annually.

11. Date

01 June 2016

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Report to the Trust Board of Directors: 29 June 2016	Paper No: 7.0
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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:		
<ul style="list-style-type: none">• The Trust has achieved a year to date surplus of £115k which is approx. £500k adverse of plan. The adverse position is driven by a combination of income and CIP shortfalls.• Compliance with the nationally mandated agency cap is positively impacting on pay costs but negatively impacting on theatre utilisation rates and waiting times. Inconsistent compliance with the agency cap by other providers is undermining whole system benefits.• Contracts for 2016/17 remain unsigned. An implied contract prevails and services continue to be delivered and funded.• Good progress is being made in developing a West Yorks STP plan and creating the governance and leadership required to support this.• Transformation funding for the Harrogate Vanguard has been confirmed, with some caveats.		
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		
<ul style="list-style-type: none">• 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

Agreement on contracts has yet to be reached. Commissioners have communicated indicative values for service lines within the community services contract in line with the agreed financial envelope. A draft specification for a new model of community nursing has been developed. Detailed Quality Impact Assessments are now being undertaken as required under the terms of the Memorandum of Understanding. A verbal update will be given at the meeting.

1.2 NHS Improvement Quarter 4 2015/16 Feedback

Following submission of the quarterly return, the Trust has been assigned a 'Green' governance rating. NHS Improvement has noted the Trusts failure to meet the A&E target while recognising that this had been by a very small margin. In line with the expectations of NHS Improvement, the Trust will continue to address the underlying issues which led to the failure to deliver the target, and further information on this will be provided via a verbal update from the Clinical Director of Long Term and Unscheduled Care Directorate at the meeting.

2.0 STRATEGIC UPDATE

2.1 West Yorkshire Sustainability and Transformation Plan (WYSTP)

A comprehensive programme of work on developing the West Yorkshire STP is now underway and a collaborative West Yorkshire STP will be submitted as required by 30 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.

Leadership and governance arrangements are largely agreed, subject to final sign off by system leaders on 5 July. A paper should be available for the July meeting of the Board of Directors in this respect.

Key points to note:

- There will be an overarching WYSTP Leadership Team with CEO or equivalent leadership representation from each partner organisation. This team will be at the centre of planning and delivering the WYSTP, providing strategic leadership, decision making and oversight on delivery and risk management.
- The 11 participating West Yorks CCGs have set up a formal Joint Committee, the Healthy Futures Collaborative. There is an agreed MoU which allows collaborative decision making on commissioning.
- Work on the financial analysis for the WYSTP continues. A risk management framework for financial planning and investment of transformation funding has been identified as a critical success factor. A very detailed template for reporting to NHS Improvement and NHS England has been received.
- There is also a Clinical Forum and a Finance and Business Intelligence Group.
- Sub groups have been established for each of the clinical priority areas and enablers. I have agreed to be the STP lead for workforce and will chair the West Yorks Local Workforce Advisory Board with Mike Curtis, HEE Local Director as co-chair.

Messaging from the centre, candid in the light of the referendum purdah, suggests that NHS finances will be subject to yet more challenge from Quarter 2 onwards and STP areas are braced for some stringent targets.

2.2 Care Quality Commission (CQC) Report

Following the Trust's formal CQC inspection carried out in February 2016 a draft report was anticipated during week commencing 13 June. Further requests for information have been received but at the time of writing the draft report remains unavailable. A Quality Summit to review the draft report has been arranged to take place on Friday 29 July 2016, and a further update will be provided to the Board in due course.

3.0 NATIONAL COMMUNICATIONS RECEIVED AND ACTED UPON

3.1 CQC Strategy – Shaping the Future

On 24 May 2016, the CQC have published 'Shaping the Future', its strategy for 2016 – 2021. The document summarises the main changes the CQC will be making over the next five years as follows:

- More resources will be put into assessing services with poor ratings or where the rating is likely to change, and less where care quality is good and likely to remain so;
- Better monitoring of changes in quality by bringing together the views of people who use services, knowledge from inspections, and data from partners;
- More unannounced inspections focused on areas where risk is greatest or quality is improving – with ratings updated where changes are found;
- A more robust approach for higher-risk registrations and a streamlined approach for low-risk applications;
- A greater focus on the quality of care for specific population groups, and coordination across organisations;
- A flexible approach to registering and inspecting new care models to encourage innovation;
- A shared data set with partners, other regulators, and commissioners, to reduce duplicative information requests;
- Online processes as the default so interactions between the CQC, Providers and the public are easy and efficient; and
- New ratings of how well NHS Trusts and Foundation Trusts are using their resources to deliver high quality care.

A copy of the full strategy document, and the NHS Providers 'On the Day Briefing' can be found in the Reading Room.

3.2 Consultation on the CQC's NHS Patient Survey Programme

On 26 May 2016, the CQC have launched a consultation on proposed changes to the NHS Patient Survey Programme, to ensure maximum impact and value for those who use the results across the health and social care system. The CQC have reviewed the current frequency and content of the survey programme, and considered how they can improve the way data is presented to make it more useful. The consultation will close on 21 July 2016 and the Trust's Clinical Effectiveness and NICE Manager will be coordinating a response on behalf of the Trust.

4.0 WORKING IN PARTNERSHIP

4.1 Harrogate Clinical Board

The Elective Care Rapid Testing Programme was launched on 16 June with excellent engagement from HDFT clinicians. The overriding aim is to transform the way care is provided for specific groups of patients in ways that increase patient choice, further improve quality and reduce demand in secondary care. The three specialty areas in scope (gastroenterology, orthopedics and dermatology) are now represented by 100-day working groups comprising HDFT, CCG and Primary care colleagues.

4.2 Harrogate Health Transformation Board (HHTB)

The next meeting of the Harrogate Health Transformation Board is on 23 June. A verbal update will be provided to the Board of Directors.

A letter received from Ian Dodge, National Director for Commissioning Strategy dated 6 June confirms the funding allocation to the Harrogate Vanguard for 2016/17 and the associated expectations and conditions of New Care Models team in respect of delivery.

NHS England is allocating transformation funding of £1.55m to the vanguard, with a further £0.15m to support work on evaluation.

- funding is conditional on agreement and delivery of control totals by Trusts associated with the PACs scheme. Funding may be reviewed based on in-year delivery of relevant control totals and the associated performance conditions.
- NHS England expects to see demonstrable systematic progress in implementing the changes on which the Vanguard was designed.
- Vanguards need to visibly demonstrate value in moderating demand and improving efficiency.
- NHS England will start to share monthly comparative performance data on core metrics such as non-elective demand.
- NHS England has identified four specific areas where progress and support are required:
 - Technology
 - GP access
 - Urgent and Emergency care reform
 - Mental health

The HHTB will be discussing the actions required to be confident of delivery, including caveats in respect of control totals and the impact of reductions in community services funding and SRG investment.

The Key Messages from the 23 June meeting will be placed in the Boardpad Reading Room in due course.

5.0 FINANCIAL POSITION

The Trust reported a surplus of £277k in May, £80k behind plan. This translates to a year to date position of £115k surplus. The year to date variance is now just over £500k behind plan. This includes a prudent assumption that c£250k of the Sustainability and Transformation funding will not be received based upon our financial performance to date.

Activity, and therefore income, is behind plan, (and this is being impacted upon by the agency cap), as is delivery against our Cost Improvement Programme. We are underspent against our pay budgets (the benefit of the agency cap), although ward staffing remains a pressure within that. The Financial Sustainability Risk Rating (FSRR) remains at 3.

Further detail in relation to the finance position and the impact upon our NHS Improvement risk rating is contained within the Integrated Board Report and the report from the Finance Director.

6.0 SENIOR MANAGEMENT TEAM (SMT) MEETING

The SMT met on 22 June. Key issues discussed and for noting by the Board of Directors are as follows:

- There have been 8 cases of C. Difficile year to date, lapses in care have been found in two of the 5 Root Cause Analysis (RCAs) completed. There is no evidence of patient to patient transmission. In 2015/16 there had been 3 cases for the same period.
- The downward trend in numbers of complaints continues (16 in May 2016, 19 in May 2015), and timeliness of responses and completion of action has also improved.
- The need to retain grip on finances and Cost Improvement Programme (CIP) delivery was discussed in detail. Adverse variance in income relates to lost income during recent Industrial Action and the impact of the agency cap. Some elective lists are being cancelled due to non-availability of staff. The Trust continues to meet 18 week Referral to Treatment Time (RTT) requirements.
- Inconsistent compliance with the terms of the agency cap across the wider system is compromising the overall opportunity to achieve pay cost savings. This matter will be discussed by acute CEOs.
- CIP planning has improved but the risk adjusted plan remains short at 785. Directorates have been asked to close this gap with particular focus on the opportunities identified through clinical transformation. Plans for 2017/18 are also being developed.
- There will be an inspection of the North Yorkshire SEND (special educational needs and disability) services commencing Monday 27 June. This is a joint inspection between the Care Quality Commission and Ofsted and will involve some of HDFT's services in the community. The services to be inspected are 0-19 (up to 25) Universal Children's Services, Specialist Children's Services and Paediatrics for all children with special educational needs and/or disability.
- Dr Matt Shepherd, Clinical Lead for the Emergency Department (ED) presented a paper on the clinical sustainability of the ED setting out short and longer term recommendations for redesign.
- The impact of commissioning decisions on community service capacity, caveats on Vanguard funding streams and emerging views on STPs were discussed.
- A verbal update on New Care Models was received. Timing of the roll out of the additional Locality Integrated Teams has slipped in to the autumn due to the extensive time commitments in respect of changes to the community services contract.
- The Trust is supporting the CCG in developing a Digital Roadmap due for submission by 30 June.

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

7.0 BOARD ASSURANCE AND CORPORATE RISK

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

is lodged in the 'Reading Room' and provides full detail on the key controls, gaps in assurance, and progress on actions being taken.

7.1 Board Assurance Framework (BAF)

The Board Assurance Framework was reviewed by the Executive Directors on 21 June 2016. No risks were removed, and all risks have comprehensive 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. Some action plan progress scores have improved during the period, a summary of which can be found in the table below. 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 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 May. The Board of Directors are considering the inclusion of a new risk on the BAF relating to the national approach to planning through Sustainability and Transformation Plans. An exercise will be undertaken to examine the content of the full BAF at the Board Strategy Away Day in July to ensure that the BAF continues to reflect the Trust's principal risks.

The Board will examine BAF 6 in detail at the Board Development session in June 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 in 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*

7.2 Corporate Risk Register (CRR)

The CRR was reviewed at the monthly meeting of the Corporate Risk Review Group on 10 June 2016. The Corporate Risk Register contains eight risks following the escalation of three directorate level risks as follows:

- CR9: Risk to the sustainability of service delivery and acute rotas due to withdrawal of trainees in Medicine by GMC/Health Education England Yorkshire and Humber. Escalation had been due to a failure to adhere to the conditions set following the annual quality management visit and subsequent triggered visit, resulting in a risk score of Red 16.
- CR10: Risk to patient experience and performance due to limited availability of anaesthetists therefore elective patients being cancelled, resulting in a risk score of Red 12.
- CR11: Financial and regulatory risk due to non-compliance with agency cap rules as issued by NHS Improvement, resulting in a risk score of Red 12.

The current risk scores for CR7 and CR9 remain the top scoring risks at Red 16:

- CR7 – Risk of failure to meet the 4-hour national standard in the Emergency Department, due to recruitment and retention of middle grade doctors in Emergency Medicine.
- CR9: Risk to the sustainability of service delivery and acute rotas due to withdrawal of trainees in Medicine.

Risks CR9 and CR10 have reported actions behind plan with the progress score of 3

Dr Ros Tolcher
Chief Executive
22 June 2016

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Report to the Trust Board of Directors: 29 th June 2016	Paper No: 8.0
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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:

- This month's Safety Thermometer survey reported 97.4% of patients were harm free.
- Performance against the A&E 4 hour standard improved and was above the required 95% level in May.
- There were 6 hospital acquired cases of C.diff reported in the year to date (to end May). Root cause analyses on these 6 cases have not yet been completed.
- The agency bill for May was 3.4% of Trust pay expenditure. Detailed work is ongoing with Clinical Directorates to reduce total agency spend and ensure compliance with the agency cap.
- Delivery of 18 weeks performance was achieved for all specialties in May.

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.

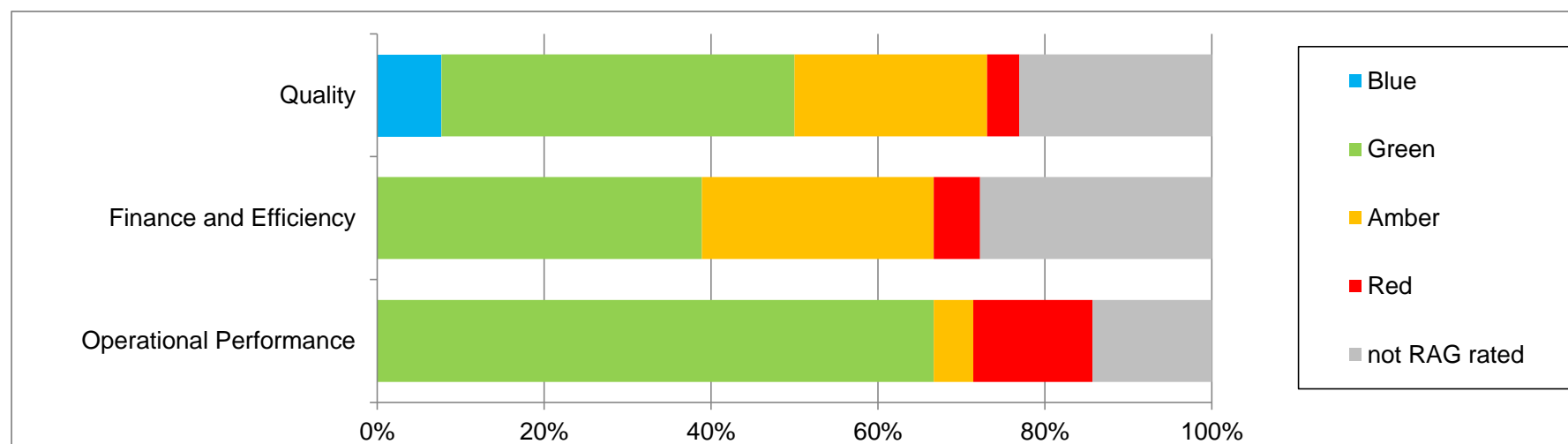
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Integrated board report - May 2016

Key points this month

1. This month's Safety Thermometer survey reported 97.4% of patients were harm free.
2. Performance against the A&E 4 hour standard improved and was above the required 95% level in May.
3. There were 6 hospital acquired cases of C.diff reported in the year to date (to end May). Root cause analyses on these 6 cases have not yet been completed.
4. The agency bill for May was 3.4% of Trust pay expenditure. Detailed work is ongoing with Clinical Directorates to reduce total agency spend and ensure compliance with the agency cap.
5. Delivery of 18 weeks performance was achieved for all specialties in May.

Summary of indicators



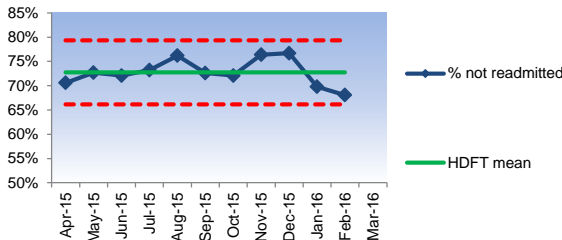

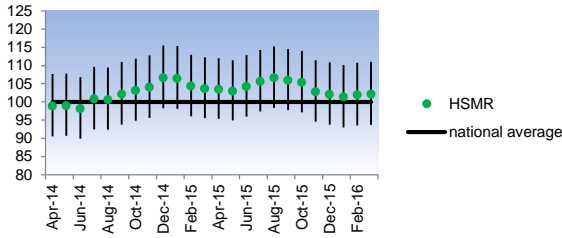

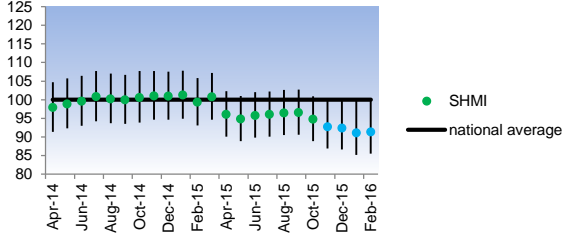

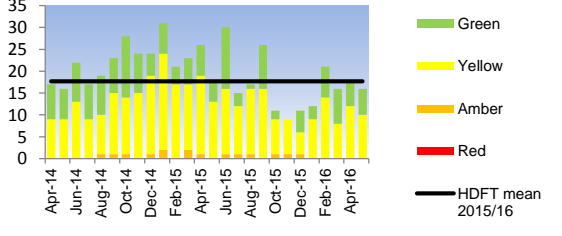

Quality - May 2016

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 May was 97.4%, an increase on the previous month, above the 95% standard and well above the latest national average of 93.9%.	✓
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 were 7 hospital acquired grade 3 or grade 4 pressure ulcers reported in May, bringing the year to date total to 10. Of the 10 cases, 1 was deemed to be avoidable, 2 unavoidable and 7 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 for the number of grade 2-4 hospital acquired pressure ulcers is being agreed at the Quality Committee this month.	✓
	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 10. This compares to 6 in the same period last year. It should be noted that an increase in the numbers reported may be indicative of improved incident reporting.	
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 5 community acquired grade 3 or grade 4 pressure ulcers reported in May, bringing the year to date total to 11. All 11 cases are still under root cause analysis (RCA). A maximum trajectory for the number of grade 2-4 community acquired pressure ulcers is being agreed at the Quality Committee this month.	✓

Quality - May 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.	<p>Rate of inpatient falls - per 1,000 bed days</p> <p>HDFT mean</p>	<p>The rate of inpatient falls was 5.1 per 1,000 bed days in May, no change on the previous month and remaining significantly below the average HDFT rate during 2015/16.</p> <p>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.</p>	✓
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.	<p>Rate of inpatient falls causing harm - per 1,000 bed days</p> <p>HDFT mean</p>	<p>The rate of inpatient falls causing moderate harm, severe harm or death was 0.1 per 1,000 bed days in May, an increase from zero last month but remaining below the average HDFT rate for 2015/16.</p> <p>There were 20 inpatient falls causing moderate or severe harm in 2015/16, of which 16 resulted in a fracture. This compares to 36 moderate or severe harm falls in 2014/15, representing a 45% reduction.</p>	✓
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.	<p>under RCA</p> <p>not due to lapse in care</p> <p>due to lapse in care</p> <p>maximum threshold for lapses in care cases</p>	<p>There were 3 cases of hospital acquired C. difficile reported in May, bringing the year to date total to 6 cases. These cases are still under root cause analysis (RCA).</p> <p>No cases of hospital acquired MRSA have been reported in 2016/17 to date.</p>	✓
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.	<p>No. avoidable admissions</p> <p>HDFT mean</p>	<p>There were 218 avoidable admissions in April, a significant decrease on recent months.</p> <p>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.</p>	✓

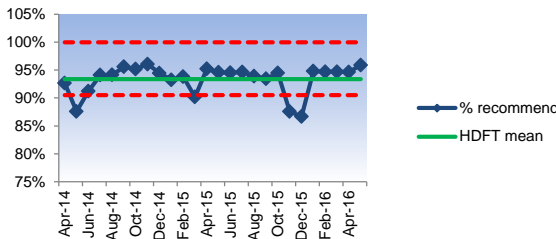
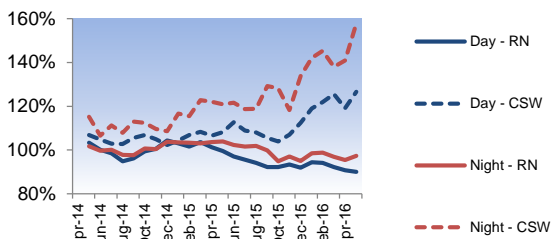
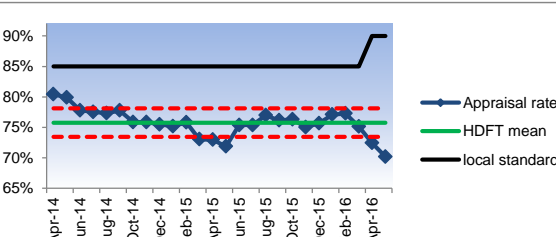
Quality - May 2016

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. <i>This indicator is in development.</i>		For patients discharged in February, 68% were still in their own home at the end of May, a decrease on the previous month. This is also the focus of the New Care Models work and one of the metrics being used to evaluate this pilot.	
Mortality - HSMR	The Hospital Standardised Mortality Ratio (HSMR) looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care. A low figure is good.		HDFT's HSMR 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.		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 Medicine 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.		16 complaints were received in May (none of which were classified as amber or red) compared to 18 last month. The recent introduction of matrons at the weekends and on evening shifts is believed to be continuing to contribute to a reduction in the number of complaints received overall.	

