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 28 October 2015**

**Start: 0900 Finish: 1230**

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

## AGENDA

| Item No | Item | Lead | Paper Number |
|---|---|---|---|
| **0900 General Business** | | | |
| **1.0** | **Welcome and Apologies for absence:**<br>*To receive any apologies for absence:*<br>Mr Andy Alldred, Mr Robert Harrison and Dr Kat Johnson | Chairman – Mrs Sandra Dodson | |
| **2.0** | **Declarations of Interest and Board of Directors Register of Interests**<br>*To declare any interests relevant to the agenda for the meeting and to receive any changes to the register of interests pursuant to section 6 of the Board Standing Orders* | Chairman – Mrs Sandra Dodson | 2.0 |
| **3.0** | **Minutes of Board of Directors meeting held on 23 September 2015**<br>*To review and approve the Minutes* | Chairman – Mrs Sandra Dodson | 3.0 |
| **4.0** | **Review of Actions schedule and Matters Arising**<br>*To review the actions schedule and provide updates on progress of actions to the Board of Directors.* | Chairman – Mrs Sandra Dodson | 4.0 |
| **4.1** | **Report on reducing avoidable admissions** | Clinical Director - Dr Natalie Lyth | 4.1 |
| **0915 - 1045** | | | |
| **5.0** | **Report by the Chief Executive**<br>*To be considered and any Board directions defined* | Chief Executive – Dr Ros Tolcher | 5.0 |
| **6.0** | **Integrated Board Report**<br>*To be considered for comment* | Chief Executive – Dr Ros Tolcher | 6.0 |
| **7.0** | **Report by the Director of Finance**<br>*To be considered for comment* | Director of Finance/Deputy Chief Executive – Mr Jonathan Coulter | 7.0 |
| **7.1** | **CIP 2015-16 and 2016-17 Updates**<br>*To be considered and noted by the Board* | Director of Finance/Deputy Chief Executive – Mr Jonathan Coulter | 7.1 |
| **7.2** | **Business Plan 2016-17**<br>*To be considered and noted by the Board* | Director of Finance/Deputy Chief Executive – Mr Jonathan Coulter | 7.2 |
| **1045 – 1100 BREAK** | | | |
| **8.0** | **Oral Reports by Directorates**<br>*i. Urgent, Community and Cancer Care*<br>*ii Elective Care*<br>*iii Integrated Care* | Operational Director – Mrs Joanne Crewe<br>Operational Director – Mrs Beth Barron<br>Clinical Director - Dr Natalie Lyth | |
| **9.0** | **Report by Chairman of Quality Committee**<br>*To include highlighted Minutes from meeting dated 2 September 2015* | Chairman – Mrs Lesley Webster, Non-Executive Director | 9.0 |

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|---|---|---|---|
| **10.0** | **Report by the Medical Director**<br>*To be considered for comment* | Medical Director – Dr David Scullion | 10.0 |
| **11.0** | **Report by the Chief Nurse**<br>*To be considered for comment* | Chief Nurse – Mrs Jill Foster | 11.0 |
| **11.1** | **Quarterly Claims Report – Q2**<br>*To be considered for comment* | Chief Nurse – Mrs Jill Foster | 11.1 |
| **12.0** | **Report by the Chief Operating Officer**<br>*To be considered for comment* | Deputy Director of Performance and Infomatics – Mr Paul Nicholas | 12.0 |
| **13.0** | **Report by the Director of Workforce and Organisational Development**<br>*To be considered for comment* | Director of Workforce and Organisational Development – Mr Phillip Marshall | 13.0 |
| **1215 - 1230** | | | |
| **14.0** | **Reports:**<br>*To receive the highlighted Minutes of, and/or oral reports from, Board Committees:*<br>*i. Finance Committee – 10 July 2015*<br>*ii. Audit Committee – 21 May 2015* | Committee Chairman - Mrs Maureen Taylor (Non-Executive Director)<br>Committee Chairman – Mr Christopher Thompson (Non-Executive Director) | 14.1<br>14.2 |
| **15.0** | **Matters relating to compliance with the Trust's Licence or other exceptional items to report or that have been reported to Monitor and/or the Care Quality Commission**<br>*To receive an update on any matters reported to regulators.* | Chairman – Mrs Sandra Dodson | |
| **16.0** | **Any Other Relevant Business**<br>*By permission of the Chairman*<br>*i. Receive Minutes of Council of Governors' Meeting 16 May 2015*<br>ii. *Treasury Management Policy – for Board* ***approval*** | Chairman – Mrs Sandra Dodson<br>Director of Finance/Deputy Chief Executive – Mr Jonathan Coulter | 16.1<br>16.2 |
| **17.0** | **Board Evaluation** | Chairman – Mrs Sandra Dodson | |
| **18.0**<br>*1230* | **Confidential Motion**<br>**The Chairman to move:**<br>*'That members of the public and representatives of the press be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'.* | | |

Harrogate and District NHS
NHS Foundation Trust

## BOARD OF DIRECTORS – REGISTERED DECLARED INTERESTS

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

The register is maintained by the Foundation Trust Office.

| Name | Position | Interests Declared |
|---|---|---|
| Mrs Sandra Dodson | Chairman | 1. Partner in Oakgate Consultants<br>2. Trustee of Masiphumelele Trust Ltd (A charity raising funds for a South African Township.)<br>3. Trustee of Yorkshire Cancer Research<br>4. Chair of Red Kite Learning Trust – multi-academy trust |
| Dr Ros Tolcher | Chief Executive | Specialist Adviser to the Care Quality Commission |
| Mr Jonathan Coulter | Finance Director/Deputy Chief Executive | None |
| Mrs Jill Foster | Chief Nurse | None |
| Mr Robert Harrison | Chief Operating Officer | 1. Appointed Voluntary Member of the Strategy and Resources Committee of the Methodist Church |
| Mr Phillip Marshall | Director of Workforce and Organisational Development | None |
| Mr Neil McLean | Non-Executive Director | Director of:<br>1. Northern Consortium UK Limited (Chairman)<br>2. Ahead Partnership (Holdings) Limited<br>3. Ahead Partnership Limited<br>4. White Rose Academies Trust<br>5. White Rose Resourcing Limited<br>6. Swinsty Fold Management Company Limited<br>7. Acumen for Enterprise Limited<br>8. Leeds Apprenticeship Training Agency Limited<br>9. Yorkshire Campaign Board Chair Maggie's Cancer Caring Centres Limited |
| Professor Sue Proctor | Non-Executive Director | 1. Director and owner of SR Proctor Consulting Ltd<br>2. Chair of LEAF Multi Academy Trust (Leeds)<br>3. Member – Council of University of Leeds<br>4. Member – Council of NHS Staff College (UCLH)<br>5. Associate – Good Governance Institute<br>6. Associate - Capsticks |
| Dr David Scullion | Medical Director | None |
| Mrs Maureen Taylor | Non-Executive Director | 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 |

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

**October 2015**

Harrogate and District NHS
NHS Foundation Trust

**Report Status: Open**

# BOARD OF DIRECTORS

Minutes of the Board of Directors meeting held on Wednesday 23 September 2015 at 8.45am 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
Mrs J Harrison, Deputy Director of Workforce and Organisational Development
Mr R Harrison, Chief Operating Officer
Mr N McLean, Non-Executive Director
Professor S Proctor, Non-Executive Director
Dr D Scullion, Medical Director
Mrs M Taylor, Non-Executive Director
Mr C Thompson, Non-Executive Director
Dr R Tolcher, Chief Executive
Mr I Ward, Non-Executive Director
Mrs L Webster, Non-Executive Director

**In attendance:**
Mr A Alldred, Clinical Director, Acute and Cancer Care Directorate
Dr K Johnson, Clinical Director, Elective Care Directorate
Dr N Lyth, Clinical Director, Integrated Care Directorate

Dr R Hobson, Director of Infection Prevention and Control (Item 1 only)
Mr D Lavalette, Consultant Surgeon, NCEPOD Ambassador (Item 7.1only)

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

Three Governors of the Trust, one member of the public

Mrs Dodson welcomed members to the meeting and in particular Dr Lyth, who was attending her first meeting as the Clinical Director of the Integrated Care Directorate, and Mrs Harrison, who was deputising for Mr Marshall for the first time. She also welcomed the one member of the public and three Governors who were observing.

## Update on Infection Prevention and Control

Dr Richard Hobson, Director of Infection Prevention and Control, gave the Board members a short update on *Clostridium difficile,* MRSA bacteraemia and MSSA bacteraemia.

Dr Hobson was pleased to report that there had been no cases of MRSA bacteraemia; indeed the last case in the Trust had been in September 2013. He also reported that there had been one case of MSSA bacteraemia in the Trust in the year

to date and that the Root Cause Analysis (RCA) had found no HDFT contributory factors.

Turning to *C. difficile,* Dr Hobson said that there had been 13 cases in the year to date (in 12 patients) against the 2015-16 objective of 12 cases. The most affected ward was Jervaulx, with three cases, although there had been no further cases on Jervaulx since a deep-clean and hydrogen peroxide decontamination exercise was carried out in July-August.

He said that molecular testing (ribotyping) had been completed on 10 of the 13 cases and has provided no evidence of cross-infection. Work was in progress to improve and speed up the RCA process for *C.difficile*. New documentation has been developed and a process map has been agreed, with a "target" time of 14 days from notification (10 working days). Nine RCA meetings had been held so far. The mean period between notification and RCA in 2015 had been 23.6 days. A new Consultant Microbiologist had now been appointed, so the element of delay caused by the lack of Consultant Microbiologist has been addressed.

No lapses in care that might have caused any of the 12 patients to contract *C. difficile* had been identified through the RCA process. However, a theme had emerged, which was an inconsistent approach in different HDFT IPC policies to sampling and/or testing patients with loose stool at HDH, resulting in delayed testing and testing that might not be clearly indicated. The advice was not entirely consistent between policies and also inconsistent with some of the nursing documentation. A 26-point Action Plan had been developed to address diarrhoea management and other issues which may have contributed to the increased number of cases. It was important, however, not to under-test because patients with undiagnosed *C.difficile* infection/colonisation represent a cross-infection hazard for other patients.

The first six *C.difficile* cases had been discussed with a representative of the Harrogate and Rural District (HaRD) Clinical Commissioning Group (CCG) on 26 August. The CCG had accepted that there was no evidence of any lapse in HDFT-delivered care having contributed to any of these cases.

Mrs Dodson thanked Dr Hobson and invited questions from Board members.

Mrs Webster asked about the impact of TACCORD and antibiotic stewardship. Dr Hobson said that the RCAs into *C.difficile* cases had not shown that antibiotic stewardship was a contributory factor. The subsequent action plans had been very effective and NICE guidance had been followed The Antibiotic Prescribing Steering Group had been examining the RCAs and if necessary would have added measures to action plans. Dr Hobson said that although there were antibiotic measures in TACCORD he could not influence how it was applied. Dr Scullion commented that electronic prescribing through ePMA and the introduction of Ward Pharmacists had helped.

Mr Alldred agreed and said that he believed that antibiotic stewardship was good and that consumption levels of antibiotics were at a lower level than in peer group trusts.

Professor Proctor asked whether there was any connection between the incidence of *C.difficile* and Norovirus. Current activity levels seemed to show that winter pressures were coming early. Dr Hobson said that there was a rise in *C.difficile* cases during outbreaks of Norovirus, partly because it was part of the testing for the

latter and showed up even if it had not been the primary reason for testing. These were crude metrics, however, and provided sub-optimal results. Where it occurred the (HaRD CCG) had been understanding that these were not primary cases.

Mrs Dodson said that infection prevention and control went to the heart of delivering quality of care and thanked Dr Hobson and his team for their important work, asking that his detailed brief be circulated after the meeting. She said that whilst there may have been some historic cynicism about targets for particular infections, it was important to keep a focus on them.

**1. Apologies for Absence**

There were apologies for absence from Mr P Marshall, who was represented by Mrs Harrison.

**2. Declarations of Interest**

There were no declarations of interest relevant to items on the agenda for the meeting or the Register of Interests which had not already been recorded

**3. Minutes of the meeting of the Board of Directors on 22 July 2015**

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

Minute 7.4 line 13 After 'the'
**Insert:** 'acute oncologist'

**4. Review of Actions Schedule and Matters Arising**

Action 1 – Dr Scullion had included this in his report at Item 7. Board action complete.

Action 2 – Mrs Foster said that the senior nursing team was examining the potential for implementing a similar scheme at HDFT and she would report back to the Board in January.

