Harrogate and District NHS
NHS Foundation Trust

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

On: Wednesday 27 May 2015
Start: 0930 Finish: 1230
In: The Derwent Room, The Pavilions, Wetherby Road, Harrogate

	AGENDA		
Item No	**Item**	**Lead**	**Paper Number**
0930 – 1000 General Business			
1.0	**Welcome and Apologies for absence:** *To receive any apologies for absence;* Mr Andrew Alldred, Clinical Director, Acute and Cancer Care; Dr Kat Johnson, Clinical Director, Elective Care	Chairman – Mrs Sandra Dodson	
2.0	**Declarations of Interest and Board of Directors Register of Interests** *To declare any interests relevant to the agenda for the meeting and to receive any changes to the register of interests pursuant to section 6 of the Board Standing Orders*	Chairman – Mrs Sandra Dodson	2.0
3.0	**Minutes of Board of Directors meeting held on 22 April 2015** *To review and approve the Minutes*	Chairman – Mrs Sandra Dodson	3.0
4.0 *1000*	**Review of Actions schedule and Matters Arising** **i GP OOH services** *To review the actions schedule and provide updates on progress of actions to the Board of Directors.*	Chairman – Mrs Sandra Dodson Operational Director – Ms Joanne Crewe	4.0 4.1
1000 – 1055 Putting Patients First			
5.0 *1010*	**Report by the Chief Executive** *To be noted*	Chief Executive – Dr Ros Tolcher	5.0
6.0 *1020*	**Report by the Medical Director** *To be noted*	Medical Director – Dr David Scullion	6.0
7.0 *1030*	**Report by the Chief Nurse** *To be noted*	Chief Nurse – Mrs Jill Foster	7.0
7.1 *1040*	**Actions arising from Lampard Report** *To receive a report on the actions arising*	Chief Nurse – Mrs Jill Foster	7.1
7.2 *1045*	**Patient Experience Report – Q4 and Annual Report** *To be noted*	Chief Nurse – Mrs Jill Foster	7.2
8.0 *1055*	**Report by the Chief Operating Officer** *To be noted*	Chief Operating Officer – Mr Robert Harrison	8.0
1055 - 1105 Break			

1105- 1130 Managing Resources Efficiently			
9.0 *1120*	**Report by the Director of Finance** *To be noted*	Director of Finance – Mr Jonathan Coulter	9.0
10.0 *1130*	**Operational Plan 2015-16** *To receive an oral report on the Plan approved by the sub- Committee on 7 May 2015*	Director of Finance – Mr Jonathan Coulter	
1130 – 1145 Valuing and Rewarding Staff			
11.0 *1140*	**Report by the Director of Workforce and Organisational Development** *To be noted*	Director of Workforce and Organisational Development – Mr Phillip Marshall	11.0
1145 – 1205 Assurance			
12.0 *1155*	**Quarterly review of the Board Assurance Framework** *To receive an update*	Chief Executive - Dr Ros Tolcher	12.0
13.0 *1205*	**Quarterly review of the Corporate Risk Register** *To receive an update*	Chief Executive - Dr Ros Tolcher	13.0
1205 – 1230			
14.0 *1210*	**Reports:** *To receive any oral and/or written reports not covered elsewhere in the Agenda*	Chairman – Mrs Sandra Dodson	
15.0 *1215*	**Serious Complaints / Incidents/matters relating to compliance with the Trust's Licence or other exceptional items to report or that have been reported to Monitor and/or the Care Quality Commission** *To receive an update on any matters reported to regulators.*	Chairman – Mrs Sandra Dodson	
16.0 *1225*	**Any Other Relevant Business** *By permission of the Chairman*	Chairman – Mrs Sandra Dodson	
17.0 *1230*	**Board Evaluation**	Chairman – Mrs Sandra Dodson	
18.0	**Confidential Motion** **The Chairman to move:** *'That members of the public and representatives of the press be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'.*		

Harrogate and District NHS
NHS Foundation Trust

BOARD OF DIRECTORS – REGISTERED DECLARED INTERESTS

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

The register is maintained by the Foundation Trust Office.

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

May 2015

Harrogate and District NHS
NHS Foundation Trust

Report Status: Open

BOARD OF DIRECTORS

Minutes of the Board of Directors meeting held on Wednesday 22 April 2015 at 9.00am in the Board Room, Harrogate District Hospital.

Present:
Mrs S Dodson, Chairman
Mr J Coulter, Director of Finance and Deputy Chief Executive
Mrs J Foster, Chief Nurse
Mr P Marshall, Director of Workforce and Organisational Development
Mr P Nicholas, Deputy Director of Performance and Informatics
Professor S Proctor, Non-Executive Director
Dr D Scullion, Medical Director
Mrs M Taylor, Non-Executive Director
Mr C Thompson, Non-Executive Director
Dr R Tolcher, Chief Executive
Mrs L Webster, Non-Executive Director

In attendance:
Mrs J Crewe, Operational Director, Acute and Cancer Care Directorate
Dr P Hammond, Clinical Director, Integrated Care
Dr K Johnson, Clinical Director, Elective Care
Mr A Forsyth, Interim Head of Corporate Affairs (Minutes)
Three Governors of the Trust, one member of the public

Brief on Rapid Improvement Workshop Programme

The Board received an update on two elements of the Rapid Process Improvement Programme from Mr D Plews, Deputy Director for Partnerships and Innovation.

Learning from Complaints and Incidents, 45 day report-out

Sponsored by Medical Director, Dr David Scullion, this improvement event focused on engaging two teams of colleagues (one from Fountains ward at Harrogate Hospital and one from Community Dentistry Services) in trialling new ways to improve the way that Trust staff learn from complaints and incidents. During the workshop, colleagues considered both higher-volume, lower-level incidents and lower-volume, more serious incidents.

Two strands of work emerged. One focused on implementing rapid daily discussions about learning from complaints and incidents in Fountains ward three times per day so that each nursing shift was engaged - and also included some environmental changes, including the erection of a “thank you” noticeboard. The second strand delivered the trial of an Achieving Behaviour Change tool in Community Dentistry in conjunction with the Academic Health Science Network. This tool, developed in Yorkshire by Prof Rebecca Lawton using insight from psychology, was used to examine the reasons that incidents and near-misses are under-reported with a view to seeing if the tool would have wider application in understanding the reasons why people are not changing their behaviour as a result of learning from wider complaints and incidents. Results are currently being analysed. A way forward will be planned in advance of the 75 day report-out.

Endoscopy/Histopathology Rapid Process Improvement Workshop, 365 day report-out

Also sponsored by Dr Scullion, this workshop focused on improving the pathway of a sample between when it left the patient's body in endoscopy to the point a report on it was completed by a Consultant Histopathologist. It was noted that sample error rates of 16% one year ago had now reduced to 4.2% (target – 0%). A 50% increase in the number of samples that were being sent to the lab on the day that they were taken from the patient was being sustained, and environmental improvements in both endoscopy and histopathology were helping to increase the efficiency of the sample flow across both departments. Lean supplies ordering systems were also continuing to bring benefits in histopathology.

Mrs Dodson thanked Mr Plews for his comprehensive update and said that the work was core to driving up standards and was significant in delivering high quality care on an enduring basis.

Mrs Dodson welcomed the Governors and public to the meeting and reminded them that this was a Board of Directors' meeting held in public so that members of the public could observe the working of the Board, but with no right to speak or ask questions. Mrs Dodson reminded the public that they were welcome at the public Council of Governors' meetings in which they could participate through a question and answer session.

1. Apologies for Absence

Apologies for absence were received from Chief Operating Officer Mr Harrison (Mr Nicholas deputising) ; Clinical Director for Acute and Cancer Care Mr Alldred (Mrs Crewe deputising) and Non-Executive Director Mr Ward .

2. Declarations of Interest

There were no declarations of interest relevant to items on the agenda for the meeting. There was one change to the register of interests. Mrs Taylor confirmed that she had resigned from all registered interests except for that of Independent Non-Executive member of the Audit Group of British Show Jumping.

3. Minutes of the meeting of the Board of Directors on 25 March 2015

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

Minute 8.8 Line 7	**Delete:**	**'**It was…..or not'
	Insert:	**'**The Mortality Review Group (MoRG) has identified thematic quality of death issues but virtually no cases of avoidable death. Despite this, identification and investigation of any avoidable deaths that come to light through the MoRG process remain an important aspect of its function.'
Minute 9.6 Line 3	**Delete:**	'Mr Foster'
	Insert:	'Mrs Foster'
Minute 12.3 Line 13	**Delete:**	'NYC'
	Insert:	'NYCC'
Minute 13.1.3 Line 7	**Delete:**	'As far as…..forecasting'
	Insert:	'As far as the financial plan was concerned, the Committee agreed with the activity and income phasing as proposed by the Executive Team'.

4. Review of Actions Schedule and Matters Arising

Action 2 – this would be covered by Mrs Foster in her report at the meeting – complete.

Action 3 – this would be covered by Dr Scullion in his report at the meeting - complete.

Action 4 – this would be covered by Mrs Foster in her report at the meeting – complete.

Action 5 – Dr Johnson tabled a short paper showing the results of an analysis of Complaints in Trauma and Orthopaedics during 2045-15. This showed that the rate of complaints against activity during Q4 had been 0.08% and across the year averaged 0.07%. There had been a small increase in complaints, the reasons for which were being considered by the Directorate Board, with the common theme of poor communication being subject to a number of actions. Dr Johnson said that there did not seem to be a particular problem in Trauma and Orthopaedics and drew attention to the comparison with two other specialities in the Directorate. She said that there would now be a similar focus on complaints in Obstetrics and Gynaecology. The Action was complete.

Action 6 – this would be covered by Mrs Foster in her report at the meeting – complete.

Action 7 – this would be covered by Dr Scullion in his report at the meeting – complete.

Action 8 – Mrs Crewe said that the results of an audit of GP OOH triage arrangements were being analysed and that Mr Alldred would bring a comprehensive report to the May meeting of the Board.

Action 9 – a meeting had been arranged for 7 May to approve the Operational Plan – complete.

There were no other matters arising.

5. Board of Directors – Terms of Reference

Mrs Dodson said that a number of changes had been proposed following the circulation of the paper. These included suggestions on quoracy, quality, finance, governance, ethics and integrity and other matters. These changes were discussed and Mrs Dodson directed that a final version incorporating them should be brought back to the May Board meeting for final approval. Mrs Webster commented that the revised Terms of Reference should take account of the template developed as part of the Governance review.

Action: Mr Forsyth

6. Third Party Schedule

Mrs Dodson received unanimous approval for the paper as circulated.

Putting Patients First

7. Report by the Chief Executive

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

7.2 Dr Tolcher provided some additional contextual information in respect of complaints. The Trust has an estimated 1.5 million patient contacts per annum, which equates to around 2,700 per day. Whilst every individual complaint is very important, especially to the complainant, the average rate of around 23 complaints per month is relatively small at one per 2,500 to 3,000 patient contacts.

7.3 Moving to the operational performance, Dr Tolcher said that the Trust owed a huge thank you to staff for delivering an excellent overall outcome. Accessibility and quality had been improved. Leaving aside the financial challenge, elective admissions had risen by 9.5% and District Nursing activity by 12% whilst all 18 week and cancer access waiting times targets had been achieved. The Trust has also achieved the required standard of more than 95% of people being seen and treated in the Emergency Department within 4 hours in every quarter. National targets had been achieved, in some cases significantly exceeded in Health Care Acquired Infections, Cancer and Stroke. The Trust had delivered high quality, safe patient care. There were areas which remained challenging – GP OOH services and ambulance delays; although the number of delays of 30 minutes or more had been reduced there remained work to be done. She also noted that there was a shortfall of approximately two Whole Time Equivalent (WTE) Health Visitors at the end of the year albeit this was against a stretch target.

7.4 In financial terms the Trust had recorded a modest operating surplus of £10,000 for 2014-15. For the second year running it had failed to deliver the planned surplus, which had implications for future investment.

7.5 Mrs Dodson said that she endorsed Dr Tolcher's comments about the work of the staff and the Board agreed to record formally its thanks for their efforts over the year. She reported that at a recent meeting of Board Chairmen, the Trust had been lauded as an exemplar on ambulance delays. Although a good service had been provided she was sure that the Trust wanted to do better. Dr Tolcher agreed and said that there was focus on Emergency Department waiting times and the patient flow across the whole organisation. A 'summit' on this subject, including representatives from all Directorates, would take place later that day; the aim was to make the Trust high-performing in this area.

7.6 Dr Tolcher noted that the New Models of Care work would deliver the Trust's strategy, moving further and faster whilst progressing with the existing business model. She asked Board members to consider the report of the Harrogate Health Transformation Board (HHTB), circulated at paper 13, which outlined the governance of delivering partnership working. There were both simple and complex systems involved in the local health economy and part of the methodology was to ensure that a consistent message was hard-wired into the governance of the partners with visibility at their Boards: the HHTB would develop and present Board-ready papers.

7.7 Mrs Dodson thanked Dr Tolcher for her report and invited questions and comments from Board members. Professor Proctor noted the increase in the use of community services and asked whether there was capacity for this, whether there were risks and was further growth anticipated in forward planning. Dr Tolcher said that community services were at the heart of New Models of Care – productivity in the community teams had increased and some new investment by the Trust had been made although there had been no investment uplift in the block contract. There were approx. 30 more staff employed now than there had been when the Trust integrated with community services. She noted that there was an anticipated 5% growth in the over-65 year old patients in the year ahead and there were challenging conversations with the HaRD CCG as to how this was recognised. Mrs Foster said there was a shortage of qualified District Nurses but that the Trust was developing its own programme, partly through a Rapid Process Improvement Project to examine nursing vacancies and

actions to fill them. Whilst international recruitment last year had been successful there was a need to act quickly.

7.8 Professor Proctor said that the age profile of District Nurses themselves presented potential problems and asked whether the Local Education Training Board (LETB) was involved. Mr Marshall confirmed that he was working with the LETB to look at future pathways and training, increasing student nurse numbers and increasing the community emphasis in their training.

7.9 Turning to the financial position, Professor Proctor asked what was the level of confidence that the Cost Improvement Programme (CIP) would be achieved, noting that there was a shortfall in the plans of all Directorates. Dr Tolcher agreed that it was very challenging but that the Trust was starting 2015-16 in a more realistic place with a credible, risk-assessed plan and stronger governance than in previous years. Work was continuing to move the high-risk (Red) proposals through Amber to Green and therefore ready for implementation, with a schedule for delivery. Following the agreement of the Enhanced Tariff it had been agreed that the original targets would be retained, both to provide some headroom and help address future winter pressures; this should also give a degree of confidence that the CIP would be achieved. Management of the CIP and cost control was at Directorate level, as close to the services as possible to encourage early intervention.

7.10 Dr Hammond said that the Board should be reassured; this year felt different, although challenging – his view was that the level of clinical engagement with the CIP process was much better and that the role of the Clinical Leads was now more robust. The foundations were more solid. In previous years he considered that once April arrived there had been a degree of relaxation in terms of cost control – this was not the case this year and he also believed that there were good systems in place. Mrs Crewe agreed that there was ownership by clinical colleagues and in her Directorate there was a focus not only on the year ahead but also looking two or three years hence, with a view to developing bigger returns in subsequent years including where to place 'invest to save' proposals. She believed that there were opportunities around Community Services and improved ways of working, which could also affect hospital services positively.

7.11 Dr Johnson echoed the positive views of her colleague – in her view it was about improved engagement and accountability. There were some high risk areas for exploration, of which Waiting List Initiatives were one; clinical leaders were considering what could be done, including increasing elective theatre work on weekday evenings. She said there was a different approach being taken and that the culture was changing, although it would take time.

7.12 Mr Marshall said that the development of the CIP around medical staffing and agency workers had been a much better process. He was working with the LETB to ensure maximum fill rate and with Leeds TH Trust to reduce the rates for locum doctors. Mr Coulter said that the feedback from the Finance Managers was that they were more confident and that measures in the CIP were more robust than in previous years. He believed that the Trust was in a better place.

7.13 Mrs Dodson said it was important to have a high degree of confidence in the delivery of the CIP even though others may not have it. The rigour of the process was encouraging, as was the need to be different. Mr Coulter said that NHS Providers had double-checked the Trust's intention to achieve a surplus in 2015-16 as this was not the norm amongst acute providers and he had re-iterated that this was a correct but challenging target.

7.14 Moving to the Board Assurance Framework, Mr Thompson said it showed consistent progress with improvements against three Risks, although he recognised there were seven Red Risks. He noted improvements in the Corporate Risk Register and believed that the process was working and making excellent progress.

7.15 Mrs Webster asked whether the recent GP Event had been successful and was there potential in the approach. Dr Tolcher said that those who had attended, both GPs and Trust staff, had been positive but that it had been hoped that more GPs would have attended. There was enthusiasm for more networking. She and Mr Harrison had now visited a majority of the local GP practices and had received comments such as 'really good' 'sorry I missed it'. The next focus would be on Leeds practices but there would also be some specialty-specific targeted sessions. She said that the real efforts made by the clinical staff were a great credit to them.

7.16 Mr Coulter clarified that the additional six Health Visitors commissioned in 2014-15 would not be funded in 2015-16. Mrs Dodson asked whether the funding from Call to Action had been utilised and Mr Coulter confirmed that it had, but additional funding received in 2014/15 had been non-recurrent and had been withdrawn.

7.17 Commenting on the GP Open Event Dr Scullion felt that it had been worthy and useful. Trust staff had been outstanding in his view and there was a need to hold it again, targeting new consultants and more GPs, and he expected a better turnout. He noted that it was proposed to develop a shadowing programme with GPs coming to the Trust and consultants visiting practices. Mrs Crewe said that the feedback had been positive and follow-on conversations had been strong. She emphasised the strength of word of mouth in improving future attendance. Dr Scullion praised the domestic arrangements, which he felt were important.

8. Report by the Medical Director

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

8.2 Dr Scullion said he was delighted that the Sign up to Safety funding bid had been successful, with the full sum sought having been approved. He noted that there were some restrictions but the learning from the programme would have wider value. He said that development of the bid had been against a challenging deadline. A Task and Finish group would bring the programme to fruition.

8.3 Moving to mortality Dr Scullion recalled the detailed discussion at the previous Board meeting. He said that whilst the crude mortality rate had fallen recently this had continued the trend for a number of years. He noted the slight reduction in the HSMR and SHMI and wondered whether the Trust had been at the top of a natural curve – the rates would be watched carefully. The Mortality Review Group (MORG) was looking carefully at the quality of end of life care. He gave a snapshot of the position in March, for Harrogate Hospital only; there had been 59 deaths, as against an average of high 70s over the winter and a long-term average of around 50. The ages of the deceased ranged between 32 and 98 years with 81.5% over 60 years of age; only four of the deceased had been younger than 60. 17% had been over 90 years of age, 40% between 80 and 89 and 30% between 70 and 79. 6.8% had been acute surgical patients with 92.3% in medical specialties.

8.4 Three deaths had taken place in the Emergency Department and three had been referred to HM Coroner. Twenty two of the deceased had been under Care of the Elderly or Stroke specialists. The average number of diagnostic codes was 2.5, which Dr Scullion

considered was low against the national average, with around 11% being coded for specialist palliative care. Dr Scullion contrasted this with the position at a Trust rated Outstanding by CQC which ran at around 50% for specialist palliative care coding but he believed that the Trust delivered high quality palliative care both in the hospital and in the community.

8.5 Dr Hammond emphasised the challenges of the demographic position. He said that the Elderly Medicine team was well-placed to provide good, high quality care but did not use specialist palliative care consultants, probably to the Trust's detriment in terms of coding, but absolutely right in terms of quality of care.

8.6 Mr Thompson welcomed the paper and noted that the paper to which Dr Scullion had provided a link suggested that there should be greater focus when the HSMR is above 100, which it had been in the Trust for at least six months. He felt that the operational report did not provide 'colour and context' and he would find it helpful for an average mortality figure to be included in Board reports monthly to allow Board members to assess trends more easily.

Action: Dr Scullion

8.7 Dr Scullion continued by indicating that the changes to the Never Event Policy and Serious incident Framework would not make a significant difference to the way the Trust operates.

8.8 Dr Law had relinquished the post of Director of Postgraduate Medical Eeducation. Dr Scullion said that her contribution to medical education the TrustMoving to the contribution of Dr Helen Law to postgraduate medical education in the Trust had been brilliant and that she had used intelligence, care and diplomacy to deliver the programme over her five years in the post of Director. The Board concurred and Mrs Dodson said that she would write to Dr Law to convey the thanks of the Board for her work. **Action: Mrs Dodson**

8.9 In response to a question on the Montgomery Ruling Dr Scullion's view was it was not clear whether it would make a difference in practice. He believed that the Trust had a robust consent regime and drew attention to the series of lectures which Professor Paul Marks would deliver to senior medical staff and agreed that it would be appropriate for any Non-Executive Directors who wished to attend. He would circulate the dates of the lectures.

Action: Dr Scullion

8.10 Dr Scullion was delighted to inform the Board that the Anaesthetic Department had recently received Anaesthesia Clinical Services Accreditation (ACSA) from the Royal College of Anaesthetists. Dr Johnson said that the Trust was one of only three Trusts nationally to be so accredited, the others being Homerton and East Suffolk. She emphasised that this recognised the high quality service provided and noted the hard work of Dr Melanie Dakin in preparing for the accreditation process and there had been particular challenges in achieving the required standards without specialist services. Dr Scullion said that the assessors had been openly surprised and impressed and Dr Tolcher believed that accreditation was very positive for patients using the Trust's services, showing that it delivered the highest quality of care on a daily basis. Mrs Dodson said that she would write to Dr Dakin to convey the thanks of the Board for the work and success of the department.

Action: Mrs Dodson

It was recognised that the award should receive appropriate public coverage.

Action: Mr Forsyth

8.11 Returning to the mortality figures and the low number of codes, Mr Nicholas reassured the Board that the quality of the coding process was audited regularly, providing confidence in the outputs. Dr Scullion said that coders attended the MORG and the process

was taken seriously – Mrs Dodson wondered whether coders could attend other meetings, to the benefit of clinicians in particular. Dr Hammond said that if there was under-reporting of codes then there could be recourse to medical notes and coders could be asked to educate junior doctors about the need to make proper records of co-morbidities, perhaps by changing the clerking form to reflect the most commonly used codes. Mrs Dodson said that this issue was not primarily about coding but about quality of care and the end of life experience of patients. Coding was but a mechanism for helping to assess these.

8.12 Finally Mrs Crewe drew attention to the transfer of the Vale of York GP OOH service, which had entailed the transfer of staff to Northern Doctors. They had welcomed the support of the Trust through the process, especially from the HR team, and a number had expressed a wish to return to working with the Trust. This reflected what had been a positive process.

9. Report by the Chief Nurse

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

9.2 She drew attention to the data on pressure ulcers, reminding Board members of the actions which were in hand to reduce the incidence of avoidable pressure ulcers. During 2014-15 there had been 27 Category 3 pressure ulcers at Harrogate District Hospital and 32 Category 3 and 2 Category 4 pressure ulcers whilst in Trust care in the community. The target for reduction agreed by the Pressure Ulcer Steering Group was 50% in 2015-16 and 100% in 2016-17. Overall there had already been a reduction and, for the second month running, in March there had been no Category 3 pressure ulcers and the Trust had met the CQUIN. She assessed that the Trust was not an outlier nationally and the direction of travel was downward.

9.3 The position on falls, according to Mrs Foster, appeared concerning notwithstanding the caveats in her paper. There had been 18 falls resulting in a harm to date and there was a need to set a target for reduction. The report included some comparative data on falls from other Trusts but this could not be used for direct benchmarking due to differing methodologies and case mix. She was continuing to work on the potential significance of the time of day at which falls occur, following the trends identified from root cause analyses. The Yorkshire Improvement Academy pilot project on Jervaulx ward, which included daily huddles around falls, had been used in Leeds and led to a huge reduction in falls, with days between incidents.

9.4 Moving to cannula care, Mrs Foster had worked on the outcome of the internal audit and the Integrated Care Directorate was leading the work which already showed success. She had placed Matrons at the focus of the work and they would need to make spot checks to assess progress and improvement.

9.5 The perceived high usage of catheters, at 25%, had been the subject of focused work and Mrs Foster said that monthly checks were now in place. The annual prevalence had been assessed as 18% with the vast majority clinically justified. There were issues with documentation and removal of catheters. The work of the specialist Continence Nurse had added value in addressing Urinary Tracts Infections. Mrs Foster expressed her frustration at not being able to extract relevant information to benchmark the Trust's position on catheter use but expected to start targeted work with Barnsley NHS Trust.

9.6 Mrs Foster noted that the Infection Prevention and Control results for the year were very good. She reported that the Trust had recently had its first Carbapenemase-producing *Enteriobacteraceae* (CPE) patient and appropriate action had been taken.

9.7 Learning from complaints and incidents only had real value if the investigations which resulted were timely, in Mrs Foster's view, and there was ready-across between Complaints, Significant Events and Serious Incidents Requiring Investigation. She was pleased to report that over 90% of investigations were reporting by the stated deadline. A concerted effort would be required to bring this up to 100%.

9.8 Mrs Foster asked Board colleagues to note that the staffing levels in her report did not show clearly the effect of staff in escalation areas and those involved in 1:1 specialling.

9.9 The report of the Local Supervising Authority had stimulated an Action Plan to take forward the recommendations and good progress was being made. The Action Plan to take forward recommendations from the report of the Healthwatch Enter and View visit in November 2014 was being taken forward through the appropriate groups.

9.10 Mrs Foster outlined the proposed Quality Priorities for 2015-16 and sought Board approval to include them in the Quality Account. The proposed Priorities had been developed by staff and the Governors. Workstreams had been identified to deliver each of the three proposed Priorities, as well as how progress and achievement would be evidenced.

9.11 Mrs Dodson invited comments and questions from Board members. Mrs Taylor wondered whether the target of 50% reduction in pressure ulcers for 2015-16 was sufficiently ambitious. Mrs Foster said that 50% was a realistic target; knowledge of pressure ulcer assessment was not robust and it was taking time to embed it across the Trust. She recalled that when the Trust had tackled significant shortcomings in Infection Prevention and Control it had set similar initial targets and the outcome had been the current high quality performance. Dr Tolcher said that it was a question of reinforcing behaviours; Mrs Taylor's had been an appropriate challenge but there were realistic plans and Board colleagues should expect that where a commitment was made then it would be delivered, a 'commit and do' approach. There was a need to engage with clinical staff to own the processes and targets. Mrs Foster said that the Trust was starting from a standing start and was at least two years behind other Trusts which had successfully tackled the challenge. The Board should trust and support the staff to deliver the target reduction and it was important to create the conditions for success.

9.12 Dr Scullion said that the CPE patient had been a high risk repatriation which had been picked up by the newly-introduced screening policy. He said that the number of falls in March seemed to be high and, in agreeing, Mrs Foster said that three of the patients who had fallen had been signed off by physiotherapists and one patient had fallen for a second time, and required a second theatre procedure.

9.13 Mrs Webster asked why Pressure Ulcers and Falls, which had been Quality Priorities for 2014-15, were not on the list for 2015-16, as they were clearly priorities for continued action. Mrs Foster said that work to improve the position would not cease, and progress against them would be reported in the 2015-16 Quality Account. Mrs Dodson emphasised that the Board should take a rolling view of initiatives to improve quality across the Trust. The new Quality Committee would focus on and report on progress with all quality priorities.

9.14 Mrs Webster asked for more information about staffing levels, which were over 150% of establishment. Mrs Foster explained that in these areas this was generally due to 1:1 care and in most cases this was staff that had been moved from other wards to provide cover; in all cases, safe staffing levels were being maintained.

9.15 Professor Proctor enquired about the progress of the Nursing and Midwifery strategy. She expected that it would be explicit around Key Performance Indicators on all the Fundamental Standards of Care outlined in the Quality Priorities, especially where they were measurable.

9.16 Mr Thompson said he was pleased that good screening had detected the CPE patient but was concerned that basic standards seemed to be falling away, particularly in the case of hand hygiene and MRSA screening, according to the metrics in Mrs Foster's report. He added that the Hospedia television system was a major irritant to patients, according to feedback he received. Dr Scullion agreed about the reduction in hand hygiene figures but pointed out that the reduced MRSA screening figures reflected the change to CPE screening and the dashboard would need to be adjusted. Mrs Dodson said that the figures showed the number of audits and not necessarily compliance – the issue was nuanced. Mr Coulter said that he would discuss the matter of the Hospedia television system directly with Mr Thompson. **Action: Mr Coulter**

10. Report by the Chief Operating Officer

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

10.2 Mr Nicholas said that the Trust had sustained a strong performance both in March and across Q4. Challenging targets had been met consistently. Whilst Community Equipment was now delivered within seven days, the Sentinel Stroke National Audit Programme rating had reduced from C to D, largely due to winter pressures. The HSMR rating had levelled off, there had been nil cases of MRSA against an annual trajectory of nil and nine cases of *Clostridium difficile* against an annual trajectory of 15.

10.3 There had been a significant increase in elective work in north Leeds during Q4 and the Trust had achieved a Green rating for both the Quarter and the year.

10.4 Mrs Dodson said that it was important to recognise the really high performance which had been achieved and Dr Tolcher said it would be interesting to benchmark the increases in elective and non-elective work nationally. She also wanted to look at what could be done to improve the planned day of discharge approach for patients.

10.5 Mrs Webster asked what progress there had been with analysing readmission rates, to which Dr Hammond replied that it was part of a wider study about establishing that admissions had been for the right reasons, which had not yet started. A proforma was being designed for the collection of information, especially about admissions from nursing homes. He expected that meaningful results would be available to bring to the Board in July.
Action: Dr Hammond

10.6 Mr Coulter drew the discussion to a close by emphasising that the performance over the year had been remarkable, and the Trust should not take for granted what had gone really well.

Managing Resources Efficiently

11. Report by the Director of Finance

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

11.2 Mrs Dodson said that this was the yearend report and invited Mr Coulter to make any further comments.

11.3 Mr Coulter said that the Audit and Finance Committees had considered the Annual Accounts at their meetings on 21 April. He drew attention to the breakdown overview of the Income and Expenditure position for March, which showed the net operating surplus of £10,000. The impairment below the line related to a valuation of the Sir Robert Ogden Macmillan Centre which was £587,000 below the original cost. The accounts also required the Charitable Funds to be consolidated – an excess of £102,000 of expenditure over income was therefore taken into the accounts. It was generally agreed that the latter was an appropriate position.

11.4 Looking back, Mr Coulter said that since November 2014 the Trust had delivered the Plan and that Q4 had been particularly good. The first six or seven months had been not so good and going into 2015-16 it was important to maintain the momentum from Q4 of 2014-15. Although more than £10m of CIP had been delivered, this had fallen short of the £11.6m target and would therefore affect this year. He proposed reporting to Monitor a Continuity of Service risk rating of 3.

11.5 The cash position of £4.9m at year end, against £2.1m at the end of February, was the result of considerable hard work from the finance team in recovering monies owed to the Trust. There had been an impact on the capital programme, due to the overall financial performance of the Trust, and there had also been a reduction in working capital.

11.6 Mr Thompson wished the Board to recognise the fantastic work involved in closing a very clean set of accounts. There had been no stretching to achieve the final position.

11.7 Dr Tolcher drew attention to page 5 of the report which showed in the table the effect of underachievement of income, a situation which had been used to plan realistically for the year ahead. Mr Coulter said that in planning the year ahead the Organisational Delivery Group and Finance Committee had taken into account the phasing of activity, including varying numbers of working days. The plan envisaged a deficit for April and May and a surplus for June, resulting in a breakeven plan for the first quarter of the year; it was likely that August would also incur a deficit. The plan was realistic and Directorates would be held to account to deliver it. The Board should note that Quarters are planned to be in surplus but individual months would vary between surplus and deficit.

11.8 Moving to the Efficiency Programme on page 9 of the report, Mr Coulter said that under the new governance arrangements endorsed at the last Board meeting £9.7m of efficiencies had been identified against the £10.2m required which equates to 95%. When risk-adjusted for delivery this figure fell to £7.9m (77%), although this improved to 90% when the effect of the Enhanced Tariff Option was taken into account. It had been agreed that the additional efficiency target (set before the ETO was published) should be achieved to provide an opportunity for investment. Some of the high risk proposals did not yet have a robust plan for delivery and had therefore been slipped to later in the year. The refinement of risk and proposals was a continuous process.

11.9 Mrs Webster said that the Finance Committee meeting had been very assuring; it had taken a strategic look at the coming year against the exit run rate. The Committee was comfortable with the phasing of the Plan and the delivery of the Efficiency Programme. The costs of activity in North Leeds were looking healthier and the Committee had also looked at proposed business developments. Future meetings would examine high value contracts and the programme of meetings had been adjusted so that they were linked less with Board meetings so that it could more properly focus on a strategic view.

11.10 Mrs Dodson thanked Mrs Webster for her report and noted that from April Mrs Webster would chair the Quality Committee and Mrs Taylor would chair the Finance Committee. She sought and received the approval of the Board for the submission to Monitor of a Continuity of Service Risk rating of 3 and a Governance rating of Green.

Valuing and Rewarding Staff

12. Report by the Director of Workforce and Organisational Development

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

12.2 Mr Marshall said that the final report of the Deanery visit had been received and he tabled copies for colleagues. He would provide a commentary and Action Plan at the May Board meeting. **Action: Mr Marshall**

12.3 It had been a good winter for nurse recruitment, Mr Marshall reported, and 23 of the 24 nurse recruited from Spain remained in post. It would be very helpful if the agency used by the Trust could replicate the position in future.

12.4 Mr Marshall believed that there was a disconnect on appraisal with higher rates being reported through the National Staff Survey than the number of reports held by the HR team. He was discussing support from the LETB to examine both the quality and the data on appraisals. He believed that because of authorised absences and churn, a 100% appraisal rate was unrealistic and a 95% rate should be regarded as the Trust target.

12.5 Mr Marshall was in discussion with his equivalent at Airedale NHS FT about working joint rotations in the Emergency and Anaesthetics departments; he would update the Board at a future meeting. Some Trusts were incentivising staff in these departments.

12.6 A recent visit to the Health Visitor team in North Harrogate had demonstrated to Mr Marshall that their GP liaison meeting had been very successful and brought benefit to both parties. On the day of the Board meeting he had launched a Rapid Process Improvement Workshop into the Chronic Pain service at Skipton and Harrogate hospitals, which attracted significant out of area referrals.

12.7 Finally Mr Marshall noted that he had attended a meeting of the Sheffield Military Society where the Trust had received credit for its engagement with reservists. The Society was keen to be involved with clinical skills training with the Trust.

12.8 In answer to a question from Professor Proctor, Mr Marshall said that the 17% rate of absence for musculoskeletal reasons was not exceptional and he had confidence that the Occupational Health team referred staff appropriately to the MSK service.

12.9 Mrs Webster asked about the Connecting for Health programme with the Department of Health (DH). Mr Marshall said that he had been very pleased to hear it discussed at the recent Partnership Forum. Mrs Crewe said that a number of DH staff had been experiencing front line services as part of their personal development. After very positive feedback from the programme last year the Trust had been inundated with requests to take part. The Trust had also devised a way of using the DH expertise – a DH analyst was helping to populate a capacity and demand model for services outside the hospital, which would produce outputs by the end of May. Mr Marshall commented that the Trust was one of highest contributors to the Connecting programme.

12.10 Mr Thompson said that the analysis of staff numbers showed that there were around 50 more staff than this time last year, although in medical and dental there was only one more. The majority of the increase was in numbers of nursing staff. Mr Coulter said that a month by month breakdown might be of assistance in future.

Assurance

13. Report of Harrogate Health Transformation Board

13. This had been taken as part of the Chief Executive's report at item 7.

14. Reports

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

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

15.1 Mrs Dodson noted that she was not aware of any reports made under this item. She confirmed with Board members that in the report at the end of Q4 Monitor would be informed that the Trust was reporting a Green on governance and a Continuity of Service risk rating of 3, and the infection control figures recorded in Minute 10.2.

16. Any Other Business

16.1 Mrs Dodson was pleased to report that after a comprehensive and searching recruitment process the Council of Governors had appointed Mr Neil McLean as a Non-Executive Director, with effect from 1 May 2015. Mr McLean had a legal background, having been a managing partner at DLA Piper, and latterly the chairman of the Leeds Local Enterprise Partnership and of Leeds Colleges. He had presented his apologies for being unable to attend the meeting even in an informal capacity. Mrs Dodson said that he would be attending the national NED Induction Course on 27 and 28 April. Dr Tolcher commented that this was a very positive appointment for the Trust and she and the executive team looked forward to welcoming Mr McLean.

16.2 Mrs Dodson reminded Board colleagues that there would be a public Council of Governors meeting at 1030 on Saturday 16 May at St Aidan's School. The day and time were at the request of Governors, with the intention of trying to improve public attendance.

17. Board Evaluation

17.1 Mrs Dodson said that she thought that the meeting had been timely and asked what colleagues felt had worked and whether some items needed more time.

17.2 Mr Nicholas felt that the meeting had flowed well and Mrs Webster valued the comments from the Clinical and Operational Directors. Mrs Dodson said that it was good to see an Operational Director and, in answer to a question from Dr Johnson, indicated that she had no preference as to whether the Deputy Clinical Director or the Operational Director should substitute when the Clinical Director was unavailable. Dr Tolcher felt that the Operational Directors were well placed to deputise, the Deputy Clinical Director could attend and shadow, much as the Deputy Medical Directors had done.

17.3 Mrs Dodson reiterated that she would welcome staff from all level attending Board meetings, even if they were able to stay for only part of the meeting. They should see it as part of their development experience.

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

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 11.47 am.

Signed…….Chairman

Dated……..

Harrogate and District NHS
NHS Foundation Trust

HDFT Board of Directors Actions Schedule – May 2015

Completed Actions

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

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

Item Description	Director/ Manager Responsible	Date due to go to Board or when a confirmation of completion/progress update is required	Confirm action Complete or detail progress and when item to return to Board if required
Update Board on progress of review of complaints governance process	Clinical Directors	February 2015	Complete
Update reports on improving complaints processing	Clinical Directors	February 2015	Complete
Report to Board on review of readmissions data	Mr Harrison, Chief Operating Officer	February 2015	Complete
Discuss financial implications of changes in casemix with Mr Ward	Mr Harrison, Chief Operating Officer ad Mr Alldred, Clinical Director, Elective Care	February 2015	Complete
Arrange for medical staff to be briefed on use of correct terminology for doctors in training	Dr Scullion, Medical Director	February 2015	Complete
Chief Operating Officer's report to be placed in 'Putting Patients First' section of Board agenda	Mr Forsyth, Interim Head of Corporate Affairs	February 2015	Complete
Local MPs to be briefed on progress of Vanguard applications	Dr Tolcher, Chief Executive	February 2015	Complete
Course of action over contracting of IPC service to be agreed	Dr Tolcher, Chief Executive and Mr Coulter, Director of Finance	February 2015	Complete
Update the Board on resilience of Paediatric Diabetes service	Dr Johnson, Clinical Director, Directorate of Elective Care	March 2015	Complete
Ensure CCG and GPs are aware of NHS Change Day Twitter site (Minute 6.15)	Mr Marshall, Director of Workforce and Organisational Development	March 2015	Complete
Write letter to Nursing Times re maternity staffing (8.7)	Mrs Foster, Chief Nurse	March 2015	Complete
Circulate anonymised Safer Staffing report to Board members (8.8)	Mrs Foster, Chief Nurse	March 2015	Complete

Investigate spike in pressure ulcers on Farndale Ward (8.14)	Mrs Foster, Chief Nurse	March 2015	Complete
Update on cash position (10.7)	Mr Coulter, Director of Finance	March 2015	Complete
Include number of temporary staff/locums in Board report (10.8)	Mr Marshall, Director of Workforce and Organisational Development	March 2015	Complete
Update on staff screening (11.9)	Mr Marshall, Director of Workforce and Organisational Development	March 2015	Complete
Inform Monitor that the Trust has opted to take up the Enhanced Tariff Option (12.7)	Dr Tolcher, Chief Executive	March 2015	Complete
November 2014	Comment on potential link between night staffing levels and number of patient falls	Mrs Foster, Chief Nurse	April 2015 (January & /March 2015)
January 2015	Update the Board on progress of Sign Up to Safety application	Dr Scullion – Medical Director	April 2015 (March 2015)
January 2015	Report on actions following Midwifery inspection and Healthwatch visit	Mrs Foster, Chief Nurse	April 2015
February 2015	Report on analysis of spike in complaints in Trauma and Orthopaedics (8.20)	Dr Johnson, Clinical Director, Elective Care	April 2015 (March 2015)
February 2015	Report to the Board on progress with improving the Trust position on catheter and cannula care (8.4)	Mrs Foster, Chief Nurse	April 2015
March 2015	Report on work to reduce mortality indices (8.2)	Dr Scullion, Medical Director	April 2015
March 2015	Arrange sub-Committee meeting to approve Operational Plan (13.1.5)	Mr Forsyth, Interim Head of Corporate Affairs	April 2015

Harrogate and District NHS
NHS Foundation Trust

HDFT Board of Directors Actions Schedule – Outstanding Actions

May 2015

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

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

Ref	Meeting Date	Item Description	Director/Manager Responsible	Date due to go to Board or when a confirmation of completion/ progress update is required	Detail progress and when item to return to Board if required
1	July 24 2013	Report any future complaints about the LCP to the Board via the Chief Nurse report	Mrs Foster, Chief Nurse	Ongoing	Ongoing
2	March 2015	Report on audit of possible delays in triage of OOH patients (10.6)	Mr Alldred, Clinical Director Acute and Cancer Care	**May 2015**	
3	September 2014	Update to Board on progress of safeguarding review	Mrs Foster, Chief Nurse	**May 2015** (November 2014)	
4	March 2105	Report on progress of NCEPOD work (10.1.6)	Mr Lavalette, NCEPOD Ambassador	**May 2015**	
5	April 2015	Revise Board Terms of Reference iaw comments and new template (5)	Mr Forsyth, Interim Head of Corporate Affairs	**May 2015**	
6	April 2015	Include average mortality figure in monthly Board report (8.6)	Dr Scullion, Medical Director	**May 2015 *et seq***	
7	April 2015	Write to Dr Law to acknowledge term as DPGME (8.8)	Mrs Dodson, Chairman	**May 2015**	
8	April 2015	Circulate to NEDs dates of medico-legal lectures by Professor Marks (8.9)	Dr Scullion, Medical Director	**May 2015**	
9	April 2015	Arrange publicity around RCoA accreditation of Anaesthetic Department (8.10)	Mr Forsyth, Interim Head of Corporate Affairs	**May 2015**	
10	April 2015	Discuss Hospedia system with Mr Thompson (9.16)	Mr Coulter, Deputy Chief Executive and Director of Finance	**May 2015**	

11	April 2015	Commentary and Action Plan on report of Deanery visit (12.2)	Mr Marshall, Director of Workforce and Organisational Development	**May 2015**	
12	February 2015	Report on communications campaign around nurse and midwife revalidation (8.16)	Mrs Foster, Chief Nurse	June 2015	
13	April 2015	Board Paper on Admissions (including readmissions) (10.5)	Dr Hammond, Clinical Director, Integrated Care Directorate	July 2015	
14	February 2015	Brief Board on emerging models at next BDD (6.14)	Dr Tolcher, Chief Executive	July 2015	
15	March 2015	Update on immunisation screening of staff (11.9)	Mr Marshall, Director of Workforce and Organisational Development	September 2015	
16	March 2015	Possible changes to the Remuneration Committee to be discussed by NEDs (14.6)	Mrs Dodson, Chairman	*Date to be confirmed*	
17	March 2015	Action Plan following Morecambe Bay Inquiry	Chief Nurse – Mrs Foster	*Date to be confirmed*	

Harrogate & District Foundation Trust - Out of Hours Service

Team: HDFT

National Quality Requirement 9:

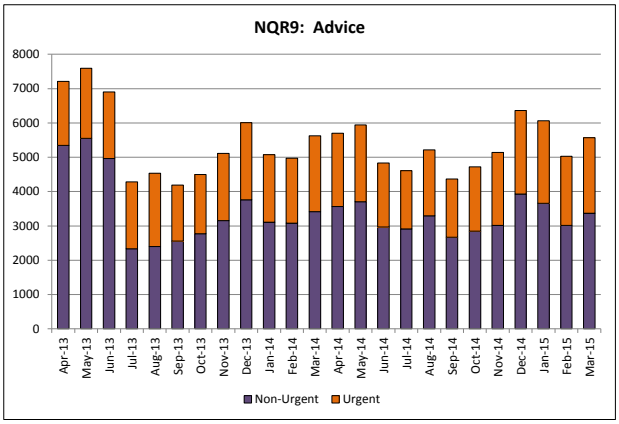
Providers that can demonstrate that they have a clinically safe and effective system for prioritising calls, must meet the following standards:

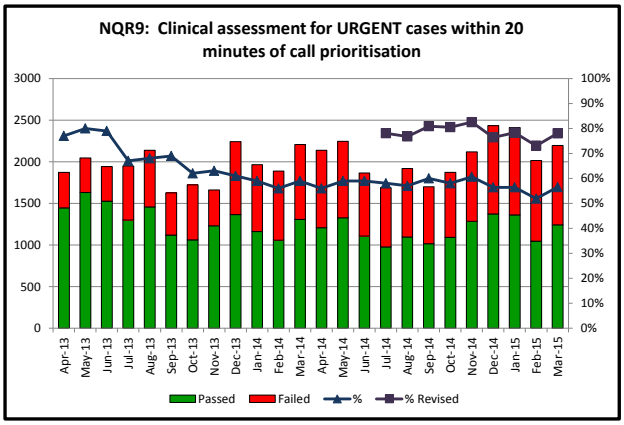
Start definitive clinical assessment for urgent calls within 20 minutes of the call being answered by a person
Start definitive clinical assessment for all other calls within 60 minutes of the call being answered by a person

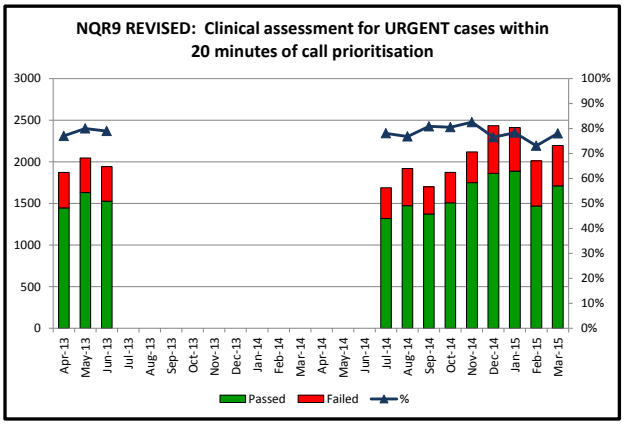
National Quality Requirement 9 REVISED:

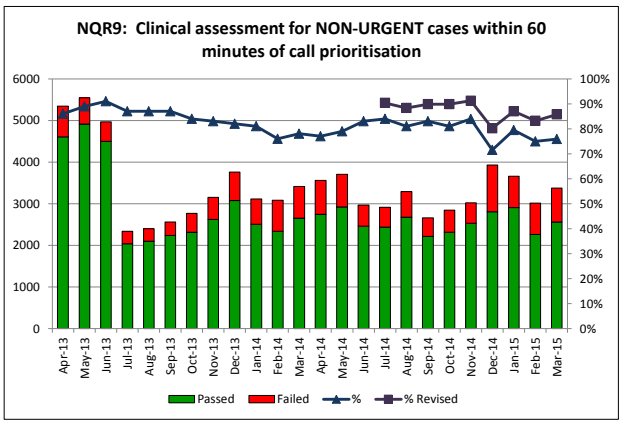
The local introduction of NHS111 occurred in July 2013 prompting a reduction in activity in the months following

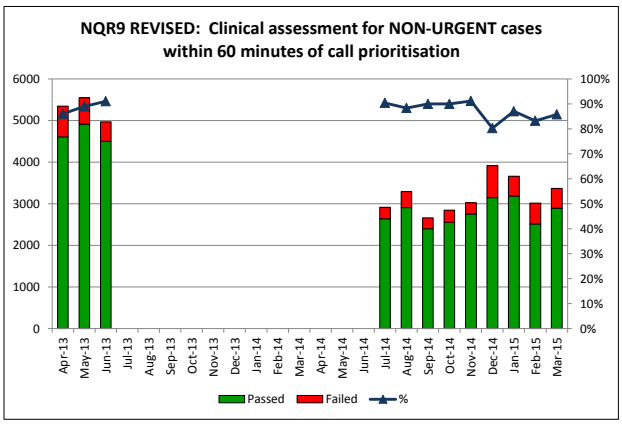
Yorkshire Ambulance Service began providing a revised figure for NQR9 from Jul 2014. Between July 2013 - June 2014 the clock start time was recorded from when the patients call was received by the NHS111 Service. The revised figure presents the NQR from when the NHS111 calls are transferred to the OOH Service Database.