Quality - May 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Incidents - all	<p>The chart shows the number of incidents reported within the Trust each month. It includes all categories of incidents, including those that were categorised as "no harm". The data includes hospital and community services.</p> <p>A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture</p>		<p>There were 431 incidents reported in May. 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.</p> <p>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.</p>	✓
Incidents - SIRIs and never events	<p>The chart shows the number of Serious Incidents Requiring Investigation (SIRIs) and Never Events reported within the Trust each month. The data includes hospital and community services.</p> <p>We have changed this indicator to now include both comprehensive and concise SIRIs and have amended the presentation to show a cumulative position.</p>		<p>There were no never events reported in May. There have been 22 concise SIRIs and 2 comprehensive SIRIs reported in the year to date. In 2015/16, HDFT reported an average of 9.6 SIRIs per month.</p>	✓
Friends & Family Test (FFT) - Staff - % recommend as a place to work	<p>The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organisation they work in.</p> <p>The chart shows the percentage of staff that would recommend the Trust as a place to work. A high percentage is good. The Trust's aim is to feature in the top 20% of Trusts nationally.</p>		<p>In Q4 2015/16, staff from Integrated Care Directorate and some staff from Corporate Directorate were surveyed. 74% of HDFT staff recommended the Trust as a place to work - this compares to the national average of 62%.</p> <p>The verbatim narrative received with the survey results is shared with the relevant directorates to identify trends in the data, in turn influencing the national staff survey action plan.</p>	✓
Friends & Family Test (FFT) - Staff - % recommend as a place to receive care	<p>The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organisation they work in.</p> <p>The chart shows the percentage of staff that would recommend the Trust as a place to receive care. A high percentage is good. The Trust's aim is to feature in the top 20% of Trusts nationally.</p>		<p>In Q4 2015/16, staff from Integrated Care Directorate and some staff from Corporate Directorate were surveyed. 87% of HDFT staff recommended the Trust as a place to receive care - this compares to the national average of 79%.</p>	✓

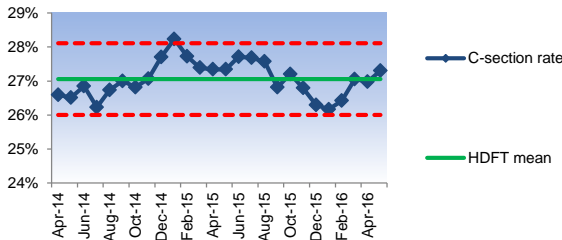
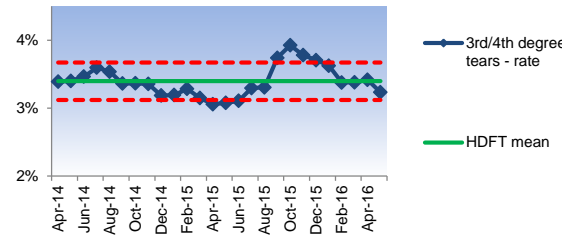
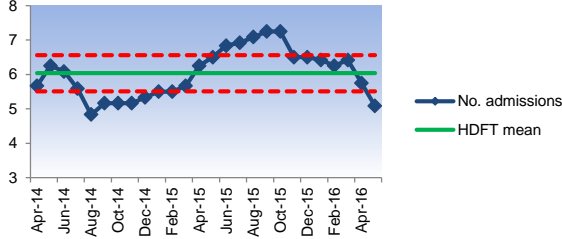
Quality - May 2016

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 May (3,100 compared to 5,700 in April). However, 95.9% of patients surveyed would recommend our services, an increase on last month. The latest published national average is 93.0%.	<div>✓</div>																											
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 107%, compared to 103% 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.	<div>✓</div>																											
Staff appraisal rates	<p>The chart shows the staff appraisal rate over the most recent rolling 12 months. The Trusts aims to have 90% of staff appraised. A high percentage is good.</p> <p>The figures from May 2016 now exclude employees currently on maternity leave, career break or suspension.</p>		<p>The locally reported cumulative appraisal rate for the 12 months to end May 2016 was 70.2%, a decrease of 2.3 percentage points on last month. In order to ensure there is accountability in the appraisal process, an amendment to the Trust's Pay Progression Policy is currently being proposed for implementation from July. Managers will not be able to proceed on the pay scale unless all staff in their area have had an appraisal in the last 12 months.</p> <p>Directorates have highlighted that capacity for appraisal completion is a particular problem and confirmed the new appraisal system is easy to use and a significant improvement on the previous appraisal system. Training for appraisers will continue to be offered including how to conduct team based appraisals.</p>	<div>✓</div>																											
Mandatory training rates	The table shows the most recent training rates for all mandatory elements for substantive staff. A high percentage is good.	<table><tr><th>Competence Name</th><th>Total Employees</th><th>% Completed</th></tr><tr><td>Equality, Diversity and Human Rights - Level 1</td><td>3572</td><td>95</td></tr><tr><td>Fire Safety Awareness</td><td>3572</td><td>92</td></tr><tr><td>Infection Prevention & Control 1</td><td>687</td><td>100</td></tr><tr><td>Infection Prevention & Control 2</td><td>2835</td><td>87</td></tr><tr><td>Information Governance: Introduction</td><td>3293</td><td>91</td></tr><tr><td>Information Governance: The Beginners Guide</td><td>270</td><td>88</td></tr><tr><td>Prevent Basic Awareness (December 2015)</td><td>3572</td><td>100</td></tr><tr><td>Safeguarding Children & Young People Level 1</td><td>3572</td><td>95</td></tr></table>	Competence Name	Total Employees	% Completed	Equality, Diversity and Human Rights - Level 1	3572	95	Fire Safety Awareness	3572	92	Infection Prevention & Control 1	687	100	Infection Prevention & Control 2	2835	87	Information Governance: Introduction	3293	91	Information Governance: The Beginners Guide	270	88	Prevent Basic Awareness (December 2015)	3572	100	Safeguarding Children & Young People Level 1	3572	95	<p>The data shown is for end May. The overall training rate for mandatory elements for substantive staff is 93.7%, compared to 94.5% last month.</p> <p>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.</p>	<div>✓</div>
Competence Name	Total Employees	% Completed																													
Equality, Diversity and Human Rights - Level 1	3572	95																													
Fire Safety Awareness	3572	92																													
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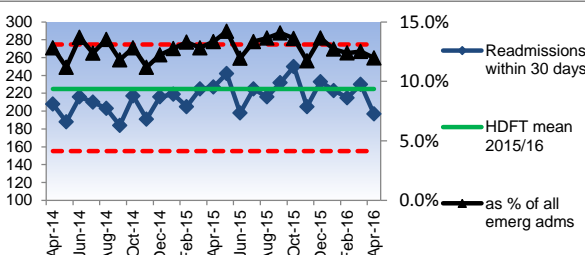
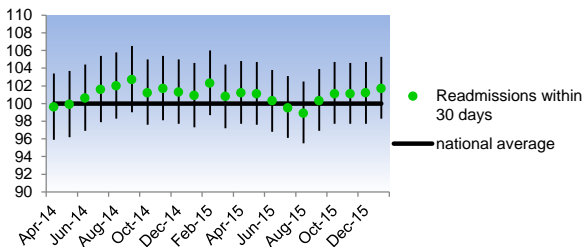
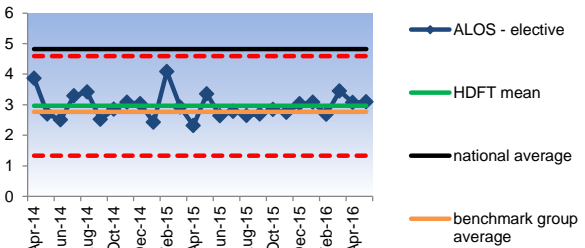
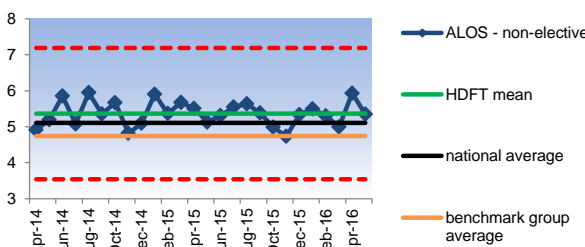
Quality - May 2016

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 has seen an increase in April to 4.37%. There have been discussions at ODG this month with an aim to targeting Care Support Workers and nurses to attend Health and Wellbeing assessments. Workforce development are currently working with Heads of Nursing to establish sessions in ward based settings. The number of sickness cases being progressed to Stage 3 is increasing, therefore cases with significant absence issues will be shortly concluding with a view to dismiss.	✓
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. <i>The traffic light criteria applied to this indicator is currently under review.</i>		The proportion of spend on temporary staff during April was 8.4%, compared to 7.6% during 2015/16. The significant increase in expenditure for contracted staff in April was 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.		Turnover rates are remaining fairly static with the Trust rate for the rolling 12 months to April 2016 being 12.58%, which is a slight increase from 12.53% seen last month. There have been concerns raised from the Trade Unions through Partnership Forum regarding the labour turnover of Health Visitors. These concerns will be monitored to see if there are any issues within the Trust.	✓
Research internal monitoring	The Trust internally monitors research studies active within the Trust. The department mirrors the MHRA categorisation of critical, major and other findings (departures from legislative or GCP requirements). The department has set a standard of no critical and no more than four major findings per annum. Major and other findings are non-notifiable and dealt with locally.		There were no critical or major findings reported in 2015/16.	✓

Quality - May 2016

Indicator	Description	Trend chart	Interpretation	Data quality
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 May 2016 was 27.1% of deliveries, a slight increase 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.	✓
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 May 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 6 term admissions to SCBU in May, compared to 4 in April. The average number per month over the last 12 months is 5.	✓

Finance and Efficiency - May 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 decreased in April, both actual numbers and as a percentage of all emergency admissions. An audit of readmissions of Leeds patients was recently carried out. 59 readmissions were reviewed in conjunction with Leeds CCGs - of which only 4 were deemed to be avoidable, with a further 6 potentially avoidable.	✓
Readmissions - standardised	This indicator looks at the standardised readmission rate within 30 days. The data is standardised against various criteria including age, sex, diagnosis, comorbidities etc. The standardisation enables a more like for like comparison with other organisations. The national average is set at 100. A low rate is good - rates below 100 indicate a lower than expected readmission rate and rates above 100 indicate higher than expected readmission rate.		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 May was 3.1 days, no change 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 May was 5.3 days, a decrease on the previous month.	✓

Finance and Efficiency - May 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 demographic 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 increased to 86.8% in May. However the number of cancelled sessions has increased since the beginning of April due to the implementation of the Agency Cap. The impact has been felt across all theatre teams. There has been considerable "back filling" from within the department with staff working extremely flexibly to fill gaps, but there has still been cancellation of elective sessions. In anaesthetics, there is also a combination of under recruitment and maternity leave with an inability to find suitable short term locums for these consultant positions. A high level of orthopaedic trauma cases has also been seen and this has resulted in the need to convert some orthopaedic elective sessions to non-elective trauma lists.	⚠
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 increased to 3.3% when the snapshot was taken in May, but remains 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.		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 - May 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.	<p>Ratio HDFT mean national average benchmark group average</p>	<p>Actions with HARD CCG continue and are on plan.</p> <p>HDFT's new to follow up ratio decreased slightly in March - it is below the benchmark group average and the national average.</p>	✓
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.	<p>Day case rate HDFT mean</p>	<p>The Day Surgery Transformation group continues their work and are on plan.</p>	✓
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.	<p>Plan (cum) Actual (cum)</p>	<p>The Trust reported a surplus of £277k in May, £80k behind plan. This resulted in an improved year to date position of £115k surplus. There is still an adverse year to date variance to plan which increased to £514k, £256k relating to the sustainability and transformation fund.</p>	✓
Cash balance	Monthly cash balance (£'000s)	<p>Plan Actual</p>	<p>The Trust was £1,783k behind plan for cash in May with a balance of £8,891k.</p>	✓

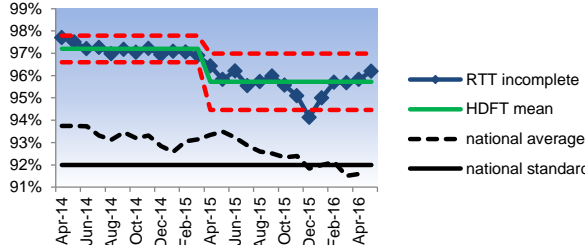
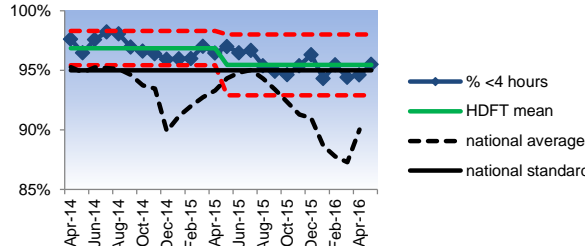
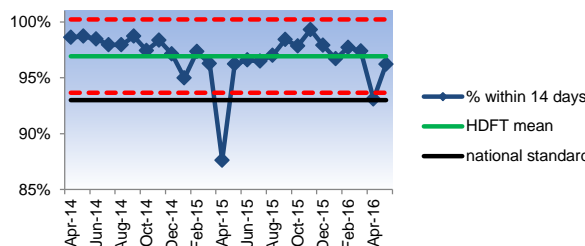
Finance and Efficiency - May 2016