Action 3 – Dr Johnson said that she had prepared a full report, which was included in the confidential part of the meeting. However, she said that the implementation of the new growth charts had been reviewed; she gave the Board assurance that lessons had been learnt. Board action complete.

Action 4 – Mr Lavalette would report to the board at Item 7.1. Board action complete.

Action 5 – Mr Alldred said that a detailed action plan was in place to ensure that the Trust achieved the required level of performance against the National Quality Requirements. The key change which had been made was the institution of a direct booking service from NHS 111 from the end of July. Although it was too early for evidence to be available, anecdotally the position had improved, especially around the 20-minute target. There had been no increase in harms since the change. Mrs Dodson commented that further reports should go to the Quality Committee. Board action complete.

Action 6 – Mrs Harrison said that the update on immunisation was included in the Workforce and Organisational Development report at Item 11. Board action complete.

Action 7 – Mrs Foster said that, where possible, substitute IPC nurses were being provided and she had tasked Matrons to substitute if they were not available. Board action complete.

Action 8 – Mr Coulter would deliver the briefing on completion of the Board meeting. Board action complete.

Action 9 – Mrs Foster reported that a new Tissue Viability nurse had been appointed and she would be investigating links with other organisations, including Leeds University and how they could inform the Trust processes. Board action complete.

Action 10 – Dr Johnson said that candidates for Clinical Lead in Obstetrics and Gynaecology would be interviewed on 28 September. Board action complete.

Action 11 – Mrs Foster confirmed that she had written to the Nursing and Midwifery Council but did not expect to receive a response soon. The issue would be discussed at the Chief Nursing Officer conference in December. The Local Supervisory Authority was considering a framework for the reprovision of statutory oversight and she was examining the potential of how to implement a process in HDFT. Board action complete.

Action 12 – Mrs Harrison noted that the link had been shared. Board action complete.

Action 13 – Mr Alldred had circulated the report to Board members as requested. Board action complete.

There were no other Matters Arising.

## Implementing the Strategic Plan

### 5. Report from the Chief Executive

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

5.2 Dr Tolcher noted that contrary to the statement in her written report, verbal updates on Patient Safety Visits and Director Inspections would continue to be given to the Board. Dr Tolcher noted that recent reports on the Clinical Assessment Team, Fountains and Bolton Wards (all areas of high clinical need) had found staff under pressure and stretched whilst being positive about the quality of care being delivered.

5.3 Mr Ward reported that he had visited the Emergency Department (ED) on 21 September. It had been very busy and staff were working hard; there had been some breaches of the four-hour targets. The staff were positive and the three patients to whom he had spoken were similarly positive about their experience. Mr Alldred said that it was tough at present and August had also been unusually tough. There had been an increase in medical patient numbers, both through ED and through the Out

of Hours service. The Department was not where it wanted to be. Staff were indeed under pressure and there were vacancies but the quality of care was high even when breaches in waiting time standards occurred. Performance on waiting times at HDFT remained better than most across the Yorkshire and Humber region. There was work underway, both short-term (rapid reviews, flow studies) and wider – nationally urgent care was under pressure. System-based solutions were essential. Demand was increasing in medical NEL both through greater numbers and higher acuity of patients. The Directorate was looking at plans for winter resilience. He noted that the ED had 11 cubicles and often had 40 patients at any one time.

5.4 Mr Ward said that he had been told during his visit that an increase in the number of care support workers would improve the situation. Dr Scullion reported that he had been on call over the previous weekend and it had been the busiest weekend he had experienced in his 20 years as a radiologist at HDFT.

5.5 The key for Dr Tolcher was ensuring that the service was safe. She said that considerable attention was focused on improving flow while protecting patients from harm. Clinical acuity was, rightly, being prioritised which means that people with less urgent needs will wait longer. Some of the breaches relate to people with complex needs and are clinically appropriate. Important work was in train to examine the patterns of demand in ED; increased demand between 10pm and 4am has been noted, with a mixture of elderly, unwell patients and others with less urgent needs who chose to visit ED at those times. Work to improve patient flow includes improving consultant to consultant referral and timeliness of specialty assessment.

5.6 Moving on, Mr Coulter reported that he and Mr McLean had visited the theatres. Staff had been positive and talked openly about the support which they offered to the wards, when necessary. There had been focus on the use of the World Health Organisation (WHO) checklist. On theatre staff being used to support wards Dr Johnson said that it was having a negative effect on staff morale in her Directorate. Myths were being perpetuated at all levels. There were issues around how staff transferred between wards were valued, treated and respected, and whether they had the competencies to deliver safe care.

5.7 The perceptions around these issues, and wards not being properly staffed, were having a detrimental effect. The orthopaedic surgeons were unhappy with the high levels of sickness in theatres. Mr Marshall was collecting views and there would need to be cross-Directorate agreement about competencies and respect. Dr Scullion noted that the recent Care Quality Commission (CQC) report on Cambridge University Hospitals Trust had included specific adverse comment on the issue of staff being moved between wards and departments. Mrs Dodson commented that this was a key issue not only in the theatres but also on the wards. Dr Johnson said that pay for weekend working was also a concern for theatre staff; whilst medical staff were paid premium rates the essential theatre staff were paid at standard Agenda for Change rates because the time was included in their contracted hours.

5.8 Mrs Dodson questioned how progress would be reported back to the Board. Dr Tolcher said that there was well-established cross-Directorate work on these issues. There would always be a requirement for flexibility and some bridge-building was necessary. However, transferring staff without the appropriate competencies was indefensible. Mr Mclean expressed his extreme concern – he had felt the depth of feeling and emotion in the staff and believed that it was a threat to the service. Whilst some of the concerns may be misplaced, morale was undoubtedly low. Dr

Scullion said that there was clear acceptance that the position was serious and urgent action was needed. Mrs Foster said that the vacancies in theatre staffing were being addressed and that the establishment was now recruited to one gap. Dr Tolcher concluded discussion on this issue by confirming that she would update the Board in October. **Action: Dr Tolcher**

5.9 Mr McLean expressed his extreme concern about the lack of repairs and works in the theatres. Mr Harrison said that the condition of the theatre paint was poor but was being addressed – he conceded that communication of the action in hand could perhaps have been better. There had been a need to change paint suppliers – the existing paint required theatres to be closed for three days and could only be applied by outside contractors. Temporary measures which had been taken were not aesthetically satisfactory. The Trust had been working with an alternative supplier to identify a new product which was much easier to apply and by Trust staff. It was also available in a range of colours which was increasingly important given the large number of patients undergoing surgery under local or regional anaesthesia. More broadly the Estates department remained under pressure and continued to operate the risk-assessed process for material faults. Mr Harrison was pleased to report that recent recruitment had been much better and that the transfer of some functions to Imtech, under the Carbon Energy Fund contract, had freed up some time for the Trust staff, but resource constraints remained.

5.10 Dr Tolcher endorsed Mr Harrison's comments about insufficient resources and said that there were continuing conversations about staffing and maintenance. It was important to strike the right balance between quality of care, safety and financial prudence. Mr Ward noted that he was aware that there were 27 property and estates issues in the Sir Robert Ogden Macmillan Centre – Mr Harrison said that he and Mr Sturdy had recently held a long meeting to discuss and resolve these.

5.11 Moving to the forthcoming CQC inspection, Dr Tolcher welcomed the opportunity to demonstrate the quality of the services provided by HDFT. It was important to be open about areas where there were issues; and where there were risks there must be effective plans in place to mitigate and eliminate them. She had instituted a weekly planning meeting in preparation.

5.12 Dr Tolcher was pleased to report that the Trust had now agreed a contract with HaRD CCG, although there were some matters which required resolution. Mr Thompson expressed dismay that it was already six months into the year and asked how the finally agreed position differed from that at the outset. Had lessons been learnt, he wondered, and could the time taken have been better spent? Mr Coulter said that the issues had been straightforward and that the key things had related to the community contract, which was fundamental to provide the resource to deliver services in the community and safeguard staff employment. Dr Tolcher said that the baseline value of the community block contract was now substantially more than that offered in February.

5.13 Dr Tolcher noted that a substantial number of posts for New Models of Care (NMOC) were being recruited 'at risk' but reassured Board members that confirmation of funding from NHS England, through the Value Proposition (expected on 25 September), would be available before any posts were confirmed. Financially August 2015 had been better than in previous years with income in line with the plan, although costs had been slightly more. Directorates had been more robust on rostering of leave.

5.14 Turning to her report on the Senior Management Team (SMT) meeting, Dr Tolcher noted the change in performance reporting. In August the meeting had focused on additional staffing; in September it had concentrated on the financial recovery plans of the Directorates, particularly the shortfall in Cost Improvement Programmes for 2015-16 including non-recurrent measures, and how to support them to return to the Operational Plan.

5.15 Professor Proctor said that she found the report on the SMT to be really helpful. She asked about the contractual and regulatory implications of the Infection controls data. Dr Tolcher replied that monetary fines could be levied for cases above the ceiling figure for *C. difficile*. However, of the 13 recorded cases examined so far, none had been the result of lapses in care and the Trust. Commissioners have the discretion on whether to apply fines and have been supportive of our approach. The details would be flagged in the Intelligent Monitoring data and the Trust would explain the position – Mr Coulter said that Monitor was already aware of this trend and our discussions with the CCG. More cases had been identified but it was clear that patients were not being infected at the Trust and this was the pattern across the Yorkshire and Humber region. Professor Proctor asked how the CQC would interpret this in the context of providing safe services and Dr Tolcher replied that CQC would look at systems, processes and whether the Board was sighted on actions being taken. Mrs Foster added that they would be discussed with the Trust CQC manager in their regular meetings.

5.16 Moving on Professor Proctor said that she had found the report on policies on the Trust Intranet to be worrying. Dr Tolcher agreed but said that the scale of issue was now known and action was in hand to bring the policies up to date – clearly there had been a lack of process control and applications of the processes which were in place. The owners of the policies and the sub-group which would ratify the updated versions had been identified. The new website, which was planned to be online in January, would make the policies more accessible so it was important that they were up to date. Mr McLean asked about the timing and focus of recovery action, which Dr Tolcher confirmed to be the end of November. Mrs Dodson commented that it had been an important audit which linked with wider governance issues and staff morale. She asked for a report on progress at the November Board meeting and for a final report to be brought to the Board in January 2016.

**Action: Dr Tolcher**

5.17 Mr Ward commented on the income and expenditure figures at this halfway point of the year. He wondered whether the trend was likely to continue or show an improvement. Mr Coulter said that there would be an improvement and pointed to the work of the SMT in pursuing the Cost Improvement Programme (CIP) and looking at ways to bring income back on plan and reduce expenditure. Directorate plans had been risk-assessed and it was important that the CIP picked up the shortfall from the first five months of the year. He said that challenging and positive discussions were taking place especially around improving quality and performance alongside financial performance. In the specific of the PLACE results, and changes which needed to be made, he said that these could only be funded if the Trust achieved the plan at the end of the year.

5.18 Moving to discussions at the meeting with Governors, Mr Ward said that there were discharge issues which needed to be addressed. These impacted on both the financial position and on patient satisfaction with the services. Mr Coulter agreed and

said that on the wider front fully established rosters across wards and theatres would reduce costs and improve quality as well. Mrs Webster said that there also needed to be rostering improvements and made the link between staffing and finance. She understood that many staff did not use Rosterpro. Mrs Dodson said that the issue was that some staff did not use Rosterpro for planning their rosters and that a 'hearts and minds' campaign was needed for key ward managers. Mrs Harrison agreed and said that the real savings to be made were being lost because of a lack of engagement by some staff with the rostering tool. She said that a company was being brought in to cleanse the data and sit alongside staff to ensure that the data was correct. It could also monitor the acuity of patients to give visibility of issues across different areas of the Trust.

5.19 Coming back to policies, Mrs Taylor asked about the review process. Mr Harrison said that a significant number of those assessed to be out of date had not been archived appropriately when the new version was loaded. He assessed that the bulk of those found to be out of date would be archived. Professor Proctor wondered whether there was any risk to safe care and compliance. Mr Harrison said that the risk lay in potentially having obsolete policies which may not have been based on the current best evidence. The speed of the review process would reduce this.