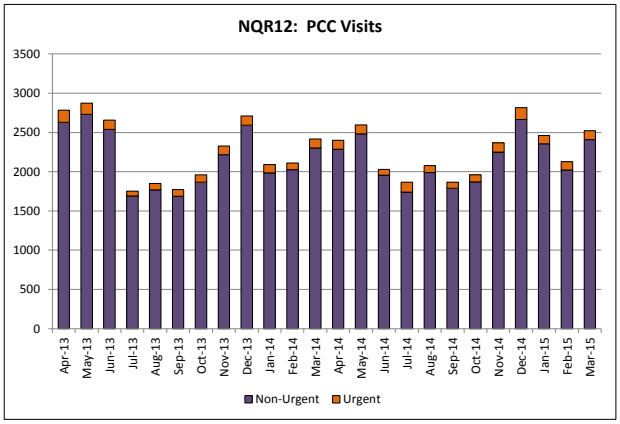
National Quality Requirement 12:

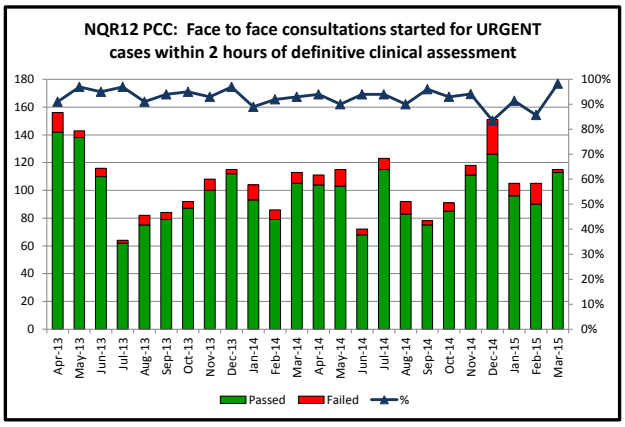
Face-to-face consultations (whether in a centre or in the patient's place of residence) must be started within the following timescales, after the definitive clinical assessment has been completed:

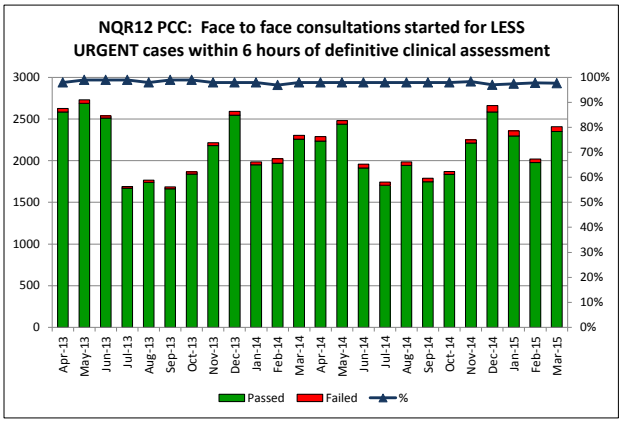
Emergency: Within 1 hour.

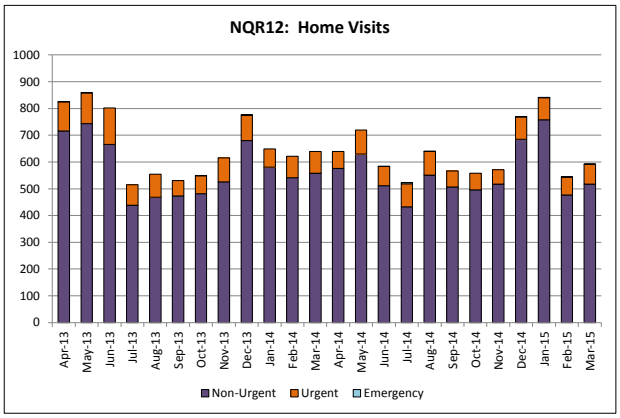
Urgent: Within 2 hours.

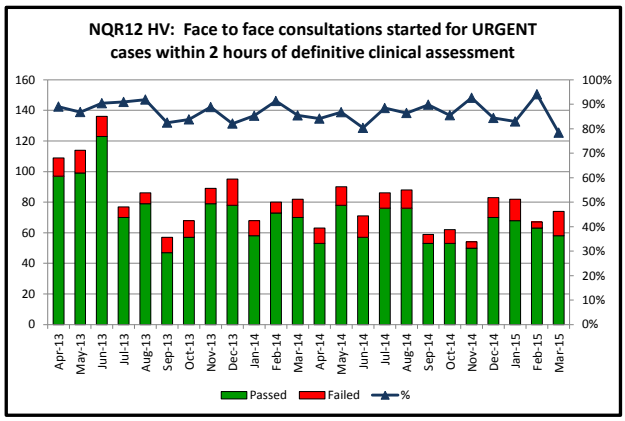
Less urgent: Within 6 hours.

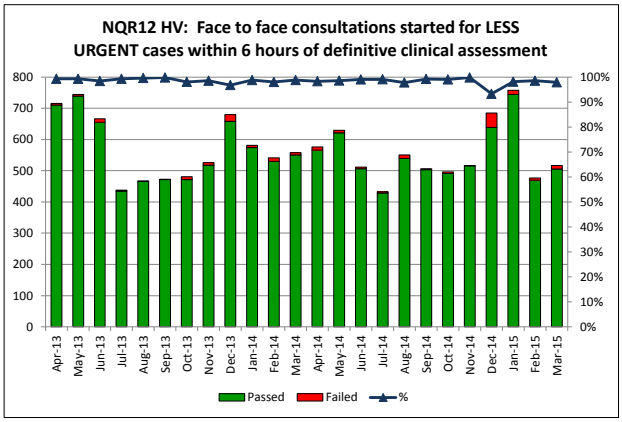



NQR12 PCC: Face to face consultations started for URGENT cases within 2 hours of definitive clinical assessment
Passed
Failed
%


NQR12 PCC: Face to face consultations started for LESS URGENT cases within 6 hours of definitive clinical assessment
Passed
Failed
%


NQR12: Home Visits
Non-Urgent
Urgent
Emergency


NQR12 HV: Face to face consultations started for URGENT cases within 2 hours of definitive clinical assessment
Passed
Failed
%


NQR12 HV: Face to face consultations started for LESS URGENT cases within 6 hours of definitive clinical assessment
Passed
Failed
%

Action Plan - Name and Year							Action Plan Progress Monitoring - 6 months						
ID number	Issue / Audit Finding / Theme	Initial Risk (H/M/L)	Action/s	Operational Lead	Responsible Lead	Target Date	ID number	Risk at review (H/M/L or complete)	Progress on actions	Further action/s to ensure completion	Operational Lead (if changed)	Responsible Lead (if changed)	Target Date
	Engagement & Communication	Low	Action plan to be finalised and agreed. Meeting/T.con to arrange. Sign off at directorate board & Q&G	MW	AA/JC/ SM/MW	20-Oct-14		Complete	Action plan signed off at directorate board, Q&G and Trust Q&G.				
	Engagement & Communication	Low	Initial engagement letter to all clinical staff about importance of quality and timely consultations with patients and ideas and buy in for improvement of NQRs. 1st priority is 20min calls, Emergency and Urgent calls/PCC attendance/Home Visit.	MW	SM/MW	31-Oct-14		Complete	Letter went to all staff with 5th Dec. Staff engaged and feedback to compile for next CMB (20th Jan 2015)				
	Engagement & Communication	Low	Guidelines to be developed of how support staff and clinicians can safety net patients and close calls.	MW	SM/MW	21-Nov-14		Complete	Guidelines developed by Clinical Lead and circulated. Further review needed.	Ciurculated and further review needed.			31-Jan-15
	Engagement & Communication	Low	NQRs to be included on all support staff agenda. Suggestions and improvement ideas to be fed back to Clinical Lead and Speciality Manager.	MW	EE/JE/JH/AM/ HM/CR/ST	31-Oct-14		Complete	Standard item on all meeting agendas	Feedback to be compiled for inclusion at LMGs/CMBs			
	Engagement & Communication	Low	NQRs to be made to all staff on intranet and available on a hyperlink in the Unscheduled Care Newsletter.	MW	MW	29-Sep-14		Complete	Now available on intranet and hyperlink on newsletter.	Standard item on newsletter. Next edition due January 2015			
	Engagement & Communication	Low	Raised profile of NQRs at LMGs and CMB.	MW	MW	01-Dec-14		Complete	Data discussed at each meeting (included in each agenda)				
	Data & Contractual Issues	Medium	Contractual Review and outstanding issues - YAS	MW	JC/MW	10-Oct-14		Medium	Several meetings with YAS. Data not fully understood and have gone back to software develper of ADASTRA.	Strategic longerterm vision is to move GPOOH to systmone. Scope and timescales to be investigated.			31-Oct-15
	Data & Contractual Issues	Medium	HDFT contract review with YAS – update and future strategy.	MW	JC/RH/MW	13-Oct-14		Medium	RH to talk to Paul & Andy about S1 and visits to other providers (Airedale whole trust move to S1). MW has contacted systmone team at HDFT to explore.	Needs corporate response and input from the IT Steering group. ACC CIP			31-Oct-15
	Data & Contractual Issues	Medium	ADASTRA source datasets to be made available to HDFT	MW	RM/MW	01-Nov-14		Medium	YAS awaiting ADASTRA to come back to answer queries from Information Services. YAS will be moving data to a virtual warehouse.	Information Services to update. Capacity planning to be undertaken by T/L. Review at LMGs and CMB.			31-May-15
	Data & Contractual Issues	Medium	Refreshed Performance Report – activity correlated to performance measures.	MW	RM	01-Dec-14		Complete	Information Services now have a refreshed dashboard. Circulated to CCGs (positive response - user friendley, easy to understand and spot trends				
	Activity and Capacity Flow	Medium	Work with the Information Team to understand and model activity/capacity flow.	MW	SM/RM/MW	01-Dec-14		Complete	To be reviewed fully at next CMB/LMGs				
	Validation Audit	High	Audit of 20min urgent call to determine % "true urgent" answered within target at PCC level	MW	RM/SM	01-Nov-14		Medium	Data report provided by information services. Manual audit to be completed by salaried GP. GP Identified and work to start. Urgent Conditions need to be defined. Dr PP & Dr Simon Miers started the work. Needs completion and the feedback and actions.	*DNA protocol *Guidance on how to structure your day? Including things like writing consultation up asap as this distorts our figures. *Home visits policy. *What can we learn from other Providers (Primecare)?? Additional resource needed? CCG's for funding or use more of BTA? *Direct booking of patients in to the service trial, working with NHS 111 and HaRD CCG *DNA protocol *Guidance on how to structure your day?			30-Jun-15
	Validation Audit	Medium	Share 1% audit of 2013, repeat for 2014 and develop meaningful audit.	MW	EE/SM/MW	01-Dec-14		Medium	Clinical staff identified. Info./consultations distributed. Other Regular audits to be considered at CMB. CD audit conducted. Antibiotic audit to be conducted.	Audit function of GPOOH to reviewed and resourced. Clinical lead to devise audit work based on conceration with GP appraisers. Likley to include every GP/Nurse to have random consulations reviwed			31-May-15

TELEPHONE TRIAGE AUDIT
SUMMARY OF FEEDBACK SHEETS

Question	Aug-14			Sep-14			Oct-14			Nov-14			Dec-14			Comments
	Well done	Partly done	Not done	Well done	Partly done	Not done	Well done	Partly done	Not done	Well done	Partly done	Not done	Well done	Partly done	Not done	
Introduced self clearly & identified to whom talking	3	1		7			6			6			6	2		
Started with an appropriate opening question	3		1	7			6			6			7		1	
Empathetic approach, including assessing relevant psychological history	3		1	7			6			5	1		4	3	1	
Listened & developed rapport	2	2		7			6			6			4	3	1	
Responded to patient - offered cues	3	1		7			6			6			3	1	2	December - this section not completed on two forms
Clearly defined the person's reason for call (and/or their concerns; and/or their health beliefs)	3		1	7			6			6			6	1		December - this section not completed on one form
Asked appropriate questions to ascertain clinical scenario, & confirm/exclude acute life threatening illness/red flags	1	1	2	6		1	6			5	1		4		4	
Identified relevant PMH including medications & allergies			4	4	1	2	4	2		4	2	2	3	1	4	
Allowed patient to relate their expectations of calling	2	1	1	6		1	6			5	1		2	3	3	
Clarified or summarised the given history	2		2	6	1		6			5	1		3	3	2	
Offered appropriate advice and/or management/disposition, i.e. clinically safe consultation reflecting good practice	1	1	2	7			6			5	1		6	1	1	
Involved & achieved shared agreement with patient/caller in the chosen action or outcome	3	1		7			6			6			5	2	1	
Used a clear & specific safety net, if appropriate (i.e. specific changes in symptoms +/- timeframe +/- action)	1	1	2	7			6			6			3	1	3	December - one form stated "N/A"
Used time appropriately	4			7			6			6			7		1	

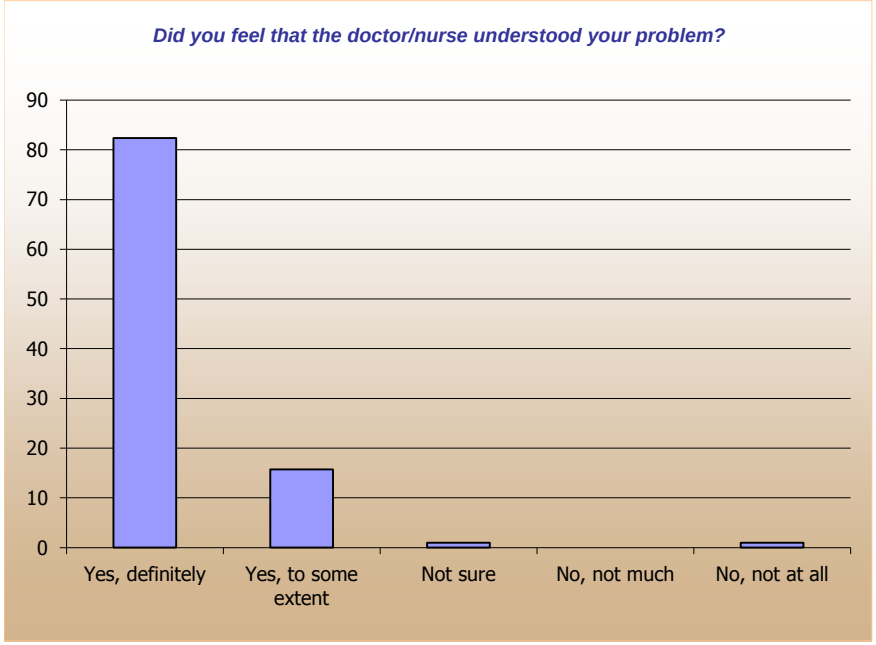
Results of the OOH Clinical Records Audit 2014							
	Y	N	N/A	Grand Total	Y	N	N/A
Presenting Complaint	897	25	2	924	97%	3%	0%
Age	924			924	100%	0%	0%
Relevent Past Medical History	645	259	20	924	70%	28%	2%
Allergies	206	488	230	924	22%	53%	25%
Relevent Drug History	452	362	110	924	49%	39%	12%
Relevent Examination Findings	443	40	441	924	48%	4%	48%
Provisional / Diffrential Diagnosis	632	213	79	924	68%	23%	9%
Tests/Results clearly indicated	154	31	739	924	17%	3%	80%
Treatment / Discharge Plan	800	78	46	924	87%	8%	5%
Any unacceptable abbreviations	24	896	4	924	3%	97%	0%
Safety Netting includeed	512	266	146	924	55%	29%	16%
Intelligable	903	21		924	98%	2%	0%
Prescribing function used when appropriate	202	129	593	924	22%	14%	64%
Informational Outcome Used	732	172	20	924	79%	19%	2%
Children under 1 with fever referred to PCC	7	16	520	543	1%	3%	96%
Children under 1 with fever used PEWS	7	26	348	381	2%	7%	91%
Was the record satisfactory	813	111		924	88%	12%	0%

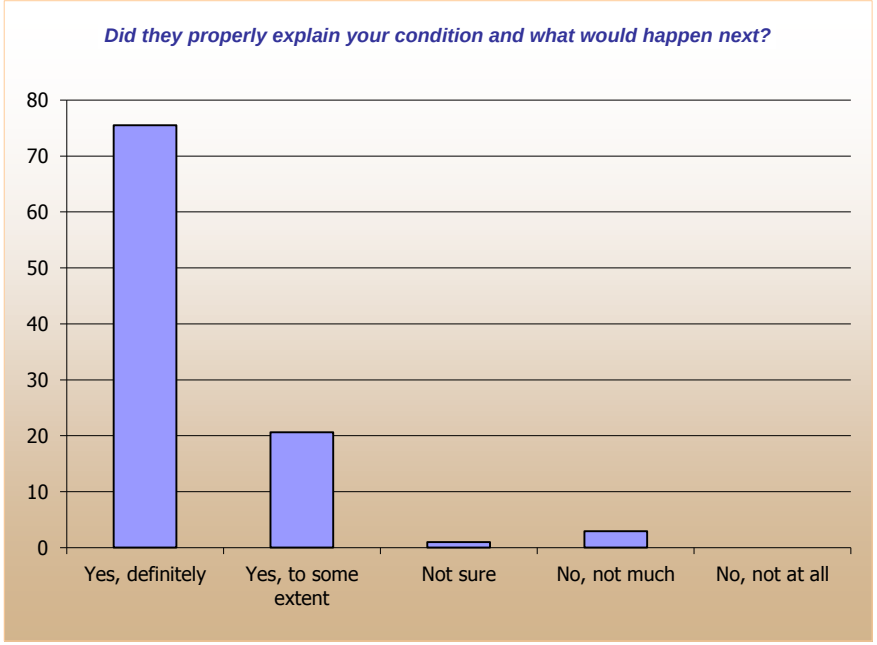
Adjusted Figures

Results of the OOH Clinical Records Audit 2014							
	Y	N	N/A	Grand Total	Y	N	N/A
Presenting Complaint	897	25	2	924	97%	3%	0%
Age	924			924	100%	0%	0%
Relevent Past Medical History	645	259		904	71%	29%	0%
Allergies	206	488		694	30%	70%	0%
Relevent Drug History	452	362		814	56%	44%	0%
Relevent Examination Findings	443	40		483	92%	8%	0%
Provisional / Diffrential Diagnosis	632	213		845	75%	25%	0%
Tests/Results clearly indicated	154	31		185	83%	17%	0%
Treatment / Discharge Plan	800	78		878	91%	9%	0%
Any unacceptable abbreviations	24	896	4	924	3%	97%	0%
Safety Netting includeed	512	266		778	66%	34%	0%
Intelligable	903	21		924	98%	2%	0%
Prescribing function used when appropriate	202	129		331	61%	39%	0%
Informational Outcome Used	732	172	20	924	79%	19%	2%
Children under 1 with fever referred to PCC	7	16		23	30%	70%	0%
Children under 1 with fever used PEWS	7	26		33	21%	79%	0%
Was the record satisfactory	813	111		924	88%	12%	0%

Key

	Keep the NA





Question 9	Did you feel that the doctor/nurse understood your problem?
Yes, definitely	82.35
Yes, to some extent	15.69
Not sure	0.98
No, not much	0
No, not at all	0.98

Question 10	Did they properly explain your condition and what would happen next?
Yes, definitely	75.49
Yes, to some extent	20.59
Not sure	0.98
No, not much	2.94
No, not at all	0

Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 27 May 2015	**Paper No: 4.1**

Title	Improvement plan, GP Out of Hours – National Quality Requirements
Sponsoring Director	Andrew Alldred, Clinical Director - Acute and Cancer Care / Director of Pharmacy
Author(s)	Matt Walker, Speciality Manager - Unscheduled Care (GPOOH & MIU)
Report Purpose	To give assurance to the board that the GP Out of Hours service gives a safe, high quality service to patients. Improvement plans are in place to improve performance indicators

Executive Summary

This report summarises HDFT's latest performance position – based on key performance indicators included in the National Quality Requirements for GP Out of Hours services. The report includes details about the actions being taken to improve the current performance position and how we are able to provide assurance to Board that there is no harm being caused to patients.

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

Risk and Assurance	
Legal implications/ Regulatory Requirements	National OOH Quality requirements as defined by the Department of Health – 1st January 2005.

Action Required by the Board of Directors

That the Board of Directors notes the information and improvement plan provided in the report.

1. Purpose

1.1 GP Out of Hours (GPOOH) consistently fails to meet most of its targets at an aggregated and locality level. This paper describes the challenges and solutions to improving our performance. In large parts the targets are a measure of the responsiveness of the service and not a measure of the quality of care we give to our patients. The current limited clinical audit work demonstrates that the delay in seeing patients does not cause harm.

1.2 The introduction of NHS 111, clinical staffing shortages and challenging budget constraints have contributed to difficult performance against targets.
Patient pathways are to be modified working in partnership with the NHS 111, Yorkshire Ambulance Service and HaRD CCG. This will align the service with other local providers and improve our performance.

1.3 Clinical Audit plays a critical role in evidencing that out patients receive a safe, high quality and compassionate service. Our portfolio of clinical audit tools is to be strengthened and reviewed by the service Clinical Lead. A dedicated audit function will be established within the service.

2. Background

2.1 Harrogate and District Foundation Trust have provided GPOOH in North Yorkshire since Transforming Community Services in April 2011. On 1st April 2015 Vale of York CCG re-commissioned the service provided in York and Selby localities following a competitive tender process and transferred the service to a new provider (Yorkshire Doctors Urgent Care). HDFT made a strategic decision not to bid for these services and now provides GPOOH in Harrogate and Rural District and Hambleton and Richmondshire.

2.2 The service in Harrogate and Rural District locality is provided predominantly by local GPs, however in the Hambleton and Richmondshire local GPs are more difficult to recruit and it is more dependent on bank or agency medical staff.

2.3 In addition to GPs, the service is skill mixed appropriately with Advanced Clinical Practitioners who support the adequate fill of rotas. There are also a number of trainee practitioners who are rotating between the Emergency Department and GPOOH.

The service provides telephone and face to face contact and advice either in the Primary Care Centres located at Harrogate, Ripon, Catterick & North Allerton or a GP home visit, if deemed appropriate following clinical triage.

From 1st January 2005, all GPOOH providers have been required to comply with the National Quality Requirements (NQRs) as defined by the Department of Health. The reporting guidance has not been revised since 2005 and to some extent do not reflect or take account of the evolving health care system.

3. HDFT NQR Performance 2014/15 - Current Issues and factors affecting performance [See appendix 1 for NQR Performance].

3.1 Introduction of NHS 111

The largest change to the GP OOH administrative and clinical pathway systems has been the introduction of NHS 111. This adds an additional step to the patient journey. The 111 call is triaged by a call handler using a national algorithm and then triaged again by the

GP OOH service. NHS 111 triage is often described by patients as a poor experience and is a contributing factor in HDFT NQR performance.

3.1.1 In some instances NHS 111 passes through calls to GP OOH that have already breached the priority target.
3.1.2 A large proportion of calls that are classified by NHS 111 as urgent and therefore needing a 20 min response time are re-triaged by the GPOOH clinical team and are not deemed as urgent.
3.1.3 The volume of Urgent Calls passed through from NHS 111 makes it difficult for the service to deal with in a timely manner.
3.1.4 There is not a managed appointments system used with our clinical system. Patients currently present to the centre at times when we do not have the capacity to see them in a responsive way. There is no clear DNA policy to prevent patients breaching and distorting the NQRs.
3.1.5 When patients are re-assessed by the GP OOH clinician, they may be given a time to attend the PCC. Patients often chose not to present at the centre within the allocated or invited time.

3.2 Workforce Issues

3.2.1 The rota cover is predominately provided by salaried GPs. There are shortages of GPs to cover the full rota and bank and agency GPs provide a substantial amount of shifts to fill the rota safely.
3.2.2 Use of agency and bank staff, or suboptimal rota cover, lead to increased waits for patients to be seen.
3.2.3 A number of initiatives have already been implemented to encourage local GPs to work in the service. This includes a GP working in ED at Harrogate. We have also worked cooperatively with the Heart Beat Alliance, providing administrative support to an “Open Later” initiative in North Allerton & Catterick.

3.3 Data Issues

3.3.1 The service uses the clinical administrative and reporting system ADASTRA, subcontracted from YAS. We intend to move to Systemone™ which will allow a much more robust reporting and analytical system of analysis but also effective data integration with local practices and our community service teams.
3.3.2 Current reporting is distorted, if there is any delay in the time it takes to make initial contact with the patient, or due to connection problems or failed patient pick up responses.
3.3.3 During a home visit the clock does not stop until the consultation is written up and closed. The GPs will prioritise the need to see patients due to clinical need and a delay is created as they choose to write up their consultations on returning to the centre.

3.4 Staff Engagement

3.4.1 Over the last 12 months we have seen an improvement in the GPOOH staff understanding of the value and importance of the NQRs performance measures and the impact of failing to achieve these may have on safe patient care and patient experience.
3.4.2 The NQRs did not historically have regular visibility with staff or in staff meetings and there was lack of ownership in improving performance against these standards.

4. Actions and Improvement Plan [Detailed action plan – Appendix 2.]

4.1 The last 12 months has seen an increased emphasis on the understanding of the NQRs, understanding the impact of NHS 111, delivery of the NQRs and managing any risks or harm to our patients based on our under performance.
4.2 We have written to all our staff and are engaging and raising awareness with clinicians through the Unscheduled Care Newsletter and support staff meetings.
4.3 We need to have a more robust system for monitoring local trends of activity and performance and HDFTs information team are refreshing the NQR report to enable the information to be more easily accessible and visible to teams.
4.4 Examples of good practice and examples of efficiency are been shared across the service. This includes a recent telephone triage course and how to better manage home visits.
4.5 We are actively seeking information from others about how we could improve our service model and to learn from other providers of GP OOH services. Some of these service providers appear to utilise support staff to free up clinical time e.g. a dispatcher chases failed calls and ensures home visits are better co-ordinated.
4.6 We are working jointly with YAS and HaRD CCG to look at patient flows and modify the pathway through NHS 111 and GP OOH. On 1st June we will be implementing a significant change within the service and running a direct booking pilot with NHS111, to enable call handlers to directly book into Harrogate PCC. A process and project plan is jointly agreed between GPOOH, YAS, NHS 111 and HaRD CCG. This initiative based on evidence is that rework is reduced.

- This approach will improve capacity planning and availability of clinical face to face contact time. It allows us to review what conditions come to the service and the pathway they follow. It will also reduce home visits by putting a strict home visiting policy in place.
- This project will be fully evaluated by GPOOH and HaRD CCG.

5. Clinical Governance

5.1 Quality, safety and patient experience are fundamental to our service provision. We use a range of methods to provide assurance in these areas.

5.2 There is an active programme of work to make improvements to the quality of our service which is being delivered through our Local Management Groups (LMGs) and overseen and monitored through the Combined Management Group (CMB). The LMG chairs and Clinical Lead are responsible with the management team for delivering NQRs that meet the national standard.

Quality of care and our quality report ensures we discuss and review all incidents, including those taken to CORM, any SIRI's, complaints and compliments. Learning outcomes are shared with all staff in the service.

6. Patient Safety

6.1 *An Audit of urgent patients to be seen or triaged within 20 minutes has been undertaken in March 2015*

6..2 A small percentage of patient originally prioritised by NHS 111 as urgent, are considered to be genuinely urgent once triaged by the doctor. Clinicians do try prioritising genuinely urgent calls. In the patients audited no harm was caused by a delay in being seen by a clinician. No patients have made us aware of any significant issues through complaints.

6.3 The service generally completes about 60% of telephone calls marked as urgent within the 20 minute target. The service receives approximately 5000 calls per month.

	Monthley	
	%	Patients
Triage Calls		5000
% Classified Urgent by NHS 111	40%	2000
% Responded to withing 20min	60%	1200
% Responded to withing 30min	72%	1440
% Responded to withing 60min	88%	1760

6.4 Of the calls completed within 20min, only 7.8 % are deemed urgent after triage (94 patients per month). Of those not completed within 20 minutes, 6.7% are deemed urgent afterwards (53 patients per month).

3.4% of “routine calls” were reclassified as urgent after triage (102 patients per month). This demonstrates that clinicians also reclassify (escalate) some calls as urgent. No clinical issues were highlighted in the audit.

6. 5 23 calls that were genuinely urgent and sent by NHS 111 were reviewed. Of those 18 (78%) were completed within 20mins. This again suggests that clinicians do try prioritising genuinely urgent calls and dealing with them quickly.

6.6 We are discussing with our Local Appraisal Team, what individual performance information we should ideally measure and provide for the clinicians working for the service, to satisfy the requirements for GP Appraisal and to help monitor and improve individual clinician's performance. We anticipate auditing a number of clinical records for every clinician. This will also involve auditing a number of telephone consultations for every clinician and collecting other data measuring performance. We will use this data to help any clinicians whose performance gives any cause for concern.

6. 7 *Audit of Telephone triage consultation: August 2014 – December 2014*
[A full report of the findings can be found in Appendix 3]

Each month, one hour of consultations resulting in patients only receiving telephone triage are reviewed by two GPs. Each call is measured using 14 questions to determine if the consultation is of high quality.

Of the 30 calls reviewed, two raised concerns that they were not of the high standard required. The clinical lead of the service has met with the GPs concerned and put in place individual action plans.

6.8 *Annual Audit of 1% of patients seen in GP OOH: December 2013 – November 2014*
[A full report of the findings can be found in Appendix 4]

Clinicians working within the service have peer reviewed 1% of all consultations against a set of predetermined questions looking for quality elements within the consultation.

Areas of improvement are required in the documentation of consultations including; past medical history, allergies, relevant drug history and past medical history.

The Clinical Lead for the service will be feeding back the results to the clinical staff. Our future plan is to review individual clinical staff on an annual basis and give feedback about their performance.

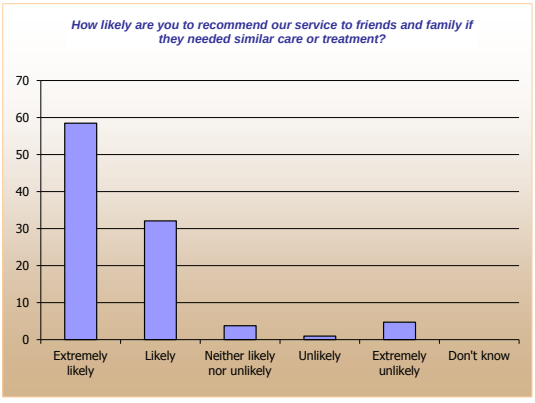
7.0 Patient Experience

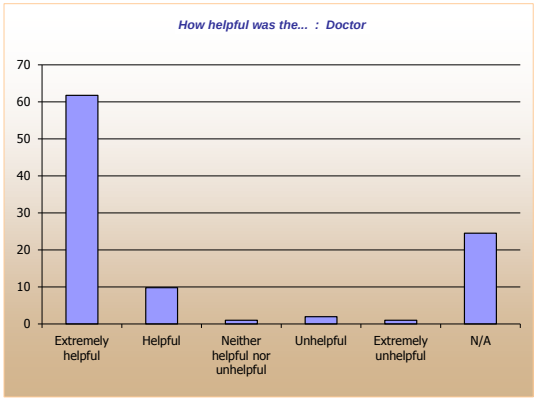
[A full report of patient's views can be seen in Appendix 5.]

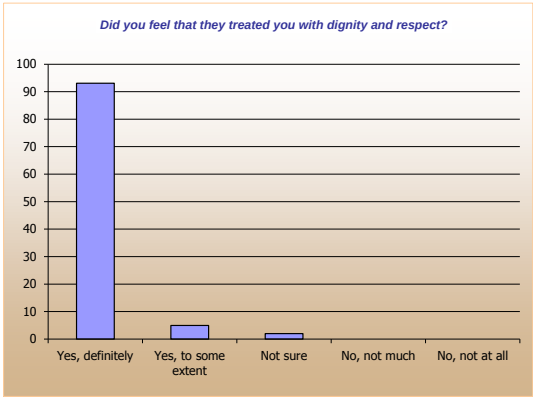
For the number of patient interactions the service has (approx.100,000), it has very few complaints and in the last 2 years one SIRI.

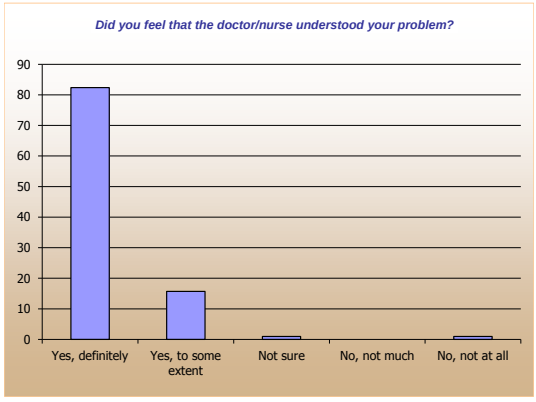
We have purchased a touch screen patient survey device. We are working with the supplier, patient group and CCG to develop meaningful quality questions including the enhanced friends and family test (FFT). The "tablet" was introduced in December 2014 and hundreds of patients have completed our electronic survey. We are working with the supplier and staff to increase participation of patients. The recent use of a volunteer increased the response rate.

The results clearly show a high level of patient satisfaction with the GPOOH service (see below).









8. Summary and Recommendations

8.1 The GPOOH service provides a safe, high quality service to patients. Quality improvement plans are in place to improve the NQR performance and consideration is been given by the Directorate to an annual audit planning cycle in line with other clinical teams at HDFT.

8.2 The Board is asked to note the current issues and progress that is being made to improve the performance position and prevent any risk of harm to patients requiring assessment or review by the GP OOH service.

9. Appendix

Appendix 1 – NQR Performance

Microsoft Excel
97-2003 Worksheet

Appendix 2 – Action & Improvement Plan

Microsoft Excel
97-2003 Worksheet

Appendix 3 – Telephone Consultation Triage

Microsoft Excel
97-2003 Worksheet

Appendix 4 – 1% Audit

Microsoft Excel
97-2003 Worksheet

Appendix 5 – Patient Experience

Microsoft Excel
97-2003 Worksheet

Between 15th December 2014 and 10th April 2015 106 patients have completed our survey on our “tablet”.

Report to the Trust Board of Directors: 27 May 2015	**Paper number: 5.0**

Title	**Report from the Chief Executive**
Sponsoring Director	Chief Executive – Dr Ros Tolcher
Author(s)	Chief Executive
Report Purpose	To receive and note the contents of the report.
Previously considered by	N/A

Executive Summary
This is my monthly report summarising key operational and strategic issues across the organisation. This report includes key messages from the Trust's Senior Management Team and the Quality and Governance Group.

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

Risk and Assurance	
Legal implications/ Regulatory Requirements	No additional risks

Action Required by the Board of Directors
The Board of Directors is asked to discuss and note the report.

1.0 MATTERS RELATING TO QUALITY AND PATIENT EXPERIENCE

1.1 Patient Safety Visits

There have been four Patient Safety Visits since the last meeting of the Board. The visits were to Endoscopy (23 April), York Wheelchair Services (30 April), Therapy Services (5 May) and Domestic Services (7 May). A further visit to the Emergency Department on 13 May was postponed.

1.2 **CQC National Inpatient Survey.**

The Trust has performed well in the 2014 national inpatient survey scoring "significantly better than average" for seven out of 59 questions, compared with six out 60 questions last year.

1.3 Complaints monitoring

The Trust received 26 new complaints in April compared with 17 in April 2014 and a monthly average for the last twelve months of 23.

Of the 26 complaints received in April 2015, one was graded Amber, 18 were graded Yellow and seven graded Green. Of note in April 2015:

- There were two complaints, both graded as Yellow, regarding medical care and medical communication in Maxillo-facial (maxfax) surgery;
- There were six complaints regarding Medical care in the Emergency Department, Orthopaedic Outpatients, Theatres, MaxFax, Endoscopy, and Littondale;
- There were eight complaints regarding Nursing care in Endoscopy, Fountains, Selby MIU, Wenslydale, Pannal, Littondale, Oakdale, and Nidderdale;
- There were two complaints, one graded as Yellow, one graded Green, regarding medication on Harlow Ward.

2.0 STRATEGIC UPDATE

2.1 Delivering New Models of Care

The Harrogate Health Vanguard project, the Harrogate Health Transformation Board provides the governance for delivering our shared ambition for a transformed health and social care system. The group has now agreed a set of principles and objectives for its programme of work. These are being translated into specific deliverables, critical success factors and a route map for delivery. Task and finish groups for each of the main work streams have been specified and are starting to explore the detailed requirements. On 28 and 29 May the NHS England New Care Models team are conducting a site visit. This provides a forum for the partners in the Vanguard work to describe our vison in more detail and identify the specific challenges for which we are seeking help from the NHS Team. The site visit will include some service visits and also a public engagement event.

2.2 2015/16 Contract

We remain in dialogue with our main commissioner, Harrogate and Rural District CCG, on the 2015/16 contract. This will be the second year of a two-year contract which has been rolled forward. A verbal update will be given at the meeting.

The executive team held a bilateral meeting with commissioning executives on 20 May. This was a positive meeting focusing on shared ambitions for new care models, potential contractual vehicles and future services at Ripon.

2.3 Ripon Partnership

The Partnership met on 12 May. A new milestone has been reached with the appointment of consultants to take forward the development of plans for a facility which is fit for purpose. This will include re-provision of existing Community Hospital services, primary care and Extra Care and supported housing, amongst other elements. The consultants are being jointly funded by North Yorkshire County Council, Harrogate Borough Council, the Harrogate and Rural District Commissioning Group and the Trust. A communications and voluntary sector engagement strategy is in the course of development.

2.4 General Election

The political landscape after the General Election remains broadly unchanged. Mr Jeremy Hunt has been re-appointed as Secretary of State and both Andrew Jones and Julian Smith were re-elected, the former being appointed to a junior ministerial post at the Department of Transport. It is expected, therefore, that the NHS Five-Year Forward View will continue to point the strategic direction for healthcare in England and Wales.

3.0 FINANCIAL POSITION

The financial position as at the end of April is a surplus of £137,000 against plan. This favourable variance is partly driven by income £229k ahead of plan balanced by some pay overspending. This compares well with month one of 2014/15 which recorded a deficit of £341,000.

This positive position falls short of our stretch target by £147,000 and it is important that firm control over our financial position continues, with further cost improvement schemes implemented in order to provide the additional resources we require for funding of the service pressures prioritised in each area.

A significant amount of work has been undertaken throughout the directorates to develop and action cost improvements while also delivering activity over planned levels and this will continue.

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

4.0 SENIOR MANAGEMENT TEAM (SMT) MEETING

The SMT met on 20 May. The meeting focused a reviewing performance across quality, workforce contracts and finance with detailed discussion on the underlying issues driving budgetary variance.

SMT received annual reports from each of its sub-groups which covered the work of the subgroup over the last 12 months, meeting attendance rates and review of terms of reference where relevant. Each sub-group has identified objectives for 2015/16 aligned to the strategic and operational objectives of the Trust. The terms of reference of the SMT were also formally adopted following revision to reflect the Trust's revised governance framework.

SMT received 13 new Internal Audit reports and scrutinised the action plans for those with limited or partial limited assurances. Executive leads for each audit provided assurances that appropriate action is being taken to address gaps in controls.

The Corporate Risk Register was received and progress on the one risk with delayed actions (risk of patient harm due to failure to identify and manage mental health and mental capacity needs) was discussed.

5.0 COMMUNICATIONS RECEIVED AND ACTED UPON

Work undertaken by the Trust on behalf of Leeds commissioners received some media coverage during the month, which was positive. Local media has focused on the financial pressures impacting on NHS services in the Yorkshire and Humber region, with no specific references to the Trust

6.0 BOARD ASSURANCE AND CORPORATE RISK

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

6.1 Board Assurance Framework (BAF)

There are 12 Risks recorded on the BAF and all were reviewed and updated, where appropriate, on 15 May by the Executive Directors. All BAF entries have action plan progress scores of 1 or 2 which provides assurance that actions are being progressed. There are no risks where the actions are either not defined or are delayed.

No new risks have been added to the BAF since last month and no risks have been removed.

The strategic risks are as follows:

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

Progress Score on Actions:

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

6.2 Corporate Risk Register (CRR)

The CRR was reviewed at the monthly meeting of the Corporate Risk Review Group on 8 May. There were no new risks to add to the register and none to be removed. As follows:

The highest scoring risk with current risk score of 15 or above remains:
Risk to business objectives due to non-delivery of locality-wide IT system – 16.

Mitigating actions have been identified for all risks and executive leads have been identified to ensure accountability for the delivery of action plans.

There remains one risk with a progress score of three – Risk of patient harm due to failure to identify and manage mental health and mental capacity needs. we anticipate this improving in the next month.

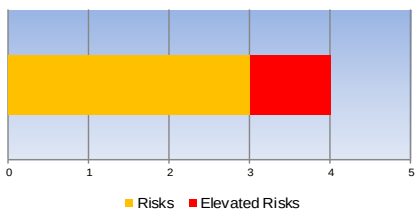
Dr Ros Tolcher
Chief Executive
May 2015

Board of Directors Overview - Apr 15

Harrogate and District NHS Foundation Trust

Quality

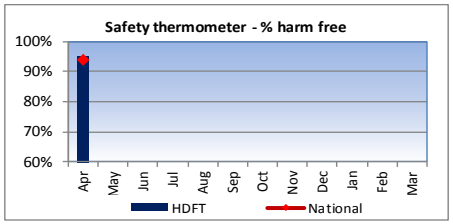
CQC Intelligent Monitoring



Priority banding for inspection	5
Number of Risks	3
Number of Elevated Risks	1
Overall Risk Score	**5**
Number of appplicable indicators	95
Maximum Possible Risk Score	190

	Description
Elevated Risk	Composite of Central Alerting System (CAS) safety alerts indicators
Risk	Potential under-reporting of patient safety incidents
Risk	Composite of hip related PROMS indicators
Risk	Consistency of reporting to the National Reporting and Learning System (NRLS)

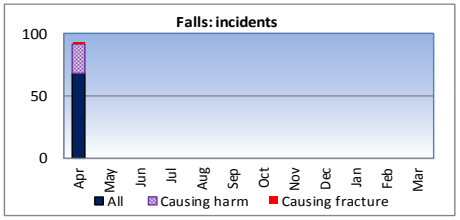
Safety Thermometer - % harm free



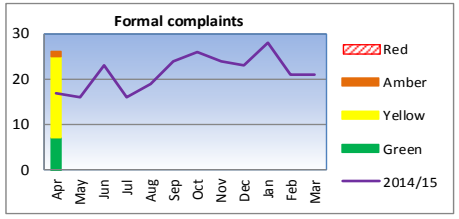
Pressure Ulcers

Hospital acquired	APR	YTD	Trend
Grade 2	17	17	
Grade 3	1	1	
Grade 4	0	0	
Community acquired	**APR**	**YTD**	**Trend**
Grade 2	10	10	
Grade 3	2	2	
Grade 4	0	0	

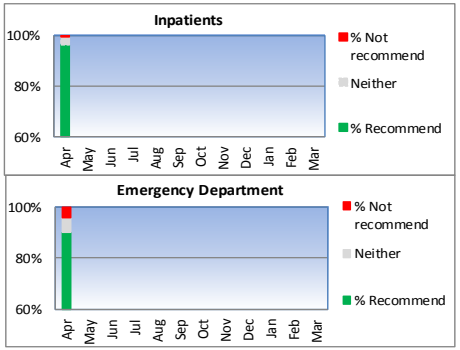
Falls



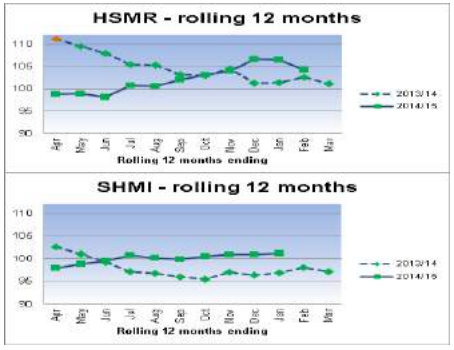
Complaints



Friends and Family - % recommend/not recommend



Hospital Mortality Information

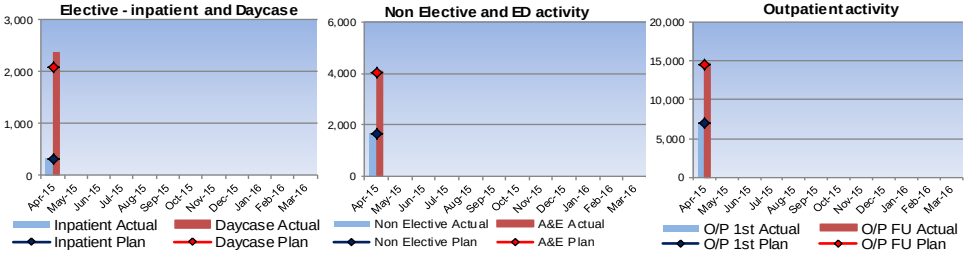


Performance

Monitor Governance Rating	Amber

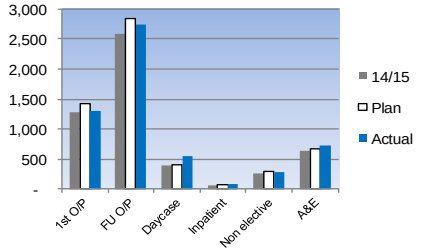
Indicator description		Target	Q1	Q2	Q3	Q4 (prov)
RTT	Admitted pathways (% within 18 weeks)	>=90%	94%			
	Non-admitted pathways (% within 18 weeks)	>=95%	97%			
	Incomplete pathways (% within 18 weeks)	>=92%	96%			
A&E	Total time spent in A&E	>=95%	96%			
Cancer	Maximum waiting time or 14 days from urgent GP ref to date first seen for all urgent suspect cancer referrals	>=93%	88%			
	Maximum waiting time of 14-days for symptomatic breast patients (cancer not initially suspected)*	>=93%	95%			
	31 day wait for second or subsequent treatment: Surgery*	>=94%	100%			
	31 day wait for second or subsequent treatment: Anti-Cancer drug*	>=98%	100%			
	31 day wait for second or subsequent treatment: Radiotherapy*	>=94%	NA			
	Maximum waiting time of 31 days from diagnosis to treatment for all cancers (%)*	>=96%	100%			
	62 day wait for first treatment from urgent GP ref to treatment: all cancers*	>=85%	88%			
	62 day wait for first treatment from consultant screening service referral: all cancers*	>=90%	100%			
C-Difficile		<= 12 cases in year	0			
Community Services	RTT information	>=50%				
	Referral information	>=50%				
	Treatment activity information	>=50%				

Performance against activity plans



	YTD Plan	YTD Actual	YTD Variance	14/15 YTD
Inpatient	308	320	12	310
Daycase	2,094	2,369	275	2,008
O/P 1st	7,047	7,006	-41	6,388
O/P FU	14,589	14,702	113	13,536
A&E	4,022	4,090	68	3,970
Non Elective	1,648	1,702	54	1,621

Activity relating to Leeds Locality



You matter most

Board of Directors Overview - Apr 15

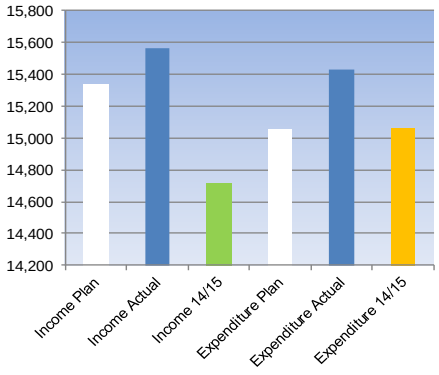
Harrogate and District NHS Foundation Trust

Finance

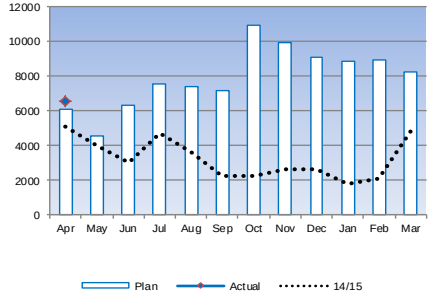
Continuity of Services Risk Rating	Q1 Plan	April
Planned Rating	3	3
Actual Rating – Capital Service Cover		3
Actual Rating – Liquidity		3
Actual Rating – Consolidated Rating		**3**

Income & Expenditure	£'000s
YTD Plan	283
YTD Actual	137
Variance	**-146**
Planned Outturn	1,800
Forecast Outturn	1,800
Variance	**0**

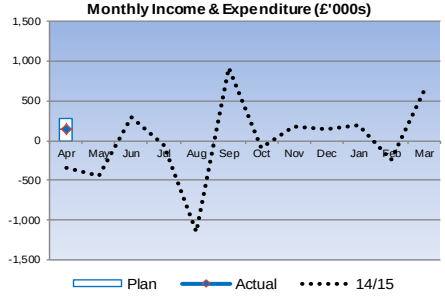
Income and Expenditure to date (£'000s)



Cashflow Monitoring
Plan £6,074k - Actual £6,560k



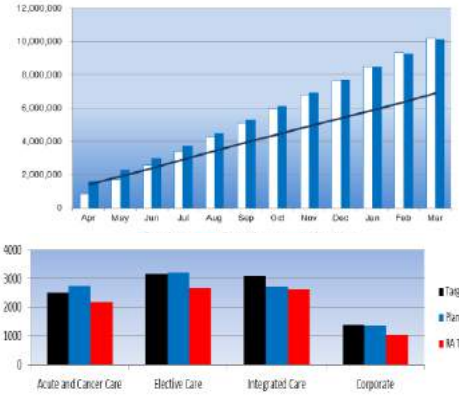
Monthly Income & Expenditure (£'000s)



Income	Plan	Actual	Variance	14/15
Apr (£'000s)	15,335	15,564	**229**	14,717
YTD (£'000s	15,335	15,564	**229**	14,717

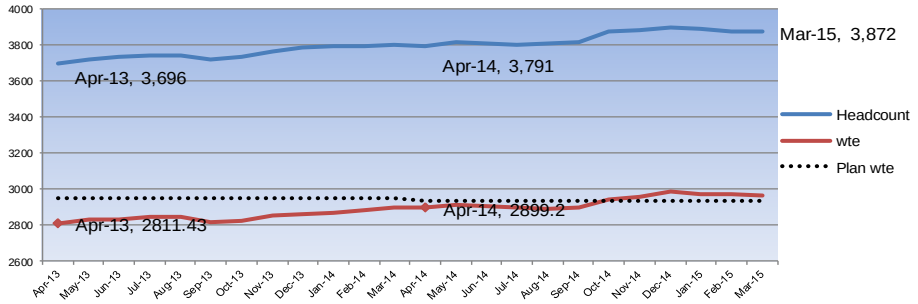
Expenditur	Plan	Actual	Variance	14/15
Apr (£'000s)	15,052	15,427	**375**	15,058
YTD (£'000s	15,052	15,427	**375**	15,058

CIP Performance 2015/16



Workforce

Trustwide WTE& Headcount



Staff Sickness Rates

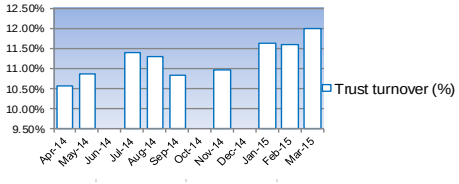
Absence Rates	Feb-15	YTD	Trend
Trustwide	4.21%	4.05%	

Type	Short Term Sickness	Long Term Sickness
Trustwide	91.13% ↑	8.87% ↓

Top 5 Absence Reasons per episode for sickness in Feb 15	% of total sickness
Cold, Cough, Flu - Influenza	19.02%
Gastrointestinal Problems	17.27%
Other Known Causes - Not Elsewhere Classified	9.19%
Anxiety/Stress/Depression/Other Psychiatric Illnesse	7.45%
Unknown Causes / Not Specified	7.45%

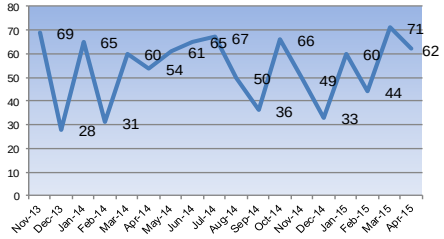
Turnover

	Ave Headcount	Leavers	Turnover %
Trustwide	**3,393**	**407**	**12.00%**
*excludes jnr doctors, fixed term contracts and zero hour			



Recruitment

Recruitment Activity by month



Appraisal

Directorate	No. of Assignme	Running Total	% Complete	Trend
ACC	639	515	80.60%	
Corporate	560	448	80.00%	
Elective	853	619	72.60%	
Integrated	974	617	63.30%	
Trustwide	**3026**	**2199**	**72.70%**	

Safer Staffing Information

Time of day	Nursing group	Current Month	Trendline (+/-100%)
Day	Registered	104%	
	Unregistered	108%	
Night	Registered	103%	
	Unregistered	123%	

Report to the Trust Board of Directors: 27 May 2015	**Paper number: 6.0**

Title	**Report from the Medical Director**
Sponsoring Director	Medical Director
Author(s)	Medical Director
Report Purpose	To update the Board on clinical matters for the month of May 2015
Previously considered by	N/A

Executive Summary
This paper provides a summary of key issues that I wish to bring to the Board's attention for the month of May 2015.