Indicator	Description	Trend chart	Interpretation	Data quality																																																																	
Monitor continuity of services risk rating	The Monitor Continuity of Services (CoS) risk rating now includes four components, as illustrated in the table to the right. An overall rating is calculated ranging from 4 (no concerns) to 1 (significant concerns). This indicator monitors our position against plan.	<table><thead><tr><th>Element</th><th>Plan</th><th>Actual</th></tr></thead><tbody><tr><td>Capital Service Capacity rating</td><td>4</td><td>3</td></tr><tr><td>Liquidity rating</td><td>4</td><td>3</td></tr><tr><td>I&E Margin rating</td><td>4</td><td>3</td></tr><tr><td>I&E Margin Variance rating</td><td>3</td><td>2</td></tr><tr><td>Financial Sustainability Risk Rating</td><td>4</td><td>3</td></tr></tbody></table>	Element	Plan	Actual	Capital Service Capacity rating	4	3	Liquidity rating	4	3	I&E Margin rating	4	3	I&E Margin Variance rating	3	2	Financial Sustainability Risk Rating	4	3	The Trust will report a risk rating of 3 for May.	<div>✓</div>																																															
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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.	<table><thead><tr><th>Month</th><th>Actual</th><th>Identified</th><th>Risk adjusted identified</th><th>Target</th></tr></thead><tbody><tr><td>Apr-16</td><td>5,000</td><td>9,000</td><td>7,000</td><td>9,500</td></tr><tr><td>May-16</td><td>5,000</td><td>9,000</td><td>7,000</td><td>9,500</td></tr><tr><td>Jun-16</td><td>5,000</td><td>9,000</td><td>7,000</td><td>9,500</td></tr><tr><td>Jul-16</td><td>5,000</td><td>9,000</td><td>7,000</td><td>9,500</td></tr><tr><td>Aug-16</td><td>5,000</td><td>9,000</td><td>7,000</td><td>9,500</td></tr><tr><td>Sep-16</td><td>5,000</td><td>9,000</td><td>7,000</td><td>9,500</td></tr><tr><td>Oct-16</td><td>5,000</td><td>9,000</td><td>7,000</td><td>9,500</td></tr><tr><td>Nov-16</td><td>5,000</td><td>9,000</td><td>7,000</td><td>9,500</td></tr><tr><td>Dec-16</td><td>5,000</td><td>9,000</td><td>7,000</td><td>9,500</td></tr><tr><td>Jan-17</td><td>5,000</td><td>9,000</td><td>7,000</td><td>9,500</td></tr><tr><td>Feb-17</td><td>5,000</td><td>9,000</td><td>7,000</td><td>9,500</td></tr><tr><td>Mar-17</td><td>5,000</td><td>9,000</td><td>7,000</td><td>9,500</td></tr></tbody></table>	Month	Actual	Identified	Risk adjusted identified	Target	Apr-16	5,000	9,000	7,000	9,500	May-16	5,000	9,000	7,000	9,500	Jun-16	5,000	9,000	7,000	9,500	Jul-16	5,000	9,000	7,000	9,500	Aug-16	5,000	9,000	7,000	9,500	Sep-16	5,000	9,000	7,000	9,500	Oct-16	5,000	9,000	7,000	9,500	Nov-16	5,000	9,000	7,000	9,500	Dec-16	5,000	9,000	7,000	9,500	Jan-17	5,000	9,000	7,000	9,500	Feb-17	5,000	9,000	7,000	9,500	Mar-17	5,000	9,000	7,000	9,500	61% of the full year CIP target was actioned to date. The risk adjusted total is a concern as only 79% of the target would be achieved.	<div>✓</div>
Month	Actual	Identified	Risk adjusted identified	Target																																																																	
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Capital spend	Cumulative Capital Expenditure by month (£'000s)	<table><thead><tr><th>Month</th><th>Actual - cum - 2015/16</th><th>Actual - cum - 2016/17</th><th>Plan - cum - 2016/17</th></tr></thead><tbody><tr><td>Apr</td><td>1,000</td><td>1,000</td><td>1,000</td></tr><tr><td>May</td><td>1,500</td><td>1,500</td><td>1,500</td></tr><tr><td>Jun</td><td>2,000</td><td>2,000</td><td>2,000</td></tr><tr><td>Jul</td><td>2,500</td><td>2,500</td><td>2,500</td></tr><tr><td>Aug</td><td>3,000</td><td>3,000</td><td>3,000</td></tr><tr><td>Sep</td><td>3,500</td><td>3,500</td><td>3,500</td></tr><tr><td>Oct</td><td>4,000</td><td>4,000</td><td>4,000</td></tr><tr><td>Nov</td><td>4,500</td><td>4,500</td><td>4,500</td></tr><tr><td>Dec</td><td>5,000</td><td>5,000</td><td>5,000</td></tr><tr><td>Jan</td><td>5,500</td><td>5,500</td><td>5,500</td></tr><tr><td>Feb</td><td>6,000</td><td>6,000</td><td>6,000</td></tr><tr><td>Mar</td><td>6,500</td><td>6,500</td><td>6,500</td></tr></tbody></table>	Month	Actual - cum - 2015/16	Actual - cum - 2016/17	Plan - cum - 2016/17	Apr	1,000	1,000	1,000	May	1,500	1,500	1,500	Jun	2,000	2,000	2,000	Jul	2,500	2,500	2,500	Aug	3,000	3,000	3,000	Sep	3,500	3,500	3,500	Oct	4,000	4,000	4,000	Nov	4,500	4,500	4,500	Dec	5,000	5,000	5,000	Jan	5,500	5,500	5,500	Feb	6,000	6,000	6,000	Mar	6,500	6,500	6,500	Capital expenditure was £220k behind plan for the year to May.	<div>✓</div>													
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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.	<table><thead><tr><th>Month</th><th>Actual</th><th>Ceiling</th></tr></thead><tbody><tr><td>Apr-16</td><td>320,000</td><td>520,000</td></tr><tr><td>May-16</td><td>420,000</td><td>520,000</td></tr><tr><td>Jun-16</td><td>320,000</td><td>520,000</td></tr><tr><td>Jul-16</td><td>320,000</td><td>520,000</td></tr><tr><td>Aug-16</td><td>320,000</td><td>520,000</td></tr><tr><td>Sep-16</td><td>320,000</td><td>520,000</td></tr><tr><td>Oct-16</td><td>320,000</td><td>520,000</td></tr><tr><td>Nov-16</td><td>320,000</td><td>520,000</td></tr><tr><td>Dec-16</td><td>320,000</td><td>520,000</td></tr><tr><td>Jan-17</td><td>320,000</td><td>520,000</td></tr><tr><td>Feb-17</td><td>320,000</td><td>520,000</td></tr><tr><td>Mar-17</td><td>320,000</td><td>520,000</td></tr></tbody></table>	Month	Actual	Ceiling	Apr-16	320,000	520,000	May-16	420,000	520,000	Jun-16	320,000	520,000	Jul-16	320,000	520,000	Aug-16	320,000	520,000	Sep-16	320,000	520,000	Oct-16	320,000	520,000	Nov-16	320,000	520,000	Dec-16	320,000	520,000	Jan-17	320,000	520,000	Feb-17	320,000	520,000	Mar-17	320,000	520,000	The agency bill for May was 3.4% 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.	<div>✓</div>																										
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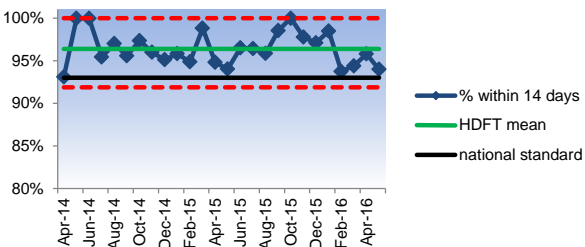
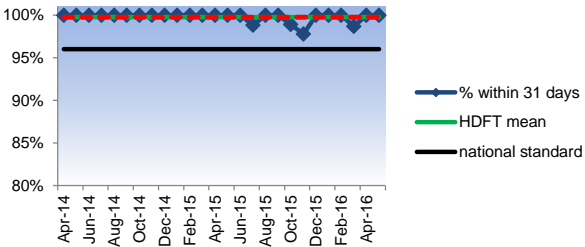
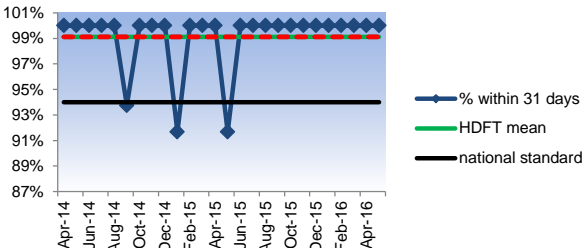
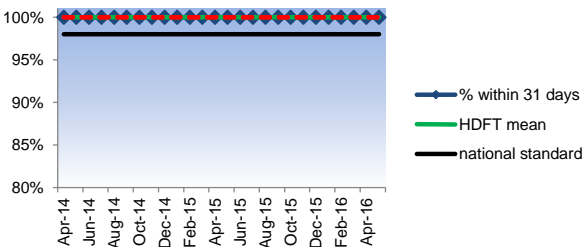
Finance and Efficiency - May 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Research - Cost per recruitment	Cost of recruitment to NIHR adopted studies. The Research department has a delivery budget of £69,212 per month. A low figure is preferable.	<p>£4,000 £3,500 £3,000 £2,500 £2,000 £1,500 £1,000 £500 £-</p> <p>Apr-16 May-16 Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17</p> <p>— Average cost 2015/16 — Cost of recruitment — Lowest in network — Highest in network</p>	The Research department has a delivery budget of £69,212 per month. The Yorkshire and Humber Clinical Research Network calculate the cost of recruitment at each NHS site. It is desired that HDFT return a cost of recruitment that is in line with previous years.	✓
Research - Invoiced research activity	Aspects of research studies are paid for by the study sponsor or funder.	<p>£300,000 £250,000 £200,000 £150,000 £100,000 £50,000 £0</p> <p>Q1 2015/16 Q2 2015/16 Q3 2015/16 Q4 2015/16</p> <p>■ Invoiced amount (cum) — Target (cum)</p>	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.	✓

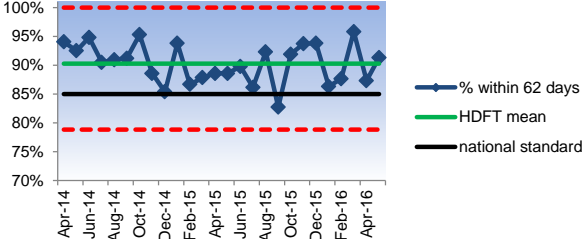
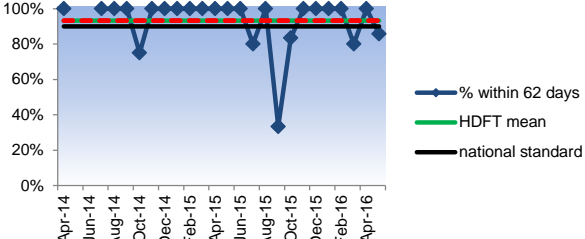
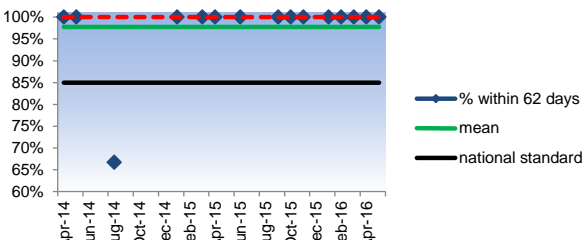
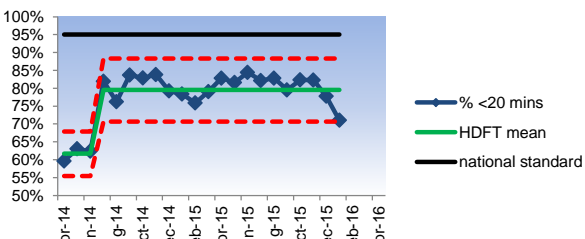
Operational Performance - May 2016

Indicator	Description	Trend chart	Interpretation	Data quality																																				
Monitor governance rating	Monitor use a variety of information to assess a Trust's governance risk rating, including CQC information, access and outcomes metrics, third party reports and quality governance metrics. The table to the left shows how the Trust is performing against the national performance standards in the "access and outcomes metrics" section of the Risk Assessment Framework.	<table><thead><tr><th>Indicator</th><th>Q1 to date score</th><th>Indicator</th><th>Q1 to date score</th></tr></thead><tbody><tr><td>18 weeks - incomplete</td><td>0.0</td><td>Cancer - 14 days</td><td>0.0</td></tr><tr><td>A&E - 4 hour standard</td><td>0.0</td><td>Cancer - 14 days - breast symptoms</td><td>0.0</td></tr><tr><td>Cancer - 62 days to treatment</td><td>0.0</td><td>C-Difficile</td><td>0.0</td></tr><tr><td>Cancer - 62 days to treatment - screening</td><td>0.0</td><td>MRSA</td><td>0.0</td></tr><tr><td>Cancer - 31 day subsequent treatment - surgery</td><td>0.0</td><td>Compliance with requirements regarding access to healthcare for patients with learning disabilities</td><td>0.0</td></tr><tr><td>Cancer - 31 day subsequent treatment - drugs</td><td>0.0</td><td>Community services data completeness - RTT information</td><td>0.0</td></tr><tr><td>Cancer - 31 day subsequent treatment - radiotherapy</td><td>N/A</td><td>Community services data completeness - Referral information</td><td>0.0</td></tr><tr><td>Cancer - 31 day first treatment</td><td>0.0</td><td>Community services data completeness - Treatment activity information</td><td>0.0</td></tr></tbody></table>	Indicator	Q1 to date score	Indicator	Q1 to date score	18 weeks - incomplete	0.0	Cancer - 14 days	0.0	A&E - 4 hour standard	0.0	Cancer - 14 days - breast symptoms	0.0	Cancer - 62 days to treatment	0.0	C-Difficile	0.0	Cancer - 62 days to treatment - screening	0.0	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	0.0	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	HDFT's governance rating for Q1 to date is Green. The Trust's performance against the A&E 4 hour standard is above 95% for Q1 to date, but sustained delivery of this standard remains challenging.	<div>✓</div>
		Indicator	Q1 to date score	Indicator	Q1 to date score																																			
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RTT Incomplete pathways performance		96.2% of patients were waiting 18 weeks or less at the end of April, above the required national standard of 92% and an increase on last month.	<div>✓</div>																																					
		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		HDFT's overall Trust level performance for May 2016 was 95.5%, above the required 95% standard. This includes data for the Emergency Department at Harrogate and Ripon MIU. Performance for Harrogate ED was 94.6%.	<div>✓</div>																																					
		The quarter to date position as at end May was 95.1%. This level of performance needs to be sustained during June if the Trust is to meet the 95% standard for the quarter overall.																																						
Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals		Provisional performance for April is 96.2%, above the 93% operational standard and an improvement on last month.	<div>✓</div>																																					

Operational Performance - May 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.	✓

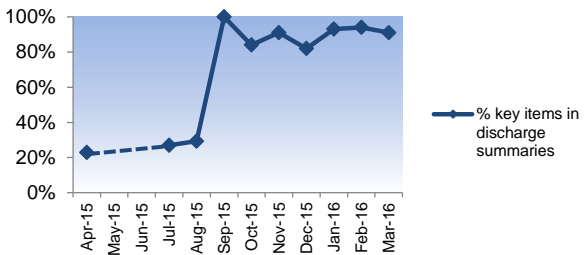
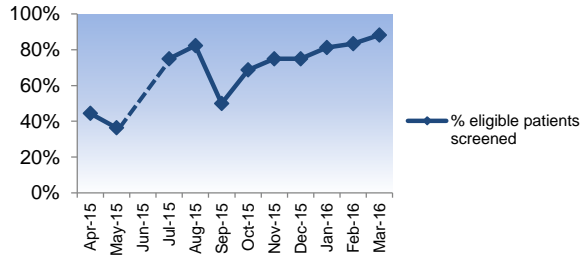
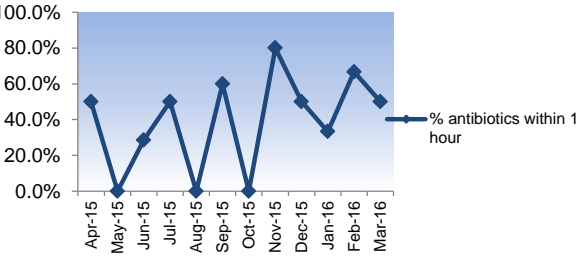
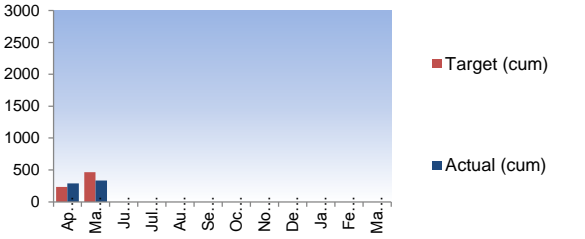
Operational Performance - May 2016

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, 2 had performance below 85% in May - colorectal (1.0 breach) and upper gastrointestinal (0.5 breach). One patient waited over 104 days for treatment in May. This was due to a complex diagnostic pathway.	✓
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 May. However the number of pathways in the quarter to date means that the Trust is currently below the small numbers threshold for reporting performance to Monitor. 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.		<i>There is no update of this data this month.</i> 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 - May 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.	
Health Visiting - new born visits	The number of babies who had a new born visit by the Health Visiting team within 14 days of birth. A high percentage is good.		In May, 82% of babies had a new born visit within 14 days of birth, an improvement on last month but remaining below the 95% standard.	
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.	
CQUIN - dementia screening	The proportion of emergency admissions aged 75 or over who are screened for dementia within 72 hours of admission (Step 1). Of those screened positive, the proportion who went on to have an assessment and onward referral as required (Step 2 and 3). The operational standard is 90% for all 3 steps. A high percentage is good.		Recurrent achievement of this standard. Ongoing monitoring. No new actions identified.	






Operational Performance - May 2016

Indicator	Description	Trend chart	Interpretation	Data quality
CQUIN - Acute Kidney Injury	Percentage of patients with Acute Kidney Injury (AKI) whose discharge summary includes four defined key items. The aim of this national CQUIN is to improve the provision of information to GPs for patients diagnosed with AKI whilst in hospital. The target for the CQUIN is to achieve at least 90% of required key items included in discharge summaries by Q4 2015/16. A high percentage is good.		There is no update of this data this month. The Trust is currently in discussions with HARD CCG to agree CQUIN indicators for 2016/17.	✓
CQUIN - sepsis screening	Percentage of patients presenting to ED/other wards/units who met the criteria of the local protocol and were screened for sepsis. A high percentage is good.		There is no update of this data this month. The Trust is currently in discussions with HARD CCG to agree CQUIN indicators for 2016/17.	✓
CQUIN - severe sepsis treatment	Percentage of patients presenting to ED/other wards/units with severe sepsis, Red Flag Sepsis or Septic Shock and who received IV antibiotics within 1 hour of presenting. A high percentage is good.		There is no update of this data this month. The Trust is currently in discussions with HARD CCG to agree CQUIN indicators for 2016/17.	✓
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 May was below plan with 286 recruited onto studies during the month. However some teams have yet to report confirmed recruitment figures for May so this position is likely to improve.	✓

Operational Performance - May 2016

Indicator	Description	Trend chart	Interpretation	Data quality
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.	<p>Legend:</p> <ul style="list-style-type: none"> Student N/A PIC Large Scale Observational Interventional Commercial 	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	Health Visiting - new born visits	Amber 	Historical data for this indicator may be incomplete. Caution should therefore be exercised when reviewing the time series and any trend in performance.