5.20 Mrs Taylor asked whether there was an element of 'robbing Peter to pay Paul' in the recruitment of staff for the New Models of Care (NMOC)? Would it not perpetuate the Trust's shortages, and where would the staff come from? Dr Tolcher agreed that there some staff may apply to move from acute teams to community teams but noted that this would offer some benefits in terms of cohesion. One of the aims of NMOC was to reduce the requirement for non-elective beds in the hospital so some movement of staff would become necessary. Mrs Foster added that there was some evidence of movement from HDFT to the NMOC but noted that the community team had recently had 19 applicants for 7 posts all of which were filled with excellent appointments.

5.21 On the subject of risk assessment, Dr Tolcher drew the Board's attention to the four new risks which had been added to the Board Assurance Framework (BAF). One of these had been escalated from the Corporate Risk Register (CRR) – this was around certification of premises occupied but not owned by the Trust. The other three were not new but followed a comprehensive review which she had undertaken; they better articulated known risks and addressed Critical Success Factors.

5.22 Mr Thompson was pleased to see that, from an Audit Committee perspective, SMT had been 'agitated' about compliance with the World Health Organisation checklist and he noted that it was concerned with the process for the certification for death and the implementation of recommendations from Internal Audit reports. Dr Tolcher said that implementation of action plans from Internal Audit reports was a live priority and Mrs Dodson asked that a report be brought to the Board in October, through SMT, on this issue. **Action: Dr Tolcher**

### 5.1 Trust Strategic Objectives

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

5.1.2 Dr Tolcher said that the strategic objectives were key to achieving the long-term goals of the Trust, and fundamentally about its mission and purpose. The

wording was important in aligning the vision, mission and objectives and values. She presented the three strategic objectives for approval by the Board, and emphasised that they would be used to increase the visibility and transparency of the vision for staff.

5.1.3 Mrs Dodson commented that it was essential that, once agreed, every other document must reflect the three objectives so there must be a wide review to ensure that this happened. Dr Scullion asked what would happen to the document which the Board was being invited to approve – would it be available in a simplified form. Dr Tolcher said that it would be used as the underpinning of visual as well as narrative engagement with staff and stakeholders. Ms Barnett was leading the work on this, and appropriate visual representation of it, and would be engaging with Non-Executive Directors before it was brought back to the Board.

5.1.4 The Board **approved** the three Strategic Objectives.

**6. Integrated Board Report**

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

6.2 Dr Tolcher drew out some particular points from the report. She said that there were continuing pressures on safer staffing levels but they remained above the threshold and were acuity-related as far as possible She was pleased to note that sickness absence levels were at an all-time low despite the pressure and that fewer were reporting stress as a cause. Dr Tolcher commented that the rate of temporary staffing was down compared with 2014 but was still driving excess staff costs; this had a potential effect on the quality of care and achieving the financial plan. On the spike in delayed transfers of care, following discussion with NYCC colleagues it had been decided not to reinstate the suspension of fines for these occurrences. This will be kept under review.

6.3 Moving to operational performance she described this as positive. A detailed report on cancer pathways was included in the confidential session of the Board. The screening of new-borns remained as issue in so far as the Key Performance Indicators were not being met, but every new-born was being visited within the required time period by at least a community midwife.

6.4 Mr McLean asked about sickness and stress-related absence – to what extent had it declined due to the holiday season? Mrs Harrison said that absence due to stress, anxiety and depression had accounted for approximately 20% of total sickness absence for the last three years. This was now down to approximately 16%. She believed that the associated work in line with our current policies and the resilience training recently piloted within the Trust had contributed to this reduction, although the latter had yet to be fully evaluated. She believed the reduction to be real. Mr Thompson commented that the Mandatory and Essential Training (MEST) compliance was graded Green even though Safeguarding Children and Information Governance were below the required level. He also noted the apparently inexorable rise in staff turnover – up 3% and asked whether this was a concern. Mrs Harrison replied that the Safeguarding Children and Young Persons training was a new requirement, whilst Information Governance training was always a challenge. The subject matters experts were working on both. Dr Scullion said that the linkage between MEST, agreed recently by the Local Negotiating Committee, might help to

increase compliance. Mr Coulter said that the level of 88% against the target of 75% gave a green rating but it was necessary to look at the detail of the green gradings as well.

6.5 On the turnover issue Mrs Harrison said that the corporate nursing team was looking at drawing up a retention strategy; this could include a mandatory exit interview, with a view to understanding why staff were leaving and if possible persuading them to stay. There was a need to gather and analyse such exit interview information.

6.6 Mrs Webster stated that the staff Friends and Family Test data had shown a reduction in the number of staff who would recommend the Trust as a place to work. Mr McLean considered that in his view this did not necessarily merit a green rating. Mr McLean sought guidance on how hard the Trust was driving to identify the five most important things which really make a difference to staff and where would the effort be best placed to achieve further improvements in staff engagement. The information contained in the Integrated Board report showed a reduction in the survey results from Quarter One of 2015/16 when 69% of staff (of the 26% of staff primarily employed in the Acute and Cancer Care Directorate that responded to the survey) stated that they would recommend the Trust as a place to work, to 66% in Q2 (of the 11% of staff primarily employed in the Elective Care Directorate that responded to the survey).

The Trust remains above the Quarter one national average of 63% for this indicator (61% in Yorkshire and the Humber) and well below the national average (positive) for the number of staff unlikely to recommend the Trust as a place to work at 7% in Quarter One and 11% in Quarter Two. The national average for the number of staff not recommending their Trust as a place to work was 18% in Quarter One.

Dr Tolcher said that aspirational targets had not yet been fixed – the national annual staff survey provided a considerable volume of data, and detailed action plans were drawn up for adverse findings. Mrs Harrison said that there was a need to collate feedback and draw up action plans as a result of exit interviews.

6.7 Mrs Dodson noted that the trend for pressure ulcers was not green – the Trust's aim was for zero avoidable hospital acquired cases and to minimise their incidence where possible. Mrs Foster replied that these were hard targets and that at the same point last year there had been 93 category 3 and 4 pressure ulcers but that figure was down to 68 for the same period this year. She was committed to identifying why there was a pressure ulcer in the first place and was it attributable to a lack of care at the Trust. Evidence had to be provided to show that good care had been in place whilst patients had been in the Trust. Mrs Dodson reminded the Board that Mrs Foster and team had been to Salford and enquired after progress on improving the position of this Trust as a result. This would be a focus of work for the Quality Committee. Mrs Foster described the work as a 'long burn' – other Trusts with low incidence had taken at least two years to reach that position – she accepted that there were actions in hand but more work to do.

6.8 Dr Tolcher described the improved positon on falls as 'green shoots' and Mrs Foster said that there were difficulties in benchmarking with other Trust because of the variation in reporting criteria. However, there had been 377 falls, with 18 graded as Moderate or Severe, during 2014 and the comparative figures for this year were

341 with seven graded as Moderate or Severe. Whilst this was a significant improvement she was not complacent and there was still work to be done.

6.9 Mrs Taylor asked about readmissions, which were graded green but with an increasing trend, and was there work underway to reduce them. Mr Coulter said that there was work in hand and Mr Harrison reminded the Board that a paper on standardised readmissions was due to be brought to the October meeting of the Board. Dr Scullion pointed out that while the number of readmissions showed an upward trend this was attributable to an increase in activity and the *rate* had been flat over a long period of time. Dr Tolcher added that the Trust was performing well on waiting times generally but reminded Board members that there were some long waits for wheelchair services and that the underlying issues were being examined.

6.10 In drawing this item to a close Mr Coulter said that the cap on nursing agency spend had been set by Monitor at 3% and that he could report that the Trust's spend was well below this level – almost all of the Trust agency spend was on doctors. The regulatory cap was therefore green and no action needed to be taken. Finally he said that the cash balance figure had improved significantly with a figure of £16.7m being paid by the HarRD CCG on the previous Friday, following a red figure at the end of August.

### 7.1 NCEPOD Interim Report

7.1.1 Mr Lavalette's report had been circulated prior to the meeting and was taken as read.

7.1.2 Mrs Dodson invited Mr Lavalette to add any comments which he wished to make. Mr Lavalette said that the concerns about the engagement of medical staff had receded – the position had improved considerably. His continuing concerns were over assurance that the action plans were being executed – there was no group overseeing compliance, it having been devolved to Directorates. He was therefore unable to give assurance because there was no single point of contact. He recommended that the Patient Safety Steering Group be given the responsibility. This was agreed.

7.1.3 Mr Lavalette drew attention to two particular studies – Emergency and Elective Surgery in the Elective Patient, which was continuing and for which there were no quick fixes because of the strategic nature of some of the challenges – and Alcohol-related Liver Disease, where there had been a robust action plan some time ago but he was not assured that progress was being made. Dr Lyth said that there had been some progress on the latter, with a clinic shared between AMU, CAT and the gastroenterology team having been established, and she expected progress within four weeks.

7.1.4 Dr Scullion agreed that surgical care of the elderly was a strategic issue. He noted that the laparotomy audit had shown that the time to Consultant review was showing good progress. A business case was in hand for the appointment of an Orthogeriatrician, which would help. Dr Johnson confirmed that this would be funded once the Directorate reached its extended CIP target. Mr Harrison sounded a note of caution – he said that there was currently a lack of clarity on the proposed role, particularly around the Job Plan and the details. This would not be new funding and would rely on the recurrent delivery of the Best Practice Tariff. The number of patients achieving this had declined due a lack of medical input to patient care.

7.1.5 Mrs Dodson said that this was an important operational issue - including both delivery and compliance elements – which needed to be resolved. Dr Scullion said that taking these issues forward would sit with the Patient Safety Steering Group and that as the chairman he would ask those leading the implementation of action plans to brief the Group in person about progress and the timelines. **Action: Dr Scullion**

7.1.6 Mr Lavalette welcomed the increased focus on NCEPOD through the Patient Safety Steering Group as the issues were fundamentally about patient safety. Dr Scullion agreed that this was important national work which the Trust would support whenever possible. Mr Thompson asked whether the final reports are available online and can progress be tracked. Dr Johnson said that they were on the NCEPOD website and widely accessible.

7.1.7 Mrs Dodson thanked Mr Lavalette for his report.

## 7.0 Report from the Medical Director

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

7.2 Dr Scullion had concluded his review of mortality figures which had shown that the highest percentage of deaths in those admitted at weekends occurred in patients admitted on a Sunday. (19% as against 10% for Saturday admissions). He cautioned that this was extraordinarily crude data and did not take into account the time taken to be assessed by a Consultant, for example. There was, however, a focus around emergency care at weekends. Dr Tolcher reflecting on the 19%, wondered about the quality of care before patients were admitted to the Trust – was there any evidence of poor decision-making outside the hospital in making the decision to admit, particularly for end of life care. Dr Scullion said that he was hopeful that there would be a region wide review of case notes which would provide benchmarking information.

7.3 Moving on Dr Scullion noted the return which had been made to NHS England around the provision of seven-day services - a condensed version would be published on the 'My NHS' website in early October. He said that the National Safety Standards for Invasive Procedures (NatSSIPs) were concentrating heavily on surgical safety, including the implementation and operation of the WHO Checklist. There was also a focus on Never Events, which were being drawn into work on the WHO Checklist and other checklists.

7.4 Dr Scullion noted that, following the letter on 62 day cancer referrals written by the Chairman of Leeds Teaching Hospital Trust (LTHT) to the Chairman, he could reassure Board members that HDFT endeavoured to meet the targets for referred patients. There were overarching issues involved, including increased demand on the back of media stories, interpretation of available data and patient flow issues. Discussions were scheduled for early October between himself and Mr Harrison and the Leeds team. The focus was always timely intervention for patients on the cancer pathway and the support from LTHT was very good, with an excellent relationship between the two Trusts. Mrs Dodson echoed this and confirmed the Board's commitment to delivering effective cancer pathways. There would be an operational

response to the LTHT letter and she would respond positively and appropriately to the Chairman of LTHT.

**Action: Mrs Dodson**

7.5 Moving to research, Mrs Dodson noted that the report stated the Local Clinical Research Network fell short on recruitment *per capita* of population. Dr Scullion said that this was a regional matter – HDFT continued to 'punch above its' weight' in terms of recruitment, and was performance-managed on this basis, and Mr Harrison said that the Integrated Board Report showed that the Trust was ahead of target this year.

7.6 Mrs Dodson wondered whether there were implications for the Trust in the closure of the Acute Stroke Service. Dr Scullion said that the impact would be small. The majority of the cases would be taken on by the Bradford Trust. There was no appetite for centralising the regional Hyperacute Stroke Service and the focus was on improving prevention and services. Dr Tolcher said that Airedale had not been part of the Stroke Alliance – HDFT may receive fewer than 10 patients per year. Mr McLean asked whether there would be lessons to learn - Mr Harrison said not to rely on one practitioner in providing a service. Dr Scullion said that although the Trust had four practitioners, there was limited local contingency; it was important for Trusts to support each other regionally. Mr Harrison noted that HDFT was seeking to achieve greater resilience through Acute Medicine in future and that its participation in the Stroke Telehealth Alliance provided significant resilience to the service.