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

Risk and Assurance	The paper provides a measure of assurance to the Board.
Legal implications/ Regulatory Requirements	None

Action Required by the Board of Directors
The Board is requested to note the information in the report.

REPORT BY THE MEDICAL DIRECTOR – MAY 2015

1. Mortality data.

There has been a further slight fall in the rolling HSMR to 104.27 (106.52 last month's figure). This is the 12 month period to February 2015. SHMI has shown a slight rise to 101.23 for the period end of January 2015 (100.89). Over the 12 month period, elderly medicine and respiratory medicine are the two higher than expected specialties for SHMI, with only respiratory medicine higher than expected for HSMR.

2. Regulatory issues.

Following an independent review commissioned by the GMC, it is recommended that when organisations refer to the GMC regarding an individual's fitness to practice, they explicitly state whether that individual has raised concerns of patient safety. There is evidence from the review that whistle-blowers can suffer and may be scapegoated by, in part, referral to the professional regulator. The Board may wish to consider who might be the most appropriate individual (or individuals) within the organisation to minimise the risk of such an occurrence.. It might for instance be the role of the NED who acts as the internal scrutineer of the Trust's whistleblowing policy. The DoH has published findings following its consultation on proposals to amend the Medical Act 1983 which governs fitness to practice investigations and Medical Practitioner Tribunal Service (MPTS) hearings. One of these is the ability of the GMC to now appeal MPTS decisions (perhaps if they feel they have been too lenient), and for MPTS to award costs against either party. See www.gmc-uk.org/news/26109.asp

3. Doctors under investigation by the GMC.

A recent report has recognised the stress associated with doctors being under investigation by the GMC. It also acknowledges the work done by the GMC to understand the impact and provide additional support for doctors. The report recommends the establishment of a National Support Service for doctors. www.gmc-uk.org/news/26011.asp.This may primarily be a function of commissioners or providers, though the GMC has agreed to explore this further. The MPTS is also piloting a telephone advice service for unrepresented doctors facing a GMC hearing. http://www.mpts-uk.org/unrepdoctors.

4. Chaplaincy Services.

I am delighted to announce the appointment of David Payne as head of Chaplaincy Services to replace Rev. Jim Grebby. David is currently working in Gateshead. It will be his first Lead Chaplaincy post. I am delighted to announce this appointment at a time when the service is under great pressure due to the additional forced temporary leave of another member of the team. In the meantime I am grateful to members of the community team who have stepped in to assist with interim staffing arrangements.

5. New appointments.

I am similarly delighted to announce the appointment of Mr David Kopacs to the post of Consultant Orthopaedic surgeon with an interest in upper limb (elbow and shoulder). This will take the complement of surgeons to 10 and will finalise the planned pairing system of surgeons with a common specialist interest.. In addition Mr Biswajit Ray has been appointed as General and Breast Surgeon to the Trust. This is a permanent post following the resignation of Mr Dyke to pursue a sabbatical in sunnier climes. Mr Ray has been working as a locum in the Trust for several months and is therefore well-known to the team and wider staff. This is an excellent appointment to the service.

6. Information sharing agreement between organisations.

This was debated at the last Board of Directors meeting. I have not been able to identify any formal written agreement or memorandum of understanding between organisations for the purposes of relevant and timely information sharing around doctors who work across different Trusts. Accurate, consistent and timely information sharing is essential across Trusts in order to inform whole practice appraisal and identify and support practitioners in difficulties. The benefits for patients are self-evident. Having made enquiries with my counterparts across our partner organisation, I have concluded there is a need for such an understanding. Our GMC affiliate agrees this is long overdue. I am currently finalising a form of words which I will agree with the GMC and Damian Riley, Medical Director for NHS North, following which it will be circulated to Medical Directors for sign off. I will keep the Board updated on progress.

7. Medical Directors Forum.

A long overdue development is being reinvigorated by Mr Karl Mainprize, MD of Airedale Trust. The proposal is for regional Medical Directors to meet regularly (probably quarterly) to discuss issues that are both topical and common to the role. The process of information sharing and networking is designed both to support and develop individuals in their role. I support this approach, as do a number of Medical Directors in the region. Information of importance to the Board arising from these discussions will be fed back through my report.

8. Yorkshire and Humber Genomic Medicine Centre.

Three hospital trusts in the region are collaborating with YH AHSN to produce a bid to be one of 12 Genomic Medicine Centres throughout the UK. To be successful, the bid will require the support of all providers in the region, not least to ensure equality of access for all patients. I have agreed to act as the local contact for the bid process. I will update the Board on developments as they arise**.**

9. Public Inquests.

Since the last Board I have represented the Trust at two planned public inquests. The first concerned a patient who died following a post-operative blood clot on the lung. The verdict was natural causes. The Trust was not criticised by the Coroner, though learning has arisen out of this episode. The second concerned a patient with learning difficulties with known Orthopaedic sepsis. The patient developed severe pneumonia, renal impairment and multi-organ failure. The case was reviewed at the time by the Medical Director and an action plan arising from this review was presented to HM Coroner in advance of the inquest hearing. The inquest verdict was natural causes. HM Coroner was satisfied with the local investigation report and actions in place. The Trust has been in contact with the families of both patients throughout the process.

A third inquest in Leeds following the death of a neonate has yet to be scheduled for hearing by HM Coroner for West Yorkshire.

10. GMC conflict of Interest Guidance for Doctors and Organisations.

The Chief Executive of the GMC has recently written to the CEO of all designated bodies in the NHS. The communication follows an investigation into private healthcare markets which uncovered evidence of incentive schemes to licensed practitioners and, in some cases, lack of fee transparency. Doctors taking part in such schemes are likely to be breaching GMC good practice guidance and could fall foul of the professional regulator. I have responded in writing to the GMC on behalf of the Trust, assuring them that no such

schemes exist in this organisation, nor am I aware of any such schemes existing elsewhere that could involve our current medical workforce. I have undertaken to inform the GMC immediately should I become aware of any such practice. In addition, I have circulated the document to the Consultant body in order that they familiarise themselves with the detail of the guidance and are in no doubt as to their professional responsibilities in this matter.

11. Final settlement agreement in medical negligence case.

There was recent media coverage around the financial settlement (£10 million) to the family of a 6 year old boy who was left severely brain damaged a result of failure to recognise *intrapartum* foetal distress. The child now requires round the clock care. The Trust welcomes final settlement of this long running case, has apologised formally for the failings of care and wishes Kit and his family the very best for the future. There is a strong link between the type of medical negligence and the SUTS initiative.

Report to the Trust Board of Directors: 27 May 2015	**Paper No: 7.0**
Title	Chief Nurse Report
Sponsoring Director	Chief Nurse
Author(s)	Jill Foster, Chief Nurse
Report Purpose	To update the board on quality and safety of patient care and to brief the board on national, local and organisational nursing and midwifery developments.

Executive Summary

This report provides the board with an update of ongoing work in relation to the safety, effectiveness and quality of patient care and supports the operational reports.

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

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

Action Required by the Board of Directors

To read and discuss the content of this report and with regard to the recommendations, to provide direction, approval and authorisation to the Chief Nurse.

Chief Nurse Report

This report is an update of ongoing work in relation to safe and quality care that supports the operational performance reports offering supplemental supporting information in relation to the delivery of quality and safe patient care. In addition, this report provides the Board with regular updates on national and local developments influencing nursing and midwifery.

Fundamental Standards of Care/Patient

In my previous reports I have provided the Board with an update on work delivered and the ongoing actions and approach being taken to enable safe, effective, high quality care across the organisation. These briefing notes provide our results to date. For this report I have continued to provide key performance metrics that are proxy indicators for quality care with benchmarking against other organisations and a narrative to describe my ambition for improving the quality of care and experience including targets for reducing harm.

Pressure Ulcers

Hospital and Community Data - April 2014 – March 2015:

Pressure ulcers acquired in receipt of HDFT care	Apr-14			May-14			Jun-14			Jul-14			Aug-14			Sep-14			Oct-14			Nov-14			Dec-14			Jan-15			Feb-15			Mar-15			All		
	Grade 2	Grade 3	Grade 4	Grade 2	Grade 3	Grade 4	Grade 2	Grade 3	Grade 4	Grade 2	Grade 3	Grade 4	Grade 2	Grade 3	Grade 4	Grade 2	Grade 3	Grade 4	Grade 2	Grade 3	Grade 4	Grade 2	Grade 3	Grade 4	Grade 2	Grade 3	Grade 4	Grade 2	Grade 3	Grade 4	Grade 2	Grade 3	Grade 4	Grade 2	Grade 3	Grade 4	Grade 2	Grade 3	Grade 4
Acute Medical Unit Bolton	1	1								1						2	2		3	1		1			2			1			2						**13**	**4**	**0**
Acute Medical Unit Fountains													1			1	2		2				1					3			1						**8**	**3**	**0**
Byland Ward	1	1		6	1		1			6			6			6			5			3			4	1		8	1		3			3			**52**	**4**	**0**
Farndale Ward	4			3			1			1			1			2			1			1			6	1		2			1						**23**	**1**	**0**
Granby Ward	2	1		1			1			1			2			2									1						1			2			**13**	**1**	**0**
ITU/ HDH				1																		1			1						1			1			**5**	**0**	**0**
Jervaulx Ward	5			3			1			3			4	2		4	1		5			4						2	2					2			**33**	**5**	**0**
Littondale Ward	1				1											1				1		1			4			3			1			3			**14**	**2**	**0**
Nidderdale Ward																													1		1						**1**	**1**	**0**
Oakdale Ward	1			4			2			2			2	1			1					1						1						2			**15**	**2**	**0**
Ripon Hospital - Trinity Ward		1		4			2				1								1	1		2				1											**9**	**4**	**0**
Wensleydale Ward							1			1						1			3			2			3						1			1			**13**	**0**	**0**
Swaledale	1																																				**1**	**0**	**0**
Lascelles	1						1															1															**3**	**0**	**0**
Harlow																																					**0**	**0**	**0**
Other	1			1			1															*3*			3			1			2			1			**13**	**0**	**0**
Total	**18**	**4**	**0**	**23**	**2**	**0**	**11**	**0**	**0**	**15**	**1**	**0**	**16**	**3**	**0**	**19**	**6**	**0**	**20**	**3**	**0**	**20**	**1**	**0**	**24**	**3**	**0**	**21**	**4**	**0**	**14**	**0**	**0**	**15**	**0**	**0**	**216**	**27**	**0**

Community acquired pressure ulcers	Apr-14			May-14			Jun-14			Jul-14			Aug-14			Sep-14			Oct-14			Nov-14			Dec-14			Jan-15			Feb-15			Mar-15			All		
	Grade 2	Grade 3	Grade 4	Grade 2	Grade 3	Grade 4	Grade 2	Grade 3	Grade 4	Grade 2	Grade 3	Grade 4	Grade 2	Grade 3	Grade 4	Grade 2	Grade 3	Grade 4	Grade 2	Grade 3	Grade 4	Grade 2	Grade 3	Grade 4	Grade 2	Grade 3	Grade 4	Grade 2	Grade 3	Grade 4	Grade 2	Grade 3	Grade 4	Grade 2	Grade 3	Grade 4	Grade 2	Grade 3	Grade 4
Acute Medical Unit Bolton																1																	1			2	0	0
Acute Medical Unit Fountains																	2																			0	2	0
Byland Ward	1															1																			2	0	0
Community Fast Response & Rehab Team																1						1	1													2	1	0
Farndale Ward										1																										1	0	0
Granby Ward																												1								1	0	0
Harrogate FRT	1																																	1			2	0	0
ITU/HDU																																					0	0	0
Jervaulx Ward																																					0	0	0
Littondale Ward																																					0	0	0
Nidderdale Ward																																					0	0	0
Oakdale Ward																																					0	0	0
Ripon Hospital - Trinity Ward				1																																	1	0	0
Theatres																																					0	0	0
HARROGATE INTEGRATED COMMUNITY CARE TEAM							2	1		2	2	1	3	1		2	2		1			2	2		2	1		2	1	1	4			5			25	10	2
KNARESBOROUGH & BOROUGHBRIDGE INTEGRATED COMMUNITY CARE TEAM		1		2	1		2	1		3			3	1		1			2	1									1		1	1			1		14	8	0
RIPON & RURAL INTEGRATED COMMUNITY CARE TEAM	3	1			1		2			5	1		3	1		3	1		4	2		4	1		4	2		2			2			1	1		33	11	0
Wensleydale Ward																																					0	0	0
Grand Total	5	2	0	3	2	0	6	2	0	11	3	1	9	3	0	9	5	0	7	3	0	7	4	0	6	3	0	5	2	1	7	1	0	8	2	0	83	32	2

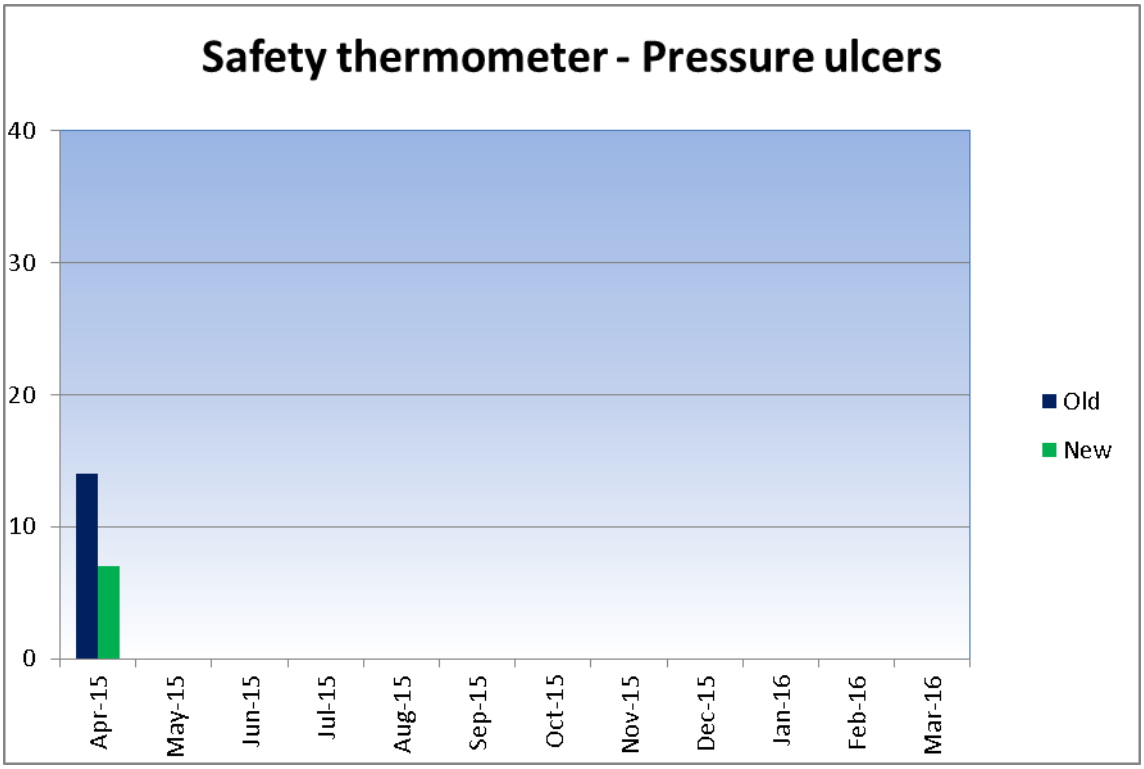
Hospital and Community Data - April 2015:

Pressure ulcers acquired in receipt of HDFT care	Apr-15		
	Grade 2	Grade 3	Grade 4
Acute Medical Unit Bolton	1		
Acute Medical Unit Fountains	1	1	
Byland Ward	1		
Farndale Ward	2		
Granby Ward	2		
ITU/ HDH			
Jervaulx Ward	1		
Littondale Ward	1		
Nidderdale Ward	2		
Oakdale Ward	1		
Ripon Hospital - Trinity Ward	1		
SROMC	1		
Wensleydale Ward	2		
Swaledale			
Lascelles	1		
Harlow			
Other			
Total	17	1	0

Community acquired pressure ulcers	Apr-15		
	Grade 2	Grade 3	Grade 4
Acute Medical Unit Bolton			
Acute Medical Unit Fountains			
Byland Ward			
Community Fast Response & Rehab Team	1		
Farndale Ward			
Granby Ward			
Harrogate FRT			
ITU/HDU			
Jervaulx Ward			
Littondale Ward			
Nidderdale Ward			
Oakdale Ward			
Ripon Hospital - Trinity Ward			
Theatres			
HARROGATE INTEGRATED COMMUNITY CARE TEAM	3	2	
KNARESBOROUGH & BOROUGHBRIDGE INTEGRATED COMMUNITY CARE TEAM	2		
RIPON & RURAL INTEGRATED COMMUNITY CARE TEAM	4		
Wensleydale Ward			
Grand Total	10	2	0

Error! Not a valid link.HDFT Safety Thermometer

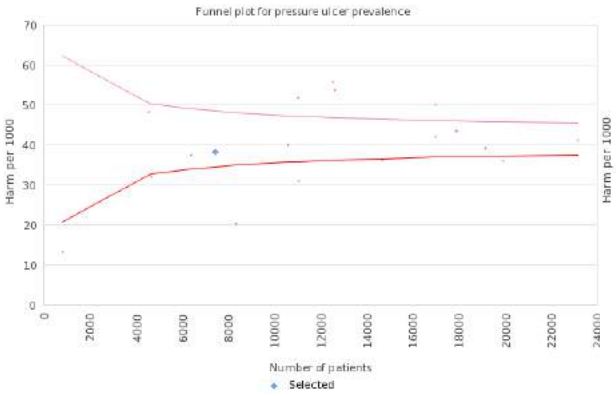
Data – April 2015:



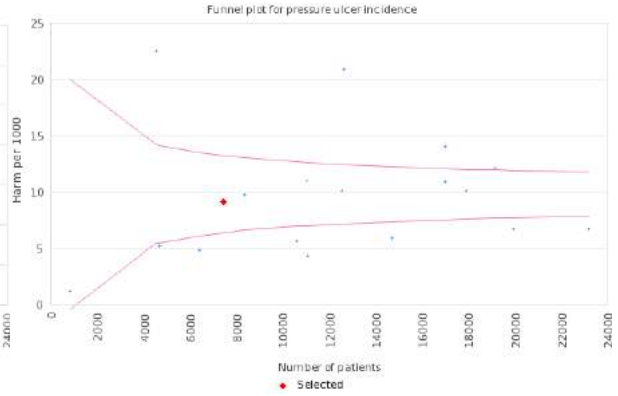
NHS Safety Thermometer Data

Pressure Ulcer Funnel Plots:

Prevalence

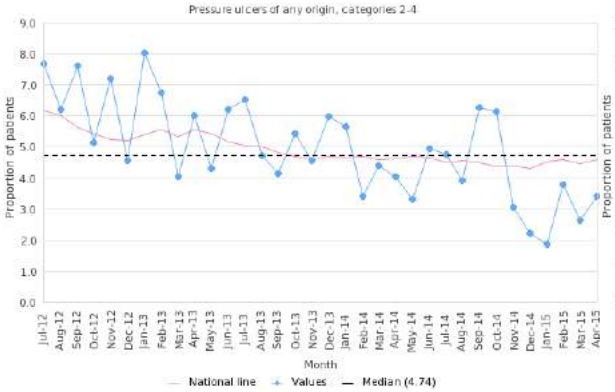


Incidence

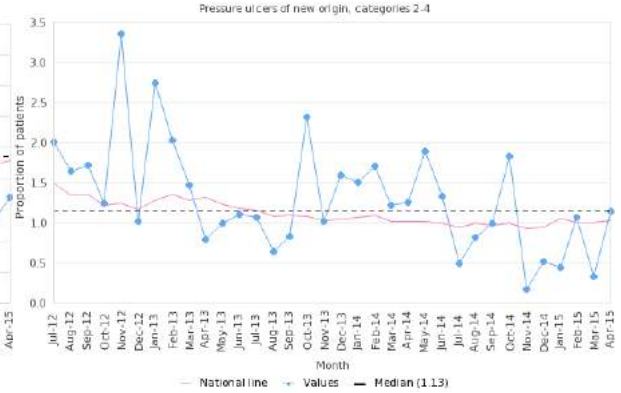


Pressure Ulcer Dashboard:

All Pressure Ulcers



New Pressure Ulcers



Pressure ulcer themes for learning identified from some submitted RCA's

Hospital

Incident ref number	Location of PU	Poor /inconsistent doc of position changes	Poor doc of skin inspection /integrity/ PU status	No photo of sores o/a to hospital	No air mattress available o/a	Delay in obtaining air mattress	Incorrect and inconsistent doc of PU grade	Incorrect RA calculation (Waterlow)	No wound care plan/reg evaluation	No timely RA on admission to ward. E.g. within 6 hours	Delay in obtaining photos during admission	Delay/No TVN referral	No re RA/delay weekly/condition change/transfer between wards (waterlow)	Delay in Datix	Poor handover/Comms. between staff
29500	R heel	X	X	X	X	X	X								
29511	Sacrum		X	X		X	X	X	X				X		
29112	L Heel		X									X	X	X	
28734	L Heel	X	X			X	X					X			
26889	R heel	X	X			X		X				X	X		
26108	Spine	X	X				X	X					X		
26722	Heel	X	X	X			X				X				
22371	sacrum												X		
29910	L heel		X							X			X		
16011	L heel	X				X							X	X	
14614	R & L elbows		X					X	X		X		X		
14608	Sacrum		X	X			X		X	X					
14730	L heel										X		X		
14791	R heel					X	X						X		
15115	R Heel		X				X			X				X	
15240	L Heel		X										X		
15963	Head		X				X								
16150	L heel		X			X					X				
16011	L heel	X	X			X							X	X	X

Community

Incident ref numb	Location of PU	No RA on first visit /or Subsequent re assessment (PURAT)	Poor doc of skin inspect on initial visits	Poor Document'n /care planning	No Photo on first visit	No PU grading	Delay in ordering/ obtaining pressure relieving equipment	Dressing changes no clear plan	Scheduling and allocation error system1	Wound chart not completed timely or consistently	Delay in Datix comp	Delay in taking photos ongoing	Comms. about PU mgt poor between DN/Pt /Rels	Wrong PU grading	Delay in supply PX dressings	TVN referral delay
29445	Heel	X		X	X	X	X	X	X							
24630	buttocks			X	X					X	X	X				
26261	L buttock			X									X	X		
23949	Sacrum			X	X	X	X		X	X		X				
27249	L Hip						X			X						
25098	R Heel				X	X					X	X	X			X
19415	R Heel								X							
22636	Sacrum			X						X		X				
19742	L Hip			X			X								X	
14360	Sacrum	X		X	X		X				X	X				
14534	L elbow		X										X			
14599	R heel	X			X					X		X				
14916	L Buttock	X			X							X				
15067	L Hip				X		X		X							
15107	R Hip	X							X			X				
15464	R Hip			X									X			
15527	Sacrum			X		X										

The grids above are the themes that have emerged from the Root Cause Analyses (RCA's) undertaken to date. The themes are being utilised to inform our prevention work.

Ambition for 2015/2016

The overall target for the Trust is to eliminate all avoidable hospital acquired category 3 and 4 pressure ulcers. The ambition for 2015/16 is

- 50% reduction in category 3 and 4 avoidable hospital acquired pressure ulcers – target 14 or less
- 20% reduction in all category 2, 3 and 4 hospital acquired pressure ulcers based on 2014/15 outturn – target 195 or less

Targets for the community 2015/16

- 30% reduction in category 3 and 4 avoidable pressure ulcers
- 20% reduction in all categories of pressure ulcers based on 2014/15 outturn

Falls

Number of falls reported in April 2015 - No Harm, Low, Moderate, Severe and Death:

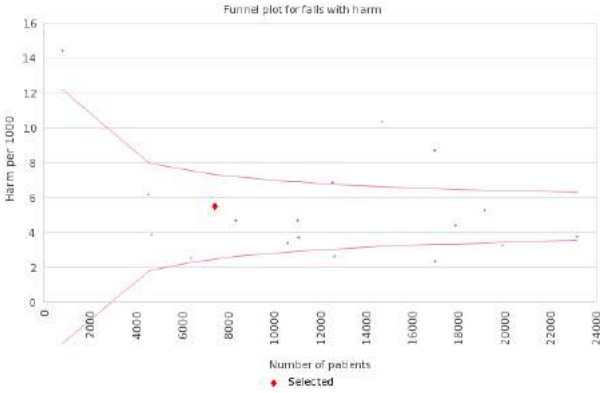
	No Harm	**Low**	**Moderate**	**Severe**	**Death**	**Totals:**
April	**44**	**21**	**3**	**0**	**0**	**68**

In terms of the numbers for 2014/15, the figures are as follows:

2014-2015	**No Harm**	**Low**	**Moderate**	**Severe**	**Death**	**Totals:**
Apr	61	19	2	0	0	82
May	55	17	2	0	1	75
Jun	42	17	3	0	0	62
Jul	71	15	5	0	0	91
Aug	44	19	4	0	0	67
Sep	41	15	6	0	0	62
Oct	48	11	3	0	0	62
Nov	46	12	0	0	0	58
Dec	73	19	1	0	0	93
Jan	43	19	3	0	0	65
Feb	54	16	1	0	0	71
Mar	46	20	5	0	0	71
Total	624	199	35	0	1	859

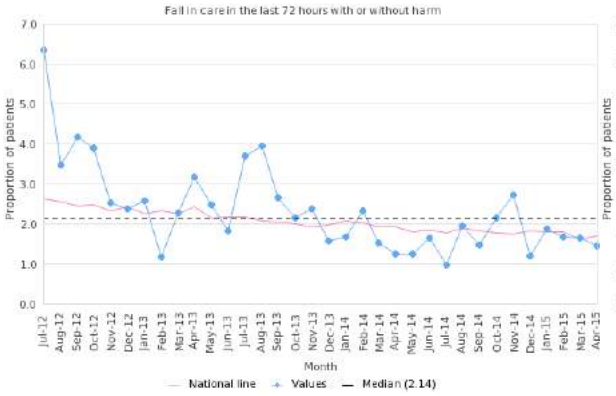
Year	2012/13	2013/14	2014/15
All Falls	991	1022	859

Falls Funnel Plot:

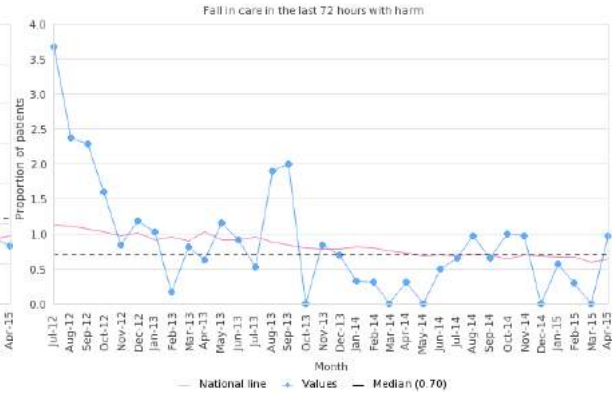


Falls Dashboard:

All Falls



Falls with harm



Actions

Falls prevention has to be an area of focus for Jervaulx ward and recently this has been heightened with several new initiatives such as

- Increased ward based falls prevention training sessions for all staff
- Focused identification and discussions at handover regarding those at high risk of falls.
- Highlighting days since last fall in team handover
- More visible signage for the patient toilet doors.
- promoting the wearing of outdoor shoes when mobilising instead of slippers and slipper socks

Future initiatives to include safety huddle with nursing/medical staff and AHP, s

Trust wide the fall prevention steering group is

- looking to develop a bundle of actions similar to the SSKIN care bundle
- reviewing the timings of falls
- analysing the results from the actions on Jervaulx for potential roll out across the Trust

Pain

Family and Friends Test responses - October 2014 – April 2015:

Since October 2014 included in the Friends and Family test questions, patients have been asked four questions relating to pain management

1. Does our staff ask you about pain regularly?
2. If you have pain are you offered pain relief?
3. If you were offered pain relief did the staff give that in a reasonable time?
4. If you had pain relief was it effective?

Number responding yes

	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	YTD
Q1) Do our staff ask you about pain regularly?	353	275	226	230	263	592	672	**2611**
Q2) If you have pain, are you offered pain relief?	290	216	184	185	186	490	524	**2075**
Q3) If you were offered pain relief, did the staff give that in reasonable time?	270	198	156	172	172	437	476	**1881**
Q4) If you had pain relief, was if effective?	252	192	154	164	160	420	455	**1797**
Total	**1165**	**881**	**720**	**751**	**781**	**1939**	**2127**	**8364**

% responding yes

	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	YTD
Q1) Do our staff ask you about pain regularly?	98.6%	98.2%	97.8%	96.6%	97.0%	97.4%	97.3%	**97.6%**
Q2) If you have pain, are you offered pain relief?	98.6%	97.3%	100.0%	98.4%	97.4%	97.4%	97.6%	**98.0%**
Q3) If you were offered pain relief, did the staff give that in reasonable time?	97.5%	94.7%	94.5%	94.0%	96.1%	95.8%	96.4%	**95.6%**
Q4) If you had pain relief, was if effective?	94.7%	94.1%	95.7%	93.2%	92.5%	95.2%	96.2%	**94.4%**
Total	**97.5%**	**96.3%**	**97.2%**	**95.7%**	**95.9%**	**96.6%**	**96.9%**	**96.6%**

Each of the directorates is continuing to use these results to target further work.

Infection Prevention and Control

***C. difficile* infection (CDI)**

YTD: 0; 2015-16 objective: 12 cases.

MRSA bacteraemia

YTD: 0; 2015-16 objective: 0 avoidable cases.

MSSA bacteraemia

YTD: 0. No specific objective.

4. Carbapenemase-producing *Enterobacteriaceae* (CPE)

In April we identified two CPE cases through screening and a third case in a clinical sample (urine). The screening cases originated in India and Portugal. Neither patient required antibiotic treatment in hospital although one has subsequently developed a UTI in the community, for which there are no antibiotic options available.

The clinical case was in a patient who had been an inpatient at a Hospital in the North West of England, which is a known high risk location. The patient was not screened on admission to HDFT because the

inpatient admission was three months earlier and the cut-off for screening proposed/agreed in the CPE screening business case is one month.

The patient was managed in an open bay, appropriately as no risk factors were identified. Exposure of other patients to this case necessitated Planned Maintenance Deep Cleans (PMDC) of entire bays in Fountains and Jervaulx (+HPV decontamination in Fountains) and PMDC in five toilets on each ward. Resources have also been spent on tracing, communicating with and screening inpatient contacts of the index case.

It is possible that consequential expenditure of this nature was not envisaged when the CPE screening business case was submitted/approved. I have asked Clare Hedges and Kath Banfield to do some cost modelling to assess the impact of extending the risk period, and the CPE task and finish group has been reconvened for 18 June to discuss the possibility of extending this.

Complaints

Of the 26 complaints received in April 2015:

- Medical = 12
- Nursing = 8
- Medical/Nursing = 4
- Other = 2

1 complaint was graded Amber
18 complaints were graded Yellow
7 complaints were graded Green

There were 265 formal complaints received in 2014/15. This is an increase on the previous year where 215 cases were received.

45% of 265 complaints have been responded to within the deadline agreed at the outset with the complainant. This is less than ideal and is monitored weekly by the PET team. The directorates have all agreed that we need to continue to improve this position and is a key objective going forward, however there has been an improvement in response rate from Q1 which was 34%.

Serious Incidents Requiring Investigation (SIRI'S)

SIRI's reported year to date (YTD) comprehensive SIRI's, for Pressure Ulcers (Grade 3 and 4) and falls causing fracture:

- Comprehensive SIRI's = 2
- Pressure Ulcers (Grade 3 and 4) = 4
- Falls causing fractures = 3

The reporting requirements SIRI reports are established and dictate that no more than 15% of all reports can have extensions requested or be submitted over time.

There is also a requirement that all SIRI incidents are reported to the CCG within 2 days of confirmation of the SIRI status.

Compliance with reporting deadlines for April 2015 is 100% of all SIRI's reported to the CCG via STEIS within 2 days and 100% of all final reports submitted on time.

Nurse Staffing April 2015

Actual versus planned nurse staffing - Inpatient areas

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

Apr-15	Day		Night	
Ward name	**Average fill rate - registered nurses/midwives**	**Average fill rate - care staff**	**Average fill rate - registered nurses/midwives**	**Average fill rate - care staff**
AMU-Bolton	96%	106%	147%	121%
AMU-Fountains	99%	93%	104%	102%
Byland	96%	111%	101%	153%
Farndale	118%	105%	107%	138%
Granby	123%	108%	101%	143%
Harlow	106%	90%	100%	-
ITU/HDU	106%	-	102%	-
Jervaulx	99%	104%	97%	113%
Lascelles	87%	93%	100%	100%
Littondale	103%	110%	100%	100%
Maternity Wards	99%	142%	104%	173%
Nidderdale	100%	106%	114%	83%
Oakdale	99%	97%	100%	98%
Special Care Baby Unit	97%	90%	98%	-
Trinity	111%	101%	100%	100%
Wensleydale	100%	128%	100%	160%
Woodlands	97%	93%	100%	97%
Trust total	**101%**	**107%**	**104%**	**122%**

Further information on this month's data

On Bolton ward the increase in night duty Registered Nurses (RN) above plan is to support the activity on the ward.
On Harlow Suite where the daytime care staff hours were less than planned, this was compensated for in RN hours.
On Granby ward the increase in Registered Nurse (RN) hours above plan was to support the opening of additional beds in April, as required.

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

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

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

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

In some wards the actual care staff hours show additional hours used for 1:1 care for those patients who require intensive support. In April this is reflected on Byland, Farndale, Granby and Wensleydale ward.

A summary of the nursing dashboard can be found in Appendix One.

Dementia CQUIN

I am pleased to report the Trust's performance against the Dementia CQUIN was on target in 2014/15. Part of the requirement to achieve the CQUIN target is to report the Trust performance against this CQUIN to the Board.

Performance on the clinical leadership element of the CQUIN was strong. The Trust's delivery of different strands of dementia training substantially exceeded its plans in terms of the numbers of people trained since in November 2014. The Trust further increased its commitment to improving colleagues' awareness of dementia by making it part of mandatory/ essential skills training at tier one or "awareness" level for all c.3,800 staff. During 2014/15, e-learning modules were completed by 1,234members of staff, with 498 staff attending awareness-raising sessions. 197 care support workers accessed tier one dementia training as part of their two day care support worker training. Tier 1 face-to-face training was accessed by 155 people.

The results of a survey of carers of people with dementia tells us that there is more work to do in the year ahead on improving the use of both the Butterfly Scheme and All About Me forms so that we provide even more personalised care.

Dementia CQUIN Review

The goal of the Dementia CQUIN is to incentivise the identification of patients with dementia and delirium - alone and in combination alongside their other medications, to prompt appropriate referral and follow-up after they leave hospital and to ensure that hospitals deliver high quality care to people with dementia, and support their carers.

I set out below updates in respect of the Trust's work to comply with national CQUINs 3.2: Dementia – Clinical Leadership; and 3.3: Dementia – supporting carers of people with dementia.

CQUIN 3.2: Dementia – Clinical Leadership

Performance Indicator Description	Q1	Q2	Q3	Q4
Dementia screening - % eligible patients screened within 72 hours of admission (FIND)	94%	96%	95%	95%
Dementia screening - % eligible patients having a full diagnostic assessment for dementia (ASSESS/INVESTIGATE)	100%	100%	100%	100%
Dementia screening - % eligible patients referred on for specialist assessment (REFER)	100%	100%	100%	100%

What was our training plan for 2014/15?

At the beginning of the financial year, the Trust planned to introduce dementia awareness training through a number of linked channels:

1. Seven e-learning modules was used for awareness-raising training with non-clinical staff. E.g. porters, domestic staff, ward clerks, volunteers and receptionists. These groups were chosen because they are more likely to come in close contact with people with dementia than other groups. Their e-learning was supported by some pilot face-to-face training sessions by volunteers from Dementia Forward. The plan was to train 60 members of these staff groups in the year.

2. A Dementia Training Day was offered to acute clinical frontline staff as this has been identified as critical to taking forward improvements within the Trust. The plan was to train 120 members of staff over seven training sessions.

3. Short face-to-face Butterfly Training took place with continued support from a local "campaign". Refresher training for every ward should be in place within twelve months.

4. Bespoke arrangements are in place for medical staff to access training: core medical trainees received dementia training as part of their curriculum; Foundation 1 trainees received dementia training from an Elderly Care consultant in June 2014.

5. All new care support workers are offered basic dementia training as part of their two day induction programme.

Did we deliver our training plan?

The Trust substantially exceeded delivery against its original plans.

1. E-learning modules were offered as planned and completed by 1,234 members of staff.
2. A Dementia Training Day was delivered in collaboration with Tees, Esk and Wear Valleys Mental Health Trust to 155 members of staff as planned.
3. Face-to-face butterfly training was delivered to 37 members of staff.
4. 498 colleagues completed dementia awareness training.
5. 197 care support workers access dementia tier one training as part of their two day care support worker training.
6. For medical staff, 8 Foundation Year 2 and Core Medical Trainees (a mixed group) received face-to-face training from the Elderly Care consultant who is the dementia lead.

In November 2014, the Trust further increased its commitment to improving colleagues' awareness of dementia by making it part of mandatory/ essential skills training at tier one or "awareness" level for all c.3,800 staff. This contributes towards the Trust's aim of delivering excellent care for older people and accounts for the much higher than originally planned numbers of staff completing e-learning modules.

CQUIN 3.3: Dementia – supporting carers of people with dementia.

The purpose of the survey of carers of people with dementia is:

- to determine the support and involvement that carers perceive they have encountered during their relative's admission, stay in hospital and discharge
- to understand how relatives and carers of patients with dementia feel that they are involved in the planning of care for their friend/family member.

For various reasons, only a fraction of those eligible to participate in the survey agree to do so. In total, 15 interviews have been undertaken in 2014-15. The results of these show further areas for improvement, which are being addressed through the delivery of the Care of Confused Patients (including people with dementia) action plan.

1. Consistent and appropriate use of the Butterfly Scheme.

a. Ensuring that written and verbal information is provided to the patient and families.

b. Displaying the butterfly above the bed in order that all staff approach and communicate appropriately.

c. Displaying the butterfly on the whiteboard.

2. Improve the consistent use of the All About Me Form include the families in discussion around

preferences and to utilise the form in daily care to enhance individualised care.

3. Improve the signposting of patients and carers to organisations which can support people living with dementia.

The survey results also show some very positive comments about the standards of care that carers said that their relative had received. These comments were typical:

"…Really kind nurses and sisters, who deserved a pat on the back."

"They involved me every step of the way."

"Incredibly excellent care…"

Next steps

As yet NHS England has not published guidance on the delivery of the Dementia CQUIN for 2015/16 I shall further update the Board on our plans for the year ahead when this is available. But work is already planned to:

- Communicate more widely the hospital pathway for patients with dementia, which has been developed this year.
- Build on the successful trials of hospital ward activity volunteers who are supporting confused patients.
- Commit to improving the use of the Butterfly Scheme and All About Me forms to support personalised care.
- Narrow the focus of the Care of Confused Patients Steering Group so that it has fewer priorities and focuses only on dementia and delirium.

Jill Foster

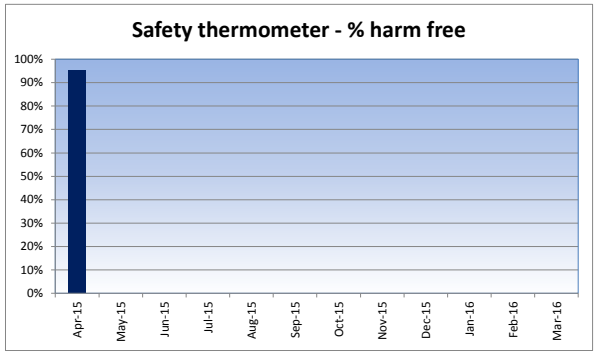
Chief Nurse

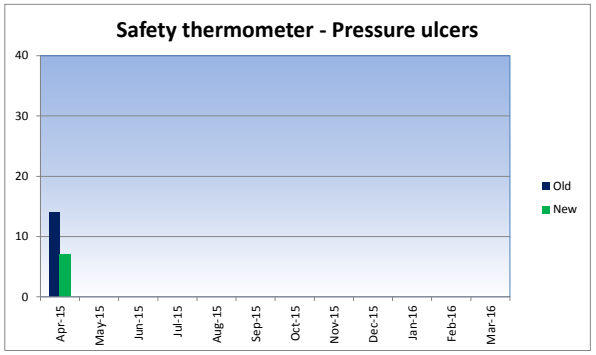
May 2015

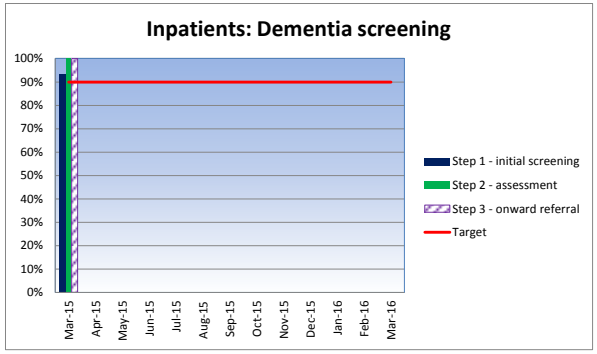
Appendix 2 Quality and Safety Dashboard - April 15

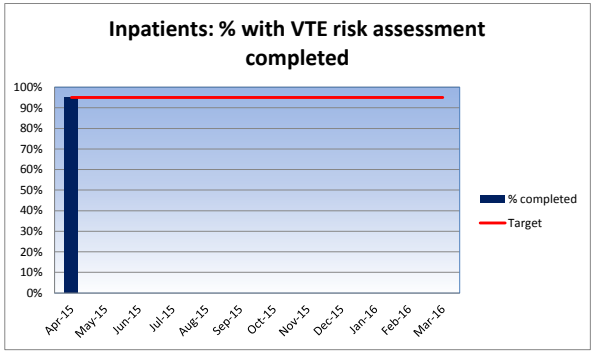
Select location: All locations

National CQUIN indicators







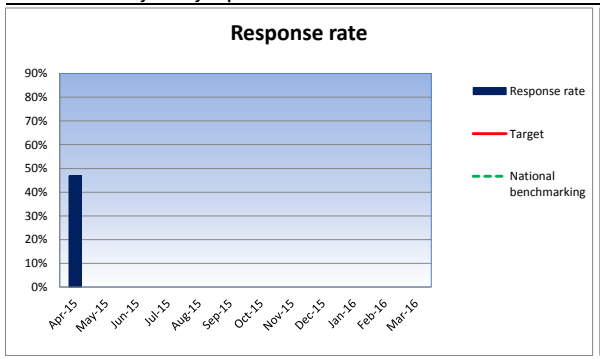


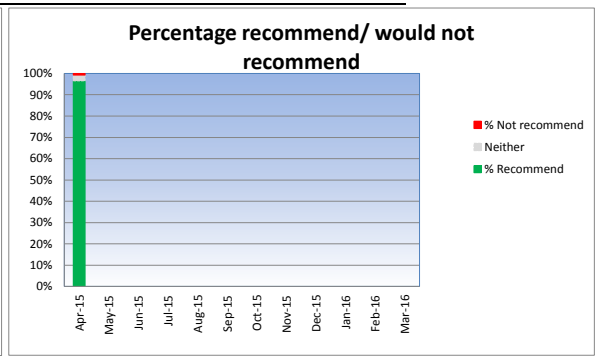
Safety thermometer - Harm free care measured using the NHS Safety Thermometer was slightly lower in April with 5% of measured care associated with a harm, largely pressure ulcers. The Pressure Ulcer Steering Group are leading the local work to reduce pressure ulcers.