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.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Quality	Falls causing harm	IP falls causing moderate harm, severe harm or death, per 1,000 bed days	Green if below trajectory YTD, Amber if above trajectory YTD, Red if above trajectory at end year or more than 10% above trajectory in year.	NHS England, Monitor and contractual requirement
Quality	Infection control	No. hospital acquired C.diff cases	tbc	tbc
Quality	Avoidable admissions	The number of avoidable emergency admissions to HDFT as per the national definition.	tbc	tbc
Quality	Reducing 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).	Comparison with national average performance.
Quality	Mortality - SHMI	Summary Hospital Mortality Index (SHMI)	Blue if no. complaints in latest month is below LCL, Green if below HDFT average for 2015/16, Amber if above HDFT average for 2015/16, Red if above UCL. In addition, Red if a new red rated complaint received in latest month.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Quality	Complaints	No. complaints, split by criteria	Blue if latest month ratio places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%	Comparison of HDFT performance against most recently published national average ratio of low to high incidents.
Quality	Incidents - all	Incidents split by grade (hosp and community)	Green if less than 8 SIRIs reported per month in the year to date and no never events reported in the current month; Amber if 8 or 9 SIRIs and reported per month in the year to date and no never events reported in the month; Red if 1 or more never event reported in the current month and/or 10 or more SIRIs reported per month in the year to date.	
Quality	Incidents - SIRIs (comprehensive and concise) and never events	The cumulative number of SIRIs (comprehensive and concise) and the number of never events reported in the year to date. The indicator includes hospital and community data.	Blue if latest month score places HDFT in the top 10% of acute trusts nationally and/or the % staff recommending the Trust is above 95%, Green if in top 25% of acute trusts nationally, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
Quality	Friends & Family Test (FFT) - Staff	% staff who would recommend HDFT as a place to work	Green if latest month >= latest published national average, Red if < latest published national average.	Comparison with national average performance.
Quality	Friends & Family Test (FFT) - Staff	% staff who would recommend HDFT as a place to receive care	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	Friends & Family Test (FFT) - Patients	% recommend, % not recommend - combined score for all services currently doing patient FFT	Annual rolling total - 90% green. Amber between 70% and 90%, red<70%.	Locally agreed target level based on historic local and NHS performance
Quality	Safer staffing levels	RN and CSW - day and night overall fill rates at trust level	Blue if latest month >=95%; Green if latest month 75%-95% overall, amber if between 50% and 75%, red if below 50%.	HDFT Employment Policy requirement. Rates compared at a regional level also
Quality	Staff appraisal rate	Latest position on no. staff who had an appraisal within the last 12 months	Green if <3.9% , amber if between 3.9% and regional average, Red if > regional average.	
Quality	Mandatory training rate	Latest position on the % staff trained for each mandatory training requirement	tbc	tbc
Quality	Staff sickness rate	Staff sickness rate	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	Temporary staffing expenditure - medical/nursing/other	Expenditure per month on staff types.	Green if <1 per quarter (cumulative)	Locally agreed target.
Quality	Staff turnover	Staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts.	Green if <25% of deliveries, amber if between 25% and 30%, red if above 30%.	tbc
Quality	Research internal monitoring	No. critical or major findings reported	Green if <3% of deliveries, amber if between 3% and 6%, red if above 6%.	tbc
Quality	Maternity - Caesarean section rate	Caesarean section rate as a % of all deliveries	tbc	tbc
Quality	Maternity - Rate of third and fourth degree tears	No. third or fourth degree tears as a % of all deliveries	Green if latest month < HDFT average for 2015/16, Red if latest month > HDFT average for 2015/16.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Quality	Maternity - Unexpected term admissions to SCBU	Admissions to SCBU for babies born at 37 weeks gestation or over.	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	Readmissions	No. emergency readmissions (following elective or non-elective admission) within 30 days.	Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
Finance and efficiency	Readmissions - standardised	Standardised emergency readmission rate within 30 days from HED	Improvement trajectory to be agreed.	Improvement trajectory to be agreed.
Finance and efficiency	Length of stay - elective	Average LOS for elective patients	Green = >=85%, Amber = between 75% and 85%, Red = <75%	A utilisation rate of around 85% is often viewed as optimal.
Finance and efficiency	Length of stay - non-elective	Average LOS for non-elective patients		
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		
Finance and efficiency	Theatre utilisation	% of theatre time utilised for elective operating sessions		

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

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: 29 th June 2016		Paper No: 9.0
Title		Report from Chief Operating Officer
Sponsoring Director		Mr 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:		
<div>1. HDFT was ranked 14th out of 136 Trusts that answered all the questions in the 2015 National Adult Inpatient Survey.</div> <div>2. Waiting lists for outpatient appointments are currently challenging, specifically in Ophthalmology and Gastroenterology.</div> <div>3. For Quarter 4 2015/16, HDFT was rated D for Sentinel Stroke National Audit Programme (SSNAP), compared to a rating of C last quarter.</div>		
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 and Rural District CCG.	
Action Required by the Board of Directors		
That the Board of Directors note the information provided in the report		

1.0 REDUCING AVOIDABLE ADMISSIONS

The Clinical Lead for the Emergency Department, Dr. Matt Shepherd is leading a piece of work on reducing avoidable admissions. These are identified through the coding process retrospectively by their primary diagnosis, based on nationally defined criteria. Based on a high level review it may appear that large volumes of patients are being admitted with seemingly low level health care needs. The highest volumes of diagnosis groups are patients with urinary tract infections, tonsillitis, and chest infection, all of which could/should be managed without the need for admission.

On analysing this cohort of patients more closely, a large proportion of patients are children who are unwell with a fever and therefore require a period of assessment to ensure their illness is benign and/or some investigations in the form of blood or urine tests. This would be considered best practice and in some institutions takes place in a bespoke paediatric assessment unit. HDFT does not have this facility and so the period of assessment which usually exceeds 4 hours (usually 6-12hrs), takes place on the paediatric ward. These patients are therefore coded as an admission and the national tariff is applied. In some health economies a local paediatric assessment tariff has been agreed and therefore the patients are not coded as an admission.

A similar phenomenon is true for adult medicine and surgery. Outside the hours of our ambulatory care service (CAT clinic), the CATT ward functions to provide this period of assessment/further investigation for patients who require assessment/tests out-with the 4 hour window, the maximum appropriate time to remain with an emergency department. These patients often stay approximately 6 hours, in line with good practice; on occasion this 6 hour window crosses midnight and therefore technically results in a 1 day length of stay. Again these patients are coded as an admission during the extended period of assessment.

A case note review of a random sample of these patients revealed the need for further investigation on several fronts:

- 1) A proportion of the sample (50%) of patients coded with simple diagnoses were extremely ill and complex, with one patient dying due to their illness on admission, however, the coding process did not differentiate this group.
- 2) A proportion (10%) of patients were elderly with the period of assessment commencing around 10.00pm resulting in the need for the patient to stay for the full night to facilitate safe and compassionate discharge.
- 3) A small proportion (5%) would, with more joined up pathways, and an extended senior assessment/surgical assessment model would have resulted in a reduced stay.

In conclusion, the Emergency Medicine team are taking forward further work to review the quality and completeness of information recorded in the patient case notes to ensure that the Clinical Coding team have sufficient information to enable them to fully reflect the acuity of the patients. The teams will also review further opportunities for the development of our assessment models in paediatrics, medicine, and surgery to ensure smoother and more timely patient flow, and the increased likelihood of managing these patients safely within a 6 hour window.

2.0 OUTPATIENT WAITING LISTS IN PLANNED AND SURGICAL CARE DIRECTORATE

RAPID TESTING

The Trust has been working in collaboration with HaRD CCG and NHS England to:

- 1) Identify opportunities for improving our collective ability to better manage and reduce demand for Elective Care Services;
- 2) Develop goals and work plans that will allow us to robustly test our ideas for the above, over 100-days; and
- 3) Strengthen the ability of team members to work across barriers in a patient-centred way.

The Trust is one of two test sites (Stockport being the other), with three specialties Gastroenterology, Orthopaedics and Dermatology leading the challenge for the collaborative review.

On 16th and 17th June, three specialty multi professional groups were brought together to launch the 100 day strategy teams, which included Consultants, Nursing, AHPs and ANPs, patient representatives, GPs and GP Commissioners, and an Executive and Team sponsor.

The process required the groups to review at least one of six priorities detailed below:

1. Consultant to consultant referrals (C2C)
2. Peer review of referrals
3. GP/Consultant advice and guidance
4. Shared decision making
5. Transforming outpatient appointments
6. Integrating technology

At the end of the two day event the teams are summarising their strategies, have setup Phone App based messenger groups (now being adopted by Stockport) and have set their first meeting date.

OPHTHALMOLOGY

There continues to be significant pressures in Ophthalmology with a number of middle grade staffing gaps. As a consequence the anticipated reduction in the follow up backlog has not been delivered, following the first stage implementation of the new system for RAG rating patients on the follow up pathway, and the introduction of the Advanced nursing roles. The implementation of the new system has caused some issues in relation to the new booking procedure and the electronic patient lists (waiting lists) used to support this and therefore the team is reviewing the waiting lists and ensuring they are consistently validated. Once this work is completed the team will have an updated position in relation to the waiting times for follow up and the backlog of patients waiting beyond their expected follow up date.

GASTROENTEROLOGY

Following changes in personal circumstances one of the long term locum consultant appointments left the Trust on 21st June at short notice. This has created an additional pressure on the service. A significant number of extra new and follow up outpatient clinics are required to meet the current demands on the service and therefore locum posts have been advertised and immediate capacity and support is being sought from the Gastro team with priority being given to urgent patients. A review of the new and follow up clinic letters is being undertaken to identify whether any other non-medical role could see the patients, or if the patients could be triaged before coming into clinic.

The team are currently taking part in the Rapid Testing 100 day challenge reviewing pathways jointly with the CCG and NHS England to understand how we can manage demand differently going forward, with Dr Davies providing medical support to this during his sabbatical.

3.0 NATIONAL ADULT INPATIENT SURVEY RESULTS 2015

The CQC have recently published the full national data set for the national inpatient survey 2015. This allows us to benchmark HDFT's performance with other Trusts. The 2015 survey involved 150 NHS acute trusts in England, with over 83,000 responses from adult patients who had at least one overnight stay within a trust during July 2015. Since the initial results were shared with Trusts in January, the responses to the questionnaire have now been weighted and standardised to allow a fair comparison between different organisations. HDFT's results and position in terms of scoring has been impacted slightly by this process.

Using the weighted results, in 3 out of the 72 questions HDFT was deemed to have performed significantly better than average:

- Q6. How do you feel about the length of time you were on the waiting list?
- Q59. Were you given any written or printed information about what you should or should not do after leaving hospital?
- Q67. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

In the remaining questions, HDFT was deemed as average and in no questions was HDFT deemed as scoring significantly worse than 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.

62 questions were used in the benchmarking data. HDFT ranked in the top 20 for 12 of these questions, with the best rank being 9th for 2 of the questions:

- Q3. While you were in the A&E Department, how much information about your condition or treatment was given to you?
- Q59. Were you given any written or printed information about what you should or should not do after leaving hospital?

At the other end of the scale, HDFT's two poorest performing questions were:

- Q42. After you used the call button, how long did it usually take before you got help?
- Q73. During your hospital stay, were you ever asked to give your views on the quality of your care?

The latter of these two responses links directly to the work Dr Sylvia Wood is leading on reviewing our approach to the Friends and Family Test.

4.0 SENTINEL STROKE NATIONAL AUDIT PROGRAMME (SSNAP)

The latest SSNAP results for Quarter 4 2015/16 have been shared with Trusts. HDFT have been rated D this quarter, compared to C last quarter, with an overall score of 54, compared to 64 last quarter and 46 the quarter before. HDFT's score has been slightly impacted this quarter by the data quality adjustment – the score prior to the data quality adjustment was 57.

Of the 10 domains in the SSNAP data set, three have seen a deterioration this quarter after improving last quarter:

- Stroke unit (B to C)
- Physiotherapy (B to D)
- Speech & Language Therapy (C to D)

The other seven domains all stayed at the same score.

There was a reduction in performance on the number of stroke patients spending 90% of time on the stroke ward – 73% compared to 91% last quarter. The main reason for patients not being placed on the stroke ward was a lack of available beds.

Performance on swallow screening within 4 hours of admission has also deteriorated this quarter. However it has now been agreed that this assessment will be carried out in the Emergency Department so an improvement should be seen in this indicator next quarter.

In terms of thrombolysis, all seven eligible patients were thrombolysed this quarter but none within an hour. However, the average time to thrombolysis has improved - 1 hour 17 mins, compared to 1 hour 40 mins.

5.0 CARBON AND ENERGY FUND

The second of the two new boilers has now completed its validation period successfully; this has now allowed the hire boiler that has been in the loading bay area since September 2015 to be removed. Work within the boiler house to form a raised platform which will support the new plate heat exchangers is progressing well and this will allow the final major items of equipment to be lifted into place.

The internal lighting replacement works continue to make good progress with approximately 95% of the fittings now replaced. Overall the project is now scheduled to complete in mid-September.

6.0 SERVICE ACTIVITY

Variances above or below 3% are as follows:

- At the end of May, new outpatient activity was 7.5% below plan, follow-up outpatient activity was 5.9% below plan, and elective admissions were 8.5% below plan.
- For Leeds North CCG, new outpatient appointments were 14.3% above plan, elective admissions were 14.9% below plan, and non-elective admissions were 8.5% below plan.

For further information on theatre utilisation during May, please refer to the Integrated Board Report (agenda item 8.0).

7.0 FOR APPROVAL

There are no items for approval this month.

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Report to the Trust Board of Directors: 29 th June 2016	Paper No: 10.0
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Title	Financial Report
Sponsoring Director	Director of Finance
Author(s)	Finance Department
Report Purpose	Review of the Trusts financial position

Key Issues for Board Focus:

1. The underlying performance of the Trust in May was a £49k surplus, resulting in an underlying deficit of £396k to date, £258k behind plan.
2. Because of this performance, it has been assumed that a lower amount of Sustainability & Transformation (S&T) funding would be received. The impact of the additional S&T funding would result in a surplus of £115k to date, £514k behind plan.
3. Plans are in place for 99% of the £9.4m target, however, this reduces to 78% following risk adjustment. 61% of plans have been actioned to date.
4. The Trust cash balance at the end of May was £8.9m. This was £1.8m behind plan. The profile of the plan will be updated once contracts are agreed with Harrogate and Rural District CCG as the profile of payment will have an impact on this.

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 process in relation to the reference cost submission. The Board is asked to take assurance from the internal audit that a robust process for costing is in place. **The Board is also asked to delegate authority to the Deputy Director of Finance to approve and sign the final reference cost return prior to submission.**

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May 2016 Financial Position

Financial Performance

- The underlying performance of the Trust in May was a £49k surplus, resulting in an underlying deficit of £396k to date, £258k behind plan.
- As a result of this performance it has been assumed that a lower amount of S&T funding would be received. The impact of the additional S&T funding would result in a surplus of £115k to date, £514k behind plan.
- There is an underlying adverse income variance of £706k 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 £346k favourable variance to date. It should be noted that within this positive position there is an adverse variance in relation to ward nursing of £218k. The work in relation to rostering and the Oceansblue system will support improvement in this area.
- The cost improvement programme is discussed in more detail on pages 6 and 7. There is an adverse variance of £560k to date as a result of plans which have not been actioned. This is a key area of focus for the Trust with work ongoing in each directorate.
- The Trust cash position at the end of May was £8.9m, £1.8m behind plan.
- There is a clear focus on improving both the income and expenditure positions across the organisation. Finance and Activity meetings will support directorate in working through these issues and the underlying risks to achieving plan.

NHSI Financial Sustainability Risk Rating (FSRR)

- The table to the right outlines the Trusts FSRR for May

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

Reference Cost Submission

- Page 9 of this report outlines the conclusion of the costing audit and the requirements for the reference cost submission. The Board is asked to take assurance from the internal audit that a robust process for costing is in place. The Board is also asked to delegate authority to the deputy director of finance to approve and sign the final reference cost return prior to submission.

May 2016 Financial Position

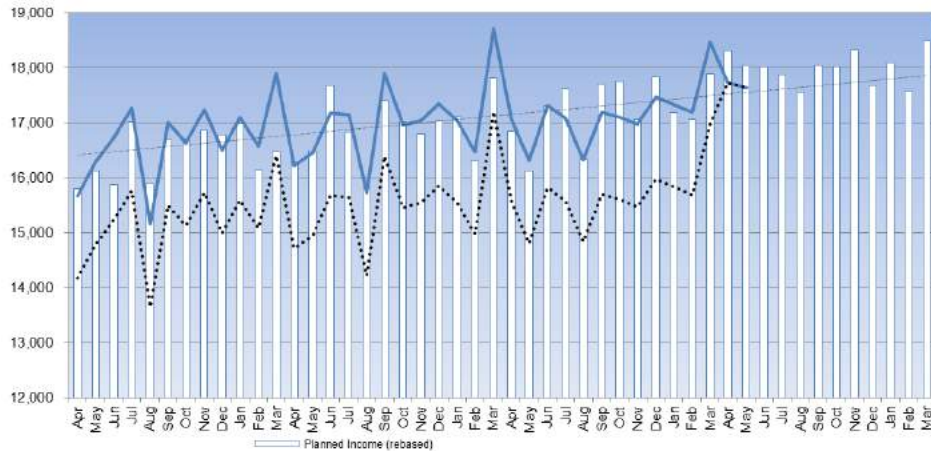
Summary Income & Expenditure 2016/17
For the month ending 31st May 2016

	Budget		Actual To Date	Cumulative Variance	May Actuals
	Annual Budget £000	Proportion To Date £000			
INCOME					
NHS Clinical Income (Commissioners)					
NHS Clinical Income - Acute	141,317	23,354	22,879	(475)	11,487
NHS Clinical Income - Community	56,595	9,488	9,318	(170)	4,591
System Resilience & Better Care Funding	561	94	94	0	47
Non NHS Clinical Income					
Private Patient & Amenity Bed Income	1,880	313	236	(77)	110
Other Non-Protected Clinical Income (RTA)	523	87	50	(37)	27
Other Income					
Non Clinical Income	11,831	2,223	2,276	53	1,149
Hosted Services	0	0	0	0	0
TOTAL INCOME	212,707	35,559	34,853	(706)	17,411
EXPENSES					
Pay					
Pay Expenditure	(145,285)	(25,540)	(25,194)	346	(12,301)
Non Pay					
Drugs	(4,846)	(2,322)	(2,352)	(30)	(1,102)
Clinical Services & Supplies	(16,271)	(2,980)	(3,018)	(38)	(1,512)
Other Costs	(14,995)	(2,569)	(3,226)	(657)	(1,683)
Reserves :					
Pay	(3,550)	0	0	0	0
Pay savings targets	0	0	0	0	0
Other Reserves	(8,591)	(887)	0	887	0
High Cost Drugs	(8,089)	0	0	0	0
Non Pay savings targets	(418)	0	0	0	0
Other Finance Costs	(18)	(3)	(8)	(5)	0
Hosted Services	(668)	(99)	(112)	(13)	(112)
TOTAL COSTS	(202,730)	(34,400)	(33,910)	490	(16,710)
EBITDA	9,976	1,158	942	(216)	701
Profit / (Loss) on disposal of assets	0	0	0	0	0
Depreciation	(5,081)	(847)	(877)	(30)	(434)
Interest Payable	(90)	(15)	(33)	(18)	(17)
Interest Receivable	41	7	4	(3)	2
Dividend Payable	(2,646)	(441)	(458)	(17)	(229)
Net Surplus/(Deficit) before donations and impairment	2,200	(138)	(422)	(284)	23
Donated Asset Income	0	0	26	26	26
Impairments re Donated assets	0	0	0	0	0
Impairments re PCT assets	0	0	0	0	0
Net Surplus/(Deficit)	2,200	(138)	(396)	(258)	49
Consolidation of Charitable Fund Accounts	0	0	0	0	0
Sustainability and Transformation Fund	4,600	767	511	(256)	228
Total and Consolidated Net Surplus/(Deficit)	6,800	629	115	(514)	277