7.7 Professor Proctor asked whether the regional mortality group could be commissioned to look at the position in the Trust. Dr Scullion replied that this was not how it was currently designed to operate. It was an acute Trust model and aimed to define a unified regional model of casenote review with a view to rolling this out as a national model. At this stage it was offering expertise to standardise and objectify casenote review. Professor Proctor noted that this was pathway decision-making rather than a tool for acute Trusts. Dr Scullion added that he would be involved in further telephone discussions after the Board meeting and would update Board colleagues in October. **Action: Dr Scullion**

7.8 Mrs Webster noted the progress made with the Making Experiences Count review and her proposal that this should be taken, along with the Patient Experience report, at the Quality Committee was endorsed by the Board.

**Action: Dr Scullion to discuss with Mrs Webster**

7.9 Dr Tolcher commented that Professor Roberts, Director of the Leeds Institute of Medical Education had asked the Trust to consider employment opportunities for medical students and suggested that medical students employed in this way would be well placed to undertake patient interviews or data analysis.

7.10 Finally Dr Scullion drew attention to the annual Statement of Compliance with the appraisal and revalidation process which was required by NHS England by 30 September and recommended that the Board approve it. Mrs Dodson invited comments and the Board approve the Statement of Compliance, which would be signed by the Chairman and Chief Executive.

## 8. Report by the Chief Nurse

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

8.2 Mrs Foster drew attention to the position on recruitment of nurses. She believed that local opportunities had not been exhausted. She had set up a nurse recruitment group in the short term and the forthcoming Open Event would be a focus for recruitment activity. The Trust had done well in recruiting theatre staff and there were no vacancies in the Emergency Department (although there was long-term sickness and maternity leave) and surgical wards. The five gaps in trauma and orthopaedics had all been recruited and four gaps in Farndale ward had similarly been filled. The biggest challenge remained Integrated Care, particularly on the acute floor with seven gaps, four vacancies and three Whole Time Equivalents on maternity leave. There were gaps in Care Support Workers and 1:1 care positions but there had been eight applications and one interview was scheduled for 24 September to complete the establishment in paediatrics. There was more traction and targeting the local community had been effective, particularly in the case of returnees to the profession. A fresh approach to marketing of opportunities at the Trust had been adopted. She was also targeting universities (and not just York) and had written to all local student graduate nurses. The intention with new recruits was to encourage movement around the Trust to gain experience quickly.

8.3 Mr Ward asked whether the processes allowed additional recruits to be taken on to anticipate future turnover. Mrs Foster confirmed that this was possible and she would be offering rotations as an alternative, as well as over-employing in known pressured areas. Mrs Harrison confirmed that the recruitment process factored in predicted turnover of staff. Mrs Dodson asked about the effect of Leeds Community Health Trust paying enhanced rates to non-District Nurse staff. Mrs Harrison replied that whilst this was indeed happening but it was not the Trust's position. Some of those staff who had left under this arrangement had now indicated a desire to return to HDFT.

8.4 Moving on to Adult Safeguarding she said that the regional Chair has exhorted Trusts to adopt the multi-agency policy and procedures. Mrs Foster said that the Trust would write formally to confirm the adoption of the policies and would be compliant by 31 December 2015, including making the necessary changes to training. The policy affected terminology, timing of reports and further areas of abuse (including neglect) and provided safeguarding around carers being abused.

8.5 Turning to the Equality Delivery Scheme of the NHS (EDS2), Mrs Foster said that the Trust was well on with the work and the template of self-assessment of compliance would be completed by 31 January 2016. There were nine service-related items to be implemented over three to five years. The first self-assessments would be by the Directorates against the three inclusive leadership templates. The governance around this would be through the Equality and Diversity Task Group and reported to the Patient Experience Steering Group. Mrs Dodson invited the Board to confirm commitment to Action 2 in the Mrs Foster's report on EDS2, which was agreed.

8.6 In discussing the next steps in guidance on nurse staffing, Mrs Foster confirmed that she would bring the National Quality Board report to the Board in October. **Action: Mrs Foster**

8.7 Mrs Webster said that, as a member, she was aware that the HaRD CCG had undertaken some work on EDS2, including a questionnaire, and suggested that this might be useful to the Trust. Mrs Foster confirmed that she was discussing the possibility of partnership working on this with the CCG. Professor Proctor sought assurance that patients with learning disabilities and mental capacity challenges were included in both the new adult safeguarding policies and EDS2. Mrs Foster said that this was the case, as part of the governance process. The capability of subject matter experts around learning disabilities was being built in to future planning.

## 9. Report by the Chief Operating Officer

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

9.2 Mr Harrison asked Board members to note the results of the PLACE survey and gave some context for the assessments where the Trust had fallen below the national average. He noted that this included having curtains inside single rooms (privacy and dignity) and for dementia a range of issues including colour of door frames, signage, toilet and bathroom designation and having shining floors – the latter because they appear wet and slippery to dementia patients. He reported that the domestic supervisors were enthused by the need to find an appropriate floor polish with a matt finish. SMT had considered a range of recommendations which if implemented in full would cost in the region of £670,000 overall, about half of which would be the cost of replacing the flooring to move away from patterned flooring in relevant wards. There was a need to strike the right balance of priorities.

9.3 Mr Harrison noted that the changes to Imtech management had caused some delay whilst they negotiated with their suppliers, but it was now back on track. It was a good partnership which would help to make the Trust both safe and effective.

9.4 On the PLACE inspection, Dr Tolcher said that more intelligence was needed to triangulate data on the correlation between patterned floors and falls before the major outlay was undertaken. Current falls mapping shows no correlation with shiney floors on site. Some of the privacy and dignity changes, by contrast, were low costs and would be done quickly.

9.5 Mr McLean asked why the Sentinel Stroke National Audit Programme rating had fallen back to D from C in the previous quarter. Mr Harrison said that the Stroke Steering Group was examining this but there had been bed pressures and higher volumes of patients and length of stay, which had an impact on the time taken to bring the patient to the unit and CT scanning. There needed to be an earlier alert and the Trust was aiming to improve to a sustainable C rating.

9.6 Mr Thompson asked about the withdrawal of the services of the Commissioning Support Unit and the implications for HDFT. Mr Harrison said that the Trust was working to ensure that they were not affected in delivery – some functions had been taken 'in house'. The biggest concern was telephony and a plan was being worked through to mitigate the costs of transfer.

## 9.1 Emergency Preparedness, Resilience and Response Assurance

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

9.1.2 Mr Harrison said that the report did not need Board approval but was brought to be noted. He was confident that the area which was not fully compliant would be rectified.

9.1.3 The Board noted the Statement of Compliance.

## Managing Resources Efficiently

### 10. Report by the Director of Finance

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

10.2 Mrs Dodson said that the focus was clearly on recovery to the planned position. Mr Coulter recapped the three areas of concern – nurse staffing costs, medical staffing costs and the Cost Improvement Programme. As of the end of July a straight line forecast of the financial position would be to be £2.9m behind plan at the end of the year. A range of measures had been taken and key actions were summarised in his report. Monthly meetings on finance and activity were continuing and, whilst it remained work in progress, the Directorates had shown absolute ownership and commitment. Mrs Dodson looked forward to hearing about their plans from the Directorates under Item 12.

10.3 Mr Coulter explained that the Monitor Risk Assurance Framework change has now been agreed and had been introduced from Q2. It was a harder measure such that in Q1 when the Trust reported a rating of 4, it would have been 3 under the new rating scheme. It was important that the Trust confirmed a rating of 3 for the next 12 months. The Board should note that although the rating had been 2 for August, it was forecast to be 3 for the end of Q2.

10.4 Mr McLean asked about the drop in income from activity in Leeds, especially as the Trust had identified this as an area for growth. Mr Coulter confirmed that this was as the result of a drop in outpatient activity, although there had been a rise in day case surgery where there was direct access to the Trust.

### 12.0 Reports from Directorates

12.1 Mrs Dodson invited the Clinical Directors to report on their Directorates in the context of Mr Coulter's remarks.

12.2 Mr Alldred said that the position felt really challenging and it as matter of balancing operational issues against financial sustainability and NMOC. The Directorate had delivered more than 80% of the CIP. He was concentrating on all things around urgent care and setting up the community hubs. The Directorate was fully focused on engagement and the commitment to put the plan back on track, with plans to deliver over the next few months. He had concerns about *C.difficile,* the Wheelchair service, the quality of care and the mortality figures at Ripon Community Hospital. The significant review of radiology services was complete and implementation of the action plan was underway. He noted that there would be step

changes to make but reaffirmed his Directorate's complete commitment to the financial recovery plan.

12.3 Dr Johnson said that Elective Care had delivered more than 84% of the CIP. She was working hard on reducing premium rate costs. The plan in orthopaedics had been reduced but had not been achieved. A new consultant would start work in the Spring but the Clinical Lead had stood down and no replacement was available. There had been some pushback on the accountability of the Clinical Lead. Mr Coulter said that some changes were being instituted from 1 October. Dr Johnson said that the Directorate was working with the orthopaedic team to et a clear vision and continued engagement. There were also Middle Grade staffing issues which were being discussed across the three Directorates, which would be hugely influential.

12.4 Dr Tolcher commented that the grip of the Clinical Directors should not be underestimated. They were having some difficult but game-changing conversations, as with premium rate payments. There was work to do to secure the buy-in of senior clinicians, some of whom thought that the financial position would 'all come good on the night'. The Consultant Forum was limited in gaining engagement from these doctors.

12.5 Dr Lyth said that she had been gaining an appreciation of the effect of support being provided by the nursing staff. She was also looking at patient flow issues, which would be reported to the Quality Committee. The changes to ward configuration (FLIP), which would take place on 5 October, were designed to rationalise and improve patient flow with an expectation that the patient would stay in hospital for the shortest time possible. She noted the progress of quality improvement work in Lascelles, where a new escalation procedure had been developed following what had been a near miss, previously reported to the Board. Finally Dr Lyth said she was working on the Older Person Strategy.

12.6 Mrs Dodson thanked the Clinical Directors for their reports.

## Valuing and Rewarding Staff

### 11. Report by the Director of Workforce and Organisational Development

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

11.2 Mrs Harrison noted that the immunisation programme was currently at 89% compliance and the acute staff programme would be completed by 31 December. She also drew attention to the progress of the Deanery visit report actions.

## Assurance

### 13. Report of Harrogate Health Transformation Board

13.1 Dr Tolcher had no assurance issues to report.

## 14. Reports

14.1 Mrs Taylor reported that the Finance Committee was due to meet on 9 October and would be looking in detail at the issues around the CEF/Imtech contract, the position on repair/replacement of equipment and take a forward look at the 2016-17 CIP.

14.2 Mrs Webster reported that the Quality Committee had held meetings in both August and September and had taken a detailed view of one of the annual Quality Priorities at each (communications and patient flow respectively). The Committee had interrogated the dashboards and looked in detail at the situation with the GP Out of Hours service. She would be ensuring that the Quality Committee sought assurance across the five CQC domains. There were two issues which the Committee wanted to bring to the attention of the Board. First, there was a concern in respect of how it can be demonstrated satisfactorily that the learning from SIRIs is being suitably embedded throughout the Trust and second, that additional, unbudgeted, costs have arisen as a result of new quality procedures related to Maternity screening following the re-training in the use of growth charts.

14.3 Mr Thompson reported that the Audit Committee had last met in September, when it looked in particular at the implantation of the WHO checklist and the follow up to Internal Audit action plans, where the Committee was pleased to see that SMT was applying its focus. Mr Thompson also drew attention to the hard and high quality work of the finance staff in preparing the Annual Accounts for the year-end meeting on 21 May.

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

15.1 Mrs Dodson confirmed that there were no such reports for September.

## 16. Any Other Business

16.1 There was no other business.

## 17. Board Evaluation

17.1 Mrs Dodson asked Board members whether it had been appropriate not to have met in August and whether it had added extra pressure to that day's meeting. She thought that the emphasis of the meeting had been open debate.

17.2 Mr Coulter said that there had been a lot of movement between July and September and he thought it may have been helpful to have updated the Board in the first week of September by way of an Integrated Board Report. Mr McLean said he thought that this would provide continuing and adequate assurance and information flow.