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

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

Friends and family survey: Inpatients



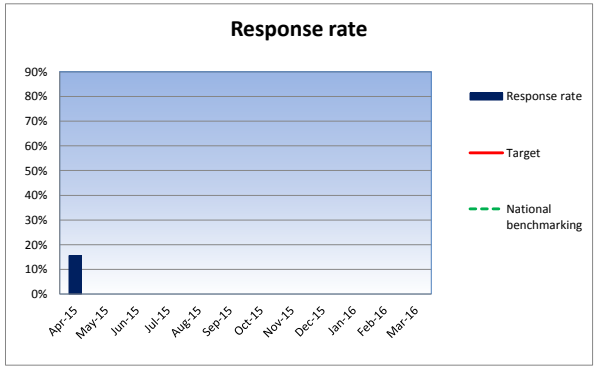


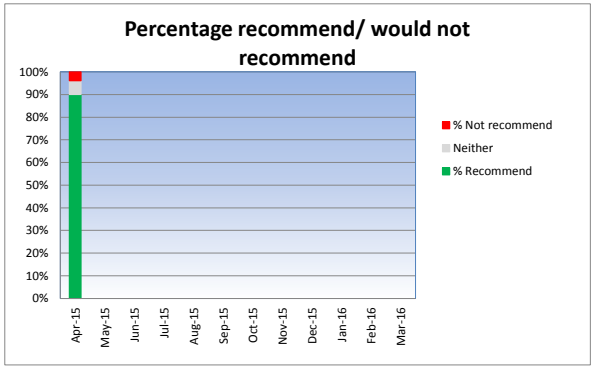
From April 2015 the FFT inpatient has been expanded to include patients seen within a daycase setting.

Response rate: The FFT inpatient response rate in April was 46.9.0%.

FFT score: The national benchmarking % would/would not recommend score for March 2015 has been published and shows that we performed slightly worse than average for inpatients (national average 95%/2%, HDFT 94%/2%). The FFT % would/would not recommend score for inpatients in April 15 is 96.5%/0.7%. Work continues to use feedback to improve patient experience.

Friends and family survey: Emergency department

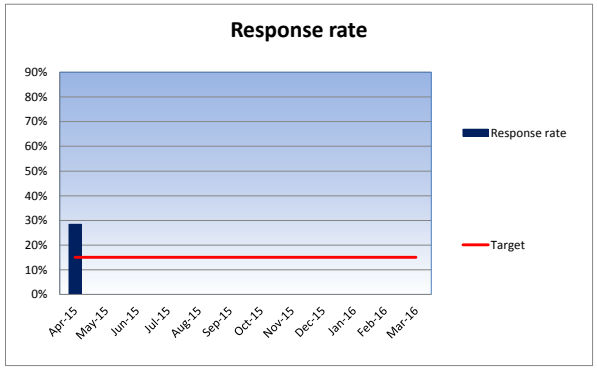


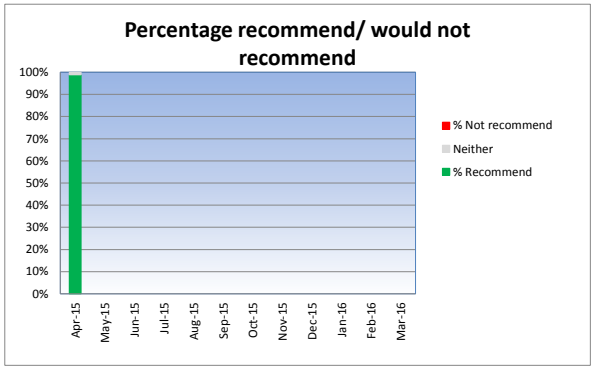


Response rate: The FFT Emergency Department response rate in April was 15.4%.

FFT score: The national benchmarking % would/would not recommend score for March 2015 shows that we performed slightly worse than average for the Emergency Department (national average 87%/6%, HDFT 83%/4%). The FFT % would/would not recommend score for Emergency Department in April is 90%/4%. Work continues to use feedback to improve patient experience.

Friends and family survey: Maternity

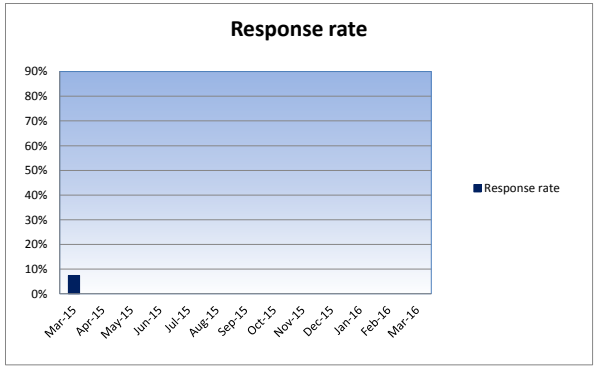


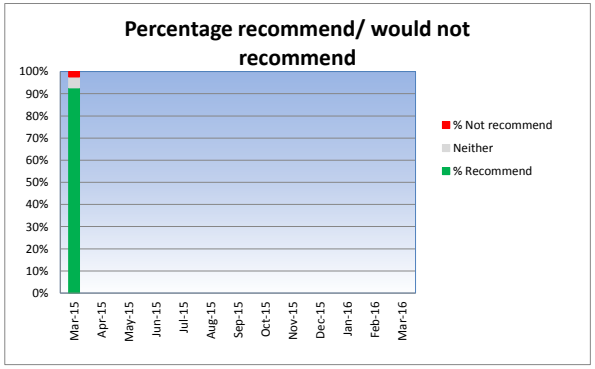


During April the combined maternity response was 28.4%. The percentage of respondents who would/would not recommend the service was 98.9%/0%. The results for each area are as follows:
1) Antenatal: response rate = 16.1%, % would/would not recommend =100%/0%
2) Birth: response rate = 36.7%, % would/would not recommend= 98%/1%
3) Postnatal ward: response rate 38.5%, % would/would not recommend= 99%/2%
4) Postnatal community: response rate 22.2%, % would/would not recommend= 100%/0%

The national benchmarking % would/would not recommend score for March 2015 shows that we performed better than average in all of the 4 of the areas: Antenatal (national average 95%/1%, HDFT 98%/0%), birth (national average 97%/1%, HDFT 99%/0%), postnatal ward (93%/2%, HDFT 98%/0%) and postnatal community (98%/1%, HDFT 100%/0%).

Friends and Family - Community

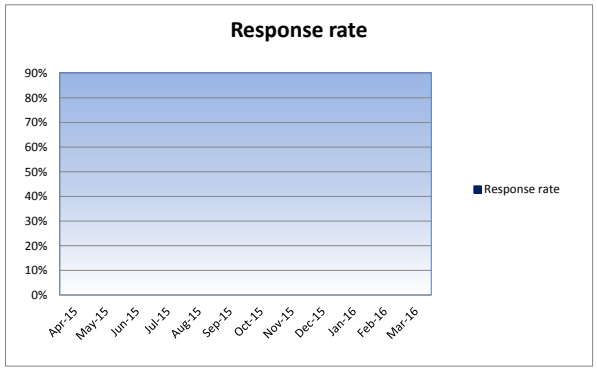


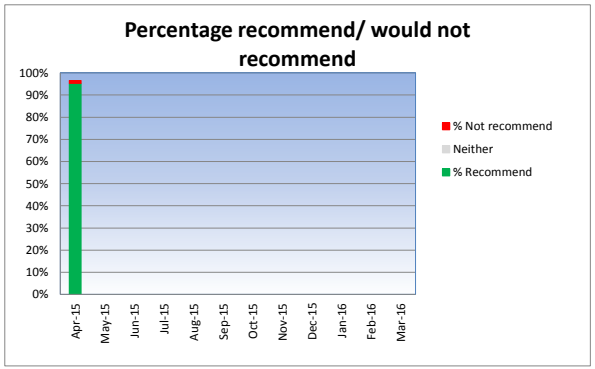


During March 2015 the combined community response was 7.4%. The percentage of respondents who would/would not recommend the service was 92.7%/2.5%. The results for each area are as follows:
1) Inpatient services response rate = 66.7%, % would/would not recommend =100%/0%
2) Nursing services: response rate = 0.3%, % would/would not recommend= 100%/0%
3) Rehabilitation & therapy services : response rate 13.5%, % would/would not recommend= 94%/2%
4) Specialist services: response rate: 4.2%, % would/would not recommend= 86%/14%
5) Children & family services: 100%, % would/would not recommend= 82%/10%
6) Healthcare other: 2%, % would/would not recommend= 93%/2%

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

Friends and Family - Outpatients



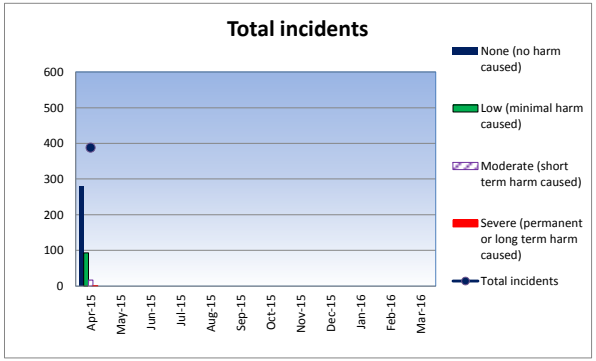


From April 2015 the FFT has been expanded to include patients seen in an outpatient setting.

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

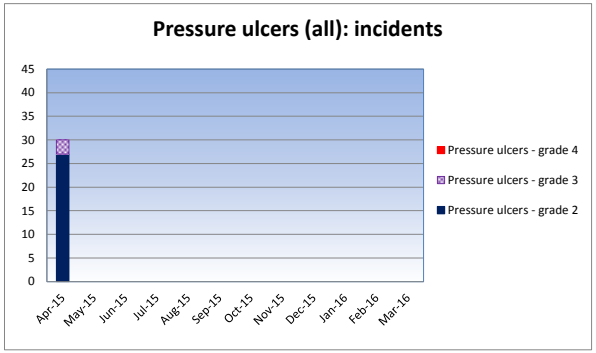
During April the percentage of respondents who would/would not recommend the service was 95.3%/1.2%.

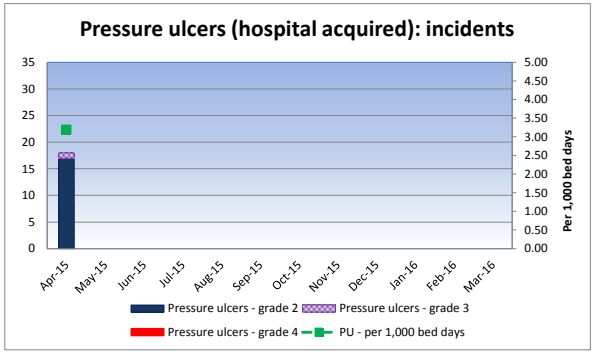
Incident reporting

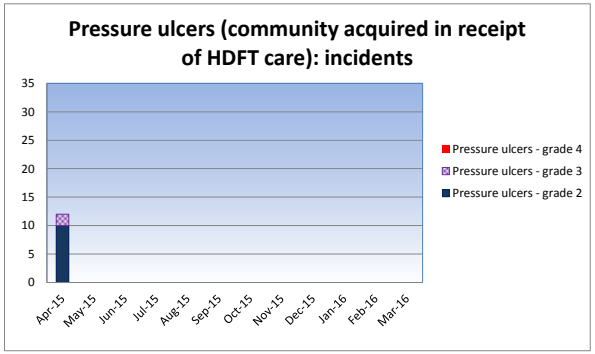


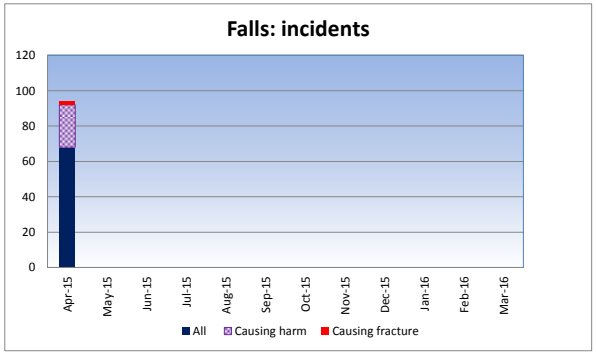
The top 5 incidents types at sub-category level, during April 15

	Incident	
1	Category 2 ulcer/Hospital acquired	18
2	Fall (found on floor) Night	17
3	Fall (found on floor) Day	15
4	Inadequate Staff for workload	13
5	Medication unavailable	13









The total number of incidents reported this month has decreased from 444 to 388 which is comparative to the month of February prior to an increase in March. There have been no incidents reported as causing severe harm. The proportion of incidents graded as moderate (short term harm) has decreased very slightly down to 4.3 from 4.5% last month.

Falls, pressure ulcers and workload staffing feature in the top 5 sub categories again this month although inadequate staff for workload has moved from top subcategory to fourth this month. Medication unavailable features as the 5th subcategory which has not been seen in the top five in the past six months. This is due to an increased number of Homecare medication provision incidents from the external provider.

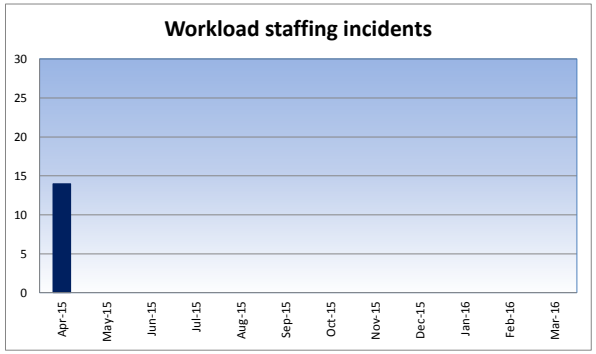
The total number of all grade 2 and 3 pressure ulcers reported this month has increased again this month from 25 to 30 this month (18 were hospital acquired and 12 were community acquired). There were 27 Grade 2 pressure ulcers (17 Hospital acquired and 10 community acquired) and 3 grade 3 ulcers this month, 2 in the community and 1 hospital acquired.

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

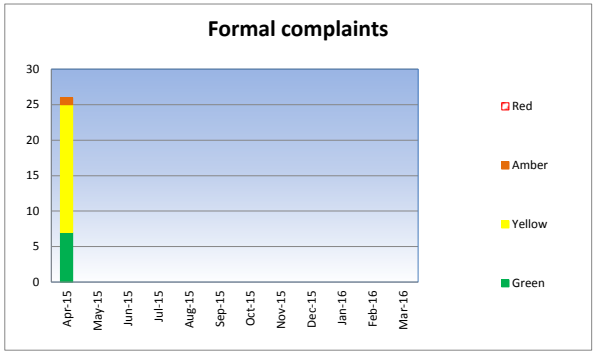
The proportion of falls causing harm remains the same this month at 35.2%. There has been a decrease in the number of fractures sustained from 4 last month to 2 this month. These are currently being investigated via root cause analysis.

There has been a decrease in workload staffing incidents reported for this month from 21 down to 14, although inadequate staff for workload still features in the top 5 subcategories. All of these incidents are reviewed at CORM and the appropriate escalation measures were put into place.

Incident reporting cont.



Formal complaints

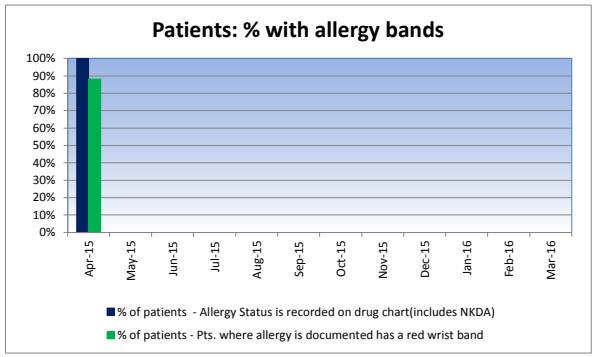


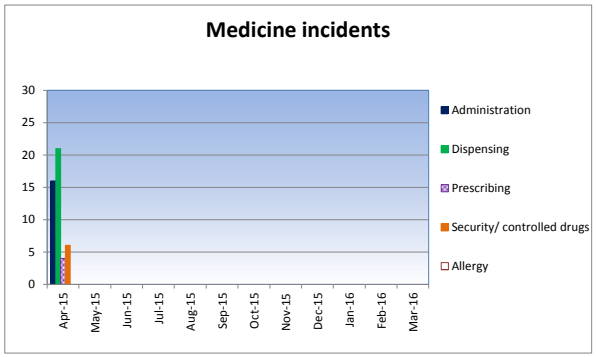
Please find attached the complaints dashboard data for April 2015.

Of the 26 complaints received in April:
Medical = 12
Nursing = 8
Medical/Nursing = 4
Other = 2

1 complaint was graded Amber
18 complaints were graded Yellow
7 complaints were graded Green

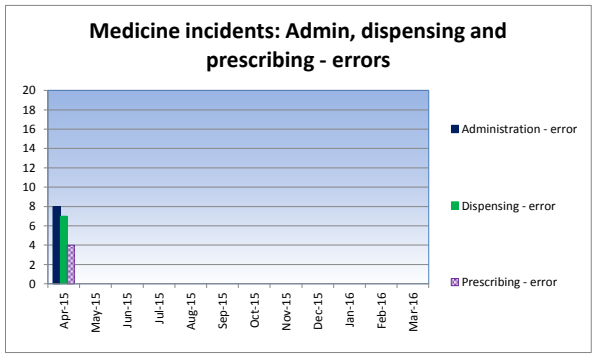
Pharmacy

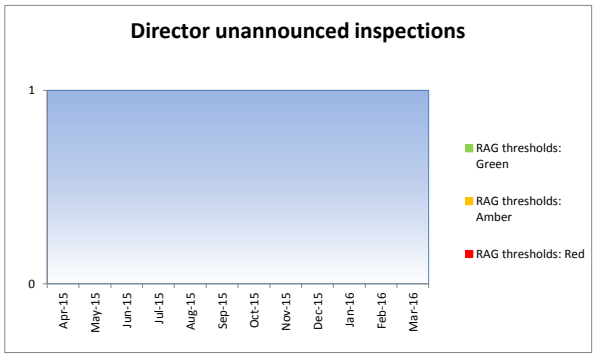




Allergies – This month's data showed that all patients had their allergy status recorded on a drug chart however it showed that several patients were not wearing a red wrist band. This was reported to the patient's nurse at the time of the audit.

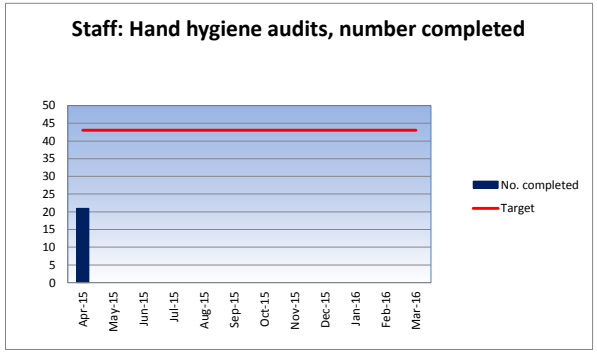
Medication Incidents – The total number of incidents has increased again this month but the number of errors has decreased. The increase in the number of incidents is predominantly due to lowering the threshold of reporting of Homecare incidents. There were no incidents regarding the lack of documentation of allergy status again this month. All incidents are discussed at CORM and reviewed at the Medication Safety Review Group.

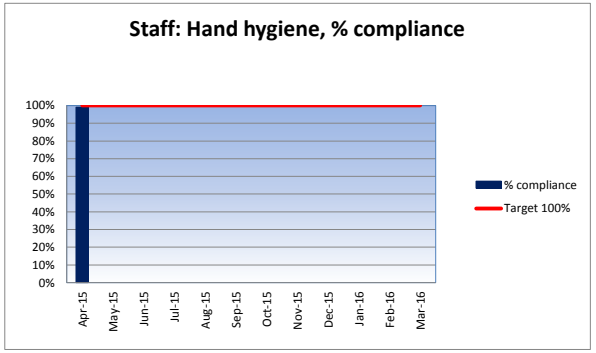


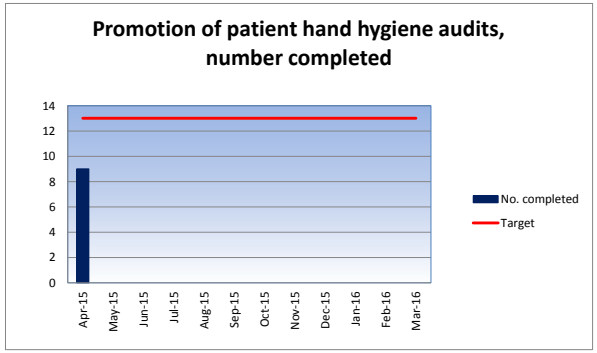


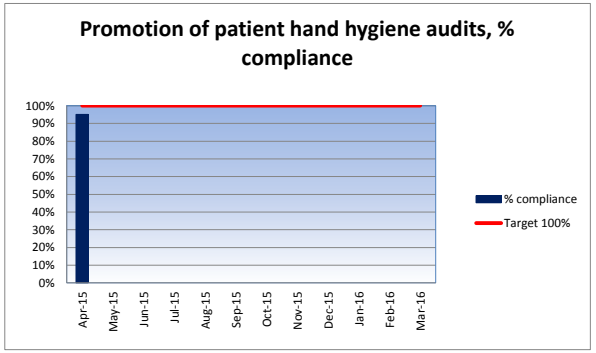
Director unannounced inspections - In April 0 inspections were undertaken.

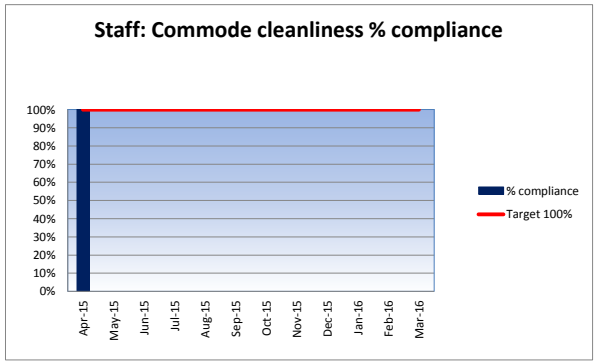
Hygiene standards

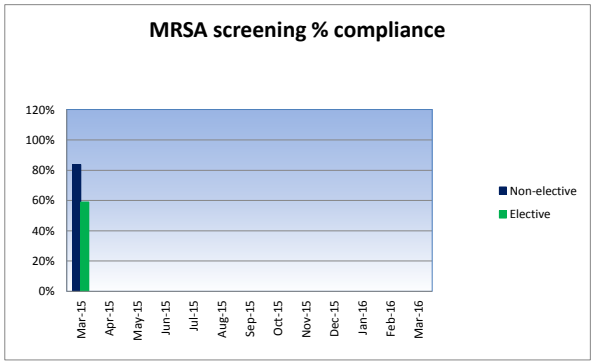












Staff Hand Hygiene and Patient Hand Hygiene: The HCAI Operational Group and IPC Team continue to support submission of both staff and patient hand hygiene audits with variable success.

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

Report to the Trust Board of Directors: 27 May 2015	**Paper No: 7.1**

Title	Actions in response to Kate Lampard's report
Sponsoring Director	Chief Nurse
Author(s)	Jill Foster
Report Purpose	To report to the Board the Trust's response to Kate Lampard's report into 'Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile' and to approve the response for Monitor

Executive Summary
To report actions being undertaken by the Trust in response to the recommendations from Kate Lampard's report into 'Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile'

Related Trust Objectives	
1. Driving up quality	Yes
2. Working with partners	No
3. Integrating care	No
4. Growing our business	No

Risk and Assurance	The paper provides assurance on the quality and governance monitoring systems and identifies risks and challenges
Legal implications/ Regulatory Requirements	The contents of this report assesses the relevance of the Kate Lampard report recommendations to this organisation and provides assurance of actions being undertaken to protect patients , staff, visitors and volunteers.

Action Required by the Board of Directors

To read and discuss the content of the report and action plan and to approve the response to Monitor.

Report on actions in response to Kate Lampard's report into <u>Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile</u>				
Name of Trust	Harrogate and District Foundation Trust			
Recommendation	**Issue identified/current situation**	**Planned Action**	**Progress to date**	**Due for completion**
R1 All NHS hospital trusts should develop a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors. The policy should apply to all such visits without exception.	The Trust does not have a policy	Policy to be developed	Deputy Chief Nurse and new Head of Communication identified to lead Example of policy obtained	September 2015
R2 All NHS trusts should review their voluntary services arrangements and ensure that: • they are fit for purpose; • volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision; and • all voluntary services managers have development opportunities and are properly supported.	Recruitment arrangements for volunteers have recently been reviewed by the Recruitment Department and recommendations have been considered to ensure they are fit for purpose. All prospective volunteers are subject to an Enhanced Disclosure & Barring Service checks and are fully inducted into the Trust. All ward and department based volunteers are supervised by the Nurse in Charge or a named member of staff. Each volunteer is personally introduced to their area on their first shift by the co-ordinator of volunteers. Application forms are available in both electronic and paper copies. Opportunities are advertised on the			

	Trust's Volunteering Internet web page, and specific opportunities through the Harrogate Volunteer Centre. All Volunteers attend a 3 hour induction session which covers items such as infection control, security and confidentiality and adult safeguarding. In addition all volunteers are provided with an induction handbook which supports their training. Hygiene Champions do not 'belong' to a ward. They attend during visiting hours and therefore are unsupervised. Currently induction or booklet does not cover information relating to children's safeguarding.	Further consideration to be given to how these volunteers are supported and supervised. Review TNA for volunteers with regard to children's safeguarding information.	Volunteers Manager reviewing how to further support 'hygiene champions' Recommendations requested from SME in children's safeguarding	June 2015 June 2015
R3 The Department of Health and NHS England should facilitate the establishment of a properly resourced forum for voluntary services managers in the NHS through which they can receive peer support and learning opportunities and disseminate best practice.	Actions - Department of Health and NHS England. No HDFT action required			

R4 All NHS trusts should ensure that their staff and volunteers undergo formal refresher training in safeguarding at the appropriate level at least every three years	All staff have personal training accounts and undertake training in Safe guarding as per the HDFT training policy.	Subject Matter Experts for safeguarding children and safeguarding adults to review the Training Needs Analysis for each area to ensure previous recommendations to the Safeguarding Children Governance Group and Safeguarding Adults Steering Group remain valid.	Training Needs Analysis reviewed – no further action required	Completed
	There is a gap in relation to volunteers.	Need to clarify the TNA for volunteers with the SME's named above	Action being progress through SME's, volunteer manager and HR Leads identified	September 2015
	Currently no formal refresher training for volunteers however updates are sent via e mail or memo.	Need to clarify the TNA for volunteers with the SME's named above	Action being progress through SME's, volunteer manager and HR Leads identified	September 2015
R5 All NHS hospital trusts should undertake regular reviews of: • their safeguarding resources, structures and	The Safeguarding Children Team Leader regularly reviews the resources of the team and assign where the need is required. Policies and Process are regularly revised in light of any change in policy or practice.	Review current governance arrangements	Governance arrangement reviewed – no further actions	Completed

processes (including their training programmes); and • the behaviours and responsiveness of management and staff in relation to safeguarding issues to ensure that their arrangements are robust and operate as effectively as possible.	Training programmes are reviewed every 2 years. The team would be involved with the conduct and responsiveness of any practitioners/employees as appropriate if any concerns were raised in relation to their behaviour or response to an alleged concern. The team report via the Team leader to the Safeguarding Children's Governance Group and the risk register is reviewed by their General Manager in Integrated Care. Evidence of governance processes is available in TOR minutes and agendas of the Safeguarding Children's Governance Group (SGCGG), Safeguarding Adults Steering Group (SASG), Section 11 annual audit, competency frame work annual self-assessment for both Safeguarding Children and Adults, Incident reporting via Datix - CORM. 3 yearly reviews of strategy, policy and procedures. Subject to regular review by Clinical effectiveness and internal audit Inc. an annual audit calendar in place. Report produced annually that demonstrates compliance with TNA, self-assessment tools, and responses to local and national standards also includes an overarching action plans and risk register.			
R6 The Home Office should amend relevant	Action - Home Office legislation. No HDFT action required			

legislation and regulations so as to ensure that all hospital staff and volunteers undertaking work or volunteering that brings them into contact with patients or their visitors are subject to enhanced DBS and Barring List Checks.				
R7 All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers.	All relevant employees cannot commence employment until their DBS clearance has been confirmed. Currently Trust does not re-check BBS clearance	A business case is in the process of being completed to recommend an action plan to ensure that all relevant employees who require DBS clearance are re-checked and signed up to DBS update service which will ensure all relevant employees have a current and up to date DBS clearance. Business Case to be submitted to Director Team in May 2015.	Business case completed and being progressed and being submitted for a decision	June 2015

R8 The department of Health and NHS England should devise and put in place an action plan for raising and maintaining NHS employers awareness of their obligations to make referrals to the local authority designated officer (LADO) and to the Disclosure and Barring Service.	Actions - Department of Health and NHS England. No HDFT actions required			
R9 All NHS hospital trusts should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, to social networks and other social media activities such as blogs and Twitter is managed and where necessary restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary.	The Trust cannot limit the access which patients and visitors through their personal devices on Trust premises. A policy of how to manage patient and visitor access to social media platforms via the Trust does not exist	To ensure patients and visitors cannot freely access hospital Wi-Fi or the internet. To consider the need to develop a policy of how patient and visitor may access to social media platforms via the Trust safely and appropriately	Access through the hospital Wi-Fi is restricted as this is a closed system. HDFT does not facilitate access to the intranet. Lead identified	 September 2015
R10 All NHS hospital trusts should ensure that	The Resourcing Department's arrangements and processes for the	More formal audits will be carried out on the	Leads identified	September 2015

arrangements and processes for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own internal HR processes and standards and are subject to monitoring and oversight by their own HR managers.	recruitment, checking and general employment are dictated by the NHS Employers standards. The 2014/2015 Internal Audit awarded Significant Assurance for those pre-employment checks carried out by the Resourcing and Medical Staffing Teams with limited Assurance for those pre-employment checks relating to Agency Workers. 'NHSP provide Quarterly governance reports to demonstrate compliance that reflects the contract and HDFT recruitment processes.	pre-employment checks in place for agency and voluntary staff, and reported to an appropriate forum. Recommendations from the internal audit to be actioned.		
R11 NHS hospital trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director.	The Resourcing Department's arrangements and processes for the recruitment, checking and general employment are dictated by the NHS Employers standards. The 2014/2015 internal audit awarded Significant Assurance for those pre-employment checks carried out by the Resourcing and Medical Staffing Teams. In addition, the annual quality and governance audit for employment checks and induction and training reported favourably the processes in place are robust and fit for purpose. There is one Executive Lead - Director of	Current arrangements to be reviewed for evidence of robustness		Completed

	Workforce and Organisational Development.			
R12 NHS hospital trusts and their associated NHS charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers adequately reflect such risks.	Harrogate Hospital & Community Charity does not have an ethics policy and risk assessment process.	Develop an ethics policy and risk assessment process around fundraising affiliations with, and accepting funds from Companies, Wealthy Individuals, Celebrities and other groups	Leads identified within the Trust Partners for scoping a robust ethics policy and risk assessment process identified	October 2015
R13 Monitor, the Trust Development Authority, the Care Quality Commission and NHS England should exercise their powers to ensure that NHS Hospital Trusts (and where applicable, independent hospital and care organisations), comply with the recommendations 1, 2, 4, 5, 7, 9, 10, and 11.	Action - Monitor, Trust Development Authority, CQC and NHS England No HDFT actions required			
R14 Monitor and the Trust Development Authority should exercise their	Action - Monitor and Trust Development Authority. No HDFT actions required			

powers to ensure that NHS Hospital Trusts comply with recommendation 12.	
I confirm that this NHS foundation Trust Board reviews the full recommendations of the Kaye Lampard's lessons learnt report SIGNED: Date: CEO Name:	

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Making the health sector work for patients

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E: enquiries@monitor.gov.uk
W: www.GOV.UK/monitor

13 March 2015

To all foundation trust chief executives

Dear colleague,

You will know that, following the death of Jimmy Savile and subsequent allegations of his wrongdoing at NHS organisations, the Department of Health launched an inquiry into his activities across the NHS. In total, 44 reports have now been published following investigations triggered by this exercise.

While many of these actions took place a long time ago and, in some cases, at institutions that no longer exist, everyone within the NHS has a responsibility to make sure nothing like this can ever happen again.

The Secretary of State for Health asked Kate Lampard QC to produce a 'lessons learned' report, drawing on the findings from all published investigations to identify areas of potential concern across the NHS. The report was published on 26 February and includes 14 recommendations for the NHS, the Department of Health and wider government. The full report can be found here.

The Secretary of State for Health has accepted in principle 13 of these recommendations, 10 of which apply to NHS trusts and foundation trusts. Although the Secretary of State did not accept recommendation 6 on Disclosure and Barring (DBS) checks, organisations are asked to consider the use of these checks (standard or enhanced) where appropriate. The recommendations are summarised in Annex A.

I ask you to read this report, assess the relevance of its recommendations to your own organisation and take any action necessary to protect patients, staff, visitors and volunteers. Given the severity of this issue, it is important to be able to demonstrate the improvements made to safeguarding across the system. I therefore ask that you respond to this letter by **5pm Monday, 15 June 2015** with an overview of any necessary actions that you have taken as a result of the recommendations in the report or, where these are in progress, the date by which they will be completed.

If you wish, you may use the template attached. Please send your response by email to:

MonitorJSlearnings@monitor.gov.uk

Thank you for your assistance in this matter.

Annex A

Report on actions in response to Kate Lampard's report into Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile				
NAME OF TRUST:				
(add more lines to the table if necessary)				
Recommendation	**Issue identified**	**Planned Action**	**Progress to date**	**Due for completion**
I confirm that this NHS foundation trust Board reviewed the full recommendations in Kate Lampard's lessons learnt report SIGNED: DATE: CE NAME:				

Please return to MonitorJSlearnings@monitor.gov.uk by 5pm Monday 15 June 2015. If you have any questions or queries you may also use this email address to send them to us.

Annex A: Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile

Recommendations for NHS trusts and NHS foundation trusts

R1 All NHS hospital trusts should develop a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors. The policy should apply to all such visits without exception.

R2 All NHS trusts should review their voluntary services arrangements and ensure that:
• they are fit for purpose;
• volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision; and
• all voluntary services managers have development opportunities and are properly supported.

R4 All NHS trusts should ensure that their staff and volunteers undergo formal refresher training in safeguarding at the appropriate level at least every three years.

R5 All NHS hospital trusts should undertake regular reviews of:
• their safeguarding resources, structures and processes (including their training programmes); and
• the behaviours and responsiveness of management and staff in relation to safeguarding issues to ensure that their arrangements are robust and operate as effectively as possible.

R7 All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers.

R9 All NHS hospital trusts should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, to social networks and other social media activities such as blogs and Twitter is managed and where necessary restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary.

R10 All NHS hospital trusts should ensure that arrangements and processes for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own internal HR processes and standards and are subject to monitoring and oversight by their own HR managers.

R11 NHS hospital trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director.

R12 NHS hospital trusts and their associated NHS charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers adequately reflect such risks.

R13 Monitor, the Trust Development Authority, the Care Quality Commission and NHS England should exercise their powers to ensure that NHS hospital trusts,(and where applicable, independent hospital and care organisations), comply with recommendations 1, 2, 4, 5, 7, 9, 10 and 11.

R14 Monitor and the Trust Development Authority should exercise their powers to ensure that NHS hospital trusts comply with recommendation 12.

Report to the Trust Board of Directors: 27 May 2015	Paper No: 7.2

Title	Patient Experience Annual Report 2014/15 and Quarter 4 (January- March 2015)
Sponsoring Director	Chief Nurse
Author(s)	Head of Risk Management
Report Purpose	For information

Executive Summary This is a summary of the Trust's performance relating to patient experience contacts in the period April 2014 to March 2015 and the trends compared with 2013/14. It details the measures taken to improve patient experience including learning. The Quality of Experience Group members would normally consider the data and discuss trends and hot spots but this role has now been undertaken by the recently formed Learning from Patient Experience Group. The Group also closely monitor the complaints investigative process within the Trust.

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

Risk and Assurance	This reports contains key information relating to number, themes and location of concerns and complaints. The monitoring of complaints and patient feedback is a key component of the Trust's key objective relating to high quality patient care.
Legal implications/ Regulatory Requirements	Department of Health Complaint Regulations 2009 stipulate quarterly complaints monitoring at Board of Director level within all Trusts.

Action Required by the Board of Directors
To consider the information provided and identify any gaps in assurance.

Harrogate and District NHS
NHS Foundation Trust

Patient Experience Annual Report 2014/2015
and
Quarter 4 (January - March 2015)

Report Author	Head of Risk Management Chief Nurse
Accountable Group / Committee	Quality of Experience Group (QEG) Board of Directors
Date	May 2015
Monitoring Group / Committee	QEG

CONTENTS

1. EXECUTIVE SUMMARY

The key messages include:-

- There have been 265 formal complaints received in 2014/15. This is an increase on the previous year where 215 cases were received.
- Quarters 3 and 4 saw the largest proportion of cases received compared with previous quarters. A large number of complaints were received in January 2015. The Trust was exceptionally busy during this period of time.
- The proportion of moderate level (yellow) complaints was higher this year compared with last year, where the greater proportion were graded green (low level).
- The number of amber (high level) complaints has doubled from four cases in 2013/14 to eight in 2014/15. Four of these eight amber cases have been reported as Serious Incidents Requiring Investigation (SIRIs).
- The number of cases dealt with informally via the Patient Experience Team at a "PALS" (Patient Advice and Liaison Service) level was significantly higher in 2014/15. Although a slight drop in the number dealt with in Quarter 4, a large number of concerns and comments were actioned, particularly in Quarter 2. This was due to the number of comments raised about the closure of Foundation Skin.
- In the year Acute and Cancer Care services received less complaints compared with the previous year.
- Over the year the themes of complaints have consistently been medical care, diagnosis issues, medical and nursing communication and nursing care.
- The specialties with the most issues raised included Medicine for the Elderly, Trauma and Orthopaedics, General Surgery, Emergency Medicine and General Medicine.
- The top locations for complaints in 2014/15 included Outpatients, Emergency Department, Nidderdale Ward and Acute Medical Unit Fountains Ward. This is similar to last year but last year also included the addition of GP Out of Hours York.
- 180 out of 265 have been upheld; this equates to 68% but there are still 17 cases yet to be concluded.
- 45% of 265 complaints have been responded to within the deadline agreed at the outset with the complainant. This is less than ideal and is monitored weekly by the PET team. The directorates have all agreed that we need to continue to improve this position and this is a key objective going forward.
- 60 actions have been identified via complaints in Q4. Learning from feedback is crucial to prevent further poor experiences and the directorates need to focus efforts on ensuring the learning has been implemented and embedded. A number of actions are still outstanding from Q4 and previous quarters.
- A Rapid Process Improvement Workshop was held at the end of February and looked at ways of sharing trends and embedding learning from actions identified during the complaint investigation. AMU

Fountains ward have been trialling the use of a 'topic' board that identifies a different theme each month for discussion. The first theme was 'communication'. Positive reports have been received from staff. A questionnaire has been developed for use in understanding why staff may be reluctant to complete datix incident reports. This model will be adapted for use in understanding whether learning is being embedded once actions have been identified.

- Nine cases were referred to the Ombudsman within the year and one case was partially upheld. A detailed action plan has been completed in respect of the Ombudsman findings. The Trust awaits confirmation on four other cases.
- The PET team are continuing to increase their profile within the organisation as best they can with the resource available (2.1 wte) and have attended some Directorate meetings to learn how best they can interact and assist with the complaints process. PET also continue to assist staff in identifying and nipping emerging issues in the bud at source as opposed to letting them escalate into formal complaints. That is the ethos of Making Experiences Count.
- The PET team have also arranged and facilitated a number of meetings with complainants and staff to help resolve issues that have been raised or provide a further and more in depth understanding of the issues raised.

2. NUMBER OF CASES RECEIVED APRIL – MARCH 2015

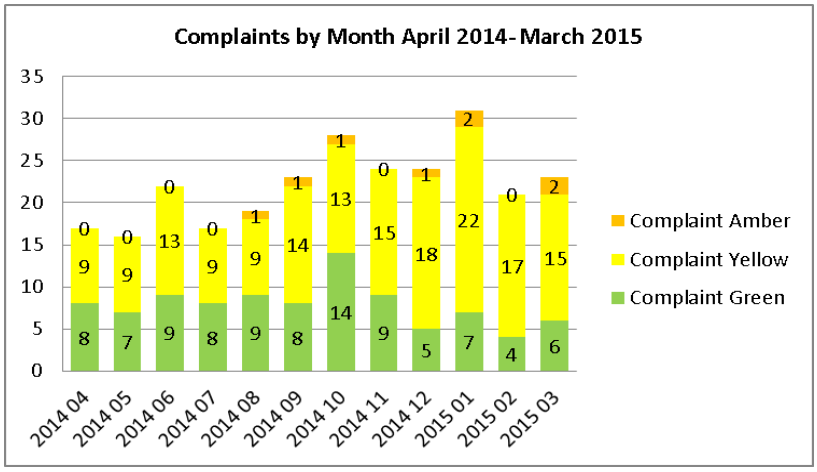
The types of contacts are described below.

	2013/14					2014/15				
	Q1	Q2	Q3	Q4	TOTAL	Q1	Q2	Q3	Q4	Total
Compliments (excluding to the media)	**68**	**99**	**91**	**72**	**330**	**67**	**63**	**79**	**106**	**315**
Complaints Total	**57**	**47**	**54**	**57**	**215**	**55**	**59**	**76**	**75**	**265**
Complaint Green	40	29	23	37	129	24	25	28	17	94
Complaint Yellow	17	17	29	19	82	31	32	46	54	163
Complaint Amber	0	1	2	1	4	0	2	2	4	8
Complaint Red	0	0	0	0	0	0	0	0	0	0
Informal "PALS" Type Contact	**192**	**199**	**162**	**183**	**745**	**205**	**330**	**185**	**182**	**902**
Concern	104	115	93	96	408	128	117	78	86	409
Information request	21	26	24	35	106	28	48	31	38	145
Positive suggestion for improvement (comment)	69	65	45	52	231	49	165	76	58	348
Other organisation responsibility	**5**	**2**	**3**	**8**	**18**	**5**	**6**	**10**	**8**	**29**
Consent awaited*	**0**	**2**	**1**	**0**	**3**	**7**	**1**	**7**	**3**	**18**
Total of all contacts handled via MEC	**322**	**349**	**311**	**320**	**1311**	**339**	**459**	**357**	**374**	**1529**

15 complaints 2014/15 were about more than one organisation.
182 additional notes of thanks for Q1-4 in local media

2.1. Number of New Complaints received April 2014- March 2015

Quarter 4 has seen the greatest number of cases received and the graph below highlights a large number were received in January (31).



In Q4 there were four amber complaints and two of these were declared as Serious Incidents Requiring Investigation (SIRIs). The issues included:

- Diagnosis and treatment of patient with epilepsy
- Two complaints about poor standards of nuring care on two different wards (one medical and one surgical)
- Patient who fell from a commode and sustained a dislocation.

Over the year there have been a total of eight amber cases and four reported as SIRIs. The issues in the cases received in Q1-Q3 included:

- Diagnosis of dermoid cyst
- Diagnosis in pathology
- Medication error in anaesthetics
- Issues regarding poor standards of nursing care on a surgical ward.

The data for complaints per Directorate is given below.

	2013/14					2014/15				
DIRECTORATE	**Q1**	**Q2**	**Q3**	**Q4**	**Total**	**Q1**	**Q2**	**Q3**	**Q4**	**Total**
Elective	26	14	25	27	92	35	26	40	37	138
Integrated	18	15	16	11	60	15	18	14	24	71
Acute and Cancer	24	22	15	22	83	13	15	25	21	74
Corporate	2	1	1	6	10	6	5	3	6	20

There was an increase in the number of complaints received for Integrated Care in Q4.

Acute and Cancer Services have received less complaints in 2014/15 compared with last year

2.2. Main Subject of Complaints

	Q1	Q2	Q3	Q4	Total	Number Upheld
Admissions, discharge and transfer arrangements	1	3	2	6	12	8
Aids and appliances, equipment, premises (including access)	1	0	1	1	3	1
Appointments, delay/cancellation (out-patient)	1	2	0	0	3	3
Appointments, delay/cancellation (in-patient)	0	0	1	0	1	1
Attitude of staff	4	3	7	12	26	20
All aspects of clinical treatment	33	39	45	47	164	101
Communication/information to patients (written and oral)	12	6	9	6	33	28
Complaints handling	0	0	1	0	1	1
Patients' privacy and dignity	0	0	1	0	1	1
Patients' property and expenses	0	0	1	0	1	1
Personal records (including medical and/or complaints)	0	1	1	1	3	2
Failure to follow agreed procedure	3	4	6	1	14	10
Patients' status, discrimination (eg racial, gender, age)	0	0	1	0	1	1
Policy and commercial decisions of trusts	0	1	0	1	2	2
Totals:	55	59	76	75	265	180

All aspects of treatment continues to be the primary subject of each complaint received. At the time of this report 148 cases of the 265 have been investigated and

closed. Year to date there have been 180 (68%) complaints that have been upheld. Full apologies and identification of actions to improve patient care have been detailed in the responses to the complainants.

2.3. Complaints by Location and Grade

The data is presented to the Board of Directors on a monthly basis by grade, location and by types of complaint. The data below indicates that the top locations for complaints includes Outpatients, Emergency Department, Nidderdale Ward and Acute Medical Unit Fountains Ward. This is similar to last year but last year also included the addition of Out of Hours York.

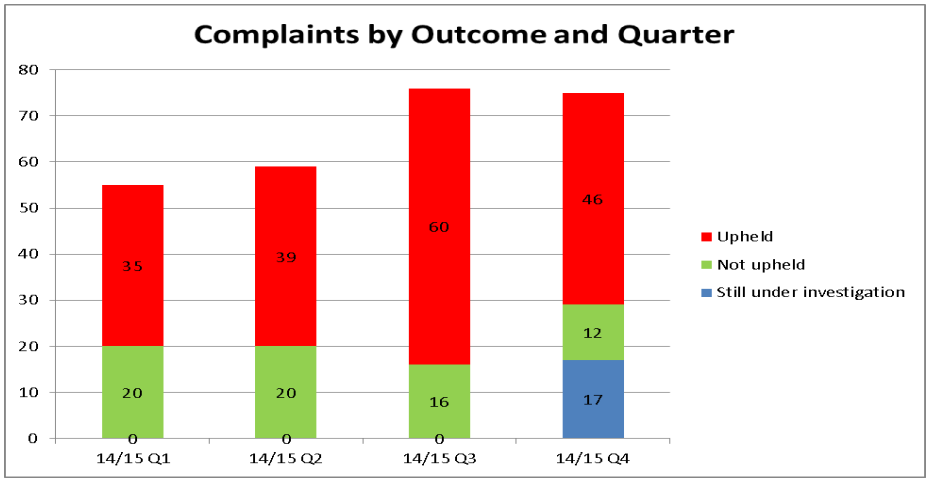
Areas that did not receive any complaints in 2014/15 include Child Development Centre, Children's Community Nursing, General Office, Joint Equipment Libraries, Occupational Therapy, Palliative Care, Safeguarding Children's Team, Special Care Baby Unit, Sexual Health Services, Sir Robert Ogden Macmillan Centre, Speech and Language Therapy and Women's Unit.