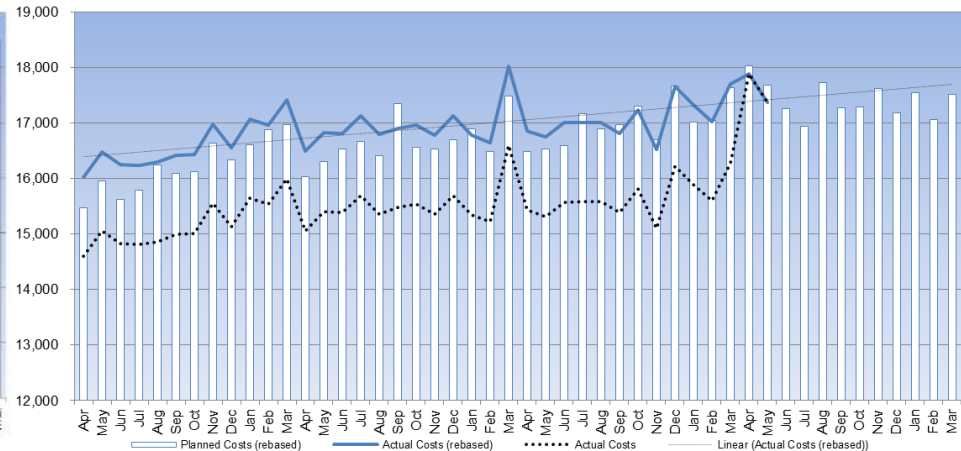
Negative sign under variance indicates an UNDER-recovery of forecast income, or an OVER-spending against budget

May 2016 Financial Position

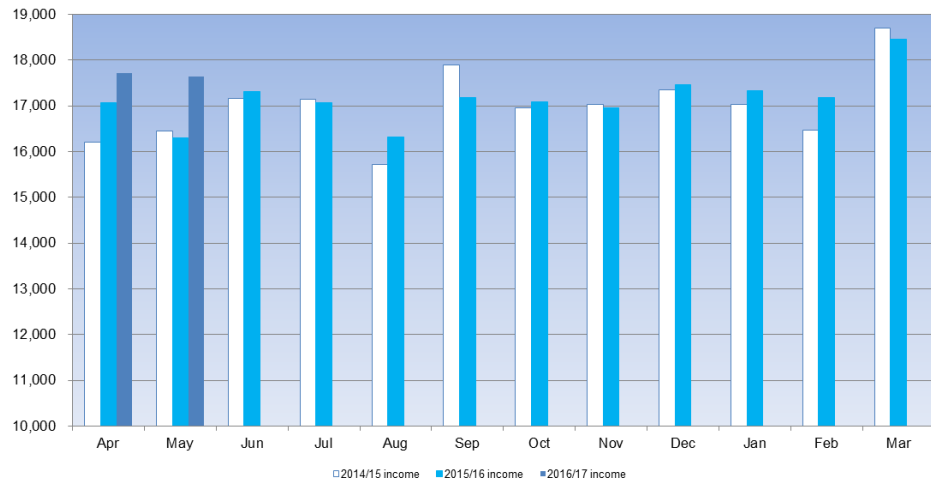
Planned and Actual Income Apr 2013 - Mar 2017 (rebased for new contracts)



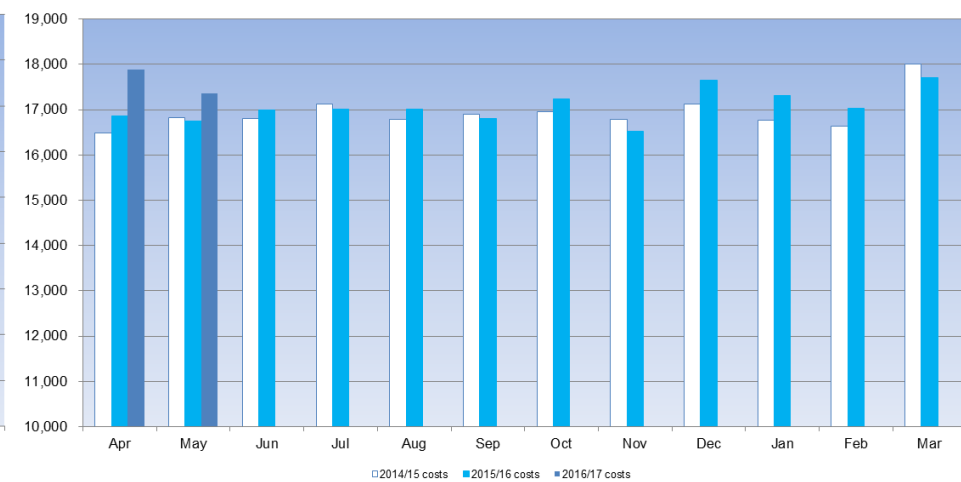
Planned and Actual Costs Apr 2013 - Mar 2017 (rebased for new contracts)



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

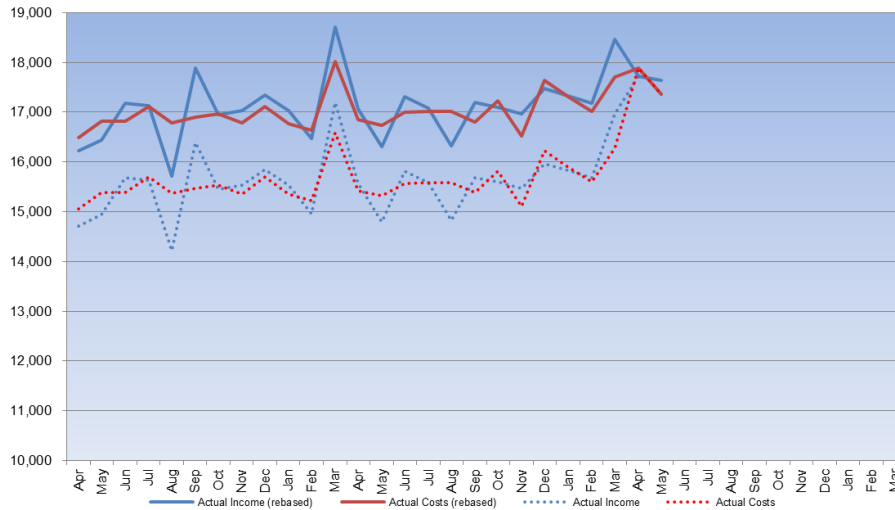


Actual costs (rebased) 2014/15, 2015/16 & 2016/17

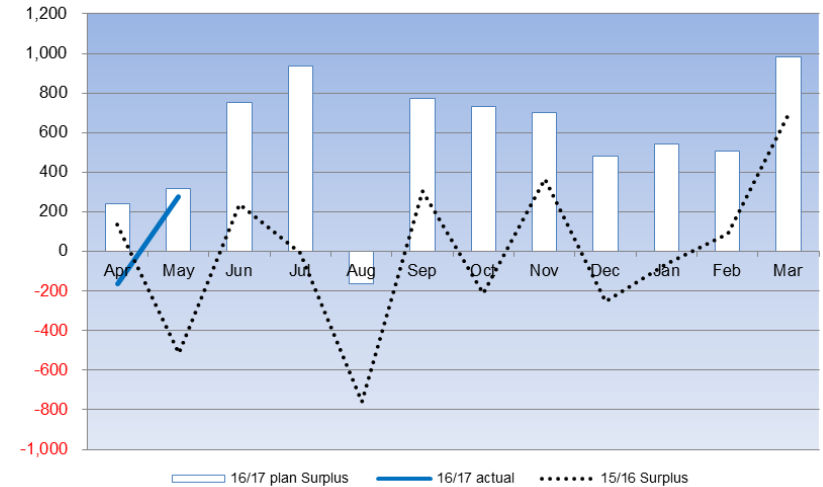


May 2016 Financial Position

Actual Income against Actual Cost April 2014 - March 2017



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



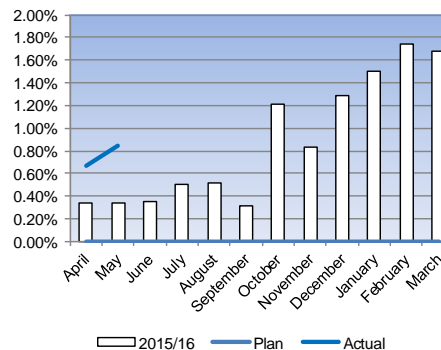
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15 income	14,717	14,945	15,674	15,637	14,221	16,388	15,451	15,533	15,845	15,539	14,967	17,201
2015/16 income	15,564	14,802	15,810	15,578	14,826	15,689	15,595	15,467	15,968	15,828	15,686	16,967
2016/17 income	17,725	17,639										
2014/15 costs	15,058	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	17,362										
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	277										

May 2016 Financial Position

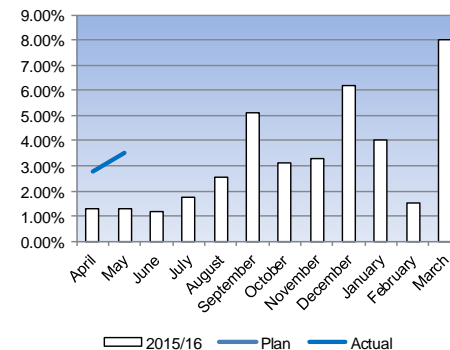
Carter Metrics

- NHSI have recently added the following metrics to the Trust monthly monitoring return. How this information will be utilised remains unclear, however, performance against plan is outlined to the right.
- The year to date spend for agency nursing and agency care workers was £72k and £167k respectively.

Agency Nursing spend as a % of total Nursing Spend



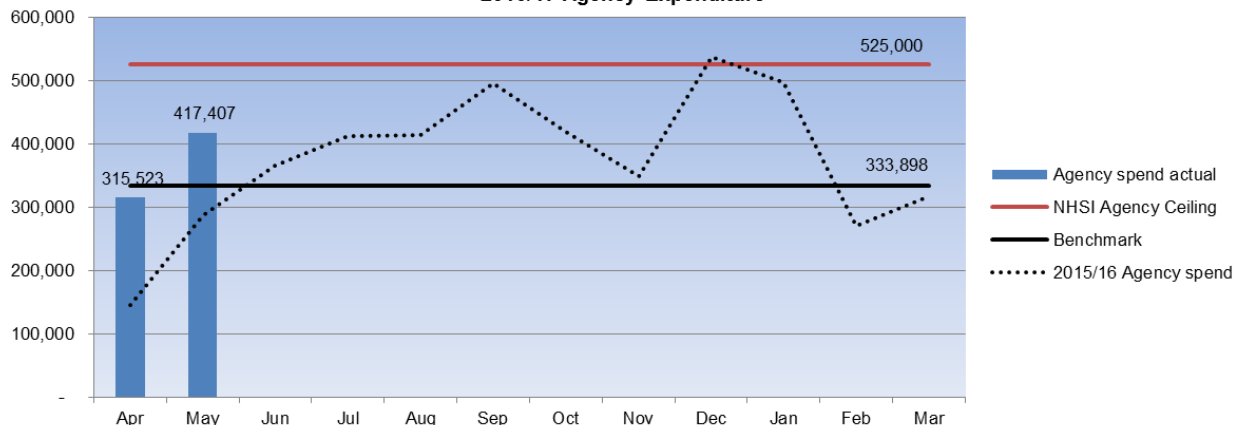
Agency Care Worker spend as a % of total Care Worker Spend



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.

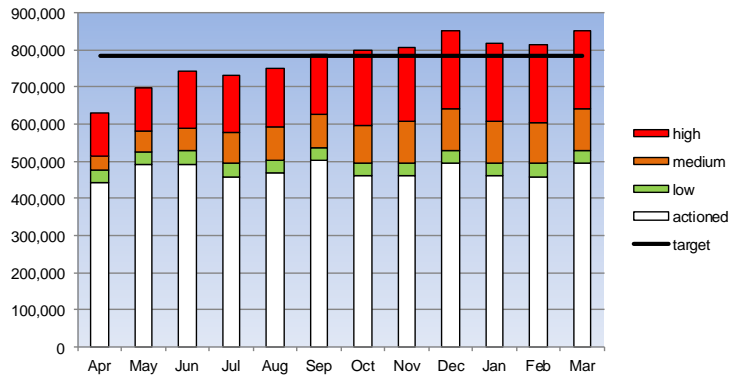
2016/17 Agency Expenditure



2016/17 Efficiency Update

Trustwide Cost Improvement Programme

2016/17

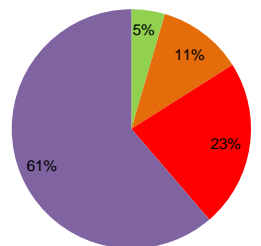


Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Trustwide	9,400,000	5,697,400	421,350	1,067,582	2,108,434	9,294,766	99%	7,373,435	78%
% age of target			4%	11%	22%				

Top 10 schemes Top 10 as % of schemes - 25%

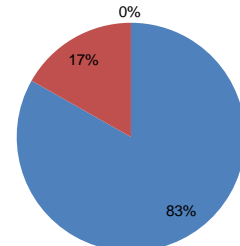
No.	Scheme	Value	Risk
1	Business Development 1	450,000	Actioned
2	Maternity Review	400,000	Actioned
3	Review Inpatient Workstream	252,300	high
4	Respiratory and Cardiology Review	243,100	Actioned
5	Service Line Reporting	201,667	high
6	Business Development 2	200,000	medium
7	Pay efficiency	200,000	high
8	Business Development 3	200,000	Actioned
9	Drug Savings	30,400	Low
10	Drug Savings	149,600	Actioned

CIP schemes by Risk



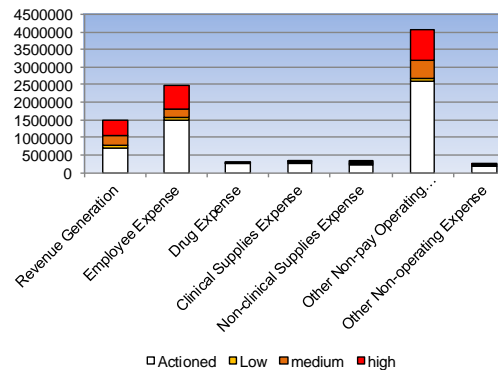
Low medium high Actioned

Recurrent V Non Recurrent Plans

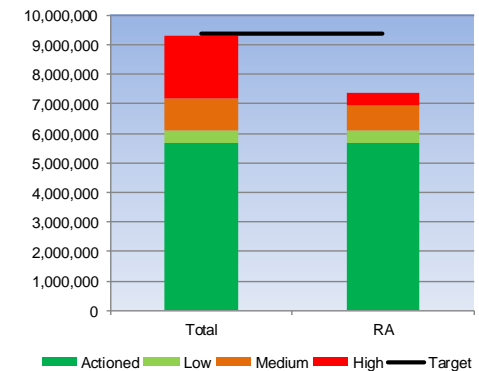


Recurrent Non Recurrent (blank)

Efficiency Category



Risk Profile



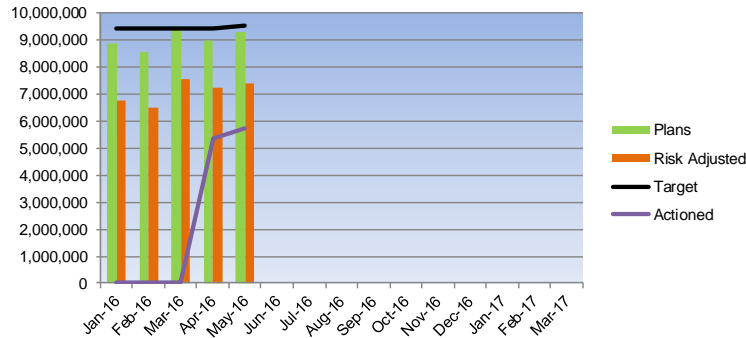
- As outlined above, £5,697,400 full year effect of cost improvement schemes have been actioned to date. This equates to 61% of the target.
- Of the high value schemes, three are rated as high risk. These are currently being reviewed with the directorates.
- Of the total above, £1.8m of schemes are linked to transformational work. 13% 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

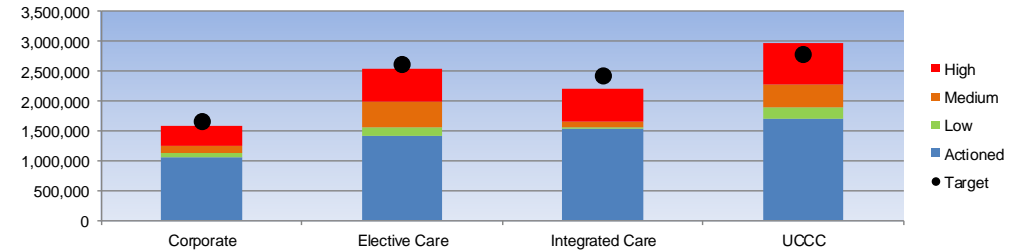
Trustwide Cost Improvement Programme

2016/17

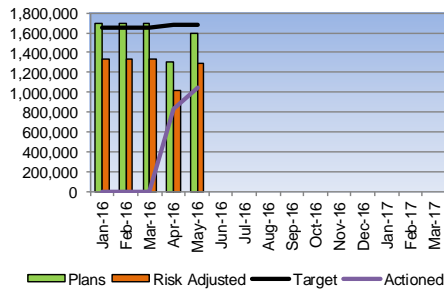
Trustwide Monthly Progress against Target (Full Year Effect)