17.3 Dr Tolcher said that the arrangement had given the staff space to undertake work on financial recovery, 2016-17 plans and CIP. She felt that an operational performance report but not a formal Board meeting was an appropriate way to proceed. Mr McLean appreciated that there was a huge volume of work going on in the background – he thought that the Board required too much to be prepared and

received too much. It needed to focus on the real priorities – hit them and move on. He felt it should be a matter of absolute priorities, deliver and receive assurance.

17.4 Dr Tolcher wondered what would need to be taken away. Whilst she would wish to spend less time it was a matter of complying with regulatory requirements. Mrs Dodson asked what was not needed – the Board required assurance. Mr Ward said that the Board needed to understand that it should spend its time on the big changes.

17.5 Mrs Webster thought that the Integrated Board Report was working well; giving the right flavour of key issues on which to focus. However, the remaining Executive reports appeared to be as long as before it was instituted. She thought that the commentary in the Integrated Board Report could be used to better effect. In her opinion the Board needed more 'clear time' to discuss longer-term strategy, for example how NMOC could improve current operations.

17.6 Professor Proctor had found the reports from SMT to be reassuring. She felt that the triangulation and connectivity were helpful in steeping away from the detailed issues.

17.7 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 12.42pm.

Signed……..Chairman

Dated……

Harrogate and District NHS
NHS Foundation Trust

# HDFT Board of Directors Actions Schedule – October 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 of completion/progress update | Confirm action Complete |
|---|---|---|---|
| Report on Action Plan following Morecambe Bay Inquiry | Mrs Foster, Chief Nurse | July 2015 | Complete |
| Circulate to Board members agreed HHTB Principles document | Dr Tolcher, Chief Executive | July 2015 | Complete |
| Board Agenda to include monthly reports from, and Minutes of, Committees of the Board | Mr Forsyth, Interim Head of Corporate Affairs | July 2015 | Complete |
| Invite comments on draft Integrated Board Report for final version at September Board meeting | Mr Forsyth, Interim Head of Corporate Affairs | July 2015 | Complete |
| Report to Board on how changes resulting from implementation of Duty of Candour are being prioritised | Dr Scullion, Medical Director | July 2015 | Complete |
| Possible changes to the Remuneration Committee to be discussed by NEDs | Mrs Dodson, Chairman | July 2015 | Complete |
| Investigate the incidence of deaths which took place within 24 or 48 hours of admission on Thursdays or Fridays | Dr Scullion, Medical Director | September 2015 (July 2015) | Complete |
| Report on overarching review of growth charts and associated issues in | Dr Johnson, Clinical Director, Elective Care | September 2015 | Complete |
| Mr Lavalette, NCEPOD Ambassador, to report biannually (Mar/Sep) on progress of NCEPOD work | Dr Scullion, Medical Director | September 2015 | Complete |
| Report progress on GPOOH service | Mr Alldred, Clinical Director, Acute and Cancer Care | September 2015 | Complete |
| Update on immunisation screening of staff | Mr Marshall, Director of Workforce and | September 2015 | Complete |

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|---|---|---|---|
| | Organisational Development | | |
| Examine the possibility of seconding a substitute IPC nurse to Director Team visits when required | Mrs Foster, Chief Nurse | September 2015 | Complete |
| Arrange a session on risk assessment for Non-Executive Directors | Mr Coulter, Director of Finance/Deputy Chief Executive | September 2015 | Complete |
| Investigate linkage between HDF research nurse and Leeds University project on pressure ulcers | Mrs Foster – Chief Nurse | September 2015 | Complete |
| Report on outcome of Clinical Lead discussions | Dr Johnson, Clinical Director, Elective Care | September 2015 | Complete |
| Write to Nursing and Midwifery Council re concern about lack of statutory replacement | Mrs Foster, Chief Nurse | September 2015 | Complete |
| Provide Board members with link to data underlying report | Mr Marshall, Director of Workforce and Organisational Development | September 2015 | Complete |
| Circulate Healthwatch report on York Wheelchair service to Board members | Mr Alldred, Clinical Director, Acute and Cancer Care | September 2015 | Complete |

Harrogate and District NHS
NHS Foundation Trust

# HDFT Board of Directors Actions Schedule – Outstanding Actions

## October 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 | September 2015 | Update the Board on progress with managing transfers of nursing staff to cover shortages (5.8) | Dr Ros Tolcher – Chief Executive | **October 2015** | |
| 2 | September 2015 | Report on implementation of action plans from Internal Audits (5.22) | Dr Ros Tolcher – Chief Executive | **October 2015** | |
| 3 | September 2015 | Update the Board on issues around surgical care of the elderly (7.1.5) | Dr David Scullion – Medical Director | **October 2015** | |
| 4 | September 2015 | Reply to letter on cancer pathways from Chairman of LTHT (7.4) | Mrs Sandra Dodson - Chairman | **October 2015** | |
| 5 | September 2015 | Brief the Board on discussions with chairman of regional mortality group (7.7) | Dr David Scullion – Medical Director | **October 2015** | |
| 6 | September 2015 | Bring National Quality Board report to the Board (8.6) | Mrs Jill Foster – Chief Nurse | **October 2015** | Not available until November |
| 7 | July 2015 (June 2015) | Develop and circulate a consistent narrative and direction of travel for the Trust (4.1.2) | Dr Tolcher - Chief Executive | **October 2015** | |
| 8 | July 2015 (April 2015) | Board Paper on Admissions (including readmissions) (10.5) | Dr Lyth - Clinical Director, Integrated Care Directorate | **October 2015 (July 2015)** | |

| | | | | | |
|---|---|---|---|---|---|
| 9 | July 2015 | Report to the Board on outcomes of National Emergency Laparotomy audit (7.3) | Dr Scullion - Medical Director | **October 2015** | |
| 10 | September 2015 | Update the Board on progress with review and archiving of policies (5.16) | Dr Ros Tolcher – Chief Executive | November 2015 | |
| 11 | June 2015 | Investigate potential for HDFT to instigate Beacon Wards scheme (4.0) | Mrs Foster - Chief Nurse | January 2016 (September 2015) | |

Harrogate and District NHS
NHS Foundation Trust

| Report to the Trust Board of Directors:<br><br>28 October 2015 | Paper No:<br>**4.1** |
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| | |
|---|---|
| **Title** | **Reducing Avoidable Readmissions** |
| **Sponsoring Director** | Dr Natalie Lyth |
| **Author(s)** | Dr Natalie Lyth, Ms Karen Barnett |
| **Report Purpose** | To update the Board on progress to reduce avoidable readmissions |

**Key Issues for Board Focus:**

- **Note the baseline data from May 2015**
- **Review of the Q2 data and number of patient readmitted multiple times**
- **Actions taken to capture information on avoidability of readmissions**
- **A further audit is underway to review all multiple readmissions to AMU**

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

| | |
|---|---|
| **Risk and Assurance** | This report provides assurance to the Board that there is focused work within the Trust on avoidable admissions and the level of readmissions |
| **Legal implications/ Regulatory Requirements** | None |

**Action Required by the Board of Directors**

- The Board will wish to **note** the details of the readmissions
- The Board is recommended to **endorse** the actions underway

**Board update report:**

**Reducing avoidable readmissions**

Lead Directorate : Integrated Care

**Context**

Out of hospital care is usually much more effective in maintaining the function and quality of life of an elderly person with frailty.

As part of the work to design and develop intermediate care to provide support for individuals to remain in the community or facilitate discharge from Hospital following an acute episode of illness, there is work to be done to prevent avoidable admissions to hospital and to reduce the readmission rate for the 4% of vulnerable people based on risk stratification.

Baseline data
A review of readmissions for May was undertaken, to provide a baseline understanding of the emergency readmissions. 332 patients were readmitted within 30 days of their previous admission as a non-elective admission. Of these 157 were readmitted to a general medical speciality, 44 patients under medical oncology or haematology, 71 under surgery, 7 gynaecology patients, 3 obstetric patients, 15 trauma and orthopaedic patients and 35 paediatric patients. It is of interest to note that in May there were 7 patients who attended and were admitted multiple times due to drug or alcohol overdose.

Quarter 2 data
In Q2 303 patients over 70 were readmitted non-electively within 30 days of their previous admission. Of these 59 were related to CAT admission and re-attendance.
76 related to care of the elderly readmissions.

In addition 11 patients have been readmitted 4 times, 1 patient 6 times and 1 patient 7 times.

The patient that has been admitted 7 times attended CAT 4 times and was admitted to the ward for overnight stays due to repeated drug overdoses. The patient who has been admitted 6 times has a cancer diagnosis.

The patients that have been admitted 4 times have the following presentations: -

1 mental health patient
4 x overdose
2 x cancer
1 x gastro
1 x diabetic complications
1 x cellulitis – 2 CAT attendance and 2 overnight stays
1 x COPD
1 x aspiration pneumonia

Actions undertaken

A review the cohort of readmissions was undertaken in July in order to determine what the primary reason for their readmission was. Whilst there has been an assumption that many patients are readmitted due to poor discharge this wasn't highlighted as the primary cause.

A proforma has been developed for trial as part of the admission documentation to capture information around whether the admission could have been avoided and this information will then enable targeted focus for these patients at MDT discussion in the future. The admissions proforma has been developed further and will be incorporated into the new admission documentation that will be launched in the first week of November 2015.

The main area of note is that of the patients receiving multiple admissions due to drug or alcohol overdose and we have therefore set up a multi-agency discussion to review the pathways for these presentations. Following the provider to provider discussion to understand the specifics of these cases and those on Q3 we will produce a report for the CCG on our findings.

In addition there are a small number of patients with significant challenging behaviour that are supported currently between TEWV Child and Adult Mental Health Services (CAMHS) and HDFT and some that are being managed between TEWV Adult Mental Health Services and HDFT. Case conferences have been set up to develop multi-agency plans for these individuals including Police, Crisis team, ED , acute medical team and psychiatric input.

The discharge team are undertaking a further audit on AMU to review all the patients that have been readmitted between 2 and 4 times, specifically focusing on discharge planning and whether the readmission has been as a result of any social, functional reasons or poor discharge preparedness. Further reports will be produced to support the CQUIN reporting process.

Natalie Lyth
Karen Barnett

Integrated Care Directorate
22/10/2015

| | |
|---|---|
| **Report to the Trust Board of Directors:**<br><br>**28 October 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 |

**Key Issues:**
The Trust's financial performance remains challenging with adverse variance in both income and expenditure year to date. Directorates have agreed recovery plans. The revised risk adjusted position while falling short of our full plan forecasts a small surplus at year end.

The Vanguard Value Proposition has been agreed with NHS England and transitional funding has been confirmed. Recruitment to the early adopted pilot site is underway.

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

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

**Action Required by the Board of Directors**
The Board of Directors is asked to:

- Note actions being taken to improve delivery of the financial plan.
- Note progress on planning for 2-015/16 in terms of clinical transformation and cost improvement.

## 1.0 MATTERS RELATING TO QUALITY AND PATIENT EXPERIENCE

### 1.1 Nursing staff transfers between wards

The Trust relies upon its flexible workforce to ensure safe care and optimal use of resources. It is not unusual for qualified and support staff to be moved between areas based on the clinical needs of patients being cared for. It is important that safeguards exist, as defined in our local guidance, to ensure all staff have the appropriate skills when moving between clinical areas and that they are inducted to local operating procedures. It is recognised that this practice is thought to have affected staff morale and retention in some areas. Following feedback from staff, the Chief Nurse is working with Matrons to ensure effective arrangements operate to protect both patients and staff when these moves are necessary. This will include some listening events that will take place throughout October, via a variety of means, to capture feedback and suggestions from staff.

### 1.2 Safe staffing levels

Monitoring of staffing levels in respect of nationally prescribe ratios continues to show high levels of compliance across our inpatient areas. Despite this, early warning indicators in the form of staff feedback and deteriorating access have triggered rapid reviews in two clinical areas in the last month. Both have resulted in skill mix changes and new investment in staffing.

In the Emergency Department clinical need and volume of work is outstripping the established staff mix. A comprehensive review led to an agreement to increase staffing as an interim measure whilst some opportunities for improvement are pursued. Staffing will be more closely aligned to predictable levels of demand and support worker capacity will be increased.

In our Clinical Assessment Team and Acute Admissions area staff escalated concerns about their ability to meet the clinical needs of the patients. Additional investment to support a safe and sustainable model has been committed.