Complaints by Location and Grade 2014/15

	Total	Green	Yellow	Amber	Red
Totals:	265	94	163	8	0
Outpatients	**46**	**21**	**25**	**0**	**0**
Emergency Department	**24**	**7**	**16**	**1**	**0**
Nidderdale Ward	**18**	**2**	**15**	**1**	**0**
Acute Medical Unit Fountains	**14**	**4**	**10**	**0**	**0**
Acute Medical Unit Bolton	**9**	**3**	**6**	**0**	**0**
Farndale Ward	**8**	**3**	**5**	**0**	**0**
Endoscopy Unit	**7**	**2**	**5**	**0**	**0**
OOH - Harrogate Hospital	**7**	**5**	**2**	**0**	**0**
Jervaulx Ward	**7**	**0**	**7**	**0**	**0**
Littondale Ward	**7**	**4**	**2**	**1**	**0**
Maxillofacial Dept	**7**	**2**	**5**	**0**	**0**
Wensleydale Ward	**7**	**3**	**3**	**1**	**0**
Granby Ward	**6**	**2**	**4**	**0**	**0**
OOH - Northallerton A&E	**6**	**5**	**1**	**0**	**0**
Day Surgery Unit	**5**	**0**	**5**	**0**	**0**
Radiology	**5**	**2**	**3**	**0**	**0**
Byland Ward	**4**	**0**	**4**	**0**	**0**
Cardiology	**4**	**2**	**2**	**0**	**0**
Central Labour Ward Suite	**4**	**0**	**4**	**0**	**0**
Ear, Nose, Throat Clinic	**4**	**2**	**2**	**0**	**0**
Oakdale Ward	**4**	**0**	**4**	**0**	**0**
Theatres	**4**	**0**	**3**	**1**	**0**
Woodlands Ward	**4**	**1**	**2**	**1**	**0**
OOH - York A&E Dept	**4**	**3**	**1**	**0**	**0**
Harlow Suite	**3**	**1**	**2**	**0**	**0**

Pannal Ward	3	2	1	0	0
Physiotherapy Dept	3	2	1	0	0
Eye Department	2	0	2	0	0
Medical Records	2	1	1	0	0
Neurology Department	2	1	1	0	0
Ripon Hospital - Trinity Ward	2	0	1	1	0
MIU -Selby	2	0	2	0	0
OOH - Selby Hospital	2	1	1	0	0
Switchboard	2	0	2	0	0
Anaesthetic room	1	0	1	0	0
Antenatal clinic	1	0	1	0	0
Car Park	1	0	1	0	0
CAT team	1	0	1	0	0
Community Midwifery	1	0	1	0	0
Continence - CHRD	1	1	0	0	0
Chronic Pain - Phoenix	1	1	0	0	0
Dermatology Clinic	1	0	1	0	0
Harrogate Integrated Community Care Team	1	1	0	0	0
Prison - Northallerton	1	1	0	0	0
ITU/HDU	1	1	0	0	0
Knaresborough and Boroughbridge Integrated Community Care Team	1	0	1	0	0
Pre Assessment Admissions Unit	1	0	1	0	0
Pathology	1	0	0	1	0
Pharmacy	1	1	0	0	0
Ripon MIU	1	0	1	0	0
OOH - Ripon Hospital	1	0	1	0	0
Ripon and Rural Integrated Community Care Team	1	0	1	0	0
Podiatry -Scarborough Hospital	1	1	0	0	0
Skipton Dental Clinic	1	1	0	0	0
Podiatry -Spring Hill	1	0	1	0	0
Strayside	1	1	0	0	0
Swaledale Ward	1	1	0	0	0
Urology Clinic	1	0	1	0	0
Harrogate Wheelchair Centre	1	1	0	0	0
Podiatry - Whitby Hospital	1	1	0	0	0
Podiatry - Zetland House	1	1	0	0	0

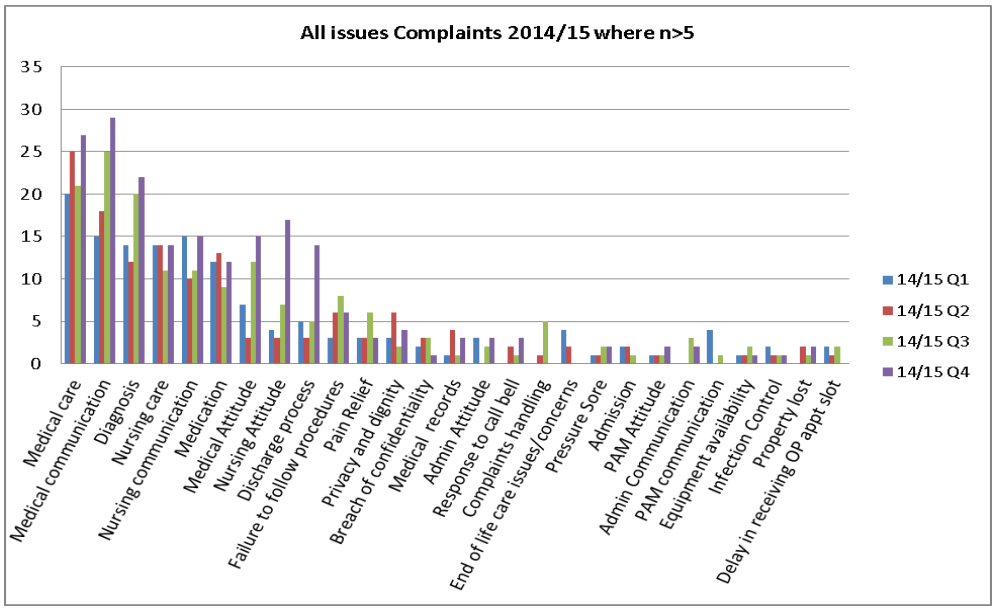
At the time of reporting for all cases received in 2014/15, 45% of complainants were responded to on time and in accordance with PET deadlines. This is a similar rate reported last quarter (44%). There is still work to do to improve this and the directorates are striving to achieve this.

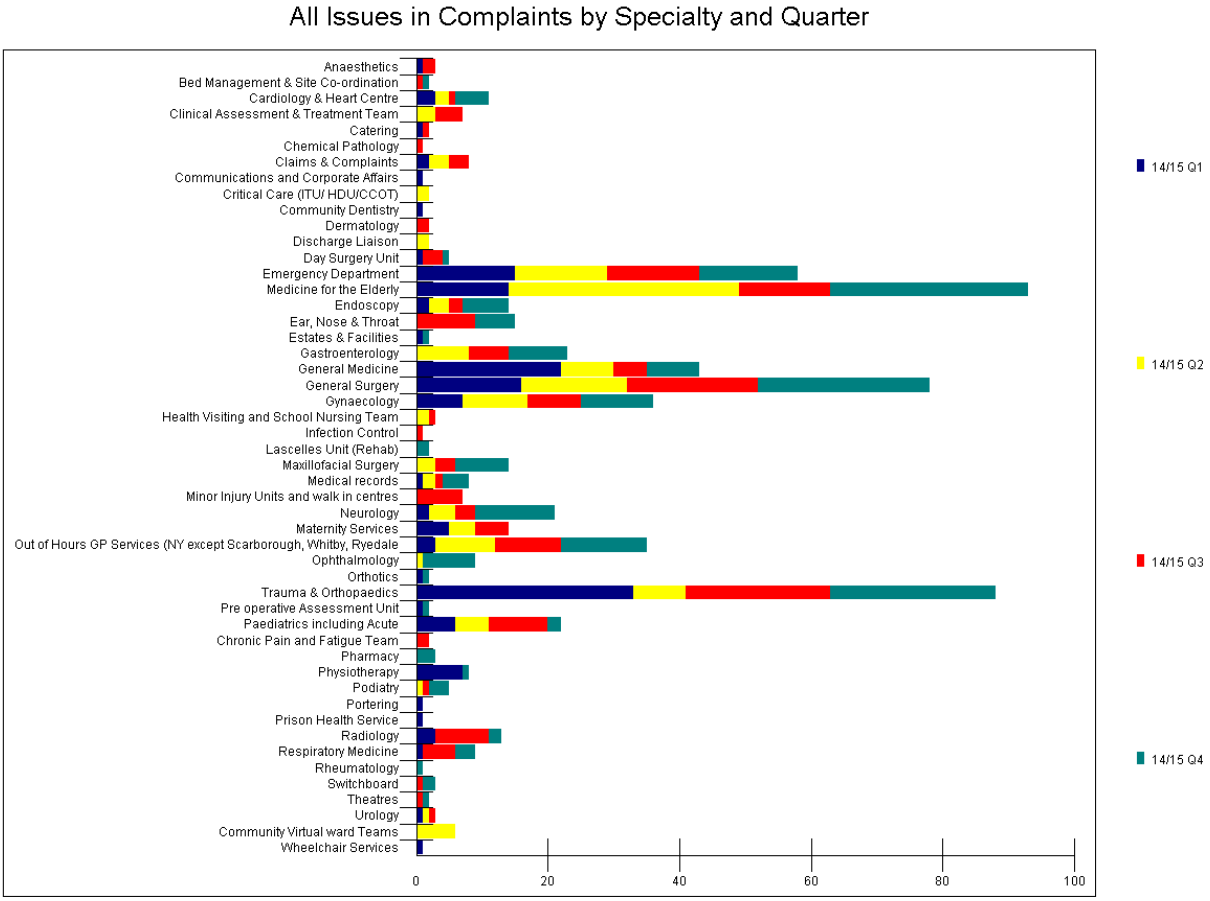


2.4. All Issues Raised in Each Complaint

Each complaint can raise a number of issues relating to poor experiences. The data on all issues is given in Appendix 1. The graph below shows the issues raised in complaints where the number year to date is more than five. Observations in Q4 include a spike in the number of issues raised regarding medical care, medical communication, diagnosis, nursing communication medical and nursing attitude and discharge issues.

The complaints are also displayed by the specialty that the issue relates to and quarter. The specialties with the most issues raised included Medicine for the Elderly, Trauma and Orthopaedics, General Surgery, Emergency Medicine and General Medicine.





2.4.1. Top 5 Raised in Each Complaint "Sub-Subjects"

The data for the top 5 issues for Q4 is as follows:

	Q4
Medical communication	29
Medical care	27
Diagnosis	22
Nursing Attitude	17
Medical Attitude	15

The data for the top 5 issues 2014/15 is as follows:

	2014/15
Medical care	93
Medical communication	87
Diagnosis	68
Nursing care	53
Nursing communication	51

2.4.2. Sub Subject Locations

The top 5 locations for all issues raised in complaints for Q4 is as follows:

	Q4
Outpatients	33
Nidderdale Ward	16
Emergency Department	15
Acute Medical Unit Bolton	13
Wensleydale Ward	13

The top 5 locations for all issues raised in complaints 2014/15 is as follows:

	2014/15
Outpatients	89
Emergency Department	61
Nidderdale Ward	58
Acute Medical Unit Fountains	47
Wensleydale Ward	31

In Q1 the Outpatient Department received the most issues (24 issues from 14 individual complaints) about diagnosis, medical care and poor medical communication.

In Q2 Nidderdale ward received the most issues (16 issues from five complaints) mainly around medical care and medical communication. AMU Fountains received 15 issues from six complaints and issues were about medical care, nursing care, pain relief and poor communication.

In Q3 Outpatients received 21 issues from 14 complaints, the Emergency Department received 17 issues from seven complaints and Nidderdale received 15 issues from five complaints.

In Q4 Outpatients received 33 issues from 15 complaints (medical care and communication), Nidderdale received 16 issues from six complaints (medical and nursing care), Emergency Department received15 issues from eight complaints (medical care, diagnosis and discharge issues), Bolton Ward received 13 issues from six complaints (admission/transfer issues, medical and nursing care) and Wensleydale Ward received 13 issues from three complaints (discharge and nursing/medical issues).

The annual report produced in May 2015 will identify any locations who did not receive any formal complaints in the year.

3. KEY LEARNING FROM COMPLAINTS AND FEEDBACK

In summary **60** actions have been put in place in **Q4**. Of these actions **21** have already been completed. **21** are still within target date and **18** are overdue.

There are still **150** actions to be addressed from **Q1/Q2/Q3** (1/4/14 to 31/12/14) all of which are overdue.
Highlighted examples of improvements to patient care from patient feedback from complaints received in Q4 are given below. Previous examples have been detailed throughout the year in each of the quarterly reports.

Admissions, discharge, transfer arrangements
A recurring theme occurs in relation to the delay in a patient's take home medication being ready in order for patients to be discharged in a timely manner.
This can often be due to the nursing staff being too busy on the ward to either physically go to the Pharmacy Department to collect medication or the doctors not being available to write up the medication. Therefore, rather than delay the patient's discharge staff will offer patients and relatives the opportunity to return to the hospital later in the day, if appropriate, to collect medications. The Discharge Lounge staff have been made aware of the need to escalate to the Site Co-ordination Team if there is a delay anticipated in the discharge because of the workload in the discharge lounge.

Communication / Information to patients
A family asked that the Trust pursue a proposal for patients to sign their DNACPR form to verify they are aware of the decision. This was raised at the Resuscitation Committee on 17 February 2015, to consider adding a signature box to the DNACPR form for patients to confirm agreement.

The Committee concluded that it was not necessary to have a patient's signature on the DNACPR form. The DNACPR form already has a section to record if the DNACPR decision has been discussed with the patient (and if not, why not). As the detail regarding DNACPR discussions should also be recorded in the medical notes the committee considered that this provides sufficient evidence that, if it is documented that a discussion took place, it should be considered that it did. There was concern that if patients were asked to sign the DNACPR form some patients may feel this is burdensome. It was confirmed that the requirement to sign a DNACPR form is not part of national guidance or the regional working party requirements.

All aspects of clinical treatment
A patient suffered a missed diagnosis of cholecystitis and further training and education was provided to the medical staff concerned.

Communication/Information
It was identified that a patient was given an incorrect histology report from a cervical biopsy which was due to it being mixed up with another patient's histology slide. Following an in depth root cause analysis which was shared with the patient concerned, the Pathology Department plan to purchase a barcode reader to improve patient and sample identification.

Communication/Information
A parent felt that their child was not fully supported by Harrogate Hospital Autistic Service. A meeting has taken place with the Clinical Commissioning Group (CCG) to address this problem.

4. COMPLAINTS SUBMITTED TO OMBUDSMAN

Our philosophy is to get it right first time and provide a thorough response to the complainant. However nine complainants have referred their case to the Ombudsman.

Of the nine cases referred this current financial year:

- One has been investigated and partially upheld. An apology and action plan to address the findings has been completed.
- Three have been investigated and not upheld.
- One case has been referred back to the Trust for local resolution.
- Four are under review by the Ombudsman.

There were nine cases referred to the Ombudsman in 2013/14 and as described in previous reports:-

- Two have been closed with no further investigation or action
- Seven have been investigated of which three have been found to be upheld and actions requested, four were not upheld

5. CONCERNS (INFORMAL COMPLAINTS PREVIOUSLY KNOWN AS PALS ISSUES)

The Patient Experience Team dealt with 902 PALS issues on an informal basis over 2014/15 compared with 265 formal complaints.

For Quarter 4, there were 182 PALS type contacts compared with 75 formal complaints. This was slightly lower for both categories in comparison with Quarter 3. The themes and trends are logged for concerns and these are detailed below. The top five sub subjects are the same as in complaints with the addition of outpatient appointment issues.

	Q4
Medical communication	11
Nursing communication	11
Delay in receiving OP appt slot	11
Medical care	6
Other communication	6

	2014/15
Delay in receiving OP appt slot	76
Medical communication	54
Medical care	31
Nursing Attitude	28
Nursing communication	24

The top five locations for concerns differ to complaints and reflect the trends in issues concerning outpatient appointments, for example ENT Clinic Department and

Medical Records feature in Q4 and Radiology, Eye Department and Dermatology Clinic feature for the full year data.

	Q4
Outpatients	20
Switchboard	5
Jervaulx Ward	4
Medical Records	4
Ear, Nose, Throat Clinic	4

	2014/15
Outpatients	92
Radiology	22
Emergency Department	21
Eye Department	20
Dermatology Clinic	19

6. COMPLIMENTS

Compliments received via the media are shown in Appendix 2.

7. APPENDICES

Appendix 1 - Complaints All Issues
Appendix 2 - Compliments received via the media
Appendix 3 - Grading Matrix

Appendix 1: Complaints issues

265 complaints raised 691 issues	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4	Total
Medical care	20	25	21	27	93
Medical communication	15	18	25	29	87
Diagnosis	14	12	20	22	68
Nursing care	14	14	11	14	53
Nursing communication	15	10	11	15	51
Medication	12	13	9	12	46
Medical Attitude	7	3	12	15	37
Nursing Attitude	4	3	7	17	31
Discharge process	5	3	5	14	27
Failure to follow procedures	3	6	8	6	23
Pain Relief	3	3	6	3	15
Privacy and dignity	3	6	2	4	15
Breach of confidentiality	2	3	3	1	9
Medical records	1	4	1	3	9
Admin Attitude	3	0	2	3	8
Response to call bell	0	2	1	3	6
Complaints handling	0	1	5	0	6
End of life care issues/concerns	4	2	0	0	6
Pressure Sore	1	1	2	2	6
Admission	2	2	1	0	5
PAM Attitude	1	1	1	2	5
Admin Communication	0	0	3	2	5
PAM communication	4	0	1	0	5
Equipment availability	1	1	2	1	5
Infection Control	2	1	1	1	5
Property lost	0	2	1	2	5
Delay in receiving OP appt slot	2	1	2	0	5
Appointment (in-pt delay)	0	0	1	3	4
Nutrition	1	2	0	1	4
Cancellation (opt)	1	2	0	1	4
Commercial decisions	1	0	2	1	4
Other communication	2	1	0	0	3
Equipment conditions	0	3	0	0	3
Delay (in-pt appt process)	0	1	1	1	3
Delay (o/p appt time over-running)	1	1	0	1	3
Aids and appliances	0	0	1	1	2
Cancellation (inpatient)	0	0	2	0	2
Catering	1	0	1	0	2
Cleaning ward staff	1	0	0	1	2
Consent	0	2	0	0	2

Discrimination (inc learning disabilities)	1	0	1	0	2
Expenses	0	0	1	1	2
Clinical Policy	0	1	0	1	2
Therapy	2	0	0	0	2
Transfer	1	1	0	0	2
Other Attitude	1	0	0	0	1
Car parking facilities	0	0	0	1	1
Cleaning domestic staff	1	0	0	0	1
Property damaged	0	0	0	1	1
State of decoration internal	1	0	0	0	1
Facilities external locations	0	0	1	0	1
X-rays	0	0	1	0	1
Totals:	153	151	175	212	691

Appendix 2: Compliments Received in the Media

2014	Hospital																Community			
	Non-specified staff	AMU (Bolton)	AMU / CCU (Fountains)	Byland	ED	Granby Ward	ICU HDU	Jervaulx Ward	Littondale Ward	Macmillan Dales Unit	Nidderdale Ward	Oakdale Ward / Stroke Unit	Palliative Care	Swaledale Ward	Paramedics	Chaplaincy	District Nurses	Fast/Rapid Response Team	Ripon Hospital	TOTAL
April 2014	2							1		1						2	1		1	8
May 2014	7				2		5	2	1	6		7				1	4	1	3	41
June 2014	4			1	1		2	1		3	1	1				1		1	4	20
July 2014	8			4		3	1	2								3	1		2	24
August 2014		1	1				1													3
September 2014	2	1						1			1	1				1				7
October 2014	1	1		3			3	3	1			1				1		1	1	16
November 2014	1	2	1			3	2		1											10
December 2014	2	1	2	2		2	2	1			1	2					1			16

2015		Hospital																	Community			
	Non-specified staff	AMU (Bolton)	AMU / CCU (Fountains)	Byland	ED	Granby Ward	ICU HDU	Jervaulx Ward	Littondale Ward	Macmillan Dales Unit	Nidderdale Ward	Oakdale Ward / Stroke Unit	Palliative Care	Swaledale Ward	Paramedics	Wensleydale Ward	Chaplaincy	SROMC	Farndale Ward	District Nurses	Fast/Rapid Response Team	Ripon Hospital	TOTAL
January 2015	3			3			1	1								1	1	3	1	1	2		17
February 2015	3																						3
March 2015	1		2	1				1				1	1		2		5	1				2	17

Report to the Trust Board of Directors: 27th May 2015	**Paper No: 8.0**

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

Executive Summary

This report summarises HDFT's latest performance position – based on key performance indicators used by the Department of Health, Monitor and the Care Quality Commission. The report also includes mortality indicators, activity levels and locally defined performance measures.

Related Trust Objectives	
1. Drive forward improvements in the quality of services to improve patient safety, outcomes and experience for people who use our services.	Yes
2. Work with our partners to develop and implement the joint service strategy across the health communities we serve.	Yes
3. Develop more integrated community based services, enabling people who use our services to be treated closer to home, or at home.	Yes
4. Continue to grow our business and maximise income.	Yes

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

Action Required by the Board of Directors

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

Performance Framework 2015/16

- The key performance indicators are based on NHS England's 2015/16 performance framework, the 2015/16 Monitor Risk Assessment Framework and a number of supporting performance measures.

Performance Highlights

- Provisional data indicates that the Trust achieved 6 of the 7 applicable Cancer Waiting Times standards for April. Delivery of the 14 day suspected cancer standard was below the expected level with 87.6% of patients seen within 14 days against the 93% national standard. Due to the effect of various national and local cancer awareness campaigns, the Trust has seen a significant increase (over 50%) in the number of urgent Upper Gastrointestinal referrals received. Work is ongoing to resolve capacity issues in Endoscopy and Dermatology in order to ensure delivery of this standard for May and Quarter 1. The current forecast for May is above the 94% standard.

- Performance at Harrogate ED was below the 95% in standard in April, with 94.7% of patients spending less than 4 hours in the department. However the combined performance for the Trust (including the two Minor Injury Units) was above the expected standard at 96.4%.

- The Trust achieved all 18 weeks standards in April for consultant led specialties that form part of Monitor's Risk Assessment Framework. However the performance for audiology was below the 95% standard.

- There were 2 ambulance handover delays of more than 60 minutes and 10 ambulance handover delays of more than 30 minutes at Harrogate ED in April. The two handovers of over 60 minutes occurred on the same day when the Emergency Department was particularly busy and were due to a lack of patient cubicles. ED attendances were 3% higher in April 2015 than in the same month last year.

- Activity levels at HDFT for outpatients, inpatients, ED and community services have increased in April 2015 compared to last year. Elective admissions were 16% higher than in April 2015, and of these, there was a 35% increase in activity from Leeds. The adult community services team have seen significant increases in activity during April, particularly within the fast response teams.

- Provisional data suggests that the stroke performance standard (the percentage of stroke patients who spend over 90% of their stay on the stroke unit) was achieved for April (85.2%). Delivery of the TIA standard for the month of April was at 87.5% against the 60% national standard.

- The Trust has performed well in the 2014 national inpatient survey scoring "significantly better than average" for 7 out of 59 questions, compared to 6 out 60 questions last year.

- No cases of hospital acquired MRSA or C-Difficile were reported in April. NHS England have now published the C-Difficile trajectories for 2015/16 and HDFT's annual trajectory for this financial year is 12 cases.

Glossary of acronyms/terminology

A&E/ ED	Accident and emergency department
Acute ward	A ward in which patients with an illness that is of short duration and rapidly progressive are given urgent care.
Admission	The act of admitting a patient for a day case or inpatient procedure.
Admission - inpatient	An admission to the hospital for diagnosis and/or treatment which requires at lease one overnight stay.
Admission - day case	A planned admission to the hospital for diagnosis and/or treatment where the patient is discharged on the same day without an overnight stay.
Admission - elective	A procedure that is chosen (elected) by the patient or consultant and arranged in advance.
Admission - non-elective	An admission to hospital which is unplanned and at short notice because of clinical need. For example, this will include patients being seen in CAT having emergency surgery and admitted to a hospital bed via A&E.
Admitted pathway	A pathway that ends in a clock-stop for admission (day case or inpatient).
Adult Community Teams	This service includes the four integrated district nursing teams, the fast response teams, and the community matrons and case managers.
Clinical Assessment Team (CAT)	A consultant led rapid assessment of medical and surgical patients. Conditions assessed include cardiac chest pain, strokes, and deep vein thrombosis (DVT's).
Choose and Book	A national electronic referral service that gives patients a choice of place, date and time for their first consultant outpatient appointment in a hospital or clinic.
Consultant-led	A consultant retains overall clinical responsibility for the service, team or treatment. The consultant will not necessarily be physically present for each patient's appointment, but he/she takes overall clinical responsibility for patient care.
Decision to admit	Where a clinical decision is taken to admit the patient for either a day case or inpatient treatment.
Decision to treat	Where a clinical decision is taken to treat the patient. This could be treatment as an inpatient or day case, but also includes treatments performed in other settings e.g. as an outpatient.
Delayed transfer of care	When the patient is ready to be discharged from hospital however they remain in a bed.
DNA – Did Not Attend	DNA (sometimes known as an FTA – Failed to attend). In the context of consultant-led waiting times, this is defined as where a patient fails to attend an appointment/ admission without prior notice.
First definitive treatment	An intervention intended to manage a patient's disease, condition or injury and avoid further intervention.
Follow-up appointment	Any subsequent attendances in an outpatient clinic following a first attendance.
General ward	A ward in which patients with many different types of ailments are given care.
MRSA	Meticillin Resistant Staphylococcus aureus
MSA	Mixed sex accommodation
MSSA	Methicillin Sensitive Staphylococcus aureus
New appointment	A patient's first attendance in a specific outpatient clinic
Non-admitted pathway	A pathway that results in a clock stop for treatment that does not require an admission or for 'non-treatment'.
OOH	Out of hours
Outpatient	A patient who comes to the hospital, clinic, or dispensary for diagnosis and/or treatment who does not require an overnight stay.
Referral to treatment period	The part of a patient's care following initial referral, which initiates a clock start, leading up to the start of first definitive treatment or other clock stop that is covered by the 18 week target.
RTT	Referral to treatment
TIA	Transient ischaemic attack

Useful documents

Outcomes Framework: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256456/NHS_outcomes.pdf

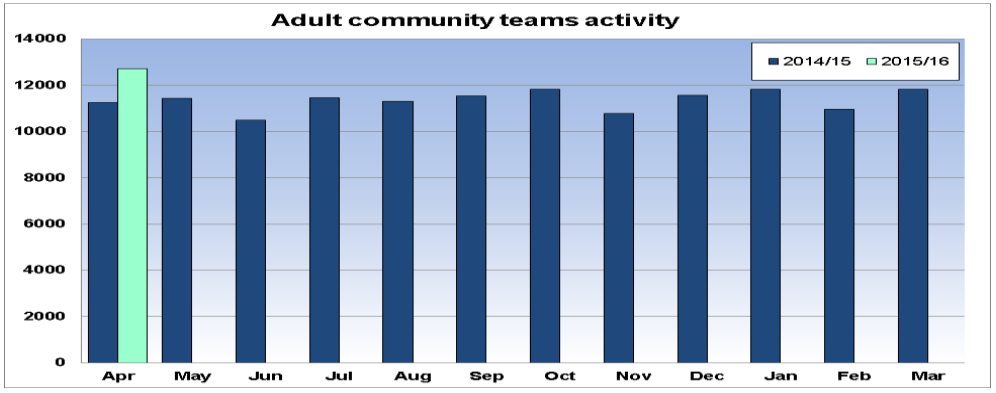
Risk Assessment Framework: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/299929/RAF_Update_AppC_1April14.pdf

2015/16 Performance Framework

Harrogate and District NHS
NHS Foundation Trust

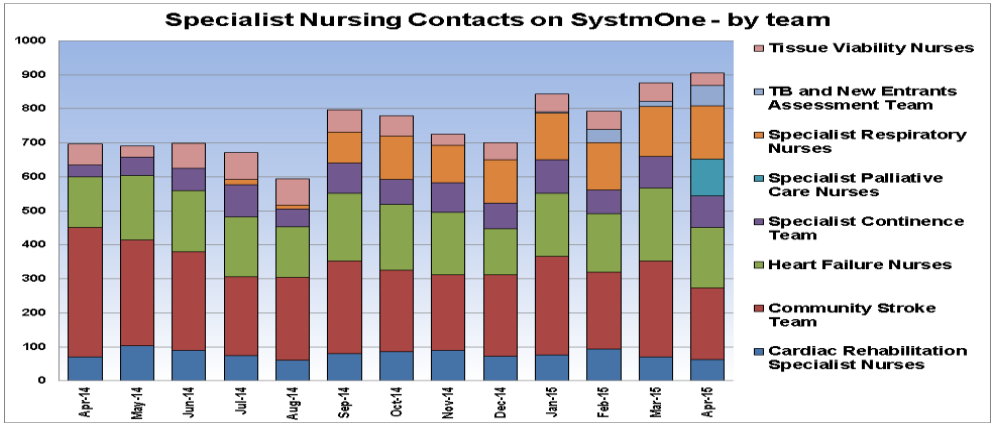
Section	Performance Indicator Description	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	YTD	Monthly RAG thresholds: Red	Amber	Green
18 weeks	RTT - admitted - 90% in 18 weeks	94.2%			94.2%													94.2%	<90%	NA	>=90%
	RTT - non-admitted - 95% in 18 weeks	97.2%			97.2%													97.2%	<95%	NA	>=95%
	RTT - incomplete - 92% in 18 weeks	97.0%			97.0%													97.0%	<92%	NA	>=92%
	RTT - delivery in all specialties - no. where standard not delivered (admitted, non-admitted and incomplete)	0			0													0	>0	NA	0
	RTT - Patients waiting >52 weeks	0			0													0	>0	NA	0
	Diagnostic waiting times - maximum wait of 6 weeks	0.04%			0.04%													0.04%	>=1%	NA	<1%
Cancer waiting times	All Cancers: 14 Days Target	87.6%			87.6%													87.6%	<93%	NA	>=93%
	All Cancers: 14 Days Target All Breast Referrals	94.9%			94.9%													94.9%	<93%	NA	>=93%
	All Cancers: 31 Day Target - 1st Treatment	100.0%			100.0%													100.0%	<96%	NA	>=96%
	All Cancers: 31 Day Target - Subsequent Treatment - Surgery	100.0%			100.0%													100.0%	<94%	NA	>=94%
	All Cancers: 31 Day Target - Subsequent Treatment - Drug treatment	100.0%			100.0%													100.0%	<98%,	NA	>=98%
	All Cancers: 62 Day Target	87.5%			87.5%													87.5%	<85%	NA	>=85%
	All Cancers: 62 Day Target Screening	100.0%			100.0%													100.0%	<90%	NA	>=90%
	All Cancers: 62 Day Target Cons Upgrade	100.0%			100.0%													100.0%	<85%	NA	>=85%
Emergency Department and Minor Injury Units	Trust total - Total time in A&E - % within 4 hours	96.4%			96.4%													96.4%	<95%	NA	>=95%
	Type 1 A&E - Harrogate ED - Total time in A&E - % within 4 hours	94.7%			94.7%													94.7%	<95%	NA	>=95%
	Type 1 A&E - Harrogate ED - trolley waits > 12 hours	0			0													0	>0	NA	0
	Type 1 A&E - Harrogate ED - ambulance handovers > 30 mins	10			10													10	>0	NA	0
	Type 1 A&E - Harrogate ED - ambulance handovers > 60 mins	2			2													2	>0	NA	0
	Type 3 A&E - Ripon MIU - Total time in A&E - % within 4 hours	100.0%			100.0%													100.0%	<95%	95%-<98%	>=98%
	Type 3 A&E - Selby MIU - Total time in A&E - % within 4 hours	100.0%			100.0%													100.0%	<95%	95%-<98%	>=98%
Patient Safety and Clinical Quality	Incidence of avoidable hospital acquired MRSA Bacteraemia	0			0													0	>6 YTD	1-6 YTD	0 YTD
	Incidence of hospital acquired C-Difficile	0			0													0	>12 YTD	NA	<=12 YTD
	Incidence of hospital acquired MSSA	0			0													0	tbc	tbc	tbc
	General & Acute bed occupancy	83.7%			83.7%													83.7%	tbc	tbc	tbc
Data quality (quarterly reporting)	Community services data completeness - RTT information																		<50%	NA	>=50%
	Community services data completeness - Referral information																		<50%	NA	>=50%
	Community services data completeness - Treatment activity information																		<50%	NA	>=50%
Patient experience	Mixed Sex Accommodation breaches	0			0													0	>0	NA	0
	Delayed Transfer of Care	2.9%			2.9%													2.9%	>3.5%	NA	<=3.5%
Stroke care	Stroke Care - 90% of time on Stroke Unit	85.2%			85.2%													85.2%	<80%	NA	>=80%
	Stroke Care - TIA Patients with a high risk of stroke seen and treated within 24 hours	87.5%			87.5%													87.5%	<60%	NA	>=60%
	Sentinel Stroke National Audit Programme (SSNAP) – overall level																		D,E	C	A,B
Out of hours	Out of hours - telephone clinical assessment for URGENT cases within 20 minutes of call prioritisation	60.4%			60.4%													60.4%	<95%	NA	>=95%
	Home visit: Face to face consultations started for URGENT cases within 2 hrs	88.1%			88.1%													88.1%	<95%	NA	>=95%
	Out of hours initial telephone call - Identification of immediately life threatening at PCC. GP or patient called 999.	99.2%			99.2%													99.2%	<95%	NA	>=95%
Community services	Health Visiting – number of WTE in post	103.59			103.59													103.59	tbc	tbc	tbc
	Health Visiting – % of infants receiving a new born visit within 14 days of birth	71.0%			71.0%													71.0%	<90%	>=90% - <95%	>=95%
	Health Visiting - % of children receiving a 12 month review	60.2%			60.2%													60.2%	<90%	>=90% - <95%	>=95%
	Community equipment – % standard items delivered within 7 days	97.6%			97.6%													97.6%	tbc	tbc	tbc
	Community equipment – % priority items delivered within 24 hours	100.0%			100.0%													100.0%	tbc	tbc	tbc
	Community equipment - % urgent items delivered within 6 hours	100.0%			100.0%													100.0%	tbc	tbc	tbc

Please note that Stroke, RTT, and Cancer figures are provisional as at 20/05/2015.



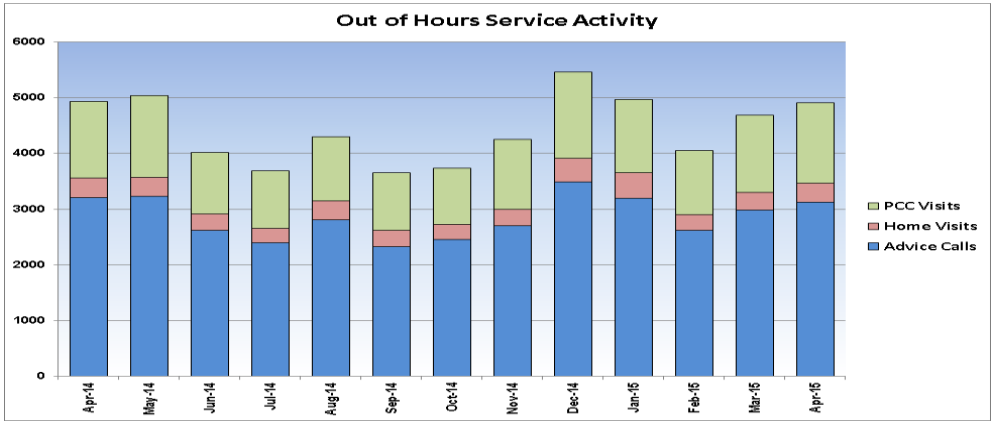
Adult community teams activity

The first chart shows the number of face to face patient contacts recorded on Systmone for the district nursing and fast response teams. In April 2015 there has been an increase in activity, with a notable rise in contacts for the fast response teams. There were 424 face to face patient contacts per calendar day across the adult community teams in April 2015 compared to 381 per day in March. Comparing to the same month last year, this is an increase, with 375 contacts per day in April 2014.



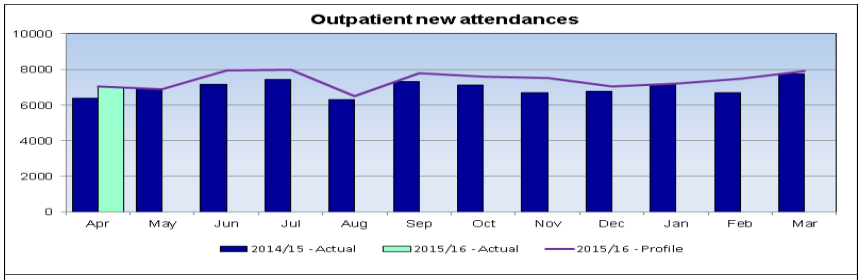
Specialist nursing activity

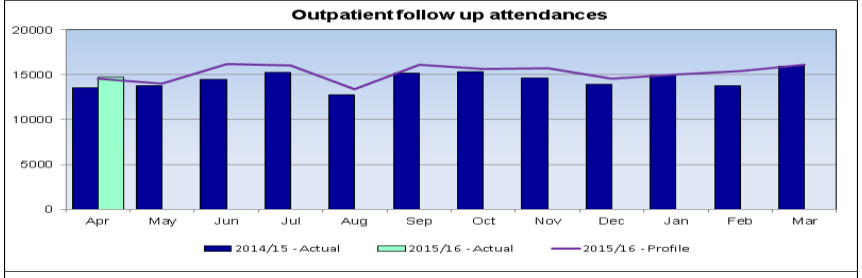
The second chart to the left shows a summary of the face to face patient contacts for each of the Specialist Nursing Teams on Systmone. As can be seen, increased activity has been reported since September 2014. As of April 2015, two new teams have been trained and are inputting onto SystmOne: the TB and New Entrants Assessment Team and the Specialist Palliative Care Nurses. This helps account for the increase in activity from the previous months. In April 2015 there were 30 contacts per day, compared to 28 contacts per day in March

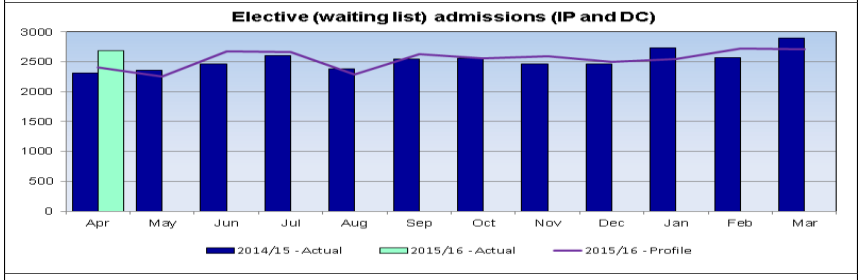


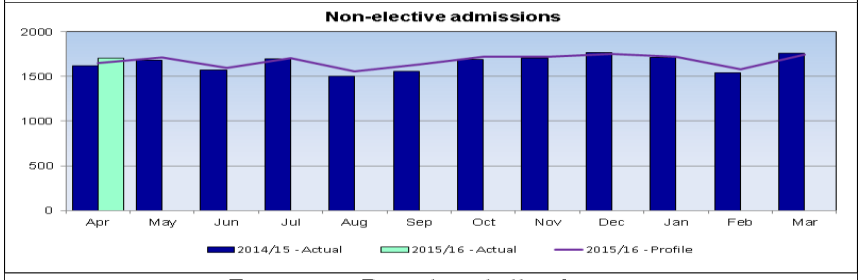
Out of Hours (OOH) Reporting

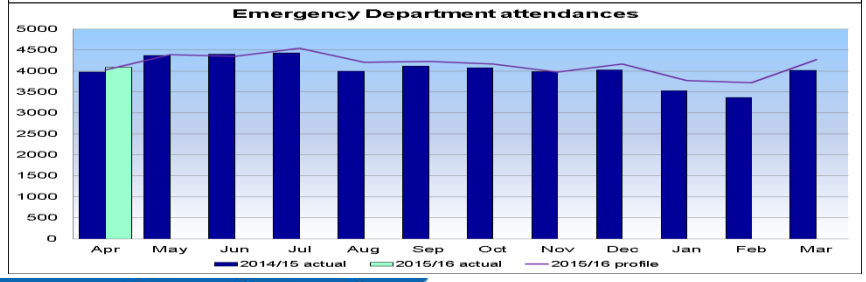
The third chart to the left shows trends in OOH activity over recent months. With effect from 1st April 2015, York and Selby OOH Service is no longer managed by Harrogate & District NHS Foundation Trust. Data for York and Selby OOH Service has been removed from previous months for comparison purposes.











Service Activity (2)

Harrogate and District NHS
NHS Foundation Trust

New Outpatients

New outpatient attendances in April were 0.6% below plan (7,006 vs. 7,047). Activity for April 2015 is 9.7% higher than for the same month last year (6,388) year.

Follow Up Outpatients

Follow-up outpatient attendances were 0.8% above plan in April (14,702 vs. 14,589). When compared to April 2014, there has been a 8.6% increase in activity for in 2015.

Elective Admissions

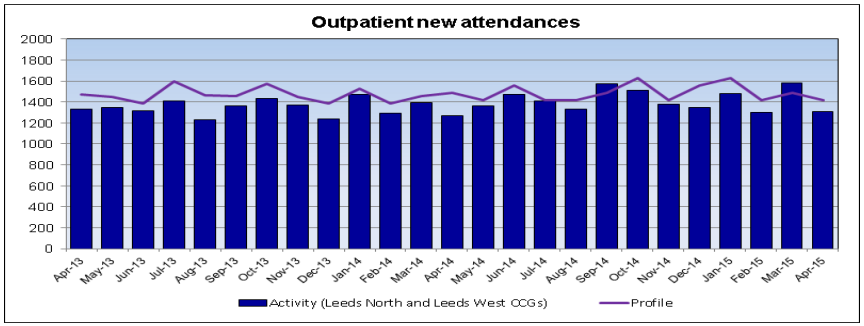
Overall, elective admissions were 12% above plan in April (2,689 vs. 2,401). Elective inpatients were 4% over plan, and elective day cases were 13% above plan. In April of this year, there were 16% more elective admissions than in the same month in 2014 (2,318). The average length of stay for elective patients was 2.3 days in April, compared to 3.9 days for the same month in 2014.

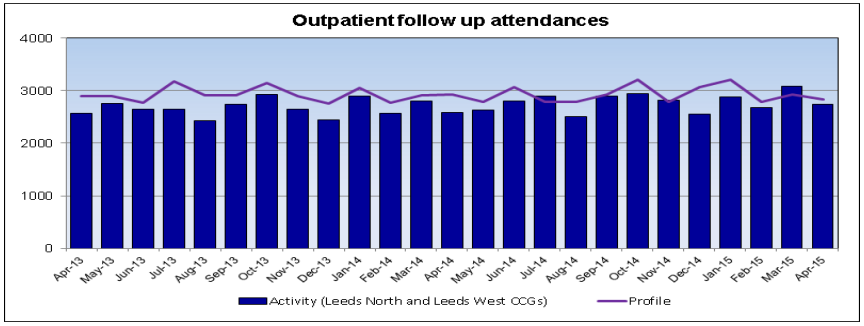
Non Elective Admissions (including CAT)

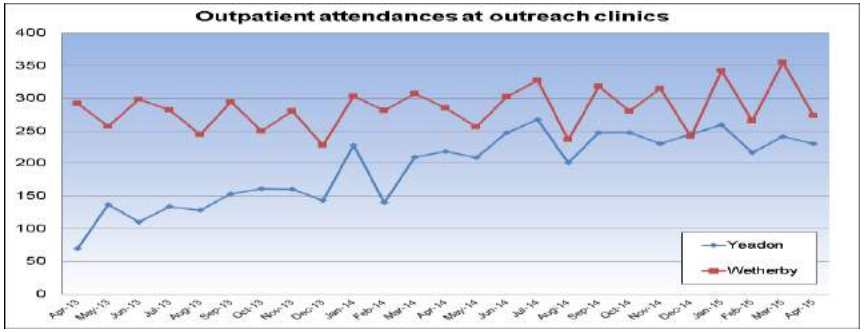
Non elective admissions were 3.3% above plan in April (1,702 vs. 1,648 and 5% higher than the same month last year (1,621). The average length of stay for non-elective patients in April was 4.8 days, compared to 4.3 days in April 2014.

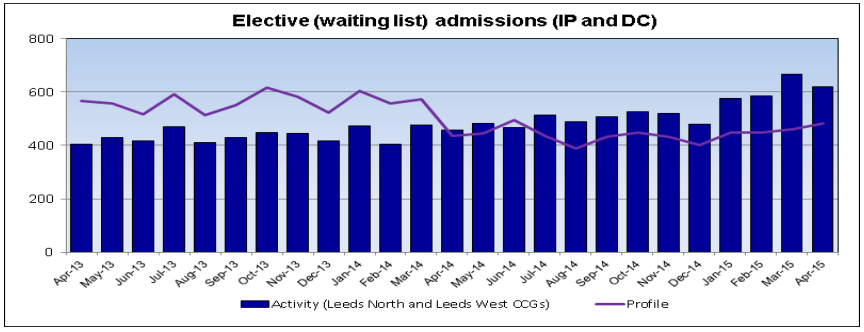
Emergency Department Attendances

Emergency Department attendances were 1.7% above plan in April (4,090 vs. 4,022). In April 2015, there were 3% more attendances than in April 2014. Of 4,090 ED attendances (planned and unplanned) in April 2015, 22% resulted in an admission to hospital. This compares to 21% in April 2014.









Service Activity (3)

Activity for Leeds North and Leeds West CCGs

New Outpatients

New outpatient attendances in April were 8% below plan (1,305 vs. 1,418). There was a 2.7% increase in activity in April 2015 when compared to the same month last year (1,271).

Follow Up Outpatients

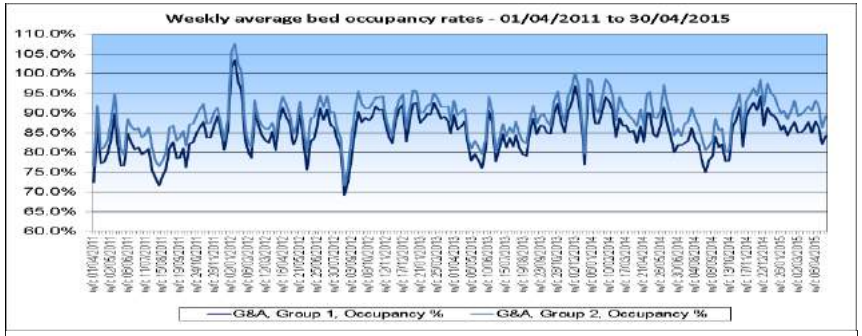
Follow-up outpatient attendances were 3.3% below plan in April (2,736 vs. 2,828). When compared to April 2014, there has been a 5.8% increase in activity for the same month this year (2,587 vs 2,736).

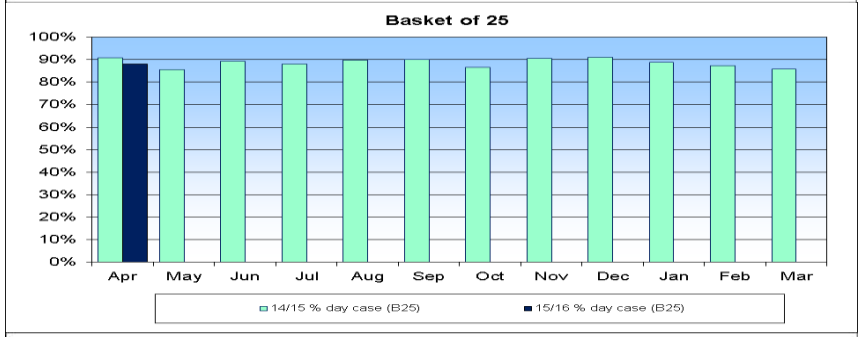
Outpatient attendances at Wetherby and Yeadon clinics

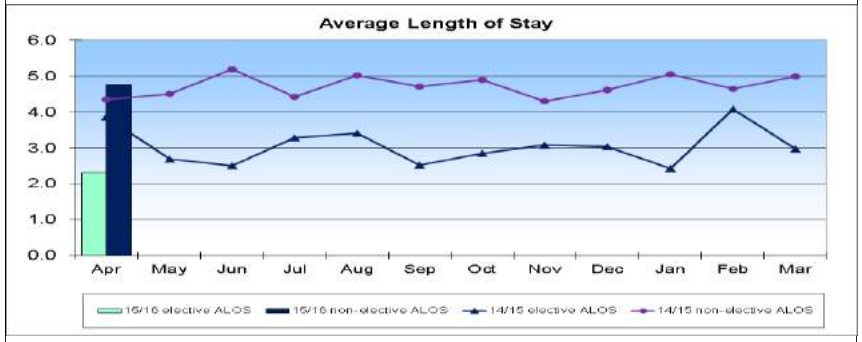
The Trust now offers outpatient clinics in Wetherby and Yeadon in a variety of specialties including orthopaedics, general surgery, dermatology and urology. Antenatal and pre-op assessment appointments are also provided at Yeadon. The third chart to the left shows monthly attendances at these clinics since April 2013. For the last 3 months, the average number of attendances at these outreach services was around 530 patients per month, compared to around 480 per month for the same period last year.