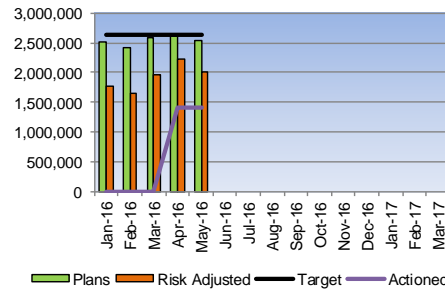
Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Corporate	1,675,100	1,050,200	79,800	127,915	332,500	1,590,415	95%	1,294,842	77%
Elective Care	2,632,600	1,419,300	130,800	450,367	535,985	2,536,452	96%	2,011,050	76%
Integrated Care	2,430,300	1,538,300	15,000	112,800	528,700	2,194,800	90%	1,748,530	72%
UCCC	2,783,500	1,695,200	195,750	376,500	711,249	2,978,699	107%	2,324,612	84%



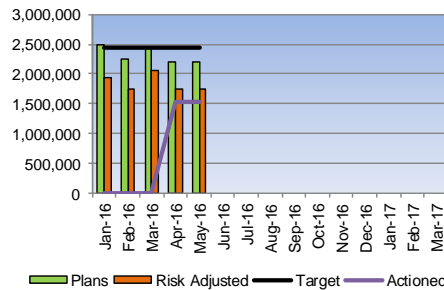
Corporate Monthly Progress against Target (Full Year Effect)



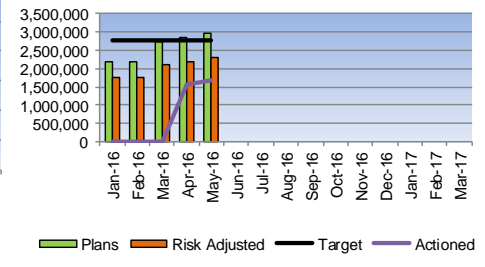
Elective Care Monthly Progress against Target (Full Year Effect)



Integrated Care Monthly Progress against Target (Full Year Effect)



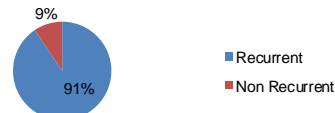
Urgent, Community and Cancer Care Monthly Progress against Target (Full Year Effect)



Corporate R - NR Split



Elective Care R - NR Split



Integrated Care R - NR Split



Urgent, Community and Cancer Care R - NR Split



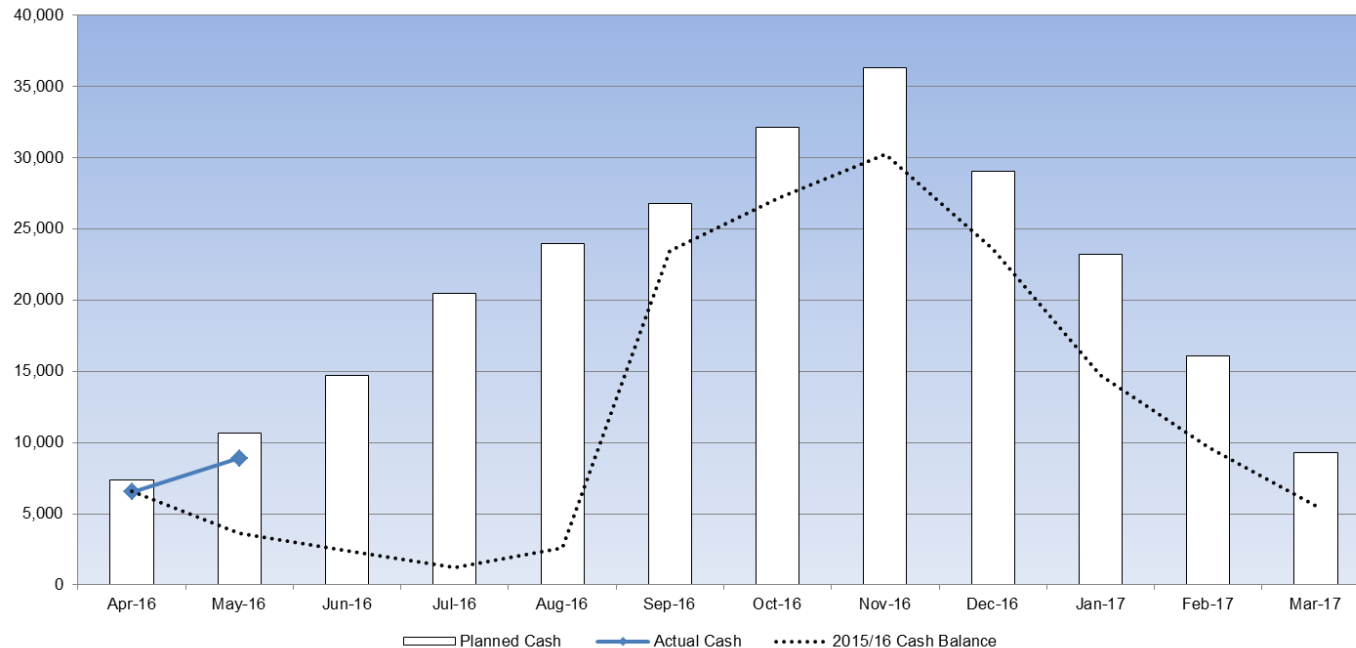
- The above outlines directorate performance. This will be updated in the near future to reflect the new directorate structure.
- Following review of plans in April the corporate directorate position worsened as outlined in the graph above. Work in May has improved this position significantly, reducing the planning gap. Work now continues to implement these plans.

Cash Management

	0 to 30 Days £000	31 to 60 Days £000	61 to 90 Days £000	Over 91 Days £000	Total £000
NHS Debts	491	875	432	3,853	5,651
Insurance Companies	39	28	44	66	177
Other	23	148	19	140	330
Totals	553	1,051	495	4,059	6,158

Top 5 Receivables - April 16	£
NHS HARROGATE AND RURAL DISTRICT CCG	5,073,527.51
DURHAM COUNTY COUNCIL	937,500.00
NHS HAMBLETON, RICHMONDSHIRE AND WHITBY CCG	1,174,843.30
NHS ENGLAND	792,138.86
YORK TEACHING HOSPITALS NHS FOUNDATION TRUST	1,023,562.66
Total	9,001,572.33

Cashflow Monitoring - Monthly Cash Position 2016/17



Reference Cost Submission

Section 5 - Overall Conclusion

The Board will be aware that the Trust has submitted Reference Cost information for many years. For the Reference Costs relating to 2015/16, the Board is required to confirm that –

- The reference cost return has been prepared in accordance with Monitor's Approved Costing Guidance, which includes the reference cost guidance
- Information, data and systems underpinning the reference cost return are reliable and accurate;
- There are proper internal controls over the collection and reporting of the information included in the reference costs, and these controls are subject to review to confirm that they are working effectively in practice; and
- Costing teams are appropriately resourced to complete the reference costs return, including the self-assessment quality checklist and validations accurately

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

The Board is asked to take assurance from the internal audit that a robust process for costing is in place. The Board is also asked to delegate authority to the deputy director of finance to approve the final reference cost return prior to submission.

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

In 2014 the Trust implemented CostMaster which is a patient level information and costing system (PLICS). CostMaster enables the production of reference costs based on cost data uploaded from the general ledger and activity data uploaded from source feeder systems. We can confirm, from a walkthrough and sample testing, that controls are in place to ensure the principles and guidance set out in Monitor's Approved Costing Guidance have been applied in order to produce reference costs for 2015/16.

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

A formal management timetable was established for the production of 2015/16 reference costs. This set out key tasks to be completed in order to ensure that the Trust achieves initial reference cost submission by 22 July 2016 and Finance Director sign-off of the final submission by 28 July 2016 in accordance with DH Guidance. The Trust expects to submit the initial submission and sign off of the final submission by the required dates.

At the time of our review, the upload of activity and costing data on to the costing system was largely complete. However, although a draft reference cost quantum had been uploaded on to the costing system, the quantum had not yet been formally reviewed and finalised in accordance with the reference cost timetable. In addition, the Trust has not yet completed the self-assessment quality checklist, which is a mandated element of the submission. The self-assessment quality checklist requires that reference cost data is benchmarked where possible against national data for individual unit costs and for activity volumes. The Trust plans to undertake benchmarking of data against national data and previous year's data and to review unit cost outliers in week commencing 27 June 2016.

One of the five costing principles in Monitor's guidance requires stakeholder engagement, including engaging clinicians and operational managers in the reference cost process and more general costing processes. Previous internal audit reviews have highlighted limited clinician and operational manager involvement in costing processes at the Trust. However, the Trust has been taking action to improve stakeholder engagement in 2015/16 by involving clinical leads from five specialties in the development of a suite of standard SLR reports. The Trust has also recently established an SLR Project Group which provides a forum to engage with clinicians and operational managers.

A number of apportionment bases used for production of the 2015/16 reference costs have also been updated including those that are based on WTE staff numbers. However, our review found that consultant job plan data used to apportion costs to individual cost pools has not been reviewed and updated since the 2014/15 submission. In addition, a thorough review of floor space data has not been completed since the 2013/14 submission. The Trust plans to continue using existing apportionment bases unless updated information becomes available during completion of this year's exercise. Any changes to these bases are not expected to have a significant impact on the 2015/16 reference costs.

Overall, this Internal Audit has found that the Trust has effective systems and controls in place to ensure the completeness and accuracy of reference cost data. We do note that at the time of this audit the 2015/16 exercise had not been fully completed and our assurance is based on the data available.

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

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

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

Head of Internal Audit:	Helen Kemp-Taylor
Audit Manager:	Tom Watson
Auditor:	John Roberts
Date:	17 June 2016

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Report to the Trust Board of Directors: 29th June 2016	Paper No: 11.0
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Title	Nursing & Midwifery Strategy (2016-19)
Sponsoring Director	Mrs Jill Foster, Chief Nurse
Author(s)	Mrs Jill Foster, Chief Nurse
Report Purpose	To inform and seek approval of the Board of the development of the Nursing and Midwifery Strategy (2016-19) for HDFT.
Key Issues for Board Focus: <p>The Nursing and Midwifery Strategy (2016-19) sets out the vision and plans for the future of nursing and midwifery at HDFT. It describes how nurses and midwives, supported by the senior nursing team and the Trust, will focus their energy and attention to further improve the care of people using our services.</p> <p>The Board are asked to approve the Strategy and support its implementation across the Trust.</p>	
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 risk incurred as a result of this paper.

Action Required by the Board of Directors

- To **approve** Nursing and Midwifery Strategy (2016-19) and **support** the implementation of the strategy across the Trust

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Nursing and Midwifery Strategy 2016/19

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FOREWORD

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Dr Ros Tolcher
Chief Executive

You matter most

INTRODUCTION

Thank you for your ongoing hard work and unwavering commitment to improving the care we deliver to people in our service. We are improving care and safety year on year as a result of your commitment and hard work.

It is with great pleasure and pride that I introduce this three-year Nursing and Midwifery Strategy (2016-2019). It sets out our vision and plans for the future of nursing and midwifery at HDFT. It describes how we'll focus our energy and attention to further improve the care of people using our services.

"This strategy will help us to ensure we consistently get it right for the people in our care, their loved ones and carers, every day."

You matter most

It also covers how we will support and enable you to be the best you can be, whether you are a nurse, midwife, health visitor or care support worker and work in one of our hospital settings or part of the community teams.

At the heart of what we do are our values, respectful, responsible and passionate – is how we do things at HDFT. Our commitment to the people we care for is that we will deliver caring, safe and thoughtful care. We are making good progress.

The implementation of this strategy will help us to ensure we consistently get it right for the people in our care, their loved ones and carers, across every ward, department and service, every day, excellence every time.

Thank you to everyone who took time to comment on the Nursing and Midwifery Strategy. We have listened to your feedback and incorporated your views into this important document.

This strategy is by you and for you, the nursing and midwifery workforce at HDFT. It refers



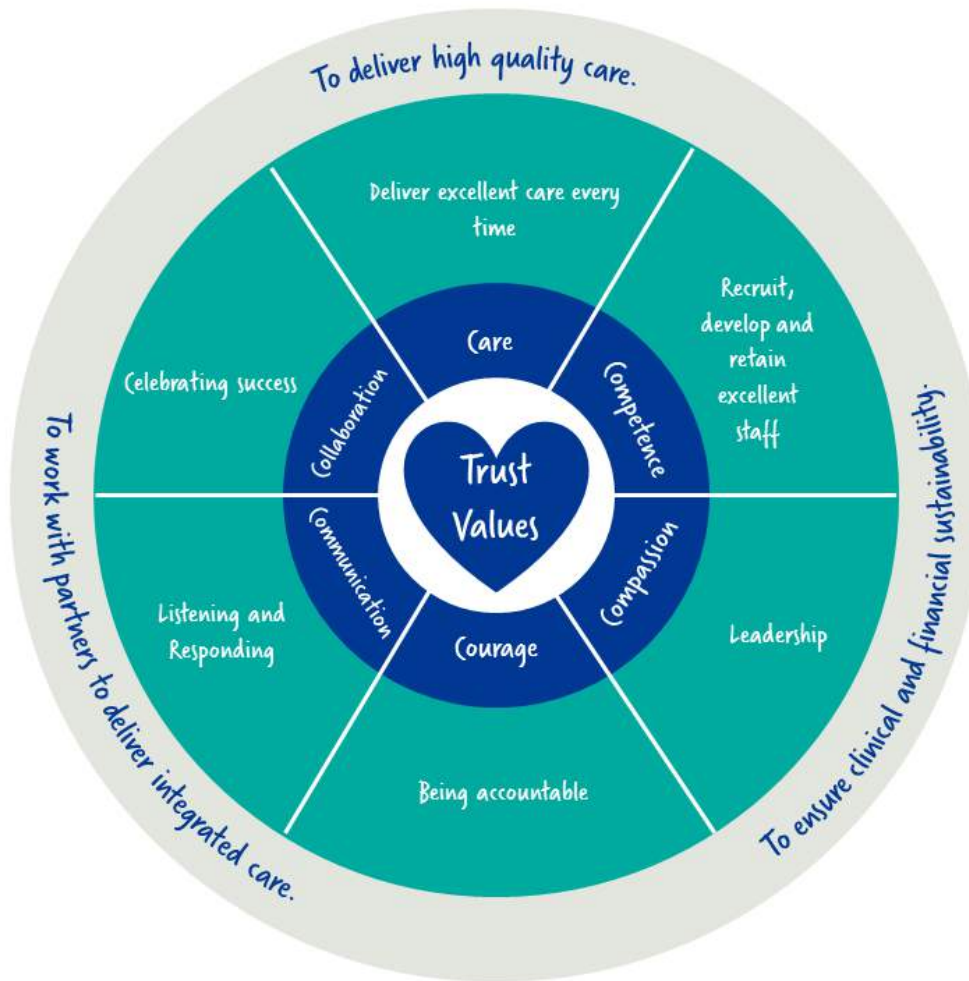
generically to nurses and midwives but this means nurses, midwives, health visitors, specialist nurses, nurses in advanced roles and our care support workers throughout the organisation in our hospitals and across the community.

The important contributions you make, often in difficult circumstances, are greatly valued and appreciated and are helping us to deliver better care to the people we look after, their relatives and carers.

I look forward to working alongside you to deliver this strategy.

Jill Foster
Chief Nurse

OUR COMMITMENT



Nurses and Midwives commit to provide care driven by our Trust values and the core values set out in this strategy.

**Care
Competence
Compassion**

**Courage
Communication
Collaboration**

Our commitment is to provide a Nursing and Midwifery Strategy that:

- Delivers the best patient care
- Develops a competent compassionate workforce capable of meeting the needs of the people in our care, now and in the future
- Demonstrates effective leadership
- Is accountable to patients, families and service users
- Listens to our patients and service users and responds to their comments and concerns
- Celebrates achievement

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COMMITMENT 1: DELIVER EXCELLENT CARE EVERY TIME

Why is this important to us?

Nurses and midwives know that providing excellent, safe, effective and personalised care is essential for the health, wellbeing and experience of all people who use our services.

We know high quality care costs less and helps people to retain independence.

Nurses and midwives want to continue to deliver a year-on-year reduction in harm to people in our care from sepsis, medication errors, falls, pressure ulcers, healthcare associated infection and pain management.

We will continue to build on past successes to develop services for people living with dementia or experiencing frailty within both community and secondary care settings.

We want to improve the care of people with learning disability to ensure that they feel safe and supported when accessing our services.



"We will continue to build on past successes to develop services for people living with dementia or experiencing frailty."

WHAT ARE NURSES AND MIDWIVES DOING TO SUPPORT THIS COMMITMENT?

- Improve patient safety through increasing the use of technology.
- A Learning Disabilities Support Nurse has been appointed to oversee the care of patients with learning disability. Staff training and awareness raising is to be expanded to ensure that patients receive high-quality personalised care. An LD database is to be developed to identify patients who may need additional support when accessing services.
- Screen all patients for sepsis on presentation to ED or ward if directly admitted and the sepsis care bundle implemented when sepsis is identified.
- Assess patients with suspected stroke by specialist nursing staff on presentation to the emergency department; door to needle time for thrombolysis will be reduced.
- Implement of the Swan Symbol to promote heightened dignity, respect and compassion for the dying person and their families at the end of life and after death.

There will be a continued focus on staff training to improve end of life care for people using our services.

- Implement the dementia strategy which includes dementia friendly signage for all ward areas, coloured crockery to be used for inpatients with cognitive impairment, development of the therapeutic support worker role to work with patients and their families. Continued focus on staff training and embedding of the butterfly scheme on all wards.
- Reduce the number of medication errors relating to insulin by continued use of the insulin safety dashboard to identify potential errors promptly and mandatory staff training and competency assessment

in the safe use of insulin.

- Reduce avoidable harm by embedding the safety brief and safety huddle concept on all wards to promptly identify and act on identified risks to patient safety.
- Improve focus on the way we support the feeding needs as well as the dietary requirements of all the people who use our services.
- Continue to improve the education in falls through patient safety huddles and the use of falls sensor technology. Ensure falls work includes community services.
- Continue the reduction in hospital acquired pressure ulcers and continue to improve the management of pressure ulcers in the community.
- Adopt a zero-tolerance approach to preventable healthcare associated infection and when it does occur put the lessons learned from root cause analysis into practice.