## 2.0 STRATEGIC UPDATE

### 2.1 2015/16 Contracts

A contract with Harrogate and Rural District CCG has now been signed.

### 2.2 Developing the Trust's Vision and Mission statements

Karen Barnett, Operational Director for Integrated Care, has been leading some staff engagement on Vision and Mission. Previous staff and public engagement as part of developing our Values, the work on 'You Matter Most', and the New Models of Care Open Space event has also been incorporated. The Board of Directors will review emerging views at its' Development session this month.

### 2.3 Ripon Partnership

The Project Initiation Document developed by the Ripon Partnership has been reviewed at a meeting between commissioners, NHS Property Services and NHS England. NHSE has requested a revised PID to include more detail in respect of commissioning intentions and associated revenue costs. They also require more information about the building itself, including matters pertaining to sustainability.

This will require some re-phasing of stages but should not change the overall timeline.

## 3.0 WORKING IN PARTNERSHIP

### 3.1 New Models of Care (Vanguard Programme) and Harrogate Health Transformation Board

The Value Proposition has been approved by the NHS England New Care Models team. We anticipate signing a Tripartite Partnership Agreement between NHSE, National ALBs and the Vanguard Partners. This will set out the support requirements which our Vanguard site has asked for, the role of the support team and the overall objectives of the programme.

Recruitment to the early implementation site is underway.

As reported previously, impact modelling has shown that implementing new models of care will improve quality and outcomes for our population and release savings. The new model will not, however, fully close the emerging funding gap. The Harrogate Health Transformation Board (HHTB) will now widen its remit to address the system-level sustainability challenges.

### 3.2 Update from the West Yorkshire Association of Acute Trusts (WYAAT)

The group met on 2 October.

The WYAAT Acute Care Collaboration Vanguard application was unfortunately not successful. There may, however, be an opportunity for some elements of the proposal to be progressed as part of the other West Yorkshire Vanguard, which covers Urgent and Emergency Care. This is the largest Vanguard project nationally and includes some ambitious plans for reshaping emergency care which could lead to a network approach on a much larger scale.

Provider Trusts in WYAAT are pursuing the procurement of a single IT platform for radiology which would potentially reduce cost and enable improved access to shared information and resources. The Trust is engaged in this work.

WYAAT has established a significant profile nationally and locally and is increasingly being seen as a route for engagement and influence.

## 4.0 FINANCIAL POSITION

The Trust achieved an in month surplus of £306k in September which is £361k adverse of plan. The Trust year to date deficit has reduced to £591k, £1410k behind plan.

The underlying position is one of adverse variance in both income and expenditure. As in previous months, adverse variance in pay relating to medical and nurse staffing and under attainment of CIPs are key drivers. Issues behind the shortfall in income are understood and being addressed.

Directorates have prepared financial recovery plans totalling an additional £2.6m.

## 5.0 SENIOR MANAGEMENT TEAM (SMT) MEETING

Key issues from the SMT meeting held on 16 September:

- Manchester Patient Safety Framework self-assessment tool. Initial results from SMT members were presented and discussed. Learning and effecting change, and communications about safety issues are the Trust's highest scoring. This is an evidence-based tool designed to promote reflection and learning as the foundation of a patient safety culture.
- Financial recovery plans. Directorates presented their plans to correct current income and expenditure variances. Clinical and corporate directorates have identified additional schemes equating to £2,652k. The actions described would enable a year end surplus of £1,452k, £348k behind plan. This is dependent on all plans being actioned at the level described and no unexpected cost pressures occurring. Applying the risk adjusted methodology suggests a surplus of £1,268k, £932k behind plan.
- CIP planning for 2016/17 and beyond was discussed. Directorates undertook to bring detailed plans and timelines for PID and Quality Impact Assessments to the October SMT.
- Operational performance:
    - GP referral via the cancer pathway - HDFT is an outlier in terms of activity (higher than average) and conversions (lower than average). This confirms anecdotal reports that the pathway is not always used appropriately. This is being addressed via clinical leads in the CCG.
    - Falls causing harm have fallen compared with last year. The year to date number of falls causing harm (fractures) is 7, compared with 18 for the same period in 2014/15. Total falls are also 10% lower.
    - Mortality rates at Ripon General Hospital have been flagged as potentially higher than expected in routine monitoring. Initial investigation show that 80 – 90% were deaths associated to end of life/palliative care. Further work is underway to understand this data. No immediate concerns relating to care quality have emerged
    - GPOOH KPIs for urgent care remain red-rated. The new NHS 111 Direct booking facility commenced in July and should start to impact on access. The safety of care is under close scrutiny and no concerns have been raised.
- Good progress on reducing staff sickness absence was applauded. In particular, a reduction in absence due to stress, anxiety and depression, which has previously been at levels between 18% and 25% which is reflected nationally. In July levels dropped to 16%. The staff wellness scheme has been well received.
- The outcome of the Spring 2015 PLACE inspection was discussed and prioritised actions agreed in order to make improvements where practicable. More information on the actual risks associated with floor coverings is required given the scale of investment which would be necessary in order to upgrade flooring across the site.
- A number of lapses in oversight of medical equipment maintenance have come to light. An internal audit has also found gaps. A centrally-held asset database is being collated to ensure systematic review and renewal.
- Internal Audit reports on Reference Costing (significant assurance); Business Cases and Domestic Services (significant/limited assurance) were received. A detailed update on progress against actions for all outstanding Internal Audits will be discussed at the October SMT meeting.
- Dr Natalie Lyth presented a briefing paper on Care of Older People strategy.

- The Corporate Risk Register was scrutinised and challenged. A timeline for reviewing and archiving of policies located on the Intranet was agreed. Where sub-group scheduling allows, all areas should be up to date by the end of November.

Attendance at SMT remains strong with all key roles and function represented.

A verbal update on matters from the October SMT (21 October) will be provided at the meeting.

## 6.0 COMMUNICATIONS RECEIVED AND ACTED UPON

### 6.1 Safe Staffing and Efficiency

The Trust has received a letter from NHS Improvement, CQC, NHSE and NICE jointly, offering clarity on safe staffing and the need to intensify efforts to meet the financial challenge, previous messages on which are described as being 'seen as contradictory.' The guidance emphasises that responsibility for both safe staffing and efficiency lie with the provider Board. Factors such as patient acuity and dependency, time of day and local factors will in some cases mean a higher number of nurses per patient and in others a lower number or different configuration. This could include Allied Health Practitioners.

The letter goes on to stress that the 1:8 ratio is a guide not a requirement and that achieving the right balance and number of clinical and support staff is the key issue for provider Boards. Trusts are, it emphasises, responsible for ensuring that they get the balance right by neither under-staffing nor over-spending. CQC assesses staffing levels as part of rating safety and staffing ratios are never the sole determinant of a rating.

In order to assist Trusts to manage agency staffing costs, the mandatory use of approved staffing frameworks was brought in on 19 October. This, the signatories affirm, as well as the work of Lord Carter on the Model hospital and the development of further safe staffing guidance, will help to support Trusts to secure safer staffing and greater efficiency.

### 6.2 New Measures to Support Foundation Trusts in Managing Workforce Challenges

This letter, from Monitor and the Trust Development Authority (TDA), refers back to the letter at 6.1 above and details a proposal to introduce hourly price caps for all agency staff across all staff groups from 23 November 2015. Whilst this is subject to the outcome of a consultation, launched on 15 October, the price caps would ratchet down in two further stages so that, from 1 April 2016, agency staff (including bank staff) would not be paid any more than the equivalent substantive worker. The letter states that full compliance would be essential for the measures to work and whilst the maximum rates would apply to Foundation Trusts in breach of their Licence for financial reasons, all Foundation Trusts would be 'very strongly encouraged to comply' and all Trusts would be required to report the reasons for and shift-level detail when they exceed the price caps. Monitor will take into account inefficient or uneconomic spending practices in the new value for money risk assessment trigger.

Monitor and the TDA recognise that adhering to price caps would not be without challenge and, where appropriate, national bodies will work together to support Trusts in meeting the price controls and other agency rules. However, Trusts

would need to ensure that they maintain patient safety at all times and a 'break glass' provision, subject to scrutiny by Monitor and the TDA, is proposed where the caps need to be overridden on exceptional safety grounds.

### 6.3 Annual Report of the North Yorkshire Safeguarding Adults Board

The Trust has received the Annual Report of the North Yorkshire Safeguarding Adults Board for 2014-15, setting out the key themes for the adult safeguarding partnership and its strategic plan. This will be taken forward by the Quality Committee.

## 7.0 BOARD ASSURANCE AND CORPORATE RISK

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

### 7.1 Board Assurance Framework (BAF)

The BAF has been fully reviewed and updated this month. There are 16 Risks recorded on the BAF.

There have been reductions in residual risk scores for three entries:

- BAF#4 (lack of integrated IT structure) has reduced from 16 to 12, , reflecting the approval of the NMOC Value Proposition for 2015-16
- BAF#6 (understanding the market) has reduced from 12 to 8, reflecting the progress made in establishing a business development function. This entry has now reached the target risk score previously agreed by the Board of Directors.
- BAF#8 (visibility and reputation) has reduced from 12 to 8, also reflecting progress in establishing a business development function. This entry has now reached the target risk score previously agreed by the Board of Directors.

There are improvements in action plan progress scores for two risks:

- BAF#16 (assurance on Buildings Safety) is now rated 2 (Actions defined – some progressing, where delays are occurring interventions are being taken) as a result of further meetings with NHS Property Services
- BAF#6 (understanding the market) is now rated 1 (actions on plan)
- BAF#8 (visibility and reputation) is now rated 1 (actions on plan).

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 12* | *unchanged at 2* |
| **BAF#5** | Service Sustainability | *Red 12* | *unchanged at 2* |
| **BAF#6** | Understanding the market | *Amber 8* | *improved at 2* |
| **BAF#7** | Lack of robust approach to new business | *Amber 8* | *unchanged at 2* |
| **BAF#8** | Visibility and reputation | *Amber 8* | *improved at 1* |

| | | | |
|---|---|---|---|
| **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* | *improved at 1* |
| **BAF#13** | Focus on Quality | *Amber 8* | *unchanged at 2* |
| **BAF#14** | Delivery of integrated models of care | *Red 12* | *unchanged at 3* |
| **BAF#15** | Alignment of strategic plans | *Red 16* | *unchanged at 3* |
| **BAF#16** | Assurance of building safety in non-HDFT owned premises | *Red 12* | *improved at 2* |

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

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

The CRR was most recently reviewed at the monthly meeting of the Corporate Risk Review Group on 9 October and SMT on 21 October.

No new risks have been added to the CRR this month.

The risk against quality of service delivery due to failures of medical devices and equipment, which was added last month, has now been defined and audits reports are being used to identify target dates.

The previous top-scoring risk (CR49c: Risk to business objectives due to non-delivery of locality wide IT system) now has a residual risk score of 12 (down from 16) as a result of the approval of the NMOC Value Proposition for 2015-16, which has decreased the likelihood to 3.

Two risks continue to have action plans which are behind plan and subject to additional work:

COR 64: Harm to ophthalmology patients
COR 74: Harm to ward-attending patients

There were no risks to escalate to the Board Assurance Framework this month. The changes in residual risk score for CR49c is to be reflected.

Dr Ros Tolcher
Chief Executive
21 October 2015

Harrogate and District NHS
NHS Foundation Trust

| | |
|---|---|
| **Report to the Trust Board of Directors:**<br>**28 October 2015** | **Paper No: 6.0** |

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

**Key Issues for Board Focus:**

- The RAG rating thresholds have been updated this month - where the metric has a defined national or contractual target level, the RAG rating is set around these thresholds. Where there is no national or contractual target, RAG ratings are set based on the Trust's performance in comparison to other acute trusts. Further details are provided in the report appendix.