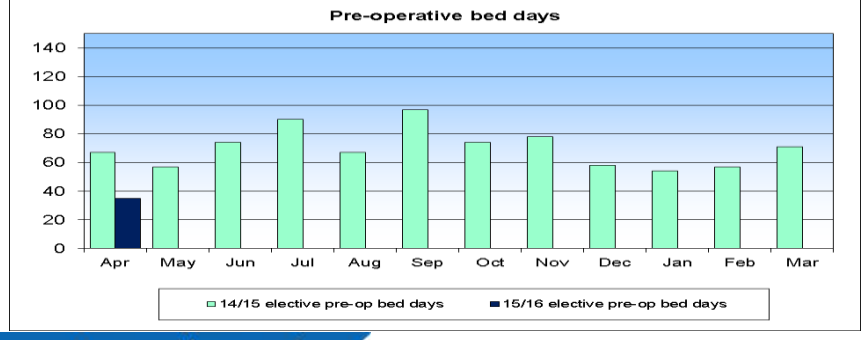
Elective Admissions

Overall, elective admissions were 28.4% above plan in April (619 vs. 482). Elective inpatients were 5.8% above plan, and elective day cases were 32.5% above plan. Elective admissions in April 2015 were 34.9% higher than for the same month in 2014 (619 vs. 459).









Acute Services - Efficiency Indicators

General and Acute (G&A) Bed Occupancy levels

General and Acute Beds (G&A) include all overnight beds at Harrogate District Hospital with the exception of maternity beds and cots. The graph on the left shows bed occupancy levels divided into two groups – Group 1 relates to all G&A beds and Group 2 relates to a sub group consisting of surgical and medical beds at Harrogate District Hospital. The average occupancy for both groups in 2015 to date is similar as for the same period last year.

Day case rates – Basket of 25

Provisional data indicates that April performance against the basket of 25 procedures performed as a day case was at 88%, compared to 91% for the same month in 2014. It is anticipated that the April 2015 figure will increase once coding is fully completed for the month.

Average Length of Stay (ALOS)

The ALOS for non-elective cases in April was 4.8 days, compared to 4.3 days in April 2014. The ALOS for elective cases in April was 2.3 days which is significantly lower than the ALOS for the same month last year (3.9 days).

Pre-operative bed days

The number of pre-operative bed days (patients brought in the day before their elective (waiting list) surgery) was 35 in April. This compares to 67 for the same month in 2014. The reduction in pre-operative bed days will have contributed to the decrease in elective average length of stay.

- The National Adult Inpatient Survey 2014 will be published by The Care Quality Commission (CQC) on 21st May. HDFT has been provided with our results on an embargoed basis. Once the full data is published, we will be able to compare our performance against other trusts.
- Overall HDFT performed very well, scoring "significantly better than average" for 7 out of 59 questions (compared to 6 out of 60 last year), including 4 questions from the "Leaving Hospital" section.
- For the fourth consecutive year, HDFT had no questions rated "significantly worse than average". 461 patients treated at HDFT responded in the survey this year - a local response rate of 56%, the same as last year.
- The table below provides a summary of HDFT's scores in each section of the survey, comparing this year's scores with last year.

- The following 7 questions are ranked "significantly better" in 2014:
    - Q6 - How do you feel about the length of time you were on the waiting list before your admission to hospital?
    - **Q9 - From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?**
    - Q21 - How would you rate the hospital food?
    - Q55 - Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?
    - **Q56 - Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?**
    - **Q58 - Were you told how to take your medication in a way you could understand?**
    - **Q63 - Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?**
- The questions highlighted in bold were not ranked "significantly better" in 2013 so have shown an improvement since last year.

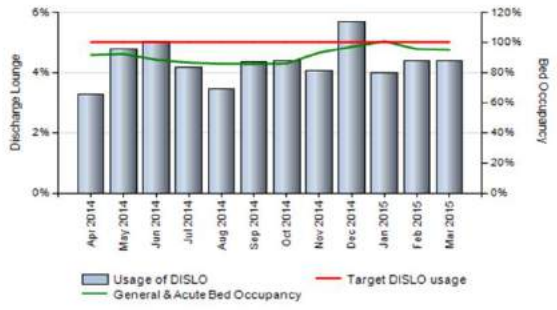
Section	Total number of questions in 2014	HDFT score compared to the national average in 2014:			Total number of questions in 2013	HDFT score compared to the national average in 2013:		
		Significantly worse	About the same	Significantly better		Significantly worse	About the same	Significantly better
Emergency Department/ A&E	2	0	2	0	2	0	2	0
Waiting list and planned admissions	3	0	2	1	3	0	1	2
Waiting to get to a bed on a ward	1	0	0	1	1	0	1	0
The hospital and ward	11	0	10	1	11	0	9	2
Doctors	3	0	3	0	3	0	3	0
Nurses	4	0	4	0	4	0	4	0
Care and treatment	10	0	10	0	9	0	9	0
Operations and procedures	6	0	6	0	6	0	5	1
Leaving hospital	15	0	11	4	17	0	16	1
Overall	4	0	4	0	4	0	4	0
Total	**59**	**0**	**52**	**7**	**60**	**0**	**54**	**6**

Discharge dashboard

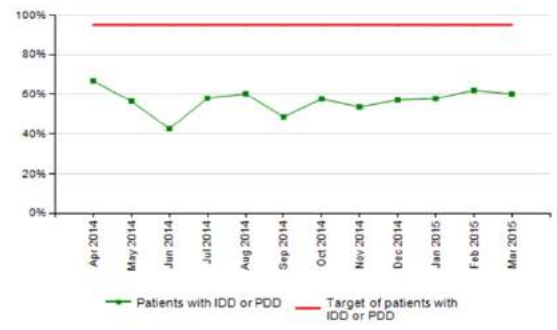
Harrogate and District NHS
NHS Foundation Trust

The charts below show the Trust's overall performance trend in each of the discharge performance indicators agreed by the Discharge steering group.

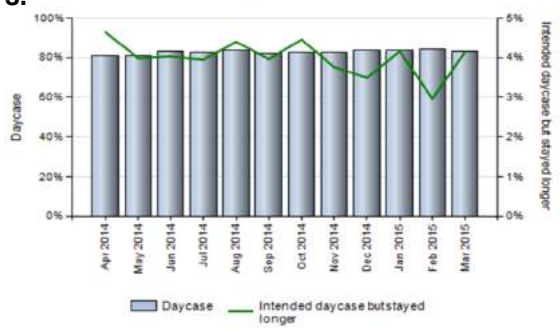
1. Use of the discharge lounge for patients discharged to usual place of residence



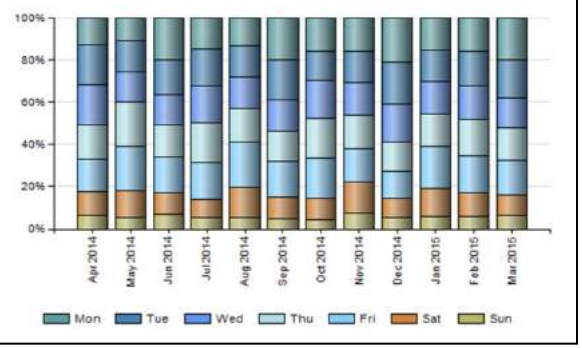
2. Snapshot use of intended discharge / planned discharge date



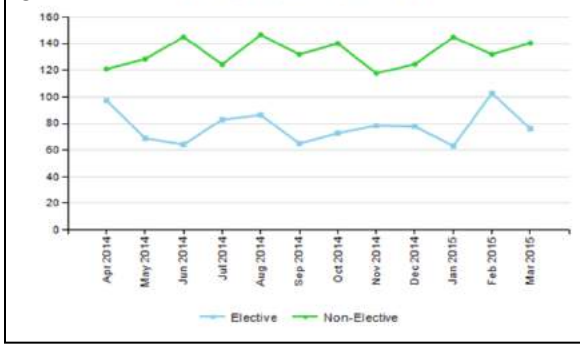
3. Daycase Rates



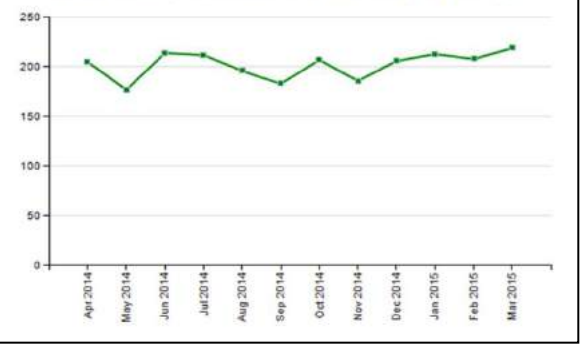
4. Discharges by day of week



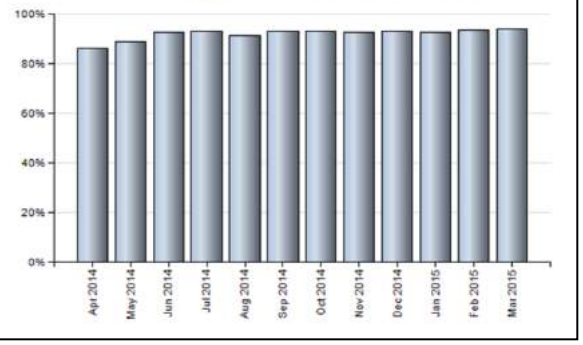
5. Average length of stay (hours)



6. Number of emergency readmissions within 30 days of discharge



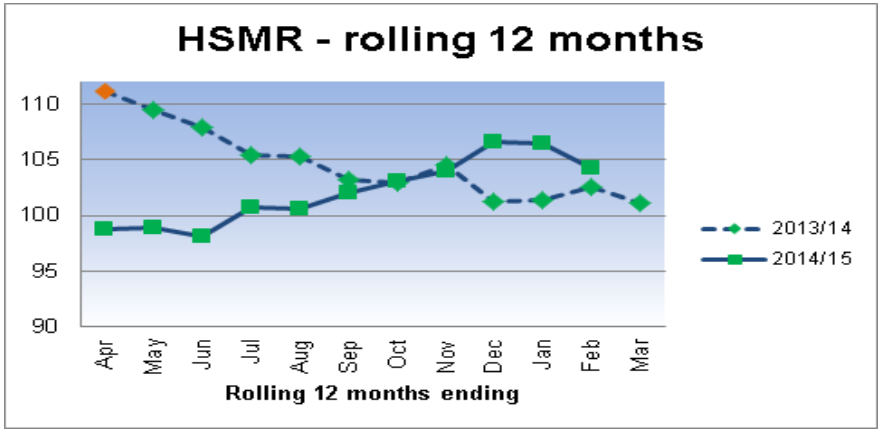
7. Patients discharged with electronic discharge summary

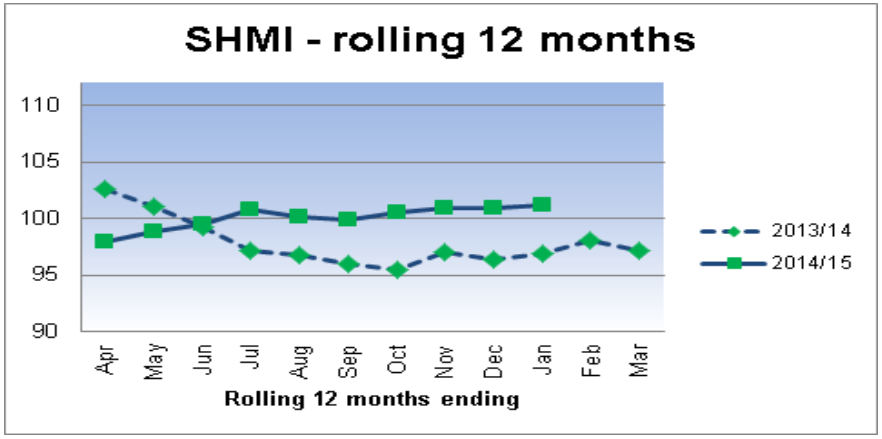


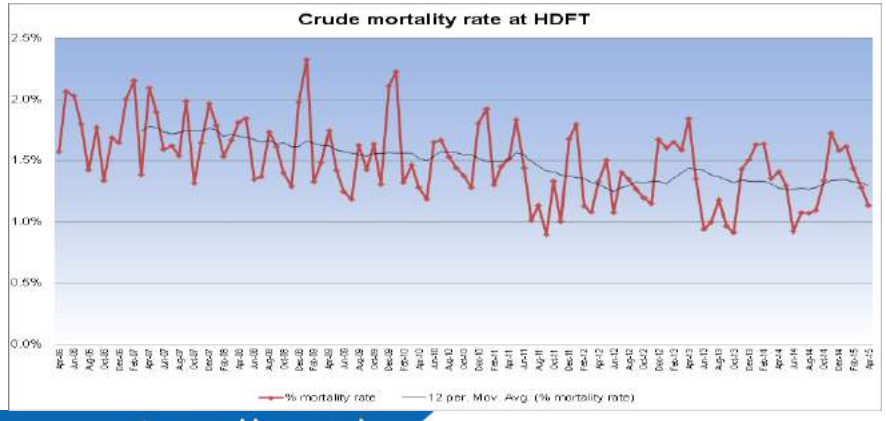
Explanatory notes:

- Emergency Readmissions are categorised by the date of readmission and are assigned to a patient's last ward/specialty/directorate of their initial admission.
- Average length of stay (hours) is calculated based on date/time of admission and date/time of discharge and not on the care spell duration field.
- Intended discharge date target is 95%.
- Use of discharge lounge target is based on a 2% increase on the last financial year for each ward/specialty/directorate.
- The following areas have been excluded from the electronic discharge figures: Endoscopy, Ophthalmology, Pannal, Delivery Suite and Special Care Baby Unit.
- The following wards have been excluded from the IDD/PDD figures: Day Surgery Unit, Intensive Therapy / High Dependency, Outpatients Ward, Lascelles, Pannal, Special Care Baby Unit, Delivery Suite and Woodlands.

Harrogate and District NHS
NHS Foundation Trust







- HDFT's HSMR for the most recent 12 months is **104.27**, which is a decrease on the previous month's position.
- The latest SHMI is **101.23**, which has seen a small increase since last month.
- The first two charts to the left track HDFT's HSMR and SHMI over 2013/14 and 2014/15. Each point on the chart shows the score for the most recently available 12 months.
- Both measures remain within expected levels at Trust level.
- At specialty level, there are two specialties with a standardised mortality rate above expected levels for the SHMI (Geriatric Medicine and Respiratory Medicine) and one specialty with a standardised mortality rate above expected levels for the HSMR (Respiratory Medicine). These are the same specialties that have been highlighted in previous months.
- The third chart shows HDFT's crude mortality rate since 2006. The black line shows the 12 month rolling average mortality rate. As can be seen, HDFT's crude mortality has reduced in recent years, in line with the national trend of in-hospital mortality, and stands at 1.30% for the most recent 12 months. The crude mortality rate reported in April 2015 was 1.14% which is lower than the same month in the previous year (1.41%).

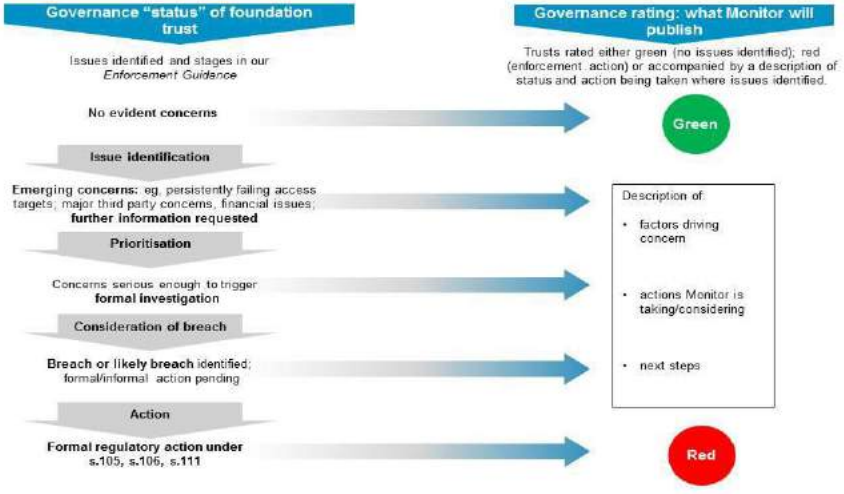
Monitor – 2015/16 Risk Assessment Framework

Category	Metrics	Governance concern triggered by
CQC information	• CQC judgments	• CQC warning notice issued • Civil and/or criminal action initiated
Access and outcomes metrics	For **acute trusts**, metrics including: • referral to treatment within 18 weeks • A&E waits (4 hours) • cancer waits (62 days) For **ambulance trusts**, Category A response times For **mental health trusts**, metrics including CPA follow-up and psychosis outreach	• Three consecutive quarters' breaches of a single metric or a service performance score of 4 or greater[1]
	For **acute trusts**, metrics including: • C. difficile – national target	• Breaching pre-determined annual C. difficile threshold (either three-quarters' breach of the year-to-date threshold or breaching the full year threshold at any time in the year)
	For **mental health trusts**, metrics including tracking accommodation/employment status (data completeness only) For providers of community services, data completeness against selected elements of the CIDS dataset	• Breaching the A&E waiting times target in two quarters over any four-quarter period and in any additional quarter over the subsequent three quarters
Third party reports	• Ad hoc reports from GMC, the Ombudsman, commissioners, Healthwatch England, auditor reports, Health & Safety Executive, patient groups, complaints, whistleblowers, medical Royal Colleges etc.	• Judgment based on the severity and frequency of reports
Quality governance indicators	• Patient metrics • patient satisfaction	• Material reductions in satisfaction, or increases in sickness or turnover rates

	• Staff metrics
	  • high executive team turnover
	  • satisfaction
	  • sickness/absence rate
	  • proportion temporary staff
	  • staff turnover
		• Material increases in proportion of temporary staff

	• Aggressive cost reduction plans	• Cost reductions in excess of 5% in any given year
Financial risk	• Continuity of services risk rating	• Breaching any continuity of services licence condition as a result of governance • Inadequate planning processes

[1] For example a service performance score as per the metrics in Appendix A



- Monitor's Risk Assessment Framework replaced the Compliance Framework from October 2013. The new framework assesses Foundation Trust's continuing compliance with the licence and focuses on financial sustainability and governance requirements. The table to the left shows the information used by Monitor to assess governance concerns.
- HDFT's performance against the national performance standards in the "Access and outcomes metrics" are shown in the table below.
- The diagram at the bottom left illustrates how Monitor assigns a governance rating to Foundation Trusts.
- **HDFT's governance rating for Q1 to date is Amber.**

Weightings and thresholds for targets and national core standards

Targets - weighted 1.0	Q4	Apr	May	Jun	Q1	Q1 expected	Q1 variance	Threshold	Weighting	Q1 score
RTT admitted pathways (% within 18 weeks)*	0.0	94.2%			94.2%	90%	4.2%	90%	1.0	0.0
RTT non-admitted pathways (% within 18 weeks)*	0.0	97.2%			97.2%	95%	2.2%	95%	1.0	0.0
RTT incomplete pathways (% within 18 weeks)*	0.0	97.0%			97.0%	92%	5.0%	92%	1.0	0.0
A&E: Total time spent in A&E (% within 4 hours)	0.0	96.4%			96.4%	95%	1.4%	95%	1.0	0.0
Cancer - 62 day wait for first treatment from urgent GP referral treatment: all cancers*	0.0	87.5%			87.5%	85%	2.5%	85%	1.0	0.0
Cancer - 62 day wait for first treatment from Screening service referral: all cancers*	0.0	100.0%			100.0%	90%	10.0%	90%		
Cancer - 31 day wait for second or subsequent treatment: Surgery*	0.0	100.0%			100.0%	94%	6.0%	94%	1.0	0.0
Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug*	0.0	100.0%			100.0%	98%	2.0%	98%		
Cancer - 31 day wait for second or subsequent treatment: Radiotherapy*	N/A	N/A			N/A	N/A	N/A	N/A	N/A	N/A
Cancer - Maximum waiting time of 31 days from diagnosis to treatment for all cancers (%)*	0.0	100.0%			100.0%	96%	4.0%	96%	1.0	0.0
Cancer - Maximum waiting time of 14 days from urgent GP referral to date first seen for all urgent suspect cancer referrals (%)*	0.0	87.6%			87.6%	93%	-5.4%	93%	1.0	1.0
Cancer - maximum waiting time of 14-days for symptomatic breast patients (cancer not initially suspected)*	0.0	94.9%			94.9%	93%	1.9%	93%		0.0
C.Difficile	0.0	0			0	4	-3	0	1.0	0.0
Compliance with requirements regarding access to healthcare for patients with learning disabilities	0.0				Y	Y		Y/N	1.0	0.0
Community services data completeness - RTT information	0.0				80.6%	50%		50%	1.0	0.0
Community services data completeness - Referral information	0.0				71.0%	50%		50%		0.0
Community services data completeness - Treatment activity information	0.0				81.7%	50%		50%		0.0
Score	0.0	Rating: Narrative								1.0
Governance concern triggered? (Y/N)	N									N

*Reporting month figures are provisional

Report to the Trust Board of Directors: 27th May 2015	**Paper No: 9.0**

Title	Monthly Finance Report
Sponsoring Director	Director of Finance
Author(s)	Finance Department
Report Purpose	Review of monthly financial position

Executive Summary

The Trust reported a surplus of £137k for April 2015. This positive performance was driven by favourable income variance, in particular relating to Acute commissioner income.

The Trust ended April with a cash balance of £6,560k, however, work continues to manage this position.

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

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

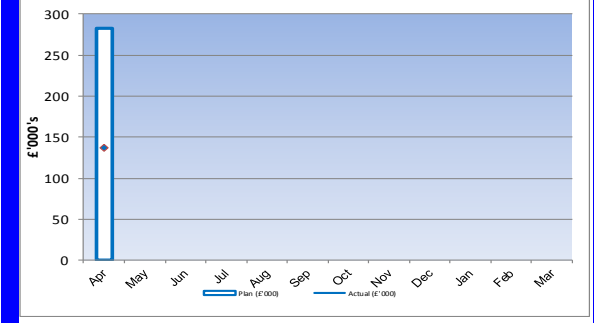
Action Required by the Board of Directors
The Board of Directors is asked to note the contents of this report

Trustwide Finance Overview as at 30th April 2015

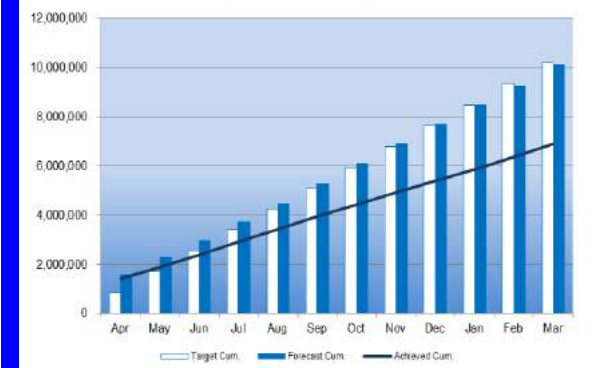
Income & Expenditure (£'000)

In Month Variance to Plan	YTD Variance to Plan
(146)	(146)

Financial Position (Income & Expenditure)



CIP Performance 2015/16

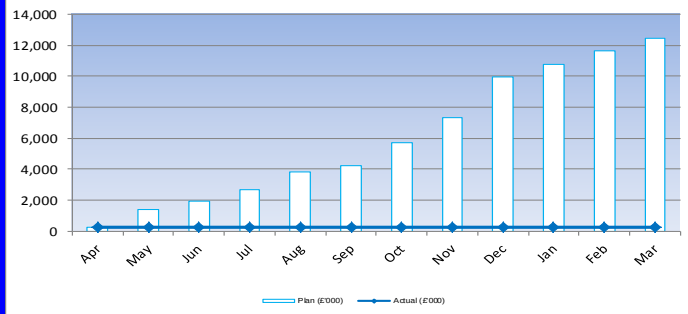


CIP Target (Internal) (£'000)	**10,179**
CIP Achieved (£'000)	**6,879**
Over-achievement/Shortfall (£'000)	**(3,300)**

Comments:

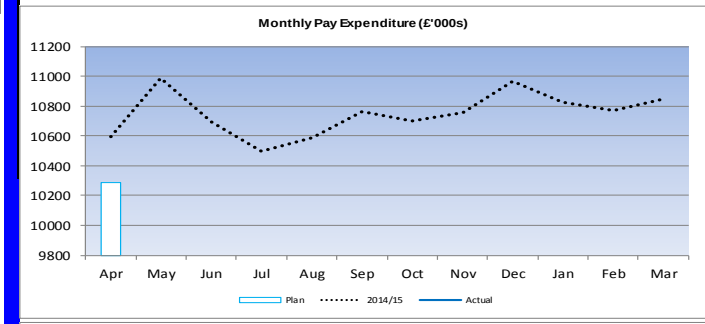
Balance Sheet

Cumulative Capital Spend 2015/16

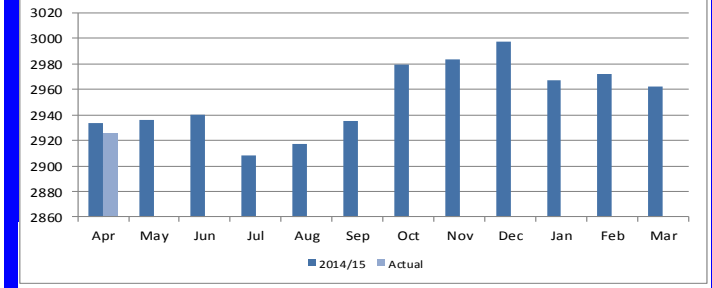


Cash (£'000)	
Cash in Hand	6,560
Planned Cash	6,074

Monthly Pay Expenditure (£'000s)



Monthly Pay Expenditure (WTE)

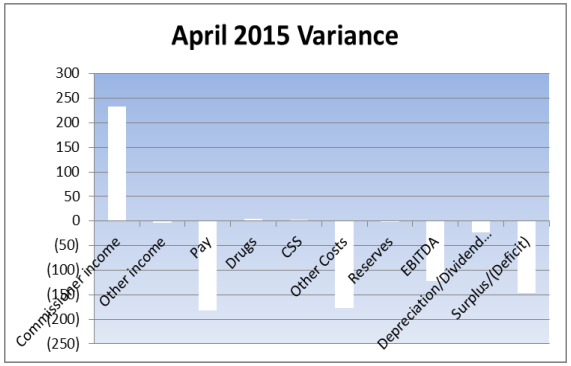


Comments:

Trust income for April was £229k ahead of plan. This was predominantly related to Commissioner income in relation to the Acute contract, in particular overtrades relating to daycase and non elective activity. Discussions continue in relation to contract agreements, therefore there is an element of risk in this position.

Key Financial Drivers

April 2015 Variance



Variance to plan by Directorate

Integrated Care	(63)
Elective Care	(146)
Acute Care & Cancer Services	(79)
Corporate Services	(203)

Comments: Directorate Overspends

Integrated Care:

The financial performance for the month was £63k overspent. The main drivers for this position were:

* Ward pay - pay on the wards was £39k overspent of which £9.1k special shifts on the wards, £10k related to sickness being over 3.9%
* Cardiology - In month the overspend was £31k due to agency SpR and agency consultant cover.
* The amount of CIP phased in month was £15k equivalent to a 7% full year effect shortfall

Elective Care:

The financial performance for the month was £146k overspent. The main drivers for this position were:

* Ward pay - pay on the wards was £39k overspent of which £11.1k unfunded special shifts on the wards and around £12k related to sickness being over 3.9%
* Theatres - non pay in theatres was £54k overspent
* CIP - in month £41k was phased in to the position to reflect the risk adjusted CIP position which current stands at 93%

Acute & Cancer Care:

The Acute & Cancer Care Directorate reported an in-month over spend against total budget of £79k. Of the overspend, pressures occurred in the following areas:

*Unfound/high risk CIP £58k overspend
*Adult Community Services - reablement posts previously funded by commissioners no longer funded overspend (£19k, 10.56wte)
*ED nursing non-recurrent £14k overspend

Corporate:

Overspend against budget of £203k in the month of April. The Significant transactions were:

Income - Under recovered by £8k
* Mainly related to a backdated VAT adjustment within IT.

Pay - Overspent by £40k
*£17k within Hotel Services related mainly to domestics pay spend.
*£13k within chief exec related to medical staffing and pay in lieu.

Non-pay - Overspent by £155k
*£120k was due to a one off purchase of Microsoft Licences.
*£35k CIP was phased into month 01 as not delivered.

Key Financial Overview

April Financial Position

- The Trust reported surplus of £137k, £146k behind the internal plan. This is summarised below –

£'000s	Plan	Actual	Variance
Income	15,335	15,564	229
Expenditure	-15,052	-15,427	-376
Surplus/(Deficit)	**283**	**137**	**-146**
Impact of internal CIP/Board Contingency/other minor adjustments	434		
Underlying position	-151		

  - The internal plan is based on the achievement of the internal CIP target of £10.2m (not the £8.8m externally required) and without the use of board contingency at this point in the financial year.
  - Board contingency is typically utilised later in the financial year, as appropriate based upon financial risk.
  - The internal CIP target was set at a higher level in order to fund service pressure priorities. As outlined later in the report the Trust is not in a position to fund these pressures at present.

- The £137k surplus is therefore a positive position for the Trust, however, there is still work to do to enable the funding of service developments as agreed with the directorates.
- The Trust-wide waterfall diagrams are on Page 4, showing the key drivers that make up the current financial position.
- Income and expenditure run charts can be seen on pages 5 and 6 showing trends from the past two financial years.
- Trust income for April was £229k ahead of plan. This was predominantly related to Commissioner income in relation to the Acute contract, in particular overtrades relating to daycase and non elective activity. Discussions continue in relation to contract agreements, therefore there is an element of risk in this position.
- There was an adverse pay expenditure of £180k in April. The table on the right outlines the main areas of overspend. This is partially offset by medical staffing reserves which are factored into the overall Trust position.
- Non Pay in April was also overspent, mostly due to the adverse variance of £178k for other costs. £163k related to the cost improvement programme. Of the £10.2m internal target 68% has been actioned, with plans in place for 84% following a risk adjustment. Page 9 contains further information relating to performance against the efficiency programme.

£'000s	Variance
Ward Nursing	78
Medical Staffing (Excluding ED)	34
ED Staffing (Medical & Nursing)	32
Estates & Facilities	15
Other smaller variances	22
Total	**180**

- A significant amount of work has been undertaken throughout the directorates to develop and action cost improvements while also delivering activity over planned levels. Regular meetings with the directorates continue in order to support the momentum in this area.

Key Financial Overview Cont.

- Page 14 outlines the current cash position. The Trust cash balance is reported at £6,560k

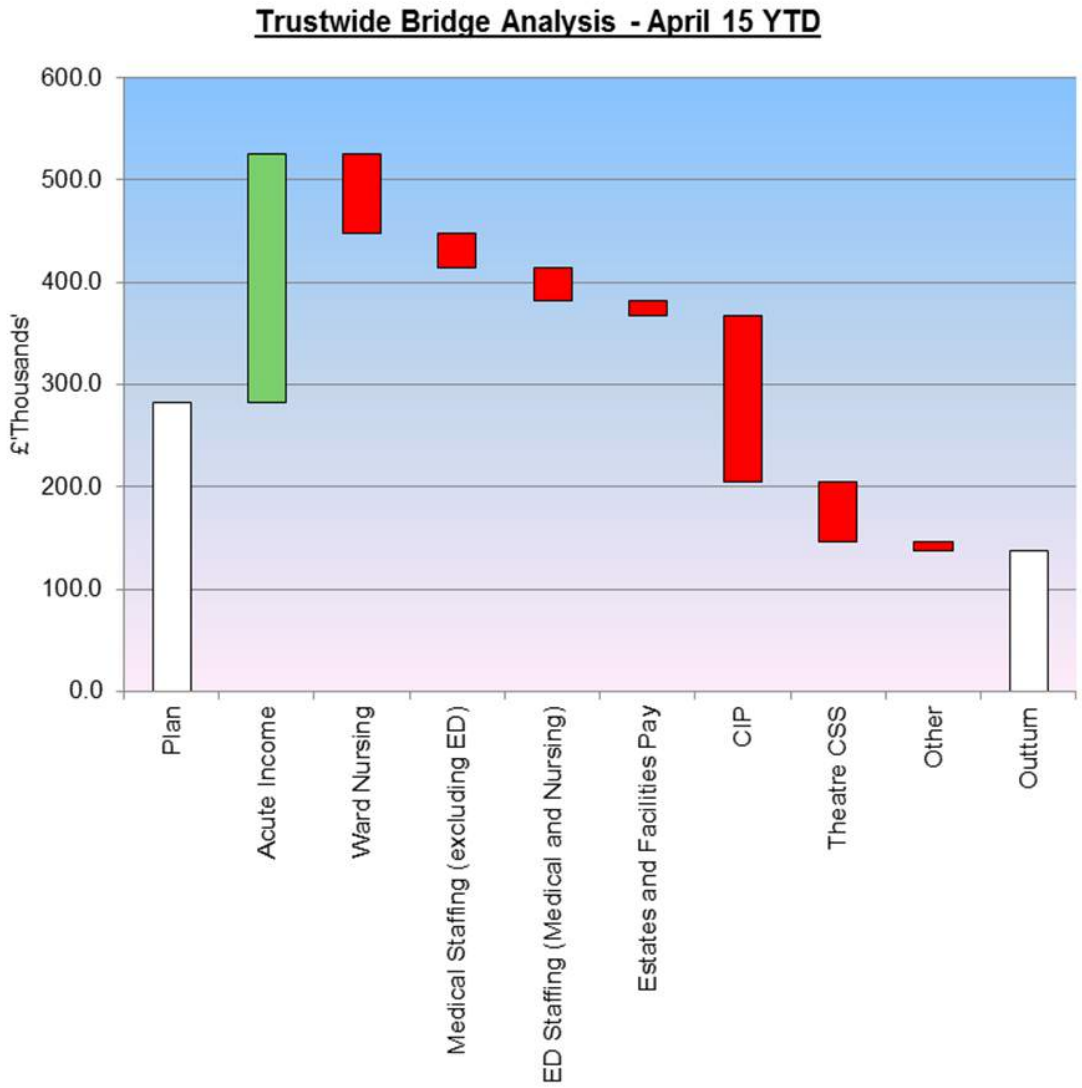
Quarterly Monitor Return

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

- The table below shows the quarterly plan and performance of the Trust-

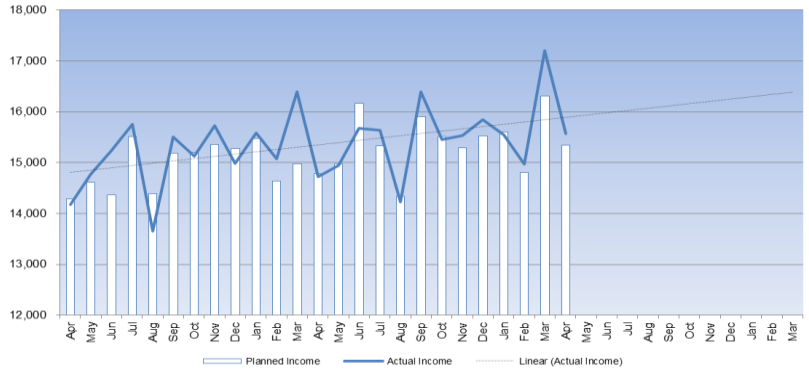
	Q1	Q2	Q3	Q4	Full Year
Planned Rating	**3**	**4**	**4**	**4**	**4**
Actual Rating – Capital Service Cover	3				
Actual Rating – Liquidity	3				
Actual Rating – Consolidated Rating	**3**				

Trust wide Bridge Analysis

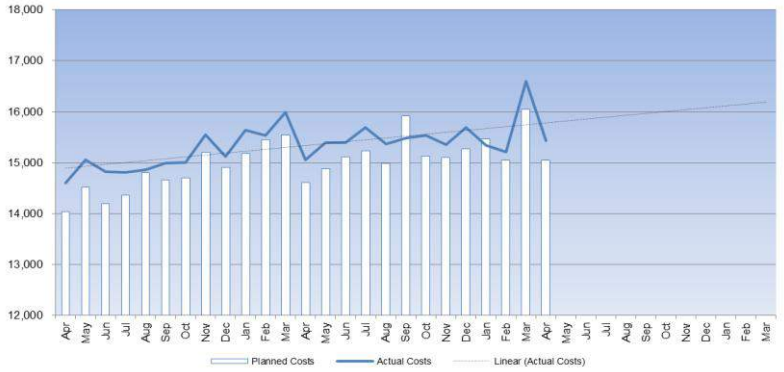


Income & Expenditure Run Charts

Planned and Actual Income Apr 2013 - Mar 2016



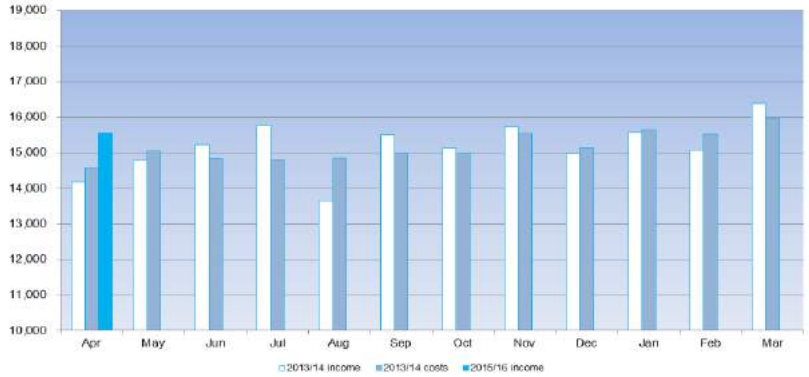
Planned and Actual Costs Apr 2013 - Mar 2016



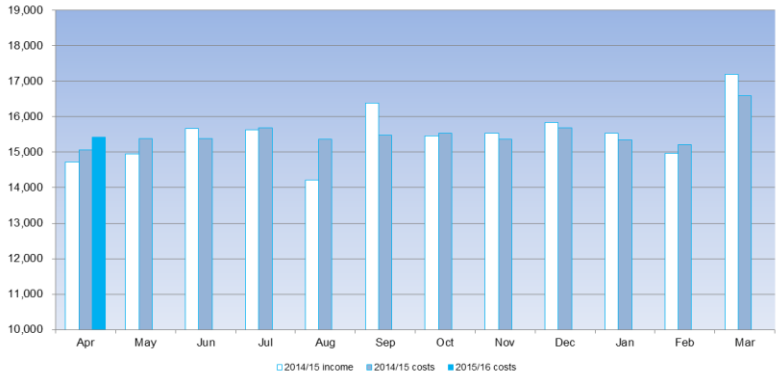
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2013/14 income plan	14,287	14,617	14,369	15,513	14,383	15,188	15,199	15,349	15,277	15,473	14,637	14,978
2013/14 income actual	14,171	14,778	15,227	15,755	13,653	15,502	15,130	15,731	14,987	15,588	15,073	16,395
2013/14 variance	**-116**	**161**	**858**	**242**	**-730**	**314**	**-69**	**382**	**-290**	**115**	**436**	**1,417**
2013/14 % variance	-0.8%	1.1%	6.0%	1.6%	-5.1%	2.1%	-0.5%	2.5%	-1.9%	0.7%	3.0%	9.5%
2014/15 income plan	14,779	14,981	16,165	15,325	14,332	15,901	15,506	15,293	15,523	15,606	14,809	16,305
2014/15 income actual	14,717	14,945	15,674	15,637	14,221	16,388	15,451	15,533	15,845	15,539	14,967	17,201
2014/15 variance	**-62**	**-36**	**-491**	**312**	**-111**	**487**	**-55**	**240**	**322**	**-67**	**158**	**896**
2014/15 % variance	-0.4%	-0.2%	-3.0%	2.0%	-0.8%	3.1%	-0.4%	1.6%	2.1%	-0.4%	1.1%	5.5%
2015/16 income plan	15,335	0	0	0	0	0	0	0	0	0	0	0
2015/16 income actual	15,564											
2015/16 variance	**229**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
2015/16 % variance	1.5%											

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2013/14 expenditure plan	14,039	14,523	14,197	14,368	14,808	14,665	14,700	15,203	14,908	15,172	15,450	15,535
2013/14 expenditure actual	14,598	15,051	14,825	14,814	14,861	14,994	15,001	15,546	15,126	15,641	15,530	15,983
2013/14 variance	**559**	**528**	**628**	**446**	**53**	**329**	**301**	**343**	**218**	**469**	**80**	**448**
2013/14 % variance	4.0%	3.6%	4.4%	3.1%	0.4%	2.2%	2.0%	2.3%	1.5%	3.1%	0.5%	2.9%
2014/15 expenditure plan	14,602	14,875	15,107	15,236	14,983	15,912	15,128	15,105	15,268	15,465	15,052	16,051
2014/15 expenditure actual	15,058	15,394	15,387	15,695	15,362	15,476	15,533	15,358	15,695	15,346	15,214	16,591
2014/15 variance	**456**	**519**	**280**	**459**	**379**	**-436**	**405**	**253**	**427**	**-119**	**162**	**540**
2014/15 % variance	3.1%	3.5%	1.9%	3.0%	2.5%	-2.7%	2.7%	1.7%	2.8%	-0.8%	1.1%	3.4%
2015/16 expenditure plan	15,052	0	0	0	0	0	0	0	0	0	0	0
2015/16 expenditure actual	15,427											
2015/16 variance	**375**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
2015/16 % variance	2.5%											

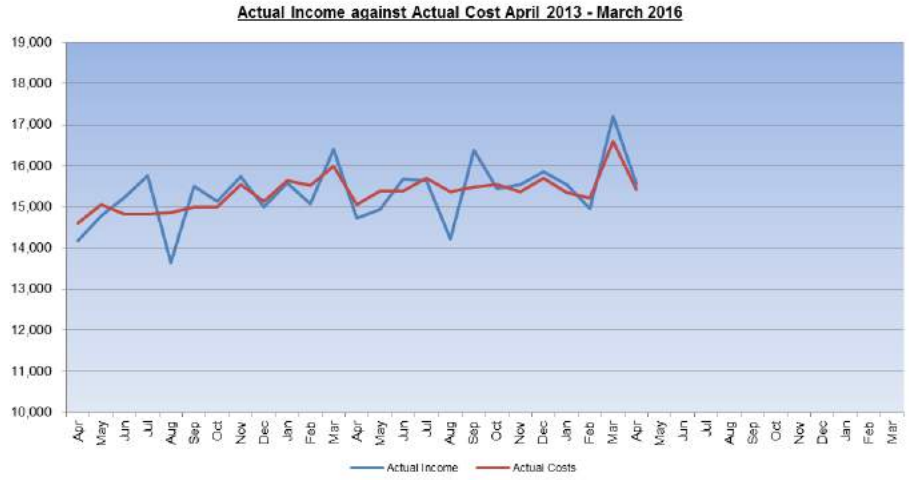
Actual Income 2013/14, 2014/15 & 2015/16

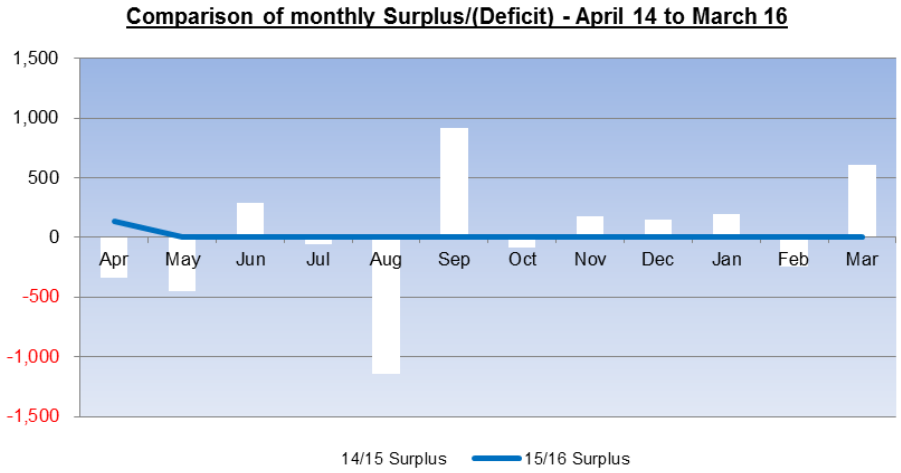


Actual costs 2013/14, 2014/15 & 2015/16



Income & Expenditure Run Charts





	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2013/14 income	14,171	14,778	15,227	15,755	13,653	15,502	15,130	15,731	14,987	15,588	15,073	16,395
2014/15 income	14,717	14,945	15,674	15,637	14,221	16,388	15,451	15,533	15,845	15,539	14,967	17,201
2015/16 income	15,564	0	0	0	0	0	0	0	0	0	0	0
2013/14 costs	14,598	15,051	14,825	14,814	14,861	14,994	15,001	15,546	15,126	15,641	15,530	15,983
2014/15 costs	15,058	15,394	15,387	15,695	15,362	15,476	15,533	15,358	15,695	15,346	15,214	16,591
2015/16 costs	15,427	0	0	0	0	0	0	0	0	0	0	0
13/14 Surplus	-427	-273	402	941	-1,208	508	129	185	-139	-53	-457	412
14/15 Surplus	-341	-449	287	-58	-1,141	912	-82	175	150	193	-247	610
15/16 Surplus	137	0	0	0	0	0	0	0	0	0	0	0

Overview Income & Expenditure Position

Summary Income & Expenditure 2014/15
For the month ending 30th April 2015

	Budget		Actual	Cumulative	April
	Annual Budget £000	Proportion To Date £000	To Date £000	Variance £000	Actuals £'000
INCOME					
NHS Clinical Income (Commissioners)					
NHS Clinical Income - Acute	134,994	10,613	10,856	243	10,856
NHS Clinical Income - Community	36,894	3,498	3,487	-11	3,487
System Resilience				0	
Better Care Funding				0	
Non NHS Clinical Income					
Private Patient & Amenity Bed Income	1,835	153	130	-22	130
Other Non-Protected Clinical Income (RTA)	523	44	53	9	53
Other Income					
Non Clinical Income	10,525	1,021	1,031	10	1,031
Hosted Services	6	6	6	0	6
TOTAL INCOME	**184,776**	**15,335**	**15,564**	**229**	**15,564**
EXPENSES					
Pay					
Pay Expenditure	(123,786)	(10,285)	(10,466)	(180)	(10,466)
Non Pay					
Drugs	(4,378)	(1,212)	(1,207)	5	(1,207)
Clinical Services & Supplies	(15,703)	(1,385)	(1,382)	3	(1,382)
Other Costs	(14,791)	(1,454)	(1,632)	(178)	(1,632)
Reserves : Pay	(3,768)	(140)	0	140	0
Pay savings targets	0	0	0	0	0
Other Reserves	(4,309)	42	(100)	(142)	(100)
High Cost Drugs	(8,984)	0	0	0	0
Non Pay savings targets	77	0	0	0	0
Other Finance Costs	(18)	(1)	0	1	0
Hosted Services	(15)	(15)	(15)	(0)	(15)
TOTAL COSTS	(175,674)	(14,452)	(14,802)	(350)	**(14,802)**
EBITDA	**9,102**	**883**	**762**	**(121)**	**762**
Profit / (Loss) on disposal of assets	0	0	0	0	0
Depreciation	(4,763)	(397)	(404)	(7)	(404)
Interest Payable	(59)	(5)	(5)	0	(5)
Interest Receivable	20	2	2	0	2
Dividend Payable	(2,500)	(200)	(219)	(17)	(219)
Net Surplus/(Deficit) before donations and impairment	**1,800**	**283**	**137**	**(146)**	**137**
Donated Asset Income	0	0	0	0	0
Impairments re Donated assets	0	0	0	0	0
Impairments re PCT assets	0	0	0	0	0
Net Surplus/(Deficit)	**1,800**	**283**	**137**	**(146)**	**137**
Consolidation of Charitable Fund Accounts	0	0	0	0	0
Consolidated Net Surplus/(Deficit)	**1,800**	**283**	**137**	**(146)**	**137**