“Implement
dementia-friendly signage
for all wards.”

You matter most

COMMITMENT 2: RECRUIT, DEVELOP AND RETAIN EXCELLENT STAFF

Why this is important to us?

The nursing and midwifery leaders at HDFT understand that patient-centred organisations pay attention to their staff.

We are also aware that success in the care environment requires that we have the right number of people with the right skills in the right locations. Therefore it is important that we recruit, retain and nurture talented people.

The current workforce is just as important as the future workforce.

"We aim to invest in improving the skills of the whole of the nursing and midwifery workforce."



We aim to nurture existing talent and invest in improving the skills of the whole of the nursing and midwifery workforce and provide a career framework that is flexible enough to enable progression and aid movement between different environments.

Talent for Care (2014) is the national strategy for investing in the healthcare support workforce. HDFT has signed the local partnership pledge which commits us to developing the skills and competencies for this group of staff which will equip them for the future and provide real opportunities for those who wish to progress.

WHAT ARE NURSES AND MIDWIVES DOING TO SUPPORT THIS COMMITMENT?

- HDFT will have a dedicated and inspirational recruitment programme and will continue to develop a reputation as an employer of choice for nurses and midwives.
- Invest in nurturing our student workforce through: providing excellent mentorship, a wide range of learning opportunities, identify talented students and actively engaging to promote HDFT as an employer of choice.
- Continuously review and monitor nursing and midwifery capacity to deliver safe care.
- Develop and deliver a nursing and midwifery workforce development strategy to ensure that we have the appropriate workforce to meet the needs of the local population now and in the future.
- Invest in the registered workforce through: a robust preceptorship programme, identification and development of a range of employment options and continuing professional development opportunities to support ongoing role progression.
- Invest in the clinical support workforce through: introduction of fundamental care certificates and apprenticeships, increase band 3 and 4 opportunities, provide a career framework and support progression into nursing/midwifery training.



COMMITMENT 3: LEADERSHIP

Why is it important to us?

The nursing and midwifery leadership team recognises that there is a clear relationship between strong leadership, a caring and compassionate culture and high quality care. We know that confident leaders will role model the Trust's values and behaviours that will create the conditions for the delivery of compassionate care of which HDFT is so proud.

Therefore it is important that we strengthen nursing and midwifery leadership at every level.



You matter most



"There is a clear relationship between strong leadership, a caring and compassionate culture and high quality care."

WHAT ARE NURSES AND MIDWIVES DOING TO SUPPORT THIS COMMITMENT?

- All nurses and midwives when they are recruited to the organisation are recruited to the trust values of respectful, responsible and passionate giving us the foundations to grow and develop the kind of leaders we need and aspire to have at HDFT.
- Develop a structured induction and preceptorship programme to ensure that all our staff has a good understanding of their role as an important basis from where we can nurture future leaders.
- We will support frontline leaders to use their skill to drive improvements in clinical practice.
- The organisation will develop leadership programmes for all levels of nurses and midwives through our workforce development strategy.
- We will develop leadership competencies for assessment and provide resilience training for all levels of staff to build resilience in leaders.



COMMITMENT 4: ACCOUNTABILITY

Why this is important to us?

Nurses and Midwives at HDFT understand the importance of being accountable for care to be able to practice effectively. Responsibility is at the heart of the Trusts Values and Behaviours Framework.

For people to be safe and treated effectively in our care nurses and midwives need to be competent, be confident when delegating tasks

"We understand the importance of being accountable for care to be able to practice effectively."



to others, be able to speak out about poor practice and raise concerns immediately if they believe people are vulnerable or at risk and need extra support and protection.

WHAT ARE NURSES AND MIDWIVES DOING TO SUPPORT THIS COMMITMENT?

- Implement a record keeping improvement plan underpinned by individual professional accountability and supported by frontline champions.
 - Ensure every nurse and midwife understands the need to work within the limit of their competency while supporting them to achieve the skills required to care for the people in their service.
 - Review the role of care support workers to ensure they have the appropriate skills to look after the people in their care.
 - Encourage all staff to be open and transparent and to have the courage to challenge suboptimal practice.
 - Train staff will reinforce the Being Open and Duty of Candour agenda along with the Values and Behaviour Framework.
 - All nursing, midwifery staff and care support workers are trained in safeguarding.
- 
- Help our nurses and midwives to understand and be supported through the process of revalidation.
 - Enable every nurse, midwife and care support worker to have an annual appraisal.

COMMITMENT 5: LISTENING AND RESPONDING

Why this is important to us?

Nurses and Midwives know that if the experience of people in our care is good then the quality of care is high. Listening and responding to complaints, comments and compliments is an integral part of improving the quality of care delivered and improving patient experience.

The Trust's Values and Behaviours Framework reinforces this aim of engendering an open and honest approach to patients and their families that fosters partnership in care and management and allows people in our care to feel safe and involved in their plan of care.

The Being Open Policy (2016) states:
“Harrogate and District NHS Foundation Trust ('the Trust') recognises and acknowledges the importance of good communication and openness between staff and people in our care at all times – not just when things go wrong.”



“Listening and responding to complaints, comments and compliments is an integral part of improving the quality of care.”

WHAT ARE NURSES AND MIDWIVES DOING TO SUPPORT THIS COMMITMENT?

- Nurses and Midwives will actively seek and listen to feedback from people using their services. This feedback will be used to improve care and develop services.
- Nurses and Midwives will seek the views of people using their services when planning change.
- Nurses and Midwives will use the results of the Friends and Family test to measure the quality of their care and the patient experience and will display comments both positive and negative on a departmental notice board along with actions taken. "What you said" "What we did".
- Develop strategies for seeking the views and opinions of children and young people.
- Publish and communicate actions to demonstrate changes in response to feedback.
- Partner organisations such as The Patient Voice Group will be closely involved in providing feedback from patients and their carers about their episodes of care to inform improvements in service provision.
- Every patient, service user and their carers and relatives will feel that their opinion of the care delivered is heard and where needed, is acted upon.



"We will actively seek and listen to feedback from people using our services."

You matter most

COMMITMENT 6: CELEBRATING SUCCESS

Why this is important to us?

Nurses and Midwives at HDFT believe we need to celebrate achievement and success because it is important to reinforce great practice throughout our teams.

Celebration maintains morale and keeps us and our colleagues delivering best care in challenging circumstances and glues our teams together so that they support each other.

As nurses and midwives we expect to deliver excellent care every time and we should. However, it feels good to get recognition whether it is from a colleague or a panel of award judges and taking a moment either alone or with a colleague to reflect on something that went really well is as valuable as a root cause analysis when things go wrong.



"We need to celebrate achievement and success because it is important to reinforce great practice throughout our teams."

WHAT ARE NURSES AND MIDWIVES DOING TO SUPPORT THIS COMMITMENT?

- Using our values and behaviours framework demonstrate to each other what success looks like - personally, as a team member and organisationally.
 - Remember to acknowledge achievement - from a first medication round for a student to a difficult situation handled well by an experienced nurse. Recognising great practice helps it happen again.
 - Signpost and look out for award programmes which could become part of wider quality improvement and build team resilience. Utilise and suggest tools to introduce incremental changes into pathways and systems. Look critically at embedded pathways for potential improvements.
 - On an individual level, nurses and midwives will reflect in their actions and observations, collecting stories and reflections for revalidation. As team members they will recount their achievements and recognise those of their colleagues. The organisation will
- take time to stop and demonstrate the achievements and successes of their staff through the annual open event and via media channels.
 - Nurses and midwives will use positive experience data to celebrate their work and achievements, to demonstrate success to the team and to themselves.
 - Nurses and midwives will endeavour to celebrate success every day, not just at celebration events but as part of day to day care.

"We will take time to demonstrate the achievements and successes of our staff."



ACKNOWLEDGEMENTS

Thank you to everyone who took part in the consultation or took time to comment on this Nursing and Midwifery Strategy:

Adam Tucker, Lascelles
Alison Marchant, Macmillan Urology CNS
Alison Mayfield, Deputy Chief Nurse
Anne Mann, CFRRT
Annie McCluskey, Matron Integrated Care
Bev Curtis, Equipment Library RGN
Caroline Fletcher, Respiratory Nurse
Chris Gill, Matron Elective Care
Christina Vento, Harlow
Claire Bullock, CAT
Claire Manley, Farndale
Elizabeth Eagin, Unscheduled Care
Emma Edgar, Cardiology
Jackie Strover, Oakdale
Jan Chaplin, Deputy Chief Nurse
Jennie Foster, Littondale
Jenny Mockford, Matron Integrated Care
Jill Foster, Chief Nurse

Joanne Burns, Jervaulx
Karen Collyer, Wensleydale
Kath Banfield, Matron UCCC
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Louise Binns, Skin Cancer Nurse
Mel Aubin, GI CNS Cancer Services
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Sara Keogh, Head of Nursing & Midwifery Elective Care
Sarah Birkett, AMU Bolton
Stephanie Davis, Matron UCCC
Sue Newton, AMU Fountains
Sue Smith, Parkinson's Nurse
Sue Wright, Orthopaedics
Terry Robinson, Respiratory Nurse
Tracy Hird, Surgical Outpatients
Beverley Neville, Rheumatology Nurse Specialist

Fran Bowden, Bed Manager Site Services
Gemma Gregory, Matron Integrated Care
Gill Johnson, Community IPC Nurse
Heather Lain, Acute Pain Nurse
Heather McKenzie-Shore, Matron Elective Care
Janet Farnhill, Senior Nurse Adult Safeguarding/Named Nurse Learning Disabilities
Judith Stephenson, Sister CAT
Linda Tunstall, Manager Women's Unit
Pauline Fitzgerald, Rheumatology Nurse Specialist
Sarah Blackburn, Lead Nurse CCOT
Sharon Burrows, Practice Learning Facilitator
Tracy Campbell, Head of Nursing Integrated Care
Maggie Peat Research Nurse
Ros Tolcher, Chief Executive
Rob Harrison Chief Operating Officer
Prof. Sue Proctor Non-Executive Director
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Report to the Trust Board of Directors: 29 th June 2016	Paper No: 12.0
Title	Chief Nurse Report
Sponsoring Director	Mrs Jill Foster, Chief Nurse
Author(s)	Mrs Jill Foster, Chief Nurse
Report Purpose	To receive, note and approve the contents of the report
Key Issues for Board Focus: <ol style="list-style-type: none"> 1. To note the results of Director Inspection Visits 2. To note the number of complaints received by the Trust in May 2016 3. To understand the steps being undertaken to maintain safe staffing levels including robust registered nurse recruitment 4. To acknowledge the effectiveness of the Trusts processes to support nurse revalidation 5. To receive notification of the imminent SEND inspection 6. To be aware of the Wood review of Local safeguarding Children's Boards 7. To be informed of how the Trust has developed a process for learning from patient feedback on quality of care 	
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: <ul style="list-style-type: none"> • To note the results of the Director Inspection Visits • To note the number of complaints received by the Trust in May 2016. • To understand the actions being undertaken to ensure safe nurse staffing levels including robust registered nurse • To acknowledge the effectiveness of the Trusts processes to support nurse revalidation. • To receive notification of the imminent SEND inspection. • To be aware of the Wood review of Local safeguarding Children's Boards • To be informed of how the Trust has developed a process for learning from patient feedback on quality of care 	

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 (<i>follow up visit</i>)	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 obtained 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 and MAU (<i>follow up visits</i>)	Red	Lack of cannula VIP scores and documentation			

Patient Safety Visits

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

Date	Area
8 June 2016	The Equipment Library
14 June 2016	Ripon Community Hospital

Complaints Update May 2016

The Trust received 16 complaints in May 2016, compared to 18 in May 2015.

Of the 16 complaints received in May 2016, 10 were graded Yellow and six Green. Of particular note:

- Three complaints about communication and attitude (a decrease from six in April)
- Three complaints about medical care (a decrease from nine in April)

Nurse Recruitment

Last month I reported the nurse recruitment campaign had been successful in that the number of registered nurses being recruited exceeded the number of registered nurses leaving the Trust. This position has continued for May moving into June.

Local recruitment initiatives continued with a successful event held on Saturday 18 June 2016 with eight registered nurses and two care support workers receiving conditional offers. Events are planned for every month moving forward.

Approximately 40 student nurses qualifying in September have committed their future to the organisation so far, a keeping in touch event is planned for 30 June 2016.

We have commenced our international recruitment campaign in the EU with a small success.

Actual versus planned nurse staffing - inpatient areas

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

This is the first month that we are also 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 May is 7.8 care hours per patient per day. NHS England will be publishing this data for every Trust, at which point, a comparison of performance against other Trusts can be undertaken.

	May-2016						
	Day		Night		Care hours per patient day (CHPPD)		
	Average fill rate - registered nurses/mid wives	Average fill rate - care staff	Average fill rate - registered nurses/mid wives	Average fill rate - care staff	Registered nurses/mid wives	Care Support Workers	Overall
Ward name							
AMU	89%	111%	94%	149%	4.20	2.85	7.05
Byland	79%	145%	82%	271%	2.81	3.74	6.54
CATT	89%	115%	120%	108%	4.83	2.70	7.53
Farndale	81%	148%	100%	169%	2.87	4.88	7.75
Granby	90%	140%	100%	190%	3.22	3.47	6.69
Harlow	105%	90%	97%	-	6.46	1.66	8.12
ITU/HDU	100%	-	103%	-	23.22	1.61	24.83
Jervaulx	70%	181%	81%	309%	2.61	4.53	7.14
Lascelles	94%	107%	100%	100%	4.96	4.79	9.75
Littondale	92%	103%	99%	106%	3.35	1.86	5.21
Maternity Wards	91%	80%	96%	94%	9.84	2.57	12.41
Nidderdale	94%	131%	98%	206%	3.35	2.98	6.33
Oakdale	96%	109%	94%	156%	4.33	3.10	7.43
Special Care Baby Unit	91%	82%	100%	-	14.93	3.65	18.58
Trinity	92%	140%	100%	118%	3.55	3.07	6.62
Wensleydale	91%	132%	106%	131%	3.51	2.97	6.48
Woodlands	94%	116%	94%	100%	9.30	3.61	12.91
Trust total	90%	127%	97%	158%	4.58	3.24	7.81

ED staffing	92%	77%	102%	94%
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Further information on this month's data

On the medical wards Jervaulx, Byland, AMU and CATT, the Registered Nurse (RN) 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 difficulties in recruiting Registered Nurses. Extra care staff was deployed to support the wards during this period and this is shown in the enhanced care staff, day and night time hours. In addition further care staff hours were required at times in these areas to provide intensive 1:1 patient support.

On Farndale ward, although the daytime RN hours in May were less than planned due to staff sickness and vacancies, the ward occupancy levels varied throughout the month and 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 the increase in care staff hours above plan was to support the opening of additional escalation beds and to provide 1:1 intensive patient support as required.

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

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 May 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 May this is reflected on the wards; Acute Medical Unit (AMU), Byland, Granby, Farndale, Oakdale, Nidderdale, Wensleydale and Trinity.

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

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

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

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. This information in conjunction with the increased reporting of workload/staffing incidents on Datix show the highest areas of risk due to nurse staffing levels continue to be on the acute floor, CATT and AMU and the frail elderly floor Byland and Jervaulx. This is also reflected in the conversations at ward level where staff are feeling under increased pressure. There is also increasing concern regarding the staffing of Farndale. In other wards and department areas the concerns being raised are the movement of staff to support these areas.

On balance, as Chief Nurse 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 is increased by the current vacancy level and should continue to be noted.

Nurse Revalidation

In June 2015 I informed the Board of the requirements for Nursing and Midwifery Revalidation which was due to commence in April 2016.

You will recall revalidation is the process that all nurses and midwives will need to engage with to demonstrate that they practice safely and effectively throughout their career. It is about promoting good practice and is not an assessment of a nurse or midwife's fitness to practice. Participation is on an on-going basis and nurses and midwives will need to revalidate every three years, at the point of their renewal of registration; this will replace the current PREP requirements and Notification of Practice form.

Nurse revalidation is a risk if the Trust does not put into place appropriate systems and processes to support nurses and midwives to meet the requirements of revalidation then they will be unable to practice, which would impact on the availability of the required workforce.

I am happy to report since 1 April 2016, 50 nurses have been supported through the revalidation process without difficulty.

Ofsted Inspection for Special Educational Needs and/or Disabilities (SEND)

We were informed on Monday 20 June 2016 by North Yorkshire County Council that they are to be inspected by Ofsted to identify the local areas effectiveness for identifying and meeting the needs of children and young people who have special educational needs and/or disabilities (SEND) from Monday 27 June.

The inspection will take place across five days and will involve visits to early years, school and post 16 settings together with multi agency focus group discussions around specific themes. Inspectors will meet/talk to a wide range of parents/carers and children and young people throughout the process and they will also analyse key performance data.

All our relevant teams have been informed and are preparing to participate in the process.

Local Children's Safeguarding Boards (LCSB)

On the 27 May 2016 the Government published the Wood Report of the review of the role and functions of Local Children's Safeguarding Board undertaken by Alan Wood and the government response to this report <https://www.gov.uk/government/publications/wood-review-of-local-safeguarding-children-boards>.

The Children's Safeguarding Governance Group will consider implications for HDFT and report to Board in September.

Developing a process for improving patient feedback on quality of care

At a previous board meeting the results from the national in-patient survey was presented and one of the lowest scores for the Trust was 'patients being asked about the quality of care they received'.

The directorates are currently developing actions in response to the national in-patients survey, responding to the above issue and six other areas agreed by the Learning from Patient Experience Group (LPEG). These action plans are being led from within the directorates and progress is being monitored by LPEG.

Jill Foster
Chief Nurse
June 2016

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Report to the Trust Board of Directors: 29 June 2016	Paper No: 13.0
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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:

- Outcome following receipt of the Cumulative Sum of Outcomes (CUSUM) alert.
- Update on progress relating to the implementation of recommendations of the Carter Report.
- Outcome of the consultation on the potential use of the Emergency Care and Treatment Plan (ECTP).
- Update on actions relating to improving management of Sepsis.