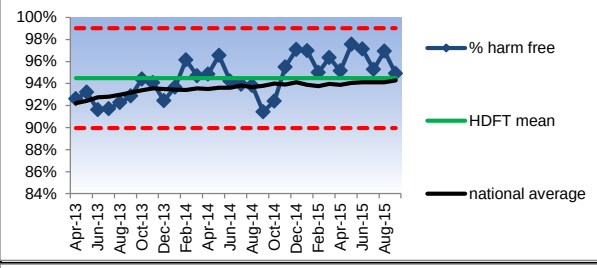
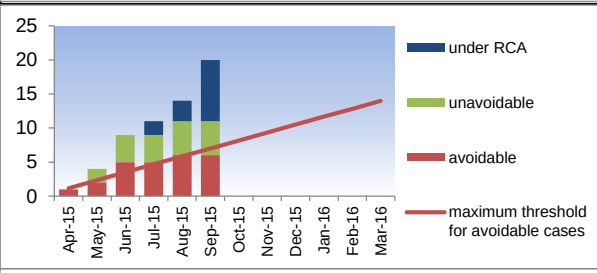
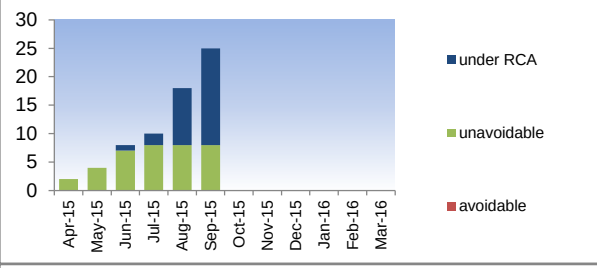
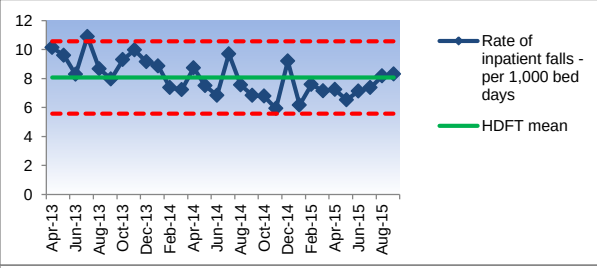
- New community metrics have been introduced this month looking at community acquired pressure ulcers, avoidable hospital admissions and readmissions in older people.

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

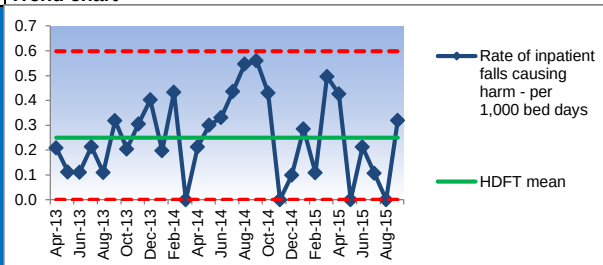
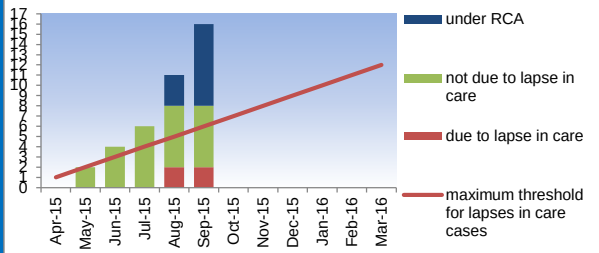
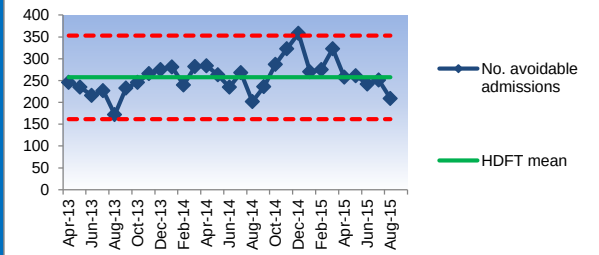
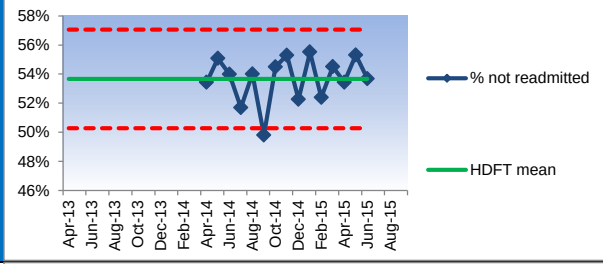
| | |
|---|---|
| **Risk and Assurance** | The report triangulates key performance metrics covering quality, finance and efficiency and operational performance, presenting trends over time to enable identification of improvements and deteriorations. |
| **Legal implications/ Regulatory Requirements**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

**Action Required by the Board of Directors**
To note current performance and consider for comment.

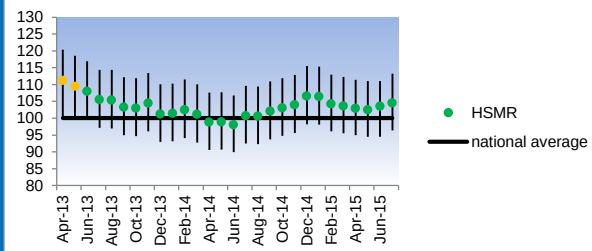
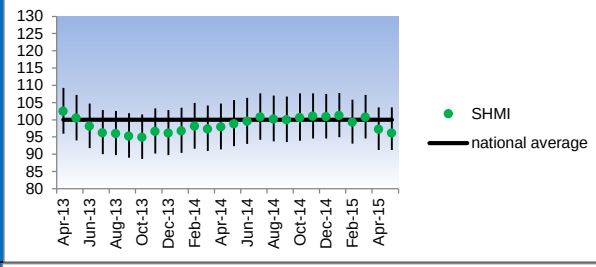
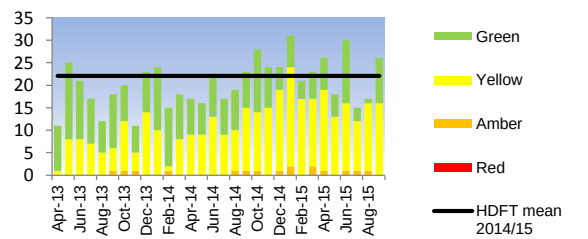
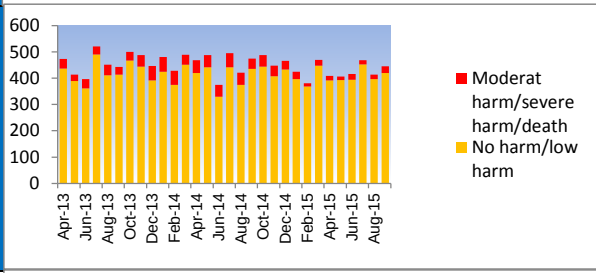
# Quality - September 2015

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Safety thermometer - harm free care** | Measures the percentage of patients receiving harm free care (defined as the absence of pressure ulcers, harm from a fall, urine infection in patients with a catheter and new VTE) in the Safety Thermometer audits conducted once a month. The data includes hospital and community teams. A high score is good. Whilst there is no nationally defined target for this measure, a score of 95% or above is considered best practice. |  | HDFT's performance dipped to just below 95% in September after 10 months of a harm free percentage above 95%. The reduced percentage was caused by an increase in falls causing low harm and an increase in old pressure ulcers reported by the wards and commuinty teams on the day of the audit.<br>The latest available national data shows that HDFT remains above the national average of 94.3%. |
| **Pressure ulcers - hospital acquired** | The chart shows the cumulative number of grade 3 or grade 4 hospital acquired pressure ulcers in 2015/16. The data includes hospital teams only.<br>A maximum threshold of 14 avoidable cases during 2015/16 has been locally agreed. This reflects a 50% reduction on last year's figure. |  | As at end September 2015, there were 20 hospital acquired grade 3 or grade 4 pressure ulcers year to date, of which 6 were deemed avoidable, 5 unavoidable and 9 were still under root cause analysis (RCA). |
| **Pressure ulcers - community acquired** | The chart shows the cumulative number of grade 3 or grade 4 community acquired pressure ulcers in 2015/16. The data includes community teams only. |  | As at end September 2015, there were 25 community acquired grade 3 or grade 4 pressure ulcers year to date, of which none were deemed avoidable, 8 unavoidable and 17 were still under root cause analysis (RCA). |
| **Falls** | The number of inpatient falls expressed as a rate per 1,000 bed days. The data includes falls causing harm and those not causing harm. A low rate is good. |  | The rate of inpatient falls per 1,000 bed days was 8.3 in September 2015, which is above the average HDFT rate during 2014/15. |

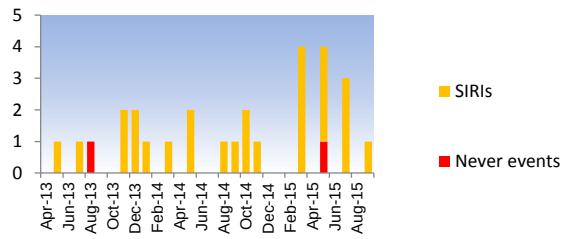
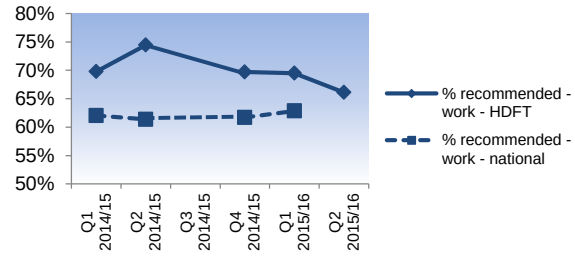
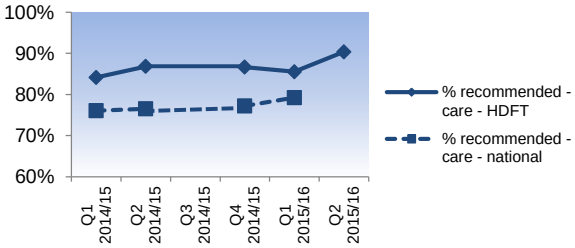
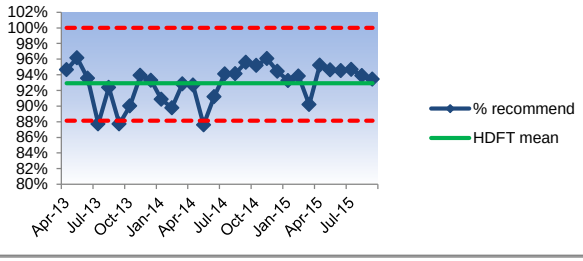
# Quality - September 2015

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Falls causing harm** | The number of inpatient falls causing significant harm, expressed as a rate per 1,000 bed days. The falls data includes falls causing moderate harm, severe harm or death. A low rate is good. |  | The rate of inpatient falls causing significant per 1,000 bed days was 0.32 in September 2015, which is the same as the average HDFT rate during 2014/15. |
| **Infection control** | The chart shows the cumulative number of hospital acquired C. difficile cases during 2015/16. HDFT's C. difficile trajectory for 2015/16 is 12 cases.<br>Hospital acquired MRSA cases will be reported on an exception basis. HDFT has a trajectory of 0 MRSA cases for 2015/16. |  | There were 5 cases of hospital acquired C. difficile reported in September 2015, bringing the year to date total to 16 cases. 11 cases have had root cause analyses completed by HDFT. The initial reports suggest that 2 were due to a lapse in care and 9 were not due to a lapse in care - these are being agreed with HARD CCG. Cases where a lapse in care has been deemed to have occurred would count towards the Monitor risk assessment framework.<br>No cases of hospital acquired MRSA have been reported in 2015/16 to date. |
| **Avoidable admissions** | The chart shows the number of avoidable emergency admissions to HDFT as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require admission. Conditions include pneumonia and urinary tract infections in adults and respiratory conditions in children. |  | The number of avoidable admissions reduced in August 2015. The chart demonstrates some seasonality with this metric with more avoidable admissions occurring over the winter months last year.<br>An admission avoidance/urgent care project group has been established and the Trust is working with HARD CCG to develop care models and pathways that support patients to stay in their own home and reduce the risk of hospital admissions. |
| **Reducing readmissions in older people** | The chart shows the proportion of older people aged 65+ who were still at home 91 days after discharge from hospital into rehabilitation or reablement services. A high figure is good.<br>*This indicator is in development.* |  | This is the first month that this indicator has been presented.<br>For patients discharged in June 2015, 54% were still in their own home at the end of September. |