Overview Total Directorate Position

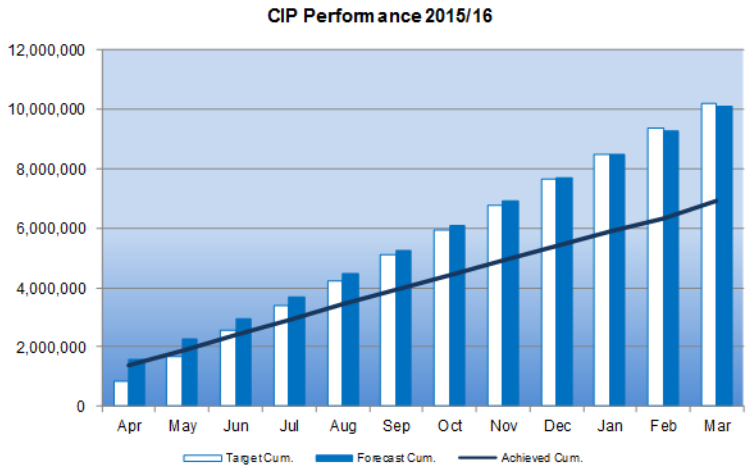
Net Income & Expenditure Position

For the month ending 30th April 2015

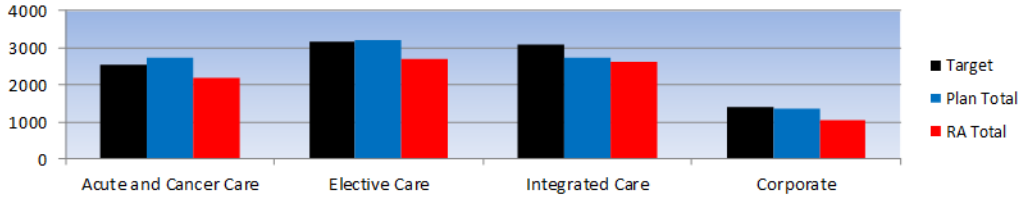
2013/14 Actual £000	Opening Budget £000		Annual Budget £000	Workforce			In Month			Cumulative		Variance (o.s)/u.s £000
				Budget wte	Contracted wte	Actual wte	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	
2,169	1,274	Non-Comissioner Income	872				121	114	(7)	121	114	(7)
(36,721)	(34,989)	Pay	(30,882)	821.43	802.29	786.37	(2,610)	(2,673)	(63)	(2,610)	(2,673)	(63)
(9,172)	(2,947)	Non-Pay	(3,449)				(783)	(777)	7	(783)	(777)	7
(43,724)	**(36,662)**	**Total Integrated Care Directorate**	**(33,458)**	**821.43**	**802.29**	**786.37**	**(3,272)**	**(3,335)**	**(63)**	**(3,272)**	**(3,335)**	**(63)**
3,180	1,764	Non-Comissioner Income	2,573				273	271	(2)	273	271	(2)
(29,388)	(28,642)	Pay	(33,779)	738.11	689.44	688.78	(2,657)	(2,679)	(22)	(2,657)	(2,679)	(22)
(12,671)	(7,202)	Non-Pay	(8,233)				(945)	(1,000)	(56)	(945)	(1,000)	(56)
(38,879)	**(34,080)**	**Total Acute & Cancer Care Services Directorate**	**(39,440)**	**738.11**	**689.44**	**688.78**	**(3,329)**	**(3,409)**	**(79)**	**(3,329)**	**(3,409)**	**(79)**
1,360	1,457	Non-Comissioner Income	1,569				137	138	0	137	138	0
(43,027)	(40,216)	Pay	(40,692)	896.59	894.22	888.22	(3,515)	(3,576)	(61)	(3,515)	(3,576)	(61)
(13,347)	(9,307)	Non-Pay	(10,429)				(1,104)	(1,189)	(85)	(1,104)	(1,189)	(85)
(55,014)	**(48,066)**	**Total Elective Care Directorate**	**(49,552)**	**896.59**	**894.22**	**888.22**	**(4,482)**	**(4,628)**	**(146)**	**(4,482)**	**(4,628)**	**(146)**
(19,852)	**(18,471)**	**Corporate (Clinical)**	**(16,223)**	**460.85**	**423.92**	**442.61**	(1,330)	(1,380)	(50)	(1,330)	(1,380)	(50)
(157,469)	(137,279)	**Total Clinical Spend**	(138,673)	2916.98	2809.87	2805.98	(12,413)	(12,752)	(339)	(12,413)	(12,752)	(339)
(7,626)	**(7,802)**	**Corporate (inc. CNST)**	(11,842)	**144.26**	**142.20**	**140.52**	(1,020)	(1,172)	(152)	(1,020)	(1,172)	(152)
(27,478)	**(26,273)**	**Total Corporate Position**	**(28,065)**	**605.11**	**566.12**	**583.13**	**(2,350)**	**(2,552)**	**(203)**	**(2,350)**	**(2,552)**	**(203)**
165,503	165,941	**Commissioner Income**	169,788				14,111	14,344	233	14,111	14,344	233
(388)	(19,158)	**Central**	(17,473)		(21.82)	(20.82)	(395)	(281)	114	(395)	(281)	114
21	**1,702**	**Total before donations & impairments**	**1,800**	**3,061.24**	**2,930.25**	**2,925.68**	**283**	**139**	**(144)**	**283**	**139**	**(144)**
5,297	0	**Donations for Capital Expenditure**	0						0	0	0	0
(3,340)	0	**Impairments on Donated assets**	0						0	0	0	0
(1,305)		**Impairments on PCT assets**	0						0	0	0	0
672	**1,702**	**Trust reporting position**	**1,800**	**3,061.24**	**2,930.25**	**2,925.68**	**283**	**139**	**(144)**	**283**	**139**	**(144)**
457		**Charitable funds consolidation**	0						0	0	0	0
1,129	**1,702**	**Total Trust reported position**	**1,800**	**3,061.24**	**2,930.25**	**2,925.68**	**283**	**139**	**(144)**	**283**	**139**	**(144)**

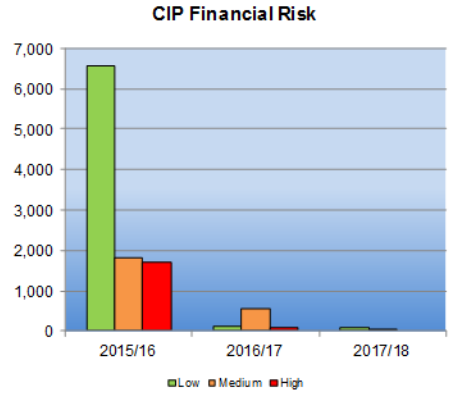
Efficiency Update

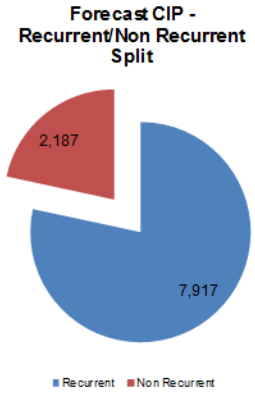
TRUSTWIDE CIP SCHEDULE 2015/16

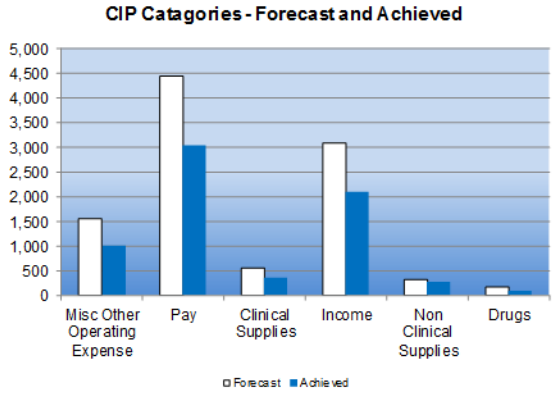


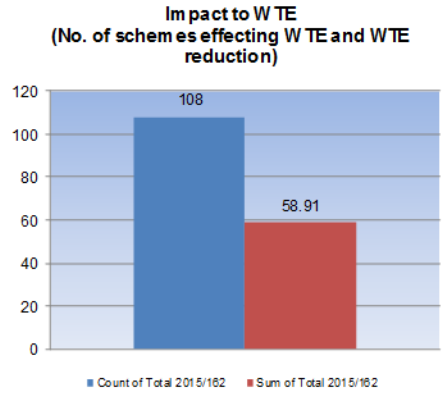
Summary	Target	Actioned	Low	Medium	High	Total	%	Risk Adjust	%
Acute Care	2,823,600	1,733,147	10,500	412,522	598,181	2,754,351	98%	2,192,776	78%
Elective Care	3,165,000	2,244,478	179,006	175,253	614,347	3,213,084	102%	2,677,606	85%
Integrated Care	2,800,200	1,966,000	291,400	459,100	0	2,716,500	97%	2,610,110	93%
Corporate	1,463,600	935,010	0	43,080	381,800	1,359,890	93%	1,045,834	71%
Total	**10,252,400**	**6,878,635**	**480,906**	**1,089,955**	**1,594,328**	**10,043,825**	**98%**	**8,526,326**	**83%**
Target						10,179,000		10,179,000	
Variance						**-135,175**	**99%**	**-1,652,674**	**84%**
Target less ETO benefit						8,779,000		8,779,000	
Variance						**1,264,825**	**114%**	**-252,674**	**97%**







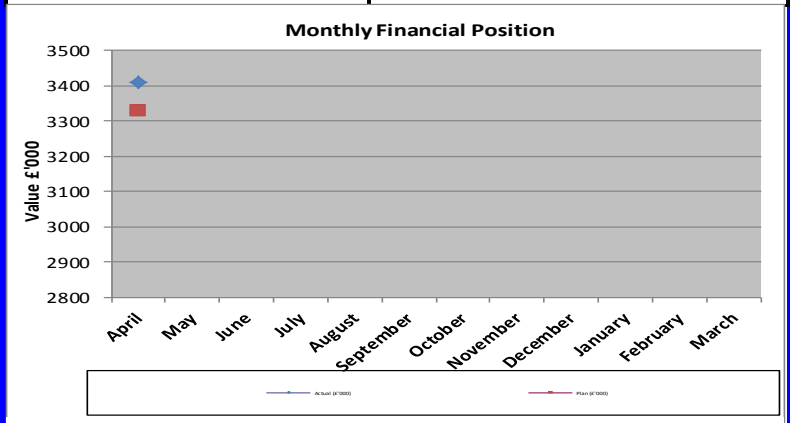


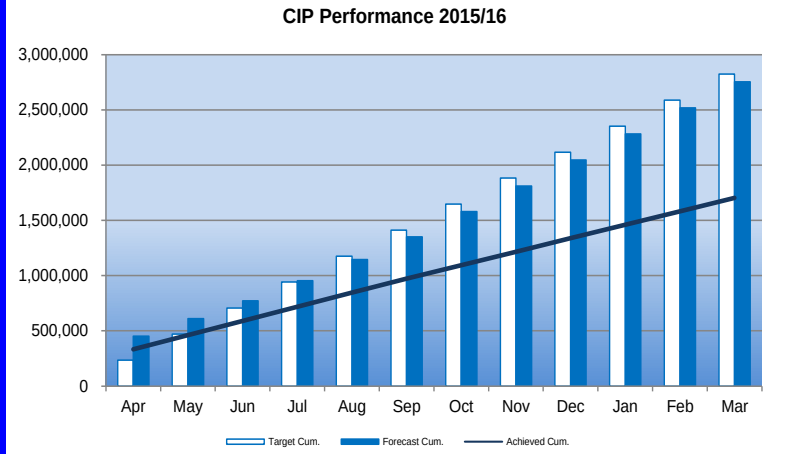


Acute & Cancer Care Directorate 30th April 2015

Directorate Income & Expenditure (£'000)

In Month Variance to Plan	YTD Variance to Plan
(79)	(79)





Target	Actioned	Low	Medium	High	Total
2,823,600	1,733,147	109,496	412,522	598,181	**2,853,347**
Risk Adjusted Total		**2,286,822**	Risk Adjusted %		**81%**

Comments:

The Acute & Cancer Care Directorate reported an in-month over spend against total budget of £79k. Of the overspend, pressures occurred in the following areas:
*Unfound/high risk CIP £58k overspend
* Adult Community Services - reablement posts previously funded by commissioners no longer funded overspend (£19k, 10.56wte)
*ED nursing non-recurrent £14k overspend

Key Financial Drivers

Variance to plan

		YTD £'000	Previous Month YTD (£'000)
Total Income:		**(2)**	**0**
Private Patient Income		(7)	0
Other Income		6	0
Total Expenditure		**(78)**	**0**
Pay:	Nursing	(11)	0
	Medical Staff	(14)	0
	Other Pay	3	0
Drugs		2	0
Clinical Supplies		16	0
Other Non Pay		(73)	0
Net Position		**(79)**	**0**

ACTIONS AGREED

CIP

The Directorate is focussed on achiveing its CIP plans. In particular the following workstreams are underway

* Urgent Care – a workstream is in place to review coding of activity in the Emergency Department to increase income (anticipated CIP up to £50,000)
* Infection Control Income – a new website to market services is now in place and is receiving a number of "hits" which has lead to increased sales. Further assessment is still required before CIP is actioned, Expected to be actioned in May (anticipated CIP £100,000)

* Wheelchair Services – a number of workstreams are in place including review of the service. In addition positive discussions have been held with North Yorkshire Counuty Council in relation to Wheelchairs being part of a pooled budget which would reduce costs by 20% (anticiipated CIP £100,000)
* The Directorate continues to robustly review all vacancies before posts are replaced with any savings going towards CIP

Reablement Posts

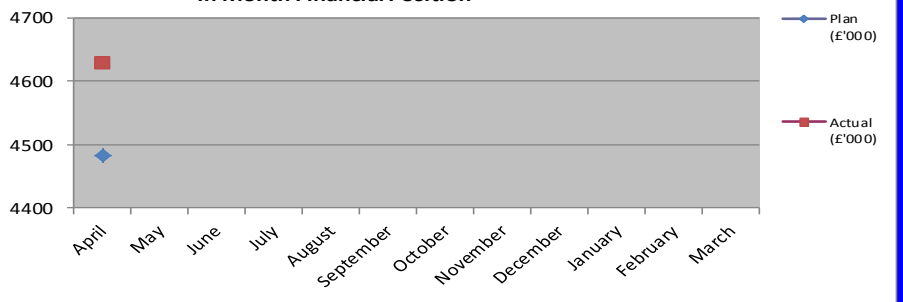
The Trust bid for "reablement" money to assist community services in treating patients in their own homes and avoiding hopsital admission in 2011/12. The Trust was awarded non-recurrent money over a 3 year period. These posts were appointed to and the service has now been established and has been in place for 3 years, howver the funding stream has now ended. The Directorate has maintained the service despite no funding being in place. If the service is not funded it is anticipated there will be an overspend of £372k for the year. It has been agreed that the Trust will continiue to seek funding for the service from commissioners whilst the Directorate maintain current service levels.

Elective Care Directorate Finance Overview as at 30th April 2015

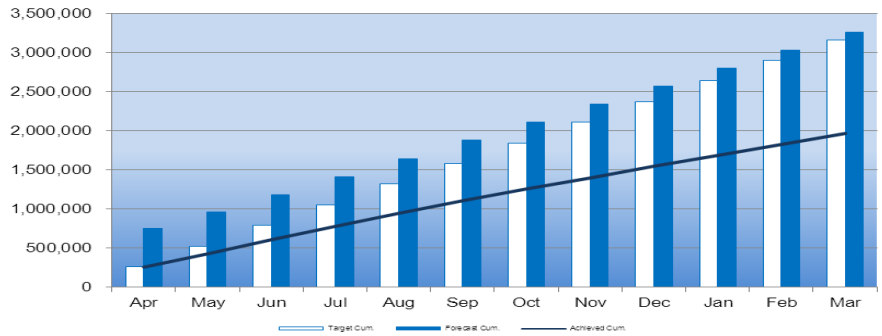
Directorate Income & Expenditure (£'000)

In Month Variance to Plan	YTD Variance to Plan
-146	-146

In Month Financial Position



CIP Performance 2015/16



Target	Actioned	Low	Medium	High	Total
3,165,000	2,244,478	179,006	175,253	614,347	**3,213,084**
Risk Adjusted Total		**2,677,606**	Risk Adjusted %		**85%**

Comments:

The financial performance for the month ending April 14/15 was one of £146k overspent. The main drivers for this position were:

* Ward pay - pay on the wards was £39k overspent of which £11.1k unfunded special shifts on the wards and around £12k related to sickness being over 3.9%
* Theatres - non pay in theatres was £54k overspent which is line with both daycase and elective inpatient activity being above plan.
* CIP - in month £41k was phased in to the position to reflect the risk adjusted CIP position which current stands at 93% or a £487k shortfall
* Medical Staffing - in month medical staffing reports were £16k overspent with the main issue around covering gaps in anaesthetics and cover consultant on call in O&G

Key Financial Drivers

Variance to plan		YTD £'000	Previous Month YTD (£'000)
Total Income:		**0**	**0**
Private Patient Income		(3)	**0**
Other Income		3	**0**
Total Expenditure		**(146)**	**0**
Pay:	Nursing	(52)	**0**
	Medical Staff	(16)	**0**
	Other Pay	8	**0**
Drugs		2	**0**
Clinical Supplies		(39)	**0**
Other Non Pay		(49)	**0**
Net Position		**(146)**	**0**

Actions Agreed:

* Explore developments of Plastics and Vascular services with York
* Look at development of Ophthalmic services at Wetherby

* Appointed 2 fixed term in Orthopaedics to reduce agency spend and increase activity

* Flexible approach to management of anaesthetic gaps with 2 fellow posts

* Review model of middle grade cover for gap in General Surgery rota

* Job plans reviews undertaken for clinical leads. These include specialty objectives around cover arrangements in terms of annual leave for both planned and unplanned activity

Activity:

* Daycase activity 11% above plan in April which mainly related to General Surgery and Urology
* Elective inpatient activity 4.7% above plan (14 cases) which was across nearly all specialities

* Outpatient activity also above plan

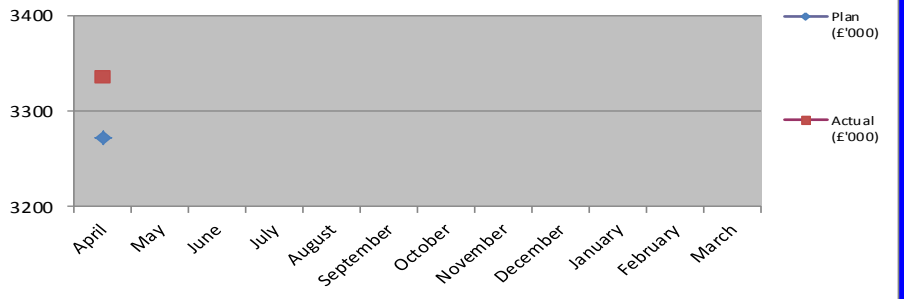
* Non elective activity on plan

Integrated Care Directorate Finance Overview as at 30th April 2015

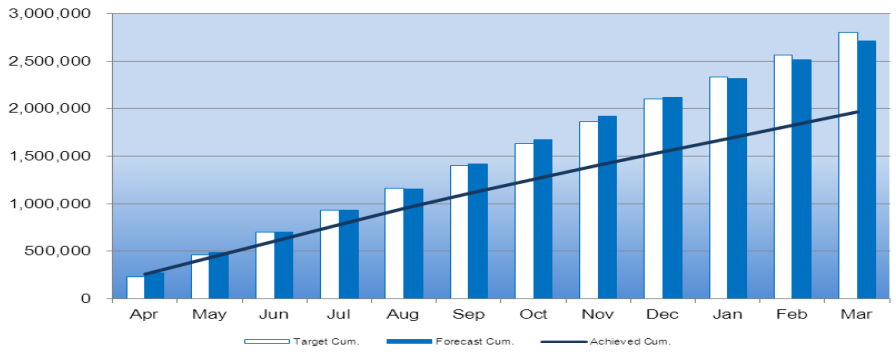
Directorate Income & Expenditure (£'000)

In Month Variance to Plan	YTD Variance to Plan
-63	-63

In Month Financial Position



CIP Performance 2015/16



Target	Actioned	Low	Medium	High	Total
2,800,200	1,966,000	291,400	459,100	0	**2,716,500**
Risk Adjusted Total		**2,610,110**	Risk Adjusted %		**93%**

Comments:

The financial performance for the month ending April 14/15 was one of £63k overspent. The main drivers for this position were:

* Ward pay - pay on the wards was £39k overspent of which £9.1k unfunded special shifts on the wards, £10k related to sickness being over 3.9%, £9k for 5 day management days rather than 3 day management days being undertaken on the wards.
* Cardiology - there are a number of pressures in the cardiology department in terms of medical staffing pressures around sickness and vacancy cover. In month the overspend was £31k due to agency SpR and agency consultant cover.
* PP Income - PP income was down by £12k across nearly all integrated care specialities
* The amount of CIP phased in month was £15k equivalent to a 7% full year effect shortfall

Key Financial Drivers

Variance to plan

		YTD £'000	Previous Month YTD (£'000)
Total Income:		**(7)**	**0**
Private Patient Income		(12)	**0**
Other Income		5	**0**
Total Expenditure		**(56)**	**0**
Pay:	Nursing	(4)	**0**
	Medical Staff	(12)	**0**
	Other Pay	(46)	**0**
Drugs		0	**0**
Clinical Supplies		22	**0**
Other Non Pay		(16)	**0**
Net Position		**(63)**	**0**

Actions Agreed:

* Achieve remaining CIP outstanding through vacancy management

* Reduce general medicine tier on call rota from 1:10 to 1:9 as part of August 2015 rota due to anticipated deanery vacancies

* Continue to reduce bank and agency hours

* Review all medical staffing vacancies and associated cover arrangements

* Ensure only 3 days management days undertaken by ward managers as per funded allocations in the ward establishments

* Review need of specials in particular those required for falls prevention

Activity:

* Activity levels on the whole above plan for April 2015 with some small exceptions

* Daycase activity 61 cases above plan which mainly related to Gastroenterology and haematology

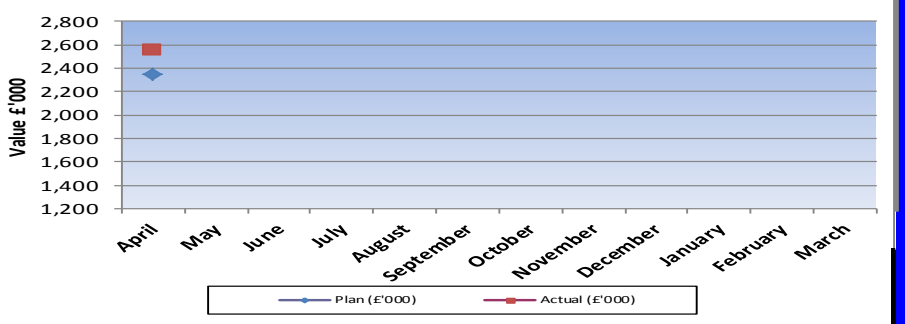
* Non elective also 6% above plan across the whole of integrated care which was mainly in elderly and general medicine

Corporate Directorate Finance Overview April 2015/16

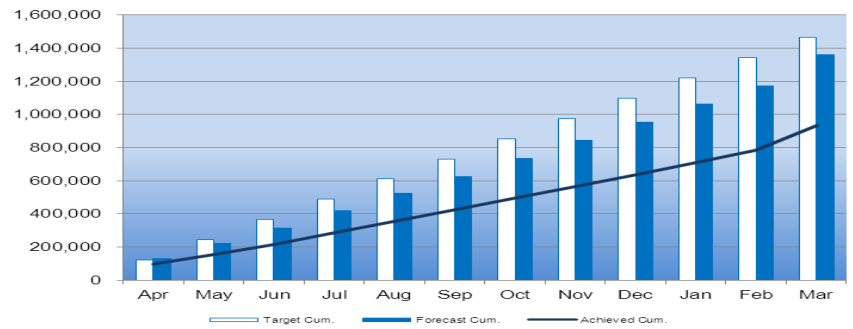
Directorate Income & Expenditure (£'000)

In Month Variance to Plan	YTD Variance to Plan
(203)	(203)

Monthly Financial Position



CIP Performance 2015/16



Target	Actioned	Low	Medium	High	Total
1,463,600	935,010	0	43,080	381,800	**1,359,890**
Risk Adjusted Total		**1,045,834**	Risk Adjusted %		**71%**

Comments:

* Corporate Services reported an overspend against budget of **£203k** in the month of April. The Significant transactions were:

Income - Under recovered by £8k

* Mainly related to a backdated VAT adjustment within IT.

Pay - Overspent by £40k

*£17k within Hotel Services related mainly to domestics pay spend.
*£13k within chief exec related to medical staffing and pay in lieu.

Non-pay - Overspent by £155k

*£120k was due to a one off purchase of Microsoft Licences.
*£35k CIP was phased into month 01 as not delivered.

Key Financial Drivers

Variance to plan

		YTD £'000	Previous Month YTD (£'000)
Total Income:		**(13)**	
Total Expenditure		**(190)**	
Pay:	Clinical Corporate	(19)	
	Non Clinical Corporate	(16)	
Non Pay:	Clinical Corporate	(25)	
	Non Clinical Corporate	(130)	
Net Position		**(203)**	**0**

Actions Agreed:

*There is a plan to meet again as a Corporate Directorate to discuss the current shortfall in the CIP plan and the non delivery of high and medium risk schemes.

Cash Flow – Receipts & Payments

DRAFT CASH FLOW FORECAST 2015-16

	APRIL		MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	TOTAL FOR YEAR
	Plan	Actual	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Opening cash balance	4,898	4,898	6,560	4,552	6,360	7,550	7,432	7,176	10,906	9,956	9,107	8,878	8,968	4,898
Receipts														
New public Dividend Capital draw	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NHS patient care - HaRD CCG	8,425	9,145	8,425	8,425	8,425	8,425	8,425	8,425	8,425	8,425	8,425	8,425	8,426	101,821
NHS patient care	5,541	5,798	5,541	5,540	5,541	5,541	5,540	5,541	5,541	5,540	5,541	5,541	5,540	66,745
Other income	1,970	1,505	1,970	1,970	1,970	1,970	1,970	1,970	1,970	1,970	1,970	1,970	1,970	23,175
Investment interest	2	2	2	1	2	2	1	2	2	1	2	2	1	20
Loan finance	0	0	0	707	2,165	0	0	5,206	0	0	838	0	0	8,916
Total cash receipts	**15,938**	**16,450**	**15,938**	**16,643**	**18,103**	**15,938**	**15,936**	**21,144**	**15,938**	**15,936**	**16,776**	**15,938**	**15,937**	**200,677**
Payments														
Cash spend - payroll	(6,051)	(6,076)	(6,176)	(6,051)	(6,051)	(6,051)	(6,051)	(6,051)	(6,051)	(6,051)	(6,051)	(6,051)	(6,051)	(72,762)
PAYE & Pensions	(4,063)	(4,063)	(4,112)	(4,187)	(4,112)	(4,112)	(4,112)	(4,112)	(4,112)	(4,112)	(4,112)	(4,112)	(4,112)	(49,370)
Cash spend - non-pay	(4,373)	(4,374)	(6,250)	(4,038)	(5,990)	(4,792)	(4,385)	(5,750)	(4,792)	(3,999)	(5,990)	(4,792)	(4,421)	(59,573)
Cash spend - non-pay - Capital	(275)	(275)	(1,110)	(559)	(760)	(1,101)	(417)	(1,501)	(1,578)	(2,623)	(852)	(893)	(793)	(12,462)
Dividend paid	0	0	0	0	0	0	(1,227)	0	0	0	0	0	(1,250)	(2,477)
Loan repayments	0	0	(298)	0	0	0	0	0	(355)	0	0	0	0	(653)
Total cash spend	**(14,762)**	**(14,788)**	**(17,946)**	**(14,835)**	**(16,913)**	**(16,056)**	**(16,192)**	**(17,414)**	**(16,888)**	**(16,785)**	**(17,005)**	**(15,848)**	**(16,627)**	**(197,297)**
Closing cash balance	**6,074**	**6,560**	**4,552**	**6,360**	**7,550**	**7,432**	**7,176**	**10,906**	**9,956**	**9,107**	**8,878**	**8,968**	**8,278**	**8,278**

Monitor plan quarter-end cash balance	**5,874**	**6,690**	**8,621**	**7,792**

Report to the Trust Board of Directors: 27 May 2015	**Paper No: 11.0**

Title	
Sponsoring Director	**Workforce and Organisational Development Update**
Author(s)	Director of Workforce and Organisational Development
Report Purpose	To provide a summary of performance against key workforce matters

Executive Summary

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

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

Action Required by the Board of Directors

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

Key Messages for April 2015

a) Health Education Yorkshire and the Humber (HEYH) Quality Management Visit

Further to the Board of Directors' meeting last month, attached is a copy of the report that was received following the annual inspection regarding postgraduate medical training delivered at this Trust. Representatives from HEYH visited Harrogate and District NHS Foundation Trust on 3 February 2015 and reviewed the training delivered to foundation trainees, core, higher and GP trainees in Medicine, Surgery, Obstetrics & Gynaecology and Paediatrics. The team assessed this Trust as a provider using the General Medical Council's seven generic standards for training domains.

An action plan is being drawn up to respond to the conditions included in the report, with work already having been carried out to deal with the issues highlighted in the report.

b) Leadership Forum

A new Trust-wide leadership forum opens with its first meeting on 2 June 2015. The forum will commence with a CPD event on the topic of authentic leadership. The session will be led by Dr Julia Taylor, National Programme Director at NHS Improving Quality. In future, the forum is likely to have a number of strands, including:-

- Strategic planning;
- Long term risk management/future scenario modelling - for example, New Care Models, the Five Year Forward View and Dalton reviews;
- Evaluation of feedback - for example, staff survey, staff Family and Friends Test;
- Information sharing;
- Showcasing of best practice - for example, clinical transformation schemes, celebrating success.

c) Leadership Development Programme

The first module of this programme was held on 28 and 29 April, with 25 participants at matron and ward manager level.

Dr Ros Tolcher, Chief Executive and Jill Foster, Chief Nurse both attended for part of Day 1 and Day 2 respectively, they talked about their vision and goals for the current and future workforce.

The programme has a further six modules and runs until November 2015 with half day peer support sessions built into the process to support learning action, as the participants are undertaking service improvement projects as part of the programme.

The outcomes of the programme are:-

Individual managers and potential managers will:

- Build their own capacity as leaders to effect positive change;
- Learn how to influence effectively;
- Learn practical strategies in leadership and management;
- Build their own confidence as decision-makers and leaders;
- Understand how to create 'open space' with their teams in order to work collaboratively;
- Move from 'expert' who solves problems to an enabler of others;
- Learn some basic coaching frameworks and skills to use with their teams;
- Be able to support other management colleagues in their own development;
- Have undertaken a 360 degree feedback process.

The programme will also support the development of the nine dimensions of leadership behaviour from the Healthcare Leadership Academy Model.

d) Local Education and Training Board – Yorkshire and the Humber

The Trust received a substantial amount of educational funding (£120,000) towards the end of the last financial year from Health Education Yorkshire and the Humber.

I am pleased to say that despite tight timescales I was able to secure many developmental activities utilising this funding, which, whilst necessary and appropriate, would not otherwise have been possible.

Examples of how this funding is to be utilised, include:

- Supporting management/leadership development activity, including the commissioning of a second programme of Leadership Development for those in clinical leadership roles;
- Consultancy support to assist with review of our appraisal processes and to support increased numbers of appraisals being carried out each year;
- Training for the HR team in running assessment and development centres to support the development of our recruitment processes;
- A programme of learning to span the whole workforce in the effective and efficient use of email – linking into the Rapid Improvement Work carried out on streamlining meeting attendance;
- Clinical skills equipment to support medical student competency assessments on behalf of the University of Leeds as required as part of the MBChB curriculum;
- Clinical skills equipment to support multi-professional training in PICC line insertion and cannulation training;

- Recruitment of a Simulation and Human Factors lead to develop a Trust simulation strategy to embed simulation pedagogy;
- Laptops for supporting undergraduate and postgraduate e-learning within the education centre;
- New PCs for the library suite to ensure all Trust staff have access to IT equipment fit for purpose for research and learning.
- Software upgrade to support the facilities management of the education centre teaching and learning facilities, to maximise access, availability and use for the benefit of all Trust staff.

e) Early Findings on extra Workforce required in line with Vanguard

The Acute and Cancer Care Directorate have undertaken some scoping work with the Department of Health Connecting for Health programme with regard to the workforce numbers required to deliver Vanguard. This work is currently on going and in tandem with development of a workforce strategy and wider staff engagement. The Operational Director and HR Business Partner for the directorate as part of the Transformation work stream are developing the figures required and this information will be available imminently.

f) RosterPro Update

We continue to roll out training to the remaining areas of the Trust based in community settings who are not currently live. The RosterPro system has been upgraded to the most recent release. This does not affect the interface for users and there is minimal difference for roster managers, the main change has been the calculation and management of time balances and assurance has been given by the provider of the system that the time balances will be maintained at an accurate level going forward. There has been further discussion regarding issuing of guidance notes and standard operating procedures surrounding best practice to ensure that managers are consistently using the system to the optimum level. The Trust has also met with a third party provider of management information which reports on both RosterPro and Electronic Staff Record data and can be overlaid with other management information eg NHS Professionals temporary staffing agency. Discussions regarding this and whether the adoption of such a system would be of benefit to nursing in particular continue.

The uplift applied to nursing establishments has been reviewed and agreed, the new percentage is based on an analysis of time taken for training including statutory and mandatory requirements, annual leave allowances and sickness, this allows headroom within the establishment to ensure there is substantive cover for these occasions. This is being implemented by each Directorate within their ward based rosters. The work stream reviewing the efficiency of rosters continues to meet to review and consider appropriate interventions to improve rostering.

g) Practice Placement Quality Assurance (PPQA) for Non-Medical Student Placements May 2015

The Trust has a contractual obligation to the Local Education & Training Board (LETB) for the provision of sufficient high quality practice learning opportunities for all non-medical students, and is required to meet specific requirements. There is an increasing emphasis on quality enhancement of the learning experience and support for both students and those who provide supervision and assessment of students.

The tool for measuring the quality of practice placements used within the Yorkshire and Humber LETB region is the PPQA. Within this tool there are 11 standards that are RAG Rated in line with LETB guidance. The current RAG Ratings are red - below 90%; amber - 90 to 95% and green - 95 to 100%.

At present the trust are compliant with 9 of the 11 standards with GREEN RAG ratings and are at AMBER with 2 RAG ratings as identified below:-

Standard	Standard Descriptor	RAG Rating	Present position
S1	PPQA Profiles are up to date and accessible online	Green	95% compliance
S2	All Practice Placements have had an educational audit completed within 2 years prior to the end of the audit period	Amber	91% of placements have an updated Educational Audit.
S3	Audit items are addressed appropriately between audits	Green	Robust monitoring remains in place
S4	There are less than 5% negative student evaluations about placements	Green	Of 101 evaluations 3% had negative comments. This remains within the 5% threshold thus maintains a green RAG Rating
S5	There are less than 5% negative practice evaluations from students relating to HEI practice preparation	Green	There are less than 5% negative practice evaluations from students relating to HEI practice preparation
S6	There are less than 5% negative mentor evaluations about practice experiences.	Green	This element of data collection remains very poorly actioned by Mentors across all NHS Trusts within the region. Requests are underway at the moment for this element to be removed from the PPQA standards
S7	There are less than 5% negative mentor evaluations about student HEI preparation prior to placement	Green	This element of data collection remains very poorly actioned by Mentors across all NHS Trusts within the region. Requests are underway at the moment for this element to be removed from the PPQA standards
S8	Nursing and Midwifery mentors have completed an update within the review period	Amber	79% of midwifery mentors have completed an update within the last 12 months (this figure will improve as we are awaiting names of mentors who have recently completed an update) 94% of nurse mentors have attended a mentor update within the last 12 months
S9	Over 60% of Nursing Mentors are identified sign off mentors	Green	60% of Nurse Mentors are Sign Off Mentors
S10	That 100% of Midwifery mentors are identified as sign off mentors	Green	100% of Midwifery Mentors are Sign Off Mentors.
S11	That all identified practice placements were utilised on at least one occasion during the review period	Green	100% of Practice Profiles are being utilised

Within the areas of AMBER RAG ratings the following actions are being taken to improve compliance.

All nurse mentors are required to undertake an annual mentor update, at present we have 94% compliance. In this area a 95% would provide a green RAG rating. Regular updates have been arranged for mentors and it is envisaged that this compliance level will improve. The present compliance level by directorate is:-

Directorate	Total Number of Mentors (active)	Mentors updated after 01.05.2014	Number of Mentors Not Updated after 01.05.2014	Percentage of Compliance
Trust total	268	251	15	94%
Integrated Care	119	116	3	98%
Elective Care	87	78	7	90%
Acute and Cancer Care	62	57	5	92%

The second standard in AMBER is that of educational audits, at present 68 of the 75 areas have up to date educational audits. Additional input is being given to non-compliant areas by the practice education team to ensure that all areas are compliant by 1 August 2015.

h) Non-Executive Director Appointment

Following the extraordinary Council of Governors meeting on 17 April 2015 the appointment has been made of Mr Neil McLean who joined the Trust on 1 May 2015.

i) International Nursing recruitment

An international nursing recruitment business case has been developed by corporate nursing colleagues proposing further recruitment of a cohort of internationally recruited nurses. This case recommends a recruitment trip in July and will proceed subject to approval of the business case.

j) Advisory Appointment Committees Updates – Consultant Medical Staff Recruitment

Mr Biswajit Ray was appointed as a General Surgeon with an interest in breast surgery on the 24 April 2015. The Trust is in the process of appointing for Trauma and Orthopaedics and Cardiology with interview dates set for 14 May and 24 July 2015 respectively.

A number of other specialities are also in the process of appointing consultants, namely Gastroenterology, Palliative Care, Community Paediatrics, Neurology and Microbiology. These appointments are still in the advertising or approval stages and dates for recruitment activity have yet to be set.

k) Healthcare People Management Association Awards (HPMA)

The Trust has been shortlisted for a national HPMA award for our innovative Incremental Pay Progression Policy. This policy remains unique to the NHS because it is employee driven. Polly McMeekin, Deputy Director of Workforce and Organisational Development and Chris Mannion, HR Business Partner presented our application to a judging panel in London on 29th April 2015. The outcome will be announced at the Award Ceremony in London on Thursday 18th June 2015 which I will be attending with members of the HR team.

l) Clinical Excellence Awards Scheme 2015

The Clinical Excellence Award Round for 2015 is about to commence with the ballot for the Local Awards Committee (LAC) representatives currently underway. Consultants eligible to apply for an award will be invited to submit an application at the beginning of June with a six week application period. The LAC panel will be scoring the applications thereafter and we hope to have this round finalised by the end of September.

m) Health Visitor Shadowing

Last month, as part of my commitment to NHS Change Day to visit a service area every month, I shadowed Joanne Martin, Health Visitor in the Harrogate North team for half a day. I was able to sit in on meetings between the Health Visitor and the GP and with two families and was able to view the invaluable work carried out by Health Visitors that help to keep families together in difficult circumstances.

During May I will be spending some time with the Chronic Pain team at Skipton Hospital and will update you on this visit next month.

n) Flu Vaccination

The 2014/15 season ended with a 58.3% uptake amongst key staff groups reported to the Department of Health, this was an increase on the previous year which was 55.8%.

The first Flu Steering Group meeting for the 2015/16 season is taking place in May when the strategy for this year will start to be planned in detail, it is expected that mechanisms to improve access and uptake in community areas will play a key aspect of the group's considerations.

o) Recruitment of Wellbeing Manager

An attempt has been made to recruit to the Wellbeing Manager post following the retirement of Helen Lill in April. Two applicants were shortlisted; one withdrew prior to interview as a result of being offered an alternative option by the current employer. No appointment was made to the post. Feedback from relevant groups/individuals about possible reasons for lack of suitable applicants is being sought prior to further plans to re-advertise.

p) Health and Wellbeing Y&H Regional Newsletter May 2015

The Trust plays an active part in the Yorkshire and Humber Health and Wellbeing Network which is supported by HEYH. The attendance at this group from across the patch has been low within the last 12 months and the group members are actively trying to encourage other NHS organisations to get involved. The newsletter was produced showcasing some best practise examples of work in the last year from across the patch, with the aim of encouraging other organisations to join the network, to enable sharing best practice and potential for joint working in the future. I am pleased to advise that the excellent work to date by the Health and Wellbeing team here at the Trust was showcased in this month's regional newsletter.

q) MMR Campaign

This project aims to review the immunisation records of pre-existing staff against current Department of Health (DH) guidance on communicable disease screening and immunisation for healthcare workers. The reason for the project is that DH standards and guidance have changed over the years and it was known that long-serving staff would not have been screened to the same level as newer staff are now screened, in particular in relation to Measles/Mumps/Rubella.

This poses a risk that unscreened staff may be non-immune to the relevant communicable diseases making them vulnerable to infection that may be passed on to other people including patients who may be at increased risk of adverse outcomes due to other underlying conditions.
The first phase of the project was to review the records of Harrogate District Hospital based staff. We have yet to commence reviewing community based staff records.

Update reporting on progress to date on this project is outlined below. It should be noted that continued refinement of the data will follow as more records are reviewed and those employees with no immunisation requirement are identified as "not applicable".

4128 record lines in employee list	
2900 identified as HDH based: 299 identified as not applicable to date (263) 523 identified as non-patient facing roles = **2078 for review** (2114)	70% of total
1225 marked as complete up to date immunisation record (1039)	**59%** of those requiring review (49%)
523 non-patient facing still to review: staff who require immunisations for personal protection e.g. laboratory staff	**25% (24%)**

Numbers in parentheses represent data from last update report dated 13 April 2015.

A total of 59% of HDH based staff who may be patient-facing are marked as complete i.e. immunisation record is complete as per DH guidance. This is a 10% increase in the number marked as complete since last report.

r) SEQOHS update

Recent work contributing to SEQOHS evidence includes completion of a clinical audit, repeat of a customer survey and a review of external customer agreement format to ensure inclusion of information required by the standards relating to business probity. Progress continues to be slower than desired due to volume of day-to-day work coming into the department and staff absence.

s) Chronic Pain Team Improvement Workshop

The Partnerships and Innovation Team have facilitated a successful improvement workshop with the Chronic Pain Team. The aim of the workshop was to examine the current performance of the service and explore ways to improve flow through different treatment options. I was the sponsor for this improvement work.

The Chronic Pain Team has developed three working groups to oversee the improvements which include:

- Clarification of the purpose of the service, inclusion and exclusion criteria and triage
- Development of service indicators
- Reduce bottlenecks which prevent access to the service

A follow-up workshop is scheduled for June 2015 and progress will be regularly reported back to the sponsor. I will be visiting this team at their base in Skipton in the near future.

t) Job Planning Audit

Following a recent re-audit of medical job planning, the actions taken include the following:-

- The introduction of a job plan policy
- Updating of job plan templates
- Introduction of directorate monitoring spreadsheets
- Introduction of ESR reporting on job plan compliance

Communication to all medical staff from the Medical Director and HR has resulted in a recent audit finding of significant assurance for Consultant job plans but with a separate finding of limited assurance for middle grade job planning which will require further action in order to affect improvements. Directorates are working through the audit findings and this has been discussed at the Trust's Senior Management Team meeting this month.

u) Resilience Training

The pilot personal resilience programme to support staff and managers to improve their skills is well underway with four of the six line manager sessions complete and one of the four staff sessions started. The programmes have been very well attended and we have received some excellent feedback. The last session will run on 30 June and following this pilot an evaluation will take place with a subsequent post course evaluation being undertaken six months later.

v) Graduate Management Trainees

I am delighted to advise that following the submission of a bid by this Trust to host a graduate on the national HR graduate training scheme, the one trainee allocated to Yorkshire and the Humber for Year One training has been allocated to this Trust which is a fantastic outcome. My thanks go to Chris Mannion, HR Business Partner and others for their work on this bid.

BOARD OF DIRECTORS' HR REPORT – MAY 2015
March 2015 data

Sickness Absence

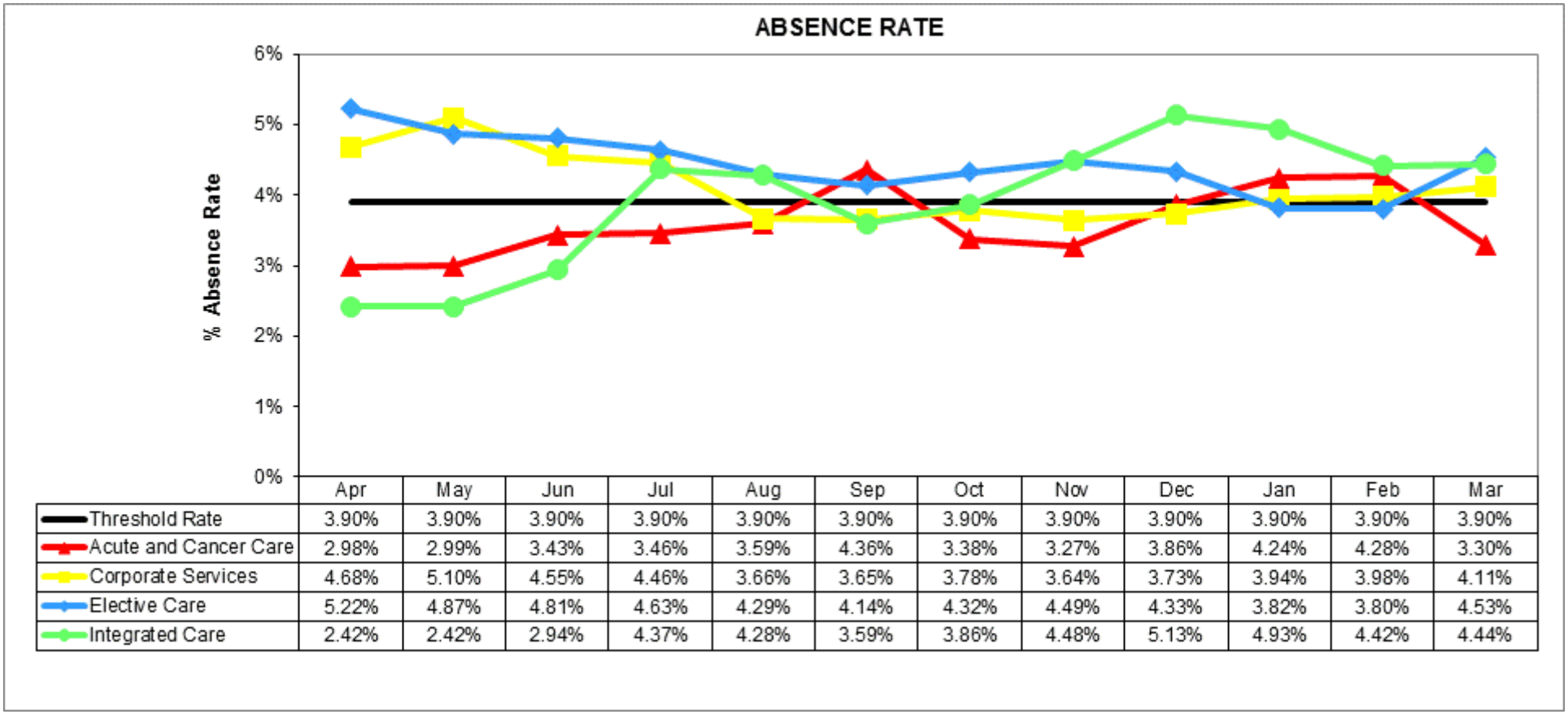
The following table shows the sickness percentage rates for the last three months of the current financial year.

	JAN 2015	FEB 2015	MAR 2015	Cumulative % Abs Rate (FTE) FINANCIAL YEAR TO DATE 14/15 (APR to MAR)
	% Abs Rate (FTE)	% Abs Rate (FTE)	% Abs Rate (FTE)	
Acute and Cancer Care	4.24%	4.28%	3.30%	**3.59%**
Corporate Services	3.94%	3.98%	4.11%	**4.11%**
Elective Care	3.82%	3.80%	4.53%	**4.44%**
Integrated Care	4.93%	4.42%	4.44%	**3.95%**
TRUST TOTAL	**4.28%**	**4.13%**	**4.19% (*)**	**4.06%**

*The planned long term sickness accounted for 0.02% of the overall absence rate for March 2015. If the planned absence rate was removed, the total would be 4.17%.

Data on sickness absence rates for other Trusts is being reported up to January 2015. Upon comparison of the Trust's rates for January 2015 our absence percentage rate was 0.88% below the rate for the Yorkshire and Humber region for that month.

Actual Absence



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Threshold Rate	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%	3.90%
Acute and Cancer Care	2.98%	2.99%	3.43%	3.46%	3.59%	4.36%	3.38%	3.27%	3.86%	4.24%	4.28%	3.30%
Corporate Services	4.68%	5.10%	4.55%	4.46%	3.66%	3.65%	3.78%	3.64%	3.73%	3.94%	3.98%	4.11%
Elective Care	5.22%	4.87%	4.81%	4.63%	4.29%	4.14%	4.32%	4.49%	4.33%	3.82%	3.80%	4.53%
Integrated Care	2.42%	2.42%	2.94%	4.37%	4.28%	3.59%	3.86%	4.48%	5.13%	4.93%	4.42%	4.44%

- The graph shows the absence rate for each Directorate for a rolling 12 months.
- The black line represents the Trust threshold of 3.9%.