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 - June 2016

1 Mortality

Following a recent Cumulative Sum of Outcomes (CUSUM) alert regarding cerebrovascular deaths, I requested a review of the case notes of the nine patients in question. Five of the nine patients suffered major intracranial haemorrhage, one also suffered a heart attack, and all patients were medical elderly. In general, diagnosis had been timely and the care provided appropriate. Only one of the nine patients had been judged as being “slight evidence of avoidability” (Grade 5 of 6-point scale). Having read the case note review summaries, as Medical Director, I am satisfied that the care provided was appropriate. Please see the Integrated Board Report for the latest indices.

2 Implementing the Carter Report – ‘where are we now?’

I attended a meeting of Medical Directors on the 9th of June. The recommendations of the report are being worked through and are gaining momentum at a national level. The main headlines from the meeting were:

- Much of the implementation should be clinically led and based on robust benchmarking data;
- Quality, outcomes, value for money and elimination of variation will be paramount;
- Getting it Right First Time (GIRFT) principles should be rolled out to ALL specialities. Perhaps 15-20 visits per Trust in the next two years (National Leads are being appointed);
- Consultant job plans should be more closely aligned to productivity and organisational goals;
- Rapid Process Improvement Workshop (RPIW) methodology should be promoted;
- There are still efficiencies to be made;
- National Key Performance Indicators (KPIs) would not be slackened;
- Carter will be crucial in meeting Provider organisations share of the deficit; and
- Responsibilities of Medical Directors around GIRFT, job planning and Pharmacy Transformation Project.

3 DNACPR Update (Do Not Resuscitate)

Following public consultation on the potential use of the Emergency Care and Treatment Plan (ECTP) in a variety of settings, the Working Group had made a number of changes to the layout and wording of the document to address the issues highlighted.

The title of the document had been changed from ECTP to ReSPECT (Recommended Summary Plan for Emergency Care and Treatment). The main reasons for this are;

- To make it clear to all that this is recording recommended care and treatment for a future emergency (the final clinical decision rests with the professionals dealing with any emergency); and
- It is a summary and not a substitute for more detailed plans.

The ReSPECT process aims to respect patient preferences and clinical judgment through shared discussions between a person and their healthcare professionals. One of its principal aims is to make sure people understand the care and treatment options that may be

available to them, and that may work in a medical emergency, and to allow them to make healthcare professionals aware of their preferences.

The latest version of the ReSPECT form, designed in collaboration with the Helix Centre, will be reviewed by focus groups and used in a pilot study to be carried out in four UK sites for one month. The Working Group will next meet in late September to review feedback from these evaluations and to decide on any further changes that may be needed. An important aim of the project is to remain responsive to ongoing feedback as it continues to develop.

4 Repatriation of patients from the Tertiary Centre

Information has been received from Leeds Teaching Hospitals NHS Trust (LTHT) regarding difficulties in repatriating patients. Whilst the numbers for Harrogate and District NHS Foundation Trust (HDFT) are modest compared to larger Trusts, the cumulative operational impact for LTHT is significant. The Trust is committed to working with LTHT in order to ensure pathways flow efficiently, not only in terms of repatriation, but also regarding referrals (one can, of course, impact upon the other). Meetings are planned with relevant Provider organisations in order to agree actions. The Board will continue to receive updates as necessary.

5 Sepsis Update

Following previous discussions, Dr Earl, Consultant Anaesthetics and I have had a very productive meeting with senior clinical staff in the Emergency Department. A number of actions were agreed:

- Standardizing the triage category with more emphasis on “red flag” signs;
- Progressing Patient-track as an aid to recognition;
- Appointing a Sepsis Champion on each shift to ensure timely intervention;
- Use of “ready mixed” antibiotic preparations, or single dose Tazocin;
- Early administration of antibiotic before all investigations are undertaken; and
- Retrospective entry of timing of dosage using EPMA.

6 NHS Organ Donation Report

The latest Organ Donation report has been received from NHS Blood and Transplant. As expected, numbers within this Trust are generally small but we are within the expected range for a Trust of this size. The average number of organs harvested per donor was 4.5. I will be liaising with the Organ Donation Committee to enquire whether there is anything more that can be done to improve our contribution to this vital resource. An executive summary of our latest report can be found in the reading room.

7 New Consultant appointments

The following new appointments to the Consultant body have been made during the May – June:

- Dr Kath Lambert, Consultant in Palliative Care (community based);
- Miss Kirstie Laughlan, Consultant in Upper GI surgery (benign); and
- Diagnostic Radiology Consultant (two posts scheduled for interview Monday 20th June. A further update will be provided to the Board on 29 June).

8 Chaplaincy update:

The interview for a new chaplain to replace Reverend Tim Parker will take place on 16 June. I hope for a successful appointment and will be able to update the Board on the outcome of this process.

Dr David Scullion
Medical Director
17 June 2016

Report to the Trust Board of Directors: 29 June 2016		Paper No: 14.0
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		
1. To deliver high quality care		Through the pro-active management of workforce matters, including recruitment, retention and staff engagement.
2. 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.
3. 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 June 2016

Please note that this report will be amended from July onwards to reflect 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

Planning is well underway for the Summer Fair at Harrogate Rugby Club on Sunday 26 June between 11am and 4pm.

The event is open to all staff and their families; the Long Service Awards and Celebrating Success Awards will be presented on the day by Sandra Dodson and Dr Ros Tolcher. Food and drink will be available to purchase in the rugby clubhouse including a barbecue. The ground has plenty of free parking with easy access from the A1 and public transport routes stop right outside.

Tickets are available on line at <https://www.justgiving.com/fundraising/HDFTsummerfair2016> and have also been available in Herriot's restaurant between 12noon and 1.30pm on various dates in June.

b) Rostering

Following a repeated internal audit finding of limited assurance it is an absolute priority that roster managers develop local working practices to ensure that RosterPro is updated in real time or as close to real time as practically possible. The Trust recognises the operational challenges facing departments; however, the opportunities it will provide to the Trust in terms of ensuring the effective use of resources make this an essential management objective.

Roster managers are being issued with a top tips' list to support them in implementing real time roster management and I have urged directorate management teams to follow this up to ensure it is delivered locally. Regular reports will be available in due course that will give improved visibility of rostering performance information through the Trust's Operational Delivery Group.

c) Appraisal

Feedback regarding the new appraisal process and documentation has been received. In summary the key themes are:-

- Positive comments about the process and the new paperwork;
- Comments welcoming the introduction of a values/behaviours discussion in the appraisal;
- Some residual but minor concerns over volume of guidance and length of appraisal process.

The Trust will continue to monitor feedback and make improvements where appropriate. It is essential that managers across the organisation now make effective plans for the completion of staff appraisals in a timely manner.

The HR Business Partners are working with Directorate Management teams to facilitate improvements in compliance levels across the Trust. Two of the key initiatives being taken forward currently are:

- Consideration of developing a set of objectives for entire teams where appropriate.
- Ensuring that departments have successfully trained and delegated appraisal activity in their area, by monitoring line management reporting lines and attendance on the 'Pathway to Management' Training (via the Learning and Development Team).

Once managers and staff become more familiar with the new process and paperwork it should be possible to complete the majority of appraisals in one hour without detracting from the quality of the appraisal process – however, this will vary depending on the role and the individual in some circumstances.

d) Doctors in Training - New Contract

The new Terms and Conditions for Doctors in Training were published on 27 May 2016, following the agreement reached at talks between the Department of Health (DoH) and the British Medical Association (BMA). There are significant changes from the Terms and Conditions published previously on 31 March 2016.

The new Terms and Conditions are subject to a ballot of all eligible BMA members, which will follow a series of roadshows to be staged using materials agreed jointly between the DoH and the BMA. The ballot will run between 17 June and 1 July 2016 with the announcement of the result scheduled for 6 July 2016. All work on the new Terms and Conditions (with the exception of the appointment to the Guardian of Safe Working Hours role and offer letters for Foundation Year One Doctors commencing in August 2016) is suspended until the result of the ballot is known.

If the BMA ballot votes to accept the Terms and Conditions, then the timetable for phased implementation indicates that the new contract will be effective from 3 August 2016 and on 5 October 2016 this will be introduced to all FY1s, FY2s on rotas with FY1s, ST3+ in obstetrics and gynaecology and ST3/4 in general practice. The implication of this is that the 20 F1s who start in the Trust on 3 August, and a small number of FY2s on rotas in the Planned and Surgical Care Directorate, will start their first rotation on the existing (2002) contract and then start on the new contract on 5 October 2016. Doctors in training in other grades and specialties will be progressively transferred to the new contract between February and August 2017.

e) Guardian of Safe Working Hours

One of the exceptions to the suspension of all work on preparation for, and implementation of, the new Terms and Conditions of Service is the recruitment process for the role of the Guardian of Safe Working Hours. The DoH and the BMA confirmed their strong commitment to this role at the ACAS talks and agreed some clarification to the original proposal, including the requirement for the Guardian of Safe Working Hours and the Director of Medical Education to jointly establish a Junior Doctors' Forum, to include doctors in training from the Trust, one of which must be the relevant LNC member and the others must be elected from those at the Trust. This Forum 'will play a vital role in the scrutiny of the distribution of incomes drawn from fines' which the Guardian of Safe Working Hours is empowered to impose for breaches of the Terms and Conditions.

The recruitment process for the Trust's Guardian of Safe Working is underway; the closing date for applications was 23 May 2016 and interviews are scheduled for 22 June 2016. The interview panel will include the Deputy Medical Director, the Director of Workforce and Organisational Development and two doctors in training, one of which must be the LNC representative for doctors in training. The Guardian of Safe Working Hours must be appointed in time to attend a national conference in London on 26 July 2016.

f) Job Planning

Below are the latest job planning figures for Consultants and Specialty Doctor and Associate Specialist grades as at 31 May 2016:-

JOB PLANNING CENTRAL REPORT – CONSULTANTS							
Directorate	Number of Consultants	Job Plans within 12 months	%	Job Plans older than 12 months	%	Number of Consultant with no Job Plans recorded	%
UCCC	24	23	95.83%	1	4.17%	0	0.00%
Elective Care	60	39	65.00%	10	16.67%	11	18.33%
Integrated Care	45	37	82.22%	0	0.00%	8	17.78%
Total	129	99	76.74%	11	8.53%	19	14.73%

JOB PLANNING CENTRAL REPORT - SAS GRADES							
Directorate	Number of SAS Doctors	Job Plans within 12 months	%	Job Plans older than 12 months	%	Number of SAS Doctors with no Job Plans recorded	%
UCCC	4	3	75.00%	0	0.00%	1	25.00%
Elective Care	40	14	35.00%	2	5.00%	24	60.00%
Integrated Care	3	3	100.00%	0	0.00%	0	0.00%
Total	47	20	42.55%	2	4.26%	25	53.19%

The Trust's Job Planning Steering Group meeting took place this month. A number of initiatives have been agreed to continue to make improvements in the job planning process and overall levels of compliance.

g) Nurse Recruitment and Incentives

The Trust has recently embarked on a campaign to recruit European Union nurses via our partner Search Recruitment. Due to recent changes to the Nursing and Midwifery Council (NMC) requirements for overseas nurses, the number of potentially suitable and immediately available applicants has become considerably smaller.

Those who registered with the NMC before January 2016 are not required to undertake the now mandatory English Language test (IELTS), passing at level 7 or above. Our recruitment partner is actively marketing to find such applicants and the Trust has offered four positions to suitable applicants. There are also a further three applicants to be interviewed via Skype. All of the aforementioned applicants will be required to arrive in the UK by 18 July 2016 in order to meet the requirements of the NMC. A working group has been created to ensure all aspects of the project including pre-employment checks, on-boarding and induction are undertaken to support each nurse appropriately.

The nursing team are currently contacting the student nurses offered positions over recent months with the Trust with the next on-boarding event to be held on the evening of 30 June 2016. This piece of work will be used to further promote our offer to all nursing students of paying their NMC fees, but also help ascertain those students who have selected Harrogate as their employer of choice.

I have also previously reported that Health Education England (HEE) have been working with the Trust for some time now to establish an international registered nurse exchange scheme with India. The funding to establish this programme has now been agreed by HEE and the Trust has been selected as a pilot site to take this project forward. The Trust has also recently established a budget for international recruitment which will be used to support our EU, EEA and International recruitment work.

The outcomes of above campaigns will be documented in the weekly nurse recruitment report.

I have also recently met with senior representatives of the Faculty of Health and Social Care at Leeds Beckett University to agree the terms for the development of our new pilot programme for ten 'non-commissioned' undergraduate nursing places to commence from January 2017.

h) Apprenticeship and Band 1-4 Workforce – Investing in Talent

The Trust is continuing to work with Skills for Health in respect of the healthcare support workforce by:-

- Implementing an apprenticeship strategy for healthcare support worker roles;
- Introducing a career development framework;
- Widening the participation in order to support and encourage young people to view the NHS as an employer of choice.

i) 2016 NHS Graduate Trainee Placement

I am delighted to confirm that the Trust has been successful in our applications to host two first placement trainees; one in HR and one in Finance. They are due to join the Trust in September and we look forward to welcoming them.

j) West Yorkshire Sustainability and Transformation Plan (STP)

Work continues to progress with the development of the STP. The Trust has an influential role in the Workforce Advisory Board that is being established to support the aims and objectives of the STP and the first meeting of the LWAB is due to take place in July.

k) Leadership

The next meeting of the Trust's Leadership Group, which has now been expanded to include all consultants, is due to take place on Friday 24th June.

The agenda will include debate about improving discharge arrangements, briefings from executive directors on changes in operating context, and a spotlight on 'live' quality improvement activities.

I) Bank and Agency Staff

This month I have established and chaired a region-wide meeting concerning the use of bank and agency staff and providers' ability to comply with the capped rates and use of framework agencies. Over 30 delegates attended the meeting and there was a significant appetite for the development of internal banks of staff which could collaborate across the region. The aims of this would be to ensure there was far less reliance on agency staff and a real focussed drive to recruit to internal banks.

The capped rates and use of framework agencies will be discussed at the next meeting of the West Yorkshire Association of Acute Trusts. I would hope following this meeting of West Yorkshire Chief Executives that further progress can be made in line with the outcomes of the meeting I chaired.

Board Committee report to the Board of Directors

Committee Name:	Quality Committee
Committee Chair:	Mrs L.A Webster, Non-Executive Director and Quality Committee Chair
Date of last meeting:	1 June 2016
Date of Board meeting for which this report is prepared	29 June 2016
Summary of live issues and matters to be raised at Board meeting:	
<p>1. Staffing levels was raised as a continued issue of concern in respect of delivering a quality service across all areas. This resulted in a discussion about the benefits of developing our programme for funding and recruitment of Advanced Care Practitioner's (ACPs). The Quality Committee would ask the Board to maintain this as a high priority action for the Trust.</p> <p>2. The Clinical Effectiveness Annual Report was received. This was an excellent report showing a huge amount of work carried out in the Trust and great work from the team.</p> <p>a. However we heard that two areas have deteriorated during the year, the most concerning was that only 50% of audits requiring an action plan were found to have one included.</p> <p>b. An updated Clinical Effectiveness Strategy and updated work-plan is to be presented at the August meeting and we expect this to show how the issues can be addressed, but each Directorate was asked to ensure focus via their individual Governance Groups.</p> <p>3. External Reports Received - National Paediatric Diabetes Audit – serious concerns were raised from this self-assessment report. The Quality Committee requested the report be re-submitted at the July meeting for assurance.</p>	
Are there any significant risks for noting by Board? (list if appropriate)	
<ul style="list-style-type: none"> DNACPR and Training Report Received – The Quality Committee was asked by the Audit and Corporate Risk Review Group to review this activity in more detail. As a result, the Quality Committee was not assured that the Trust is providing high quality care in all areas. We have requested that Senior Management Team review and identify an appropriate solution and we receive a further report at the October meeting following the next audit. 	
Matters for decision	
<ul style="list-style-type: none"> Updated Terms of Reference Updated copy submitted for approval by the Board 	
Action Required by Board of Directors: The Board are asked to receive the report for comment and decision as above.	

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Board Committee report to the Board of Directors

Committee Name:	Finance Committee
Committee Chair:	Mrs Maureen Taylor, Non-Executive Director/ Finance Committee Chair
Date of last meeting:	22 nd June 2016
Date of Board meeting for which this report is prepared	29 th June 2016
Summary of live issues and matters to be raised at Board meeting:	
<ol style="list-style-type: none"> 1. The latest financial position for 2016/17 was considered. There is an adverse variance against plan at month 2 (May). Specifically discussed was the impact on income that the agency cap is having particularly in Theatres and Nurse staffing. 2. The Committee discussed the inclusion in the financial statements of the estimated reduction in our STP funding. Whilst noting we do need to report against our control total, it was agreed that the statement be reviewed to focus on performance against our operational surplus target of £2.2m as this is the element that we could control. 3. All Cost Improvement Programme (CIP) schemes have been identified, reducing to 80% after risk assessment. Work continues to identify additional schemes. 4. The Financial Sustainability Risk Rating for Quarter 1 will be submitted at the end of July. Indications are that we will return a rating of 3 against a planned rating of 4. 5. Some discussions have taken place with specific debtors and payment on some long-standing debts is now expected. 6. No local report has emerged from the Carter Review as yet. 7. Good progress on service line reporting and the Finance Committee agreed to schedule specific review areas into the work-plan. 8. An early draft of the 5-year Sustainability and Transformation Plan was considered. The Board Strategy Away Day will consider the impact, risks and opportunities further and an update is due to be presented to September Finance Committee. 9. Very positive progress was reported on the Carbon Efficiency Fund scheme showing that savings from the scheme so far are in line with the business case with some savings due later in the scheme. 10. It was noted that a 5 year contract for the renewal of System One is recommended and that financial provision for 2016/17 had been included in the budget. The Finance Committee would seek 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 requires Board approval for any new contract above the value of £200,000, however, it was noted that this was not a new contract. 	
Are there any significant risks for noting by Board? (list if appropriate)	
<ul style="list-style-type: none"> • Items 1 and 3 above. 	

Matters for decision
<ul style="list-style-type: none">• Items relating to point 10 above.
Action Required by Board of Directors: <ul style="list-style-type: none">• The Finance Committee have recommended that the Board endorse delegated authority to Mr Robert Harrison, Chief Operating Officer, and Mr Jonathan Coulter, Deputy Chief Executive/Finance Director, as signatories for the purposes of the 5-year contract for the renewal of System One.