Short/Long Term Sickness

The following table shows the percentage difference between short and long term sickness for each Directorate based on the total number of episodes of sickness in the month.

	Short Term Sickness March 2015	* Long Term Sickness March 2015
Acute and Cancer Care	94.96%	5.04%
Corporate Services	92.98%	7.02%
Elective Care	92.82%	7.18%
Integrated Care	85.71%	14.29%
TRUST TOTAL	**91.13%**	**8.87%**

*Long term sickness is any absence where the employee is absent for over 28 consecutive days.

Sickness Reasons

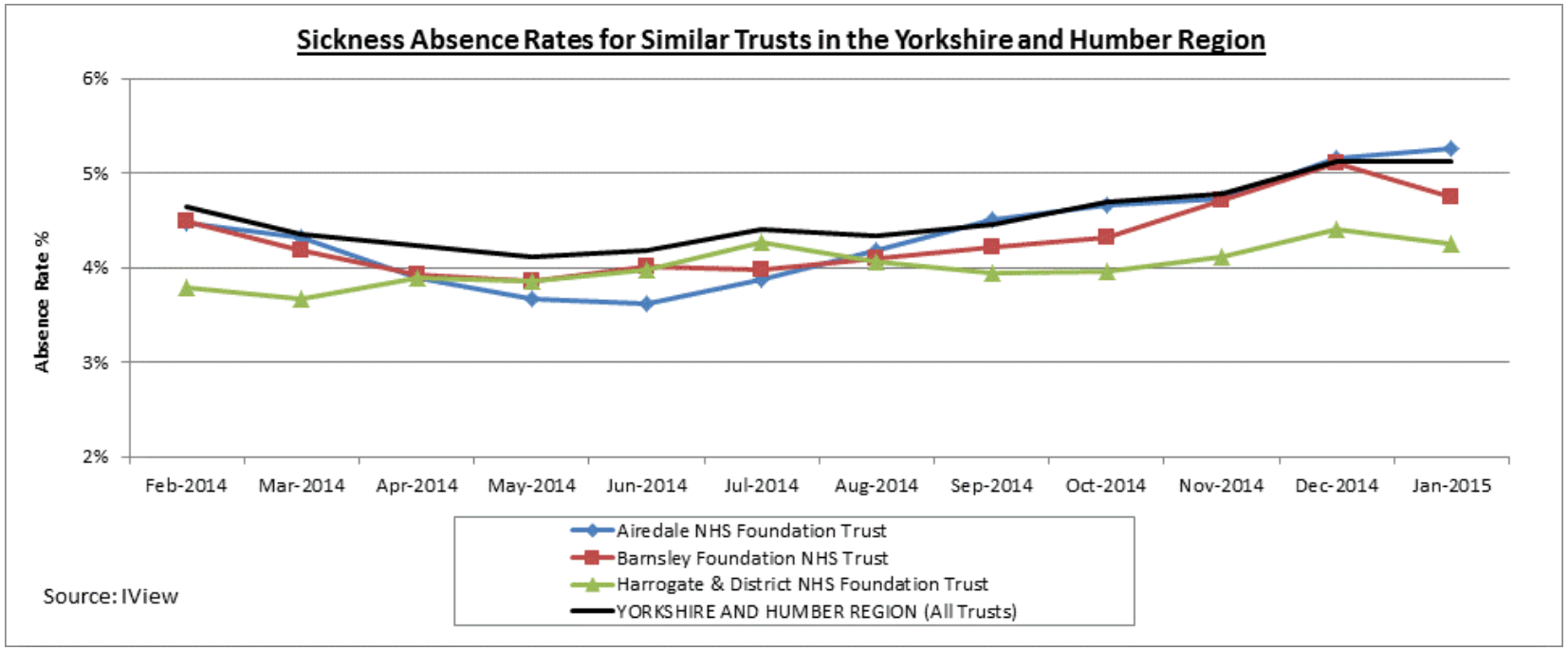
The table below shows the top five reasons for sickness across the Trust for the month based on the number of episodes. The table is sorted in descending order, displaying the reasons with the highest number of episodes at the top. In March the Trust saw 631 episodes of sickness, of which 'Cold, Cough, Flu - Influenza' was the main known reason of absence which accounted for 19.02% of the total sickness episodes. 7.45% of absences in March were recorded as 'Unknown Causes / Not Specified'.

NB. Data has been compiled using the number of episodes rather than FTE Days Lost as it demonstrates the impact of short term sickness in the Trust.

Top 5 Absence Reasons for sickness in March 2015	% of Total Sickness Episodes
Cold, Cough, Flu - Influenza	19.02%
Gastrointestinal Problems	17.27%
Other Known Causes - Not Elsewhere Classified	9.19%
Anxiety/Stress/Depression/Other Psychiatric Illnesses	7.45%
Unknown Causes / Not Specified	7.45%

Sickness Rate Comparison with other Similar Trusts in the Yorkshire and Humber Region

The graph below shows the sickness rates for similar Trusts in the Yorkshire and Humber region for the last 12 months of available data on IView, taken from the NHS Information Centre. The black line denotes the overall Yorkshire and Humber sickness rate, which includes all Trusts in the region. The data shows throughout the period that Harrogate and District NHS Foundation Trust generally has the lowest rates in comparison. January 2015 saw a general decrease in sickness rates across the Trusts shown.
The data shows that for the rolling 12 month period, Harrogate and District NHS Foundation Trust sickness rates were below the Yorkshire and Humber region figures.



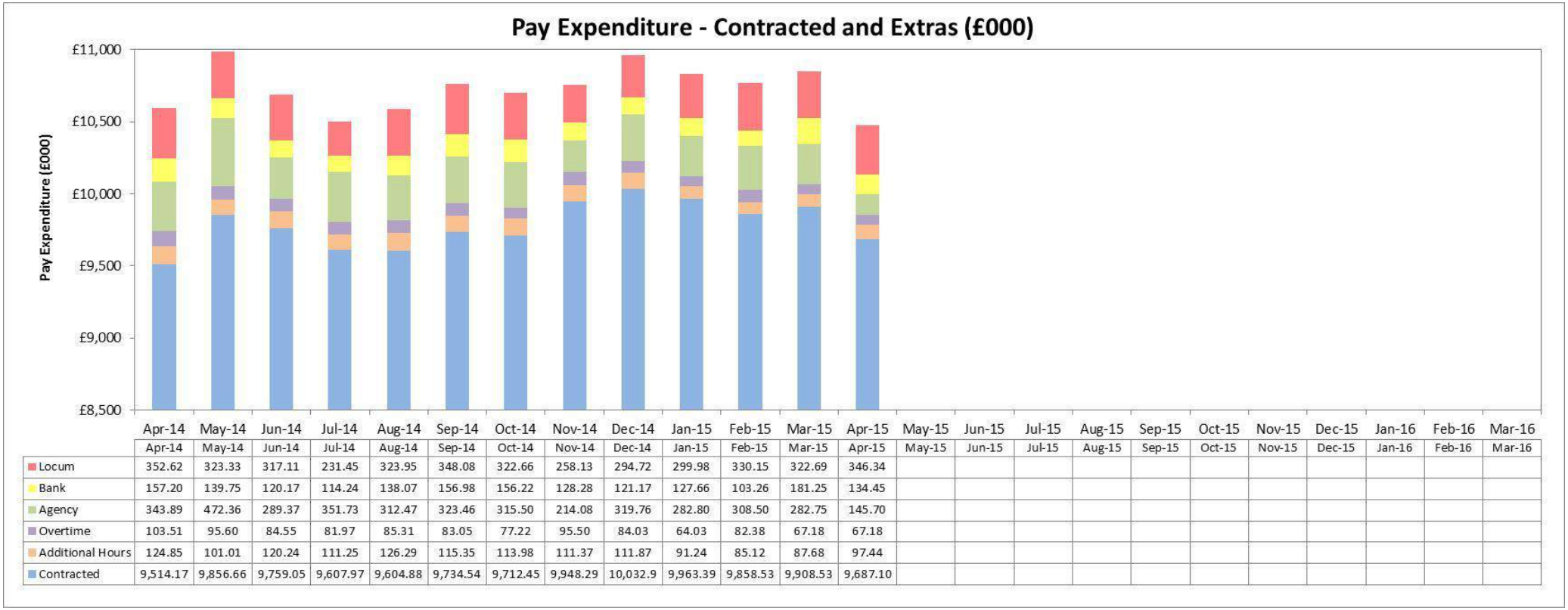
	Feb-2014	Mar-2014	Apr-2014	May-2014	Jun-2014	Jul-2014	Aug-2014	Sep-2014	Oct-2014	Nov-2014	Dec-2014	Jan-2015
Airedale NHS Foundation Trust	4.47%	4.32%	3.89%	3.67%	3.61%	3.88%	4.19%	4.51%	4.67%	4.73%	5.15%	5.26%
Barnsley Foundation NHS Trust	4.49%	4.19%	3.92%	3.85%	4.01%	3.97%	4.09%	4.21%	4.32%	4.72%	5.11%	4.75%
Harrogate & District NHS Foundation Trust	3.79%	3.67%	3.90%	3.86%	3.97%	4.27%	4.07%	3.94%	3.96%	4.12%	4.41%	4.25%
YORKSHIRE AND HUMBER REGION (All Trusts)	4.65%	4.35%	4.23%	4.12%	4.19%	4.40%	4.34%	4.46%	4.69%	4.78%	5.12%	5.13%

Staff in Post

The following graphs illustrate pay expenditure and the staffing levels of the workforce over the previous and current financial year, with contracted FTE figures taken as at the 1st of each month.

Pay Expenditure

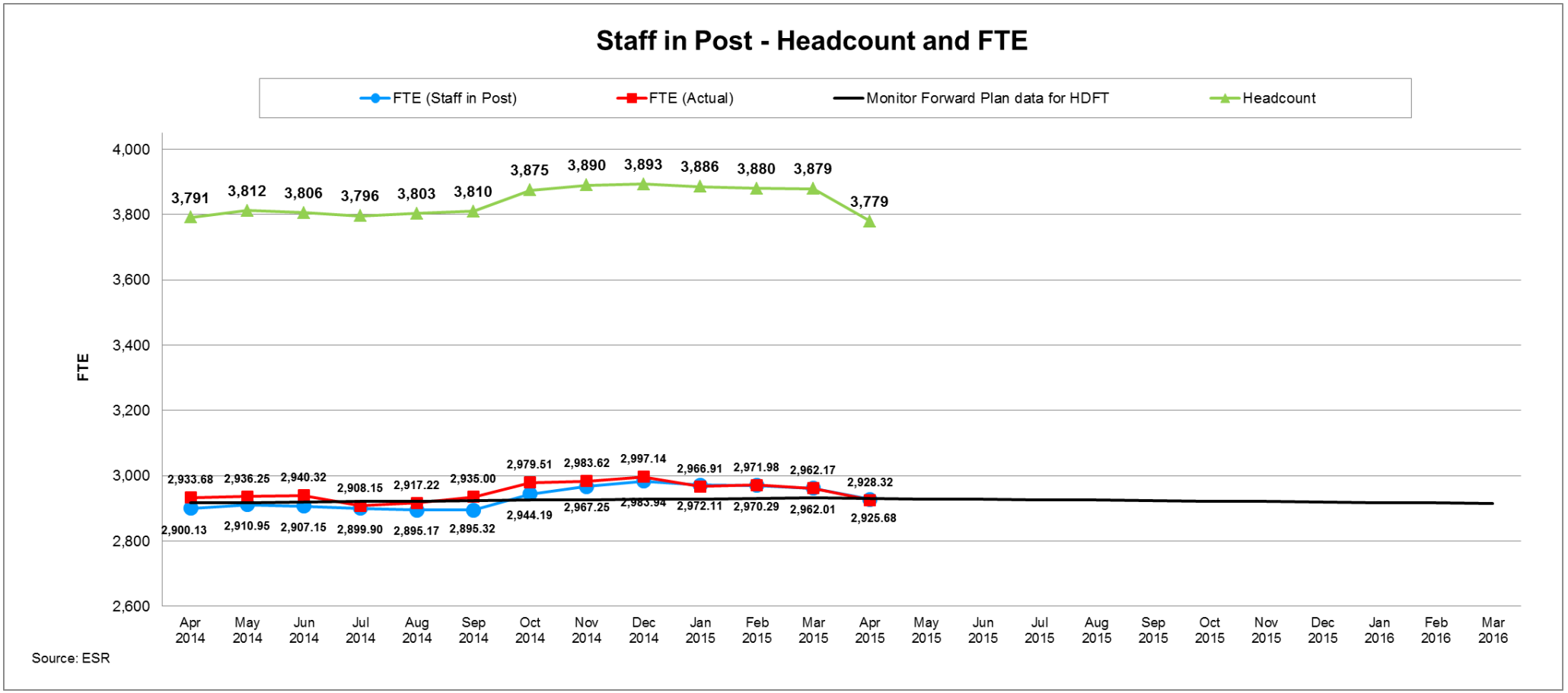
The graph below shows the pay expenditure each month, broken down by type of cost, such as contracted salary, locum spend and spend on additional hours and overtime.



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Locum	352.62	323.33	317.11	231.45	323.95	348.08	322.66	258.13	294.72	299.98	330.15	322.69	346.34											
Bank	157.20	139.75	120.17	114.24	138.07	156.98	156.22	128.28	121.17	127.66	103.26	181.25	134.45											
Agency	343.89	472.36	289.37	351.73	312.47	323.46	315.50	214.08	319.76	282.80	308.50	282.75	145.70											
Overtime	103.51	95.60	84.55	81.97	85.31	83.05	77.22	95.50	84.03	64.03	82.38	67.18	67.18											
Additional Hours	124.85	101.01	120.24	111.25	126.29	115.35	113.98	111.37	111.87	91.24	85.12	87.68	97.44											
Contracted	9,514.17	9,856.66	9,759.05	9,607.97	9,604.88	9,734.54	9,712.45	9,948.29	10,032.9	9,963.39	9,858.53	9,908.53	9,687.10											

Staff in Post - FTE and Headcount

The FTE tracker graph monitors the contracted FTE and actual FTE against a target rate, which is represented by the black line. The actual FTE includes hours worked on the bank and through NHSP.



Trust Turnover

Turnover helps determine if the Trust has any retention issues. Trust turnover is calculated as follows:-

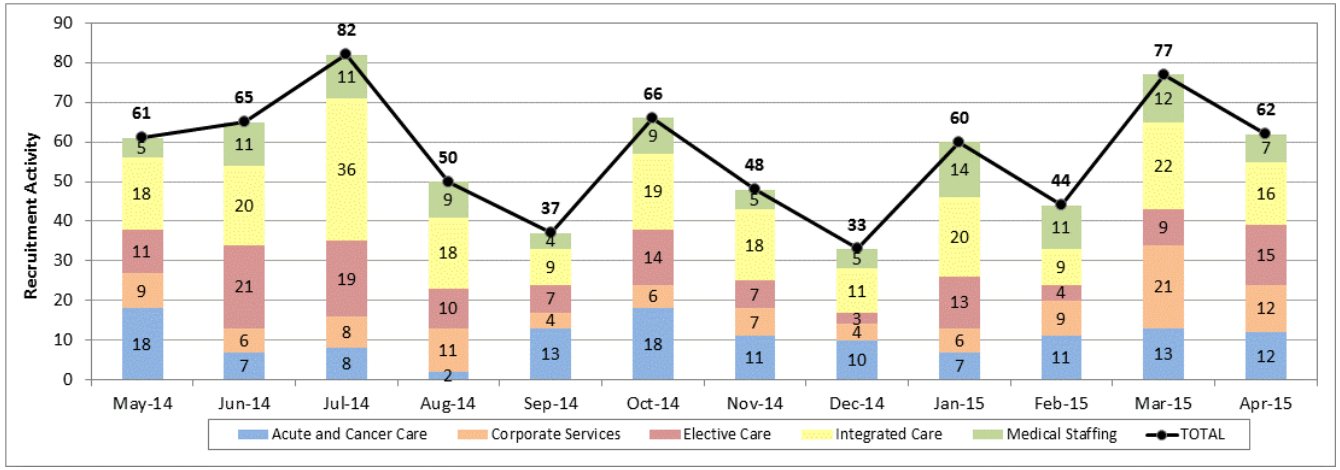
$$\frac{\text{Total Number of Staff Leaving}}{\text{Average Total Number of Staff Employed}} \times 100$$

The report indicates whether there is a change in staff numbers. This can help identify how the working patterns of the Trust's workforce are changing. The table below shows the average headcount for the period 1st April 2014 to 31st March 2015 and the turnover percentage for the last 12 months.

	Average Headcount Excluding Junior Doctors, Fixed Term Contracts and Zero-hour Contracts (April 14 – March 15)	Leavers Excluding Junior Doctors, Fixed Term Contracts and Zero-hour Contracts (April 14 – March 15)	Turnover Percentage Excluding Junior Doctors, Fixed Term Contracts and Zero-hour Contracts (April 14 – March 15)
Acute and Cancer Care	709	69	**9.73%**
Corporate Services	614	78	**12.70%**
Elective Care	983	113	**11.50%**
Integrated Care	1,087	147	**13.52%**
TRUST TOTAL	**3,393**	**407**	**12.00%**

Recruitment Activity

The graph below shows the recruitment activity for the rolling 12 month period May 2014 to April 2015.



Appraisals

The table below shows the number of completed reviews for the period 1st April 2014 to 30th April 2015.

Directorate	No. of Assignments (*) (01-Apr-15)	Apr	Running total	Percentage completed
Acute and Cancer Care	**770**	24	**24**	**3.12%**
Corporate Services	**562**	53	**53**	**9.43%**
Elective Care	**866**	39	**39**	**4.50%**
Integrated Care	**796**	67	**67**	**8.42%**
TOTALS	**2,994**	**183**	**183**	**6.11%**

(*) The 'Assignment Count' is based on the number of assignments active as at 1st April 2015 and excludes bank staff and new starters within the last 12 months. Employees who have had an absence, (such as long term sickness and maternity), of longer than 6 months in the rolling 12 month period prior to 1st April have also been removed from the assignment count to take into account absences. This headcount will be reviewed 1st October 2015.

Completed Appraisals by Directorate for 12 month period (01 May. 2014 - 30 Apr. 2015)

The table below shows the number of assignments and number of assignments appraised in the last 12 months, as at 30th April 2015.
Please note the figures differ from the table above as the headcount for the static table shown above has a constant average assignment count at a given time in the year, whereas the table below is a rolling 12 month table, with an assignment count as at the end of the month, this month being to the end of April 2015.

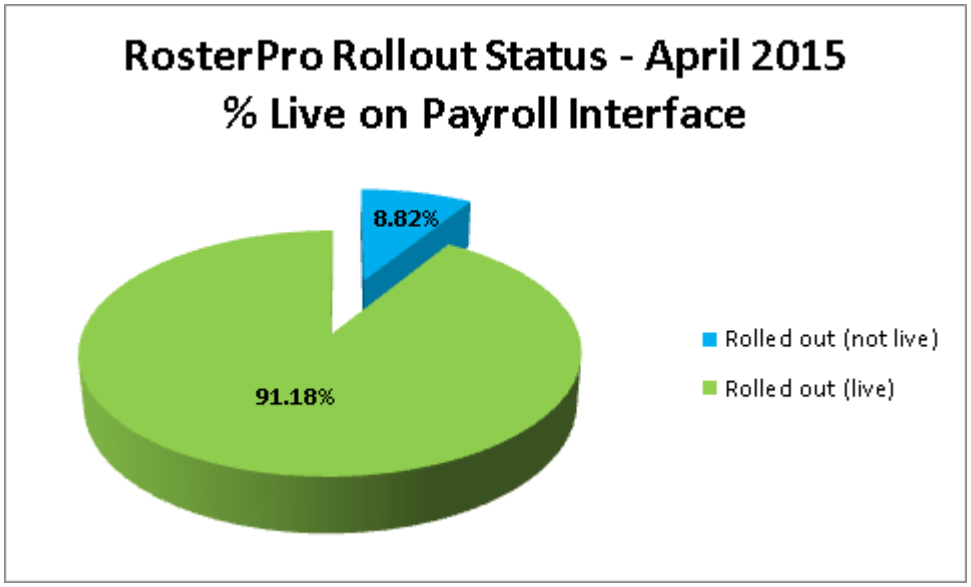
Directorate	No. of Assignments Appraised	No. of Assignments (*)	% Appraised
Acute and Cancer Care	598	763	**78.37%**
Corporate Services	438	557	**78.64%**
Elective Care	622	868	**71.66%**
Integrated Care	492	804	**61.19%**
TOTAL	**2,150**	**2,992**	**71.86%**

(*) The 'Assignment Count' is based on the number of assignments active as at 30th April 2015 and excludes bank staff and new starters within the last 12 months. Employees who have had an absence, (such as long term sickness and maternity), of longer than 6 months in the rolling 12 month period prior to 30th April 2015 have also been removed from the assignment count to take into account absences.

Time, Attendance and E-Rostering System

The new version of RosterPro is currently being internally tested. It is anticipated that barring any unknown issues, this version will be rolled out at the end of April/ beginning of May.

The current roll out status remains the same as reported last month



Rolled out (not live) = 18

Rolled out (live) = 186

Total rosters = 204

Glossary of commonly used terms:

ACCS - Acute Care Common Stem Training

ACP - Advanced Clinical Practitioner

BMA - British Medical Association

CNST - Clinical Negligence Scheme for Trusts

CPC - Commercial Procurement Collaborative

CQC - Care Quality Commission- An independent regulator of health services

E-Learning - electronic learning**-** learning delivered through the use of IT

FTE - Full time equivalent

GMC - General Medical Council

HCW - Healthcare Worker

HEYH - Health Education Yorkshire and the Humber

HDFT- Harrogate and District NHS Foundation Trust

HSE - Health and Safety Executive

LETB - Local Education and Training Board

LNC - Local Negotiating Committee

LTS - Long term sick - an absence for more than 28 days

NHS Employers - The representative body for all NHS employers in England

NICE - National Institute for Clinical Excellence

PAG - Policy Advisory Group

RosterPro - an electronic rostering system used to create rosters

SIRI - Serious Incident Requiring Investigation

STS - Short term sick**-** absence of less than 28 days

The Trust - Harrogate and District NHS Foundation Trust

Health Education
Yorkshire and the Humber

QUALITY MANAGEMENT VISIT REPORT

TRUST	Harrogate & District NHS Foundation Trust

DAY	DATE
Tuesday	3rd February 2015

Visiting Panel Members:

Mr Jon Hossain (Chair)	Deputy Postgraduate Dean
Mr Paul Johnson	Associate Postgraduate Dean
Miss Sarah Kaufmann	Associate Postgraduate Dean
Dr Tahira Naeem	Deputy Training Programme Director for Obstetrics & Gynaecology
Dr Sue Chatfield	Training Programme Director, Paediatrics
Prof Sunil Bhandari	Deputy Head of School
Mr Paul Renwick	Deputy Head of School
Ms Linda Garner	Quality Co-ordinator
Ms Alison Poxton	Quality Administrator

SPECIALTIES VISITED:

- Paediatrics
- Obstetrics and Gynaecology
- Medicine
- Surgery

This report has been agreed with the Trust.

The Trust Visit Report will be published on Health Education Yorkshire and the Humber's Website

Conditions that are RAG rated as Amber, Red and Red* will be reported to the GMC as part of HEYH's Reporting process, the reports are published on the GMC website.

Date of First Draft	**12/02/15**
First Draft Submitted to Trust	**09/03/15**
Trust comments to be submitted by	**24/03/15**
Final Report circulated	**07/04/15**

General Comments

- The visit was well organised by the Trust and the turn out of Foundation, Core, Higher trainees, and Trainers was excellent. The panel thanked the Director of Medical Education for a very informative presentation and it was noted that the DME was also a member of the Senior Management Team, thus providing valuable educational input at Senior Management level.
- The Trust should be commended for providing a safe hospital environment for training. The trainees would be happy to have their families treated there and felt the nursing staff were supportive, particularly in relation to dealing with relatives' enquiries in general surgery. However, although the Panel understand a room on one of the elderly wards has been allocated to trainees for this purpose, it appears this room is now being misused as a nurses' rest room.
- The Trust induction was well liked, with one Trainee describing it as "one of the best inductions they had received". It was reported to be not too onerous and the consultant involvement was appreciated.
- The panel noted the innovative use of the IT based Patient Tracker system. The potential for this system in terms of being able to efficiently and effectively prioritise patients was recognised.
- Handover systems in O&G labour ward were felt to be a particularly positive example with a consultant led handover occurring every morning of the week. All the Higher Trainees felt their Supervisors were very supportive, approachable and very willing to teach.
- All trainees reported being released to attend teaching sessions. Foundation and GP trainees were able to attend clinics and theatres if requested. In particular, it was noted that the T&O trainees were getting exposure to elective procedures with an appropriate number of cases. O&G trainees are being exposed to gynaecological surgery with trainees operating above their expected level of training whilst in a learning and supervised environment which is of benefit to the trainees. This Trust support from an educational and pastoral perspective was commended by the panel.
- The panel were made aware that the term "SHO" is still an existing part of the Trust's terminology, particularly by the trainees themselves. The term SHO could potentially refer to a wide range of training grade doctors, and unfairly raise expectations of level of experience and competence. It is understood that the Trust are currently having the term 'SHO' removed from rotas, name badges and any other documentation. The panel recommend that the Trust monitor this situation to ensure all staff are clear of the level of the trainee who is working with them
- In terms of Faculty development, the Panel recommend the Trust raise awareness amongst their Trainers of:-
  - GMC requirement for all Clinical Supervisors and Educational Supervisors to be fully accredited by July 2016. Any non-accredited supervisors at this point will be unable to train.
  - The Deanery blended learning programme that has replaced MIAD
  - Trainee involvement with SUI and form R/exception reports

- The majority of the trainees reported that the hospital felt cold in terms of temperature and felt that it was not conducive to a learning environment and taken to extremes could impact on patient experience. This was particularly the case in corridors between ward areas.
- The consultants and trainees felt very well supported by the DME and the staff in the education department
- It was noted that the education department was very well utilised by all groups of staff.

CONDITIONS

Condition 1		
GMC Domain: 1	Patient Safety	
Concern relates to:	Clinical Supervision	
School: Obstetrics and Gynaecology, Respiratory, Cardiology, General Surgery	**Trainee Level Affected:** Foundation, Core and Higher	**Site:** Harrogate & District NHS Foundation Trust

Clinics in General Surgery, Respiratory, and Obstetrics and Gynaecology were taking place without direct explicit consultant supervision. For example there were instances reported with clinics being run by middle grade ST4 and Foundation trainees in Obstetrics and Gynaecology (including ante-natal clinics) without a consultant present (an ST4 is a pre-membership Obstetrics and Gynaecology registrar). The trainees reported discussing cases at the next opportunity with the consultant (normally the next day) or approaching the on call team.

Cardiology trainees reported instances where there was no-one more senior than an F1 present within the trust. This appeared to be occurring on a Friday afternoon. However, the panel understand that the Trust have plans in place to address this.

Urology FYs reported being rostered to cover wards and cystoscopy clinics; Trainees reported clerking patients in urology clinics prior to cystoscopy without any feedback. This represents a loss of a learning opportunity

Action To Be Taken:

1) The Trust to develop a framework of supervision within out-patient clinics. All unsupervised clinics must cease.
2) The Trust to implement and monitor clinic supervision plans.
3) The Trust must ensure that Foundation doctors in clinic are directly supervised by a more senior doctor (middle grade or consultant) present in the clinic.
4) The Trust to ensure that senior supervision is available and that feedback is provided to trainees.

RAG Rating:		**Timeline: 30/06/2015 for evidence, 31/09/205 for action plan**

Evidence/Monitoring:

1. Copy of supervision framework/s
2. Written confirmation that unsupervised clinics have ceased
3. Evidence of result of monitoring

Condition 2		
GMC Domain: 3	Patient Safety	
Concern relates to:	Clinical Supervision	
School: Gastroenterology	**Trainee Level Affected:** Foundation	**Site:** Harrogate & District NHS Foundation Trust
Gastroenterology trainees felt that in-patient management plans were often formulated at FY2 level and had variable consultant input. This resulted in the trainees sometimes feeling a lack of confidence in managing patients which was compounded by the discomfort felt on approaching consultants regarding this.		
Action To Be Taken: 1) The Trust to examine consultant time on the ward with a view to increasing this.		
RAG Rating:	**Timeline: 30/04/2015**	
Evidence/Monitoring: 1. Copy of rotas illustrating increased consultant time on the ward.		

Condition 3		
GMC Domain: 3	Patient Safety	
Concern relates to:	Clinical Supervision	
School: Surgery	**Trainee Level Affected:** Foundation	**Site:** Harrogate & District NHS Foundation Trust
Surgical foundation trainees reported that their work based placed assessments were being performed by middle grades or other trainees. There was no consultant input, other than the induction meeting and supervisor reports. The trainees would value more time with their supervisors.		
Action To Be Taken: 1) The Trust to review current consultant supervision with regard to Workplace Based Assessments (WBAs)		
RAG Rating:	**Timeline: 31/7/2015**	
Evidence/Monitoring: 1. Revise job planning to ensure that clinical supervision and WBAs are recognised Job planning to		

Condition 4		
GMC Domain: 3	Equality, Diversity and Opportunity, Harassment and Bullying	
Concern relates to:	Undermining	
School: Obstetrics and Gynaecology, Gastro-enterology	**Trainee Level Affected:** Foundation and Core	**Site:** Harrogate & District NHS Foundation Trust

The panel are concerned that in Obstetrics and Gynaecology the nature of feedback following clinical incidents had been critical, not constructive. The trainee reported that this concern involved more than one consultant. The panel felt that receiving feedback was of critical importance to a Trainee, but that feedback should be delivered in an educational manner rather than by apportioning blame.

Trainees reported the dysfunctional behaviour of some consultants in Obstetrics and Gynaecology, for example; often disagreeing with each others management plans. The more junior core and foundation trainees found this difficult to deal with.

Gastroenterology Trainees reported that they were bullied by one middle grade trainee. The deanery is happy to support the trust in these issues (for instance coaching).

Action To Be Taken:

1) The Trust must investigate the concerns in relation to Obstetrics and Gynaecology and to develop a feedback system that takes into account the need to avoid a blame culture.
2) Trust to investigate issues relating to the sub consultant tier in Gastroenterology
3) Trust to invest in Consultant team building in Obstetrics and Gynaecology

RAG Rating:		**Timeline: 30/09/2015**

Evidence/Monitoring:

1. Evidence of Consultant training in giving effective feedback
2. Survey/audit of trainee experience
3. Evidence that consultants in Obstetrics and Gynaecology and sub consultant level in Gastroenterology involved have been approached about such behaviours

Condition 5		
GMC Domain: 1	Patient Safety	
Concern relates to:	Induction	
School: Cardiology, Elderly Medicine, Obstetrics and Gynaecology, Paediatrics	**Trainee Level Affected:** Foundation and Core	**Site:** Harrogate & District NHS Foundation Trust

Both Foundation and Core Trainees felt that the local speciality induction they received was limited and would benefit from being held over a longer time-span with more content. For example;

Elderly Medicine trainees only received a three hour induction with very little departmental induction.

Cardiology trainees felt they had not received any form of local induction and reported having to pick up protocols as they occurred, but that often these protocols were outdated e.g. Intranet (2012), particularly with regard to antiplatelet therapy.

Paediatric trainees reported overcrowding at neo-natal induction resulting in a lack of confidence in their abilities in neo-natal resuscitation.

Some Obstetrics and Gynaecology and Paediatric trainees reported not receiving e-log ins to EPRO at the time of induction.

Action To Be Taken:

1) The Trust to review the content of the local speciality inductions and to ensure that all related documentation is up-to-date and relevant.
2) The Trust to distribute induction information in a timely manner

RAG Rating:		**Timeline: 30/09/2015**

Evidence/Monitoring:

1. Copy of induction process
2. Copy of timetabled induction information

Condition 6		
GMC Domain: 1	Patient Safety	
Concern relates to:	Handover	
School: Medical and Surgery and Paediatrics	**Trainee Level Affected:** Foundation and Core	**Site:** arrogate & District NHS Foundation Trust

The panel noted that handover systems in Obstetrics & Gynaecology were felt to be particularly positive with a consultant led handover occurring every morning of the week.

However, there are concerns about the consistency and robustness of handover in Medicine. The Trainees reported that the Monday–Thursday handover involved only what was felt to be important. The quality of information depended on who had been on duty prior to them. Handover on Fridays at 5pm is done via a PC using a long word document. Doctors from different specialities all contribute, and Trainees report a wait of up to an hour before they are able to input. The panel feel this system is unwieldy and open to error.

Paediatric trainees demonstrated confusion regarding who should be present at handover, reporting that nurses are not present at either morning or evening handover.

Surgical trainees report that a general surgical consultant is not always present at handover. The T+O trauma handover was however consultant led. The panel felt that is necessary to have senior involvement at handover, both from a patient safety and teaching perspective.

Action To Be Taken:

1) The Trust to ensure that a clear, formal, recorded and auditable internal handover system is developed to include senior involvement.

RAG Rating:		**Timeline: 31/05/2015**

Evidence/Monitoring:

1. Written confirmation of the handover principles
2. Audit outcome and resulting action plan

Condition 7		
GMC Domain: 5	Delivery of Curriculum	
Concern relates to:	Workload	
School: Medicine	**Trainee Level Affected:** Foundation and Core and Higher	**Site:** Harrogate & District NHS Foundation Trust

Concerns were expressed regarding the rota system

Medical trainees reported often having to cross-cover another specialty, with existing clinics not taken into consideration. A ST4 trainee reported being shifted across specialties, resulting in a lack of exposure to their parent specialty.

Trainees felt they were often working below their level of operating and importantly not achieving competencies appropriate to their level of training.

The trainees overall felt that the Rota co-ordinator was regularly redeploying medical staff to fill gaps, to minimum numbers but was unaware of the clinical implications of these decisions.

The panel felt there was good exposure to general medicine, but speciality training may be compromised due to cross cover.

Action To Be Taken:

1) The Trust to ensure more clinical input is provided in rota co-ordination with elective endoscopy lists and being targeted to higher trainees

RAG Rating		**Timeline: 30/09/2015**

Evidence/Monitoring:

1. Written confirmation of clinical involvement in rota system
2. Copy of Rotas showing higher trainees allocated to endoscopy and clinics and core trainees allocated to clinics

Condition 8		
GMC Domain: 5	Delivery of Curriculum	
Concern relates to:	Learning environment	
School: Medicine and Surgery	**Trainee Level Affected:** Core and Higher	**Site:** Harrogate & District NHS Foundation Trust

There was a general feeling that Trainees access to specialised procedures could be improved.

General surgical trainees reported that the amount of clinics they were expected to attend prevented them from performing surgical techniques in operation lists. This meant they were not achieving indicative numbers in their log book. They should attend 3 or 4 lists per week, which should include day case surgery.

Respiratory Medicine Higher trainees are not gaining access sufficient to endoscopy lists, due to excessive ward work. This ward work also prevents core medical trainees attending clinics

Higher medical trainees should be aware that despite being in specialties they still need to be encouraged and reminded of achieving their GIM curriculum requirements

Action To Be Taken:

1) In order to fulfil curriculum requirements the Trust should ensure that all trainees gain sufficient access to appropriate procedures within each speciality.

RAG Rating:		**Timeline: 30/09/2015**

Evidence/Monitoring:

1. Copy of timetable
2. Review of trainee logbooks/theatre records/endoscopy records describing numbers of procedures achieved over a six month period

RAG guidance can be found at Appendix 1.

Approval Status

Approved pending satisfactory completion of conditions set out in this report.

Signed on behalf of HEYH **Name: Jon Hossain** **Title: Associate Postgraduate Dean** **Date: 07/04/15**	**Signed on behalf of Trust** **Name: Helen Law** **Position: Director of Medical Education** **Date: 07/04/15**

RAG Rating Guidance

The RAG rating guidance is based on the GMC RAG rating to ensure a consistent approach. The model takes into account impact and likelihood.

Impact

This takes into account:

a) patient or trainee safety

b) the risk of trainees not progressing in their training

c) educational experience – eg, the educational culture, the quality of formal/informal teaching

A concern can be rated high, medium, or low impact according to the following situations:

High impact:

- patients or trainees within the training environment are being put at risk of coming to harm
- trainees are unable to achieve required outcomes due to poor quality of the training posts/ programme

Medium impact:

- trainees are able to achieve required outcomes, but the quality of education and training is recognised as requiring improvement
- patients within the training environment are receiving safe care, but the quality of their care is recognised as requiring improvement

Low impact:

- concerns have a minimal impact on a trainee's education and training, or the quality of provision for the patient.

Likelihood

This measures the frequency at which concerns arise eg. if a rota has a gap because of one-off last minute sickness absence, the likelihood of concerns occurring as a result would be low.

High likelihood:

- the concern occurs with enough frequency that patients or trainees could be put at risk on a regular basis. What is considered to be 'enough frequency' may vary depending on the concern eg. if rotas have consistent gaps so that there is a lack of safe cover arrangements, the likelihood of concerns arising as a result would be 'high'.

Medium likelihood:

- the concern occurs with enough frequency that if left unaddressed could result in patient safety concerns or affect the quality of education and training, eg. if the rota is normally full

but there are no reliable arrangements to cover for sickness absence, the likelihood of concerns arising as a result would be 'medium'.

Low likelihood:

- the concern is unlikely to occur again eg. if a rota has a gap because of several unexpected sickness absences occurring at once, the likelihood of concerns arising as a result would be 'low'.

Risk

The risk is then determined by both the impact and likelihood, and will result in a RAG Rating, according to the below matrix:

Likelihood	**IMPACT**		
	Low	**Medium**	**High**
Low	Green	Green	Amber
Medium	Green	Amber	Red
High	Amber	Red	Red*

Please note:

* These conditions will be referred to the GMC Reponses to Concerns process and will be closely monitored

Source: GMC Guidance for Deaneries, July 2012

Report to the Trust Board of Directors: 27 May 2015	Paper No: **12.0**

Title	**Quarterly review of the Board Assurance Framework**
Sponsoring Director	Dr Ros Tolcher
Author(s)	Andrew Forsyth
Report Purpose	To update the Board of Directors on current risks and mitigating actions recorded on the Board Assurance Framework (BAF).

Executive Summary

The BAF records the critical success factors for achieving the Trust's strategic goals, identifies the risks to the achievement of these goals and captures the controls which are already in place to mitigate these risks.

All risks currently on the BAF have Action Plan scores of 1 or 2 meaning that Action Plans have been identified to address all identified gaps in controls and that work is progressing, with interventions being made for any delays.

A full copy of the BAF is available to Board members in the confidential session of the Board meeting, as it includes commercial-in-confidence information..

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

Risk and Assurance	This quarterly report offers assurance on the management of strategic risk and is also evidence of the effectiveness of internal control arrangements.
Legal implications/ Regulatory Requirements	Nil

Action Required by the Board of Directors

The Board of Directors is asked to:

1. Note the risks recorded on the Board Assurance Framework.
2. Confirm that the mitigating actions and target risk scores are acceptable.

BOARD ASSURANCE FRAMEWORK

Quarterly report to Board of Directors

March – May 2015

The BAF has been reviewed and updated by lead Executives at least monthly and cross referenced to the Corporate Risk Register where relevant.

Changes to the BAF during the period

The BAF continues to record 12 strategic risks against the Critical Success Factors, including the three which were originally escalated from the corporate risk register.

There has been no change to the number or description of the strategic risks recorded since the last quarterly report.

Progress has been made on a number of mitigating actions and all action plan scores are rated 1 or 2 indicating that plans are on track. Residual risk scores remain unchanged at this stage. This is as expected given the agreed timescales for attainment of target risk scores.

Key actions and progress updates are summarised below

BAF#1	**Lack of Medical, Nursing and Clinical staff** Additional Key Control Flexibility in Consultant approach to covering training grade gaps Update Action Plans • Develop plan for seven-day working including remuneration arrangements as part of planned care transformation programme • Concept of CESR (certified educational specialty training) rotation and investment in additional middle grade posts in ED agreed in principle, business case to be developed and signed off. • Business case for Woodlands staffing, approved in principle, Trust wide CIP plans to be delivered to release funding for this to be implemented, however recruitment commenced in anticipation of financial solution.
BAF#2	**High level of frailty in local population** Additional Key Controls ▪ Safe handover policy – Significant Assurance from Internal Audit ▪ New Quality Governance structure approved and being implemented ▪ New Dementia focussed multiagency group established as part of the Harrogate Health Transformation Board programme ▪ Mental Health/Mental Capacity Acts training Updated Action Plans • HDFT Dementia group to develop new work plan • Develop an Older Peoples Strategy

BAF#3	**Failure to learn from feedback and Incidents** Additional Key Controls • Mental Health/Mental Capacity Acts training • RPIW completed • Improving Patient Safety Steering Group established Updated Action Plans • Update PPI Strategy • Implement required changes from Internal Audit review
BAF#4	**Lack of integrated IT structure** Additional Key Controls • Information group established within New Models of Care Programme involving all appropriate partners • Clinical Transformation Board Programme – Estates and IT • HDFT Capital programme allocation for 15/16 IT infrastructure investment • Capital funding identified for Single Sign on Project for HDFT systems Updated Action Plans • IT team restructure consultation complete, new structure in place from 1st June and vacancies to be recruited • Resolve financial flows with commissioners to enable HDFT to contract directly for Telephony and Networks – COIN nearing completion, Telephony remains outstanding and work to be completed by CSU • Capital plan to support IT Strategy beyond 15/16 • Implement new Disaster Recovery Facility to support new virtual servers systems • Working with TPP and other S1 users to improve data extracts
BAF#5	**Service Sustainability** Updated Action Plans • Marketing and comms plan as part of business development workplan to be developed – new temporary member of staff in post with recruitment to team in hand • Business development team now in place to strengthen delivery • Preparation for future tenders in smoking cessation and dental service in hand • Robust process re bid:no bid now in place
BAF#6	**Understanding the market** Updated Action Plans • GP Open Event held and positively evaluated • Establishing work plan for Alliance with Leeds Teaching Hospital Trust (LTHT) • CEO/COO visits to all GP practices in HaRD completed • Business development team in place, with Comms resource in place (interim pending permanent) • Survey of local GPs underway • Alliance Board with LTHT in place, with workplan being developed (including clinical strategy timeout in Autumn)

BAF#7	**Lack of robust approach to new business** Updated Action Plans • Audit report and recommendations to strengthen SLR due May 15
BAF#8	**Visibility and reputation** Additional Controls • Continued delivery of high quality care as benchmarked through surveys, KPIs Updated Action Plans • Identified as a Vanguard site • Comms & Marketing temporary post in place, permanent post out to recruitment
BAF#9	**Failure to deliver the Operational Plan** No changes
BAF#10	**Loss of Monitor Licence to operate** No changes
BAF#11	**Risk to current business** Updated Action Plans • Business development team in place, with Comms resource in place (interim pending permanent) • Survey of local GPs underway • Alliance Board with LTHT in place, with workplan being developed (including clinical strategy timeout in Autumn)
BAF#12	**External funding constraints** Updated Action Plans • Financial plan in place for 15/16 with CIP contingency and approach to funding any developments • Internal audit of rostering to improve key controls • Engagement of clinical leads in transformation and efficiency programme improved

All of the Risks described in the BAF now have action plan progress scores of 1 or 2 which provides assurance that actions are being progressed and, where there are delays, interventions are in place.

Report to the Trust Board of Directors: 27 May 2015	**Paper No: 13.0**

Title	Quarterly report on corporate risk register
Sponsoring Director	Dr Ros Tolcher, Chief Executive
Author(s)	Dr Sylvia Wood, Deputy Director of Governance
Report Purpose	To update the Board of Directors on current risks and mitigating actions recorded on the Corporate Risk Register.

Executive Summary
This report highlights changes to corporate risks during the period April – May 2015, since the last report in March 2015. It aims to provide the Board of Directors with assurance about the identification and management of corporate risk.

The Corporate Risk Register documents all risks which have current scores of 12 or more and demonstrates the actions planned to mitigate risk and the timescale and progress for achieving the target score. There are currently five risks on the corporate risk register. Four risks have an action plan score of 1 meaning that all action plans are on track. One risk has a score of 3 indicating that actions defined and work started but this is behind plan.

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

Risk and Assurance	This quarterly report offers assurance on the management of risk and is also evidence of the effectiveness of internal control arrangements.
Legal implications/ Regulatory Requirements	This is part of our risk and assurance process which is described in the Annual Governance Statement.

Action Required by the Board of Directors
To consider the information provided and identify any gaps in assurance.

CORPORATE RISK REVIEW GROUP

Quarterly report to Board of Directors

April - May 2015

The last report from the Corporate Risk Review Group (CRRG) to the Board of Directors was in March 2015. This report will highlight changes to corporate risks during the period April – May 2015.

The CRRG meets monthly to review the corporate risk register, directorate risk registers and corporate functions risk registers. All risks on the corporate risk register (CRR) are discussed and the risk score, gaps in controls, additional controls and progress on actions are agreed. Directorate representatives and corporate function representatives provide an up to date risk register, and highlight any risks that they wish to discuss for possible inclusion on the CRR. Any high scoring risks (12+) are included on the CRR.

Work is planned to ensure all corporate risks that are on, or have been removed from the CRR remain on the relevant directorate or corporate function risk register and can be mapped between the locations. In addition, work is required to ensure that all risk registers, including departmental risk registers are in the new template, are complete and are being regularly reviewed.

Changes during April – May 2015

Risks that remain on the CRR

- **COR 63 Patient harm due to failure to identify and manage mental health and mental capacity needs**
  The risk score remains C4 x L3=12.

  Gaps in controls relate to the skills and knowledge of staff. Mental health act training provided by TEWV has now started with several dates available and circulated to key staff. There has been progress with organising initial mental capacity act training for senior staff, but there is further work to be done to ensure the training requirements for frontline staff are in place. The progress score is 3 (actions defined – work started but behind plan).

- **COR 74 Harm to ward attending patients**
  The risk score remains C4 x L3=12.

  An audit of ward attenders is being completed to clarify whether the remaining ward attenders are appropriate. It is hoped that this will provide assurance of implementation of the new processes, and enable the risk score to be reduced to C4 x L2=8. A business case has been developed for an extended EPAU service to accommodate the remaining patients that currently reside in the day room, and there is an action plan to manage this in the interim. Actions to mitigate this risk continue to be on plan (progress score 1).

- **COR 64 Harm to ophthalmology patients**
  The risk score remains C4 x L3=12.

  There is an interim target of C4 x L2=8 by June 2015, and a final target risk score of C4 x L1=4. Work has been undertaken by consultants to review cases and identify higher risk patients for priority. Improvements have been achieved following the RPIW, and the new

joint post with York for a Medical Ophthalmologist is expected to start in June 2015. Progress with actions remains 1 (fully on plan across all actions).

- **COR 49c Risk to business objectives due to non-delivery of locality wide IT system**
  The risk remains C4 x L 4= 16.

  There is a target risk of C4 x L1=4 by 2017. The gaps in controls relate to the finance and capabilities within the Trust to deliver the requirements, and organisational sign-up across North Yorkshire. Work has started on an options appraisal and there has been some progress with agreeing funding. Progress remains 2 (actions defined – most progressing, where delays are occurring interventions are being taken).

New risks that have been added to the CRR

- **C46: Reduction in trainee numbers allocated to the Trust by HEYH due to the national reduction in trainee numbers.**
  The risk is scored as C3 x L4 = 12.

  This was escalated from the HR risk register in May 2015. There main risk is to the quality of service delivery, but there is an associated financial risk.

Risk that have been removed from the CRR

- **CR1 Risk of loss of accreditation due to non-conformity with ISO 15189 CPA standard in the transfusion laboratory**
  The risk score reduced to C4 x L1=4 in April 2015.

  This risk was added to the CRR in February following a CPA accreditation inspection. The required actions have now been completed, the air conditioning unit has been serviced, and repairs completed and parts fitted. An annual maintenance contract has been arranged. It was acknowledged in April 2015 that Pathology and Estates staff had put a lot of work into the actions required, and that this risk could be removed from the corporate risk register.

Summary

During the period April - May 2015:

New risks added	1
Risks removed to be managed on the BAF	0
Risks removed to be managed on directorate / corporate functions risk registers	1
Risks currently on the corporate risk register	5

Dr Sylvia Wood
Deputy Director of Governance and Chair of the Corporate Risk Review Group
May 2015