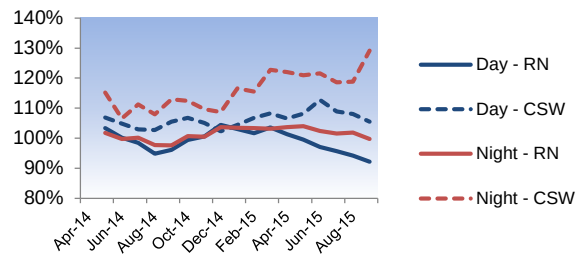
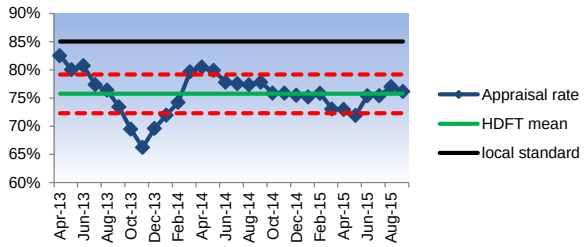
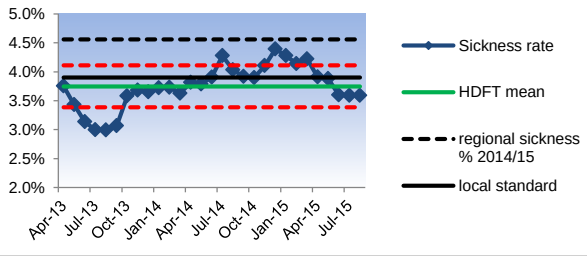
# Quality - September 2015

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Mortality - HSMR** | The Hospital Standardised Mortality Ratio (HSMR) looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care. A low figure is good. |  | HDFT's HSMR increased in July to 104.52. It is above the national average but within expected levels. At specialty level, there were 3 specialties (Geriatric Medicine, Respiratory Medicine and Gastroenterology) with a standardised mortality rate above expected levels. |
| **Mortality - SHMI** | The Summary Hospital Mortality Index (SHMI) looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care. A low figure is good. |  | *There is no update of this data this month.*<br>HDFT's SHMI reduced in May to 96.11. This is below the national average and within expected levels. At specialty level, there were 2 specialties (Geriatric Meidicine and Respiratory Medicine) with a standardised mortality rate above expected levels. Looking at the data by site, Ripon hospital has a higher than expected mortality rate. The Clinical Director for UCC Directorate has commissioned a retrospective clinical case note review of all deaths at or within 30 days of discharge from Ripon Hospital. |
| **Complaints** | The number of complaints received by the Trust, shown by month of receipt of complaint. The criteria define the severity/grading of the complaint with green and yellow signifying less serious issues, amber signifying potentially significant issues and red for complaints related to serious adverse incidents.<br>The data includes complaints relating to both hospital and community services. |  | 26 complaints were received in September, but none were classified as amber or red. |
| **Incidents - all** | The chart shows the number of incidents reported within the Trust each month. It includes all categories of incidents, including those that were categorised as "no harm". The data includes hospital and community services.<br>A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture |  | There were 425 incidents reported in September 2015. The number of incidents reported each month remains fairly static but the proportion classified as moderate harm, severe harm or death has reduced during 2015/16.<br>The latest published national data (for the 6 month period to end March 2015) showed that acute trusts reported an average ratio of 25.0 no harm/low harm incidents for each incident classified as moderate harm, severe harm or death (a high ratio is better). HDFT's reporting ratio for 2015/16 to date is 22.7. |

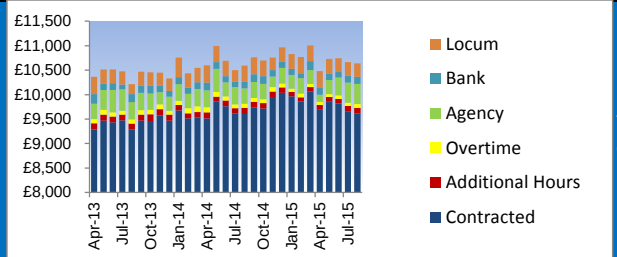
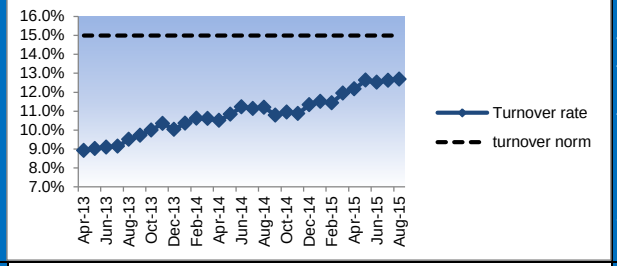
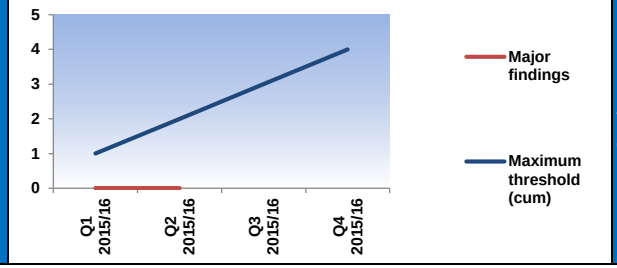
# Quality - September 2015

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Incidents - SIRIs and never events** | The chart shows the number of Serious Incidents Requiring Investigation (SIRIs) and Never Events reported within the Trust each month. The data includes hospital and community services. |  | There was one SIRI reported in September 2015 but no never events. |
| **Friends & Family Test (FFT) - Staff - % recommend as a place to work** | The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organsation they work in.<br>HDFT surveyed all staff for each survey during 2014/15. During 2015/16, a proportion of staff will be surveyed each quarter, which is in line with national guidance.<br>The chart shows the percentage of staff that would recommend the Trust as a place to work. A high percentage is good. |  | In Q2 2015/16, staff from Elective Care Directorate and some staff from the Corporate Directorate were surveyed. 66.1% of staff of staff surveyed would recommend the Trust as a place to work.<br>The latest available national data is for Q1 2015/16. HDFT's score for Q1 was above the national average and placed the Trust 50 out of 149 acute trusts. |
| **Friends & Family Test (FFT) - Staff - % recommend as a place to receive care** | The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organsation they work in.<br>HDFT surveyed all staff for each survey during 2014/15. During 2015/16, a proportion of staff will be surveyed each quarter, which is in line with national guidance.<br>The chart shows the percentage of staff that would recommend the Trust as a place to receive care. A high percentage is good. |  | In Q2 2015/16, staff from Elective Care Directorate and some staff from the Corporate Directorate were surveyed. 90.3% of staff surveyed would recommend the Trust as a place to receive care.<br>The latest available national data is for Q1 2015/16. HDFT's score for Q1 was above the national average and placed the Trust 39 out of 149 acute trusts. |
| **Friends & Family Test (FFT) - Patients** | The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of hospital and community services including inpatients, day cases, outpatients, maternity services, the emergency department, some therapy services, district nursing, community podiatry and GP OOH. A high percentage is good. |  | The chart shows the overall score (% who would recommend the service) for all HDFT services currently participating in the FFT survey. 93.4% of the 5,500 patients surveyed in September would recommend the service to friends and family. Response rates vary between services but the Clinical Directorates are working on maximising these. |

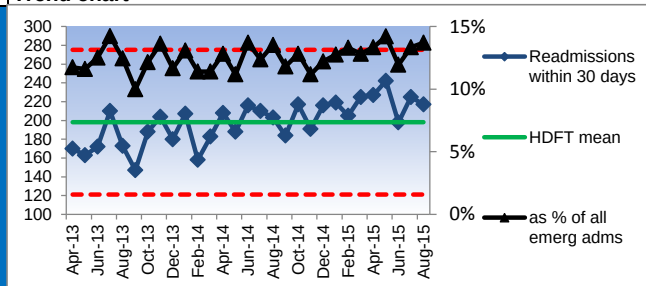
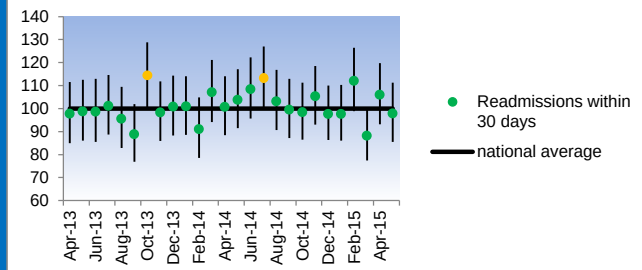
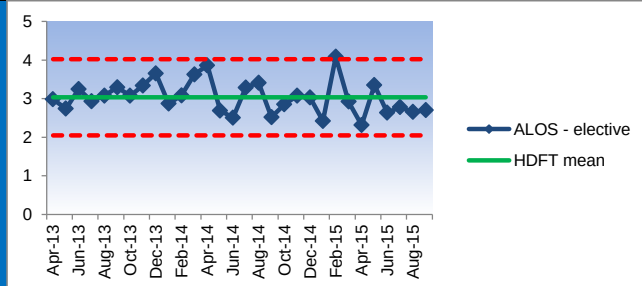
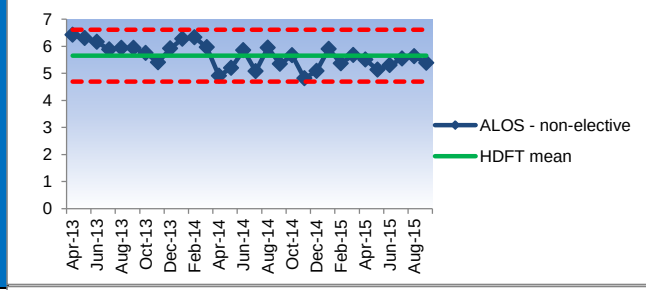
# Quality - September 2015

<table>
<tr><th>Indicator</th><th>Description</th><th>Trend chart</th><th>Interpretation</th></tr>
<tr><td>Safer staffing levels</td><td>Trusts are required to publish information about staffing levels for registered nurses/midwives (RN) and care support workers (CSW) for each inpatient ward. The chart shows the overall fill rate at HDFT for RN and CSW for day and night shifts. The fill rate is calculated by comparing planned staffing with actual levels achieved. A ward level breakdown of this data is published on the Trust website.</td><td> 
</td><td>Registered nurse/midwife (RN) staff levels reduced in September - reduced activity during the month enabled some bed closures and RN staffing was reduced as a result. Care support workers (CSW) staffing levels have increased, particularly at night. This is reflective of the increased need for 1-1 care for some inpatients.<br>The Trust aims for 100% staffing overall but staffing below or above this level on any given day is not necessarily indicative of an inappropriate or unsafe staffing level.</td></tr>
<tr><td>Staff appraisal rates</td><td>The chart shows the staff appraisal rate over the most recent rolling 12 months. The Trusts aims to have 85% of staff appraised. A high percentage is good.</td><td> 
</td><td>The locally reported cumulative appraisal rate for the 12 months to end September 2015 was 76.2%, a decrease on the previous month. Data from the 2014 national staff survey suggested that 87% of HDFT had been appraised within the last 12 months.<br>Skills for Health are currently in the Trust interviewing staff to establish how to improve appraisal complaince and asking line managers how they feel they can support staff in maximising talent management.</td></tr>
<tr><td>Mandatory training rates</td><td>The table shows the most recent training rates for all mandatory elements for substantive staff. A high percentage is good.</td><td><table>
<tr><th>Competence Name</th><th>Total Employees</th><th>% Completed</th></tr>
<tr><td>Equality and Diversity - General Awareness</td><td>3498</td><td>95</td></tr>
<tr><td>Fire Safety Awareness</td><td>3498</td><td>84</td></tr>
<tr><td>Health & Safety</td><td>1356</td><td>98</td></tr>
<tr><td>Infection Prevention & Control 1</td><td>676</td><td>100</td></tr>
<tr><td>Infection Prevention & Control 2</td><td>2769</td><td>86</td></tr>
<tr><td>Information Governance: Introduction</td><td>3228</td><td>85</td></tr>
<tr><td>Information Governance: The Beginners Guide</td><td>262</td><td>75</td></tr>
<tr><td>Safeguarding Adults Awareness</td><td>3503</td><td>98</td></tr>
<tr><td>Safeguarding Children & Young People Level 1</td><td>3498</td><td>88</td></tr>
</table></td><td>The data shown is for end September 2015. The overall training rate for mandatory elements for substantive staff is 89%, compared to 88% last month.<br>Discussions continue with the directorate management teams to ensure non-compliant staff are individually followed up. In addition Skills for Health have interviewed line managers to probe around the usage of the individual follow-up procedure.</td></tr>
<tr><td>Sickness rates</td><td>Staff sickness rate - includes short and long term sickness.<br>The Trust has set a threshold of 3.9%. A low percentage is good.</td><td> 
</td><td>HDFT's staff sickness rate was 3.59% in August 2015, below the Trust threshold level (3.9%) and no change on the previous month.<br>Work is continuing to progress the Trust's health and wellbeing agenda. The Wellbeing Adviser interviews occurred on Thursday 13th August and a preferred candidate has been selected.</td></tr>
</table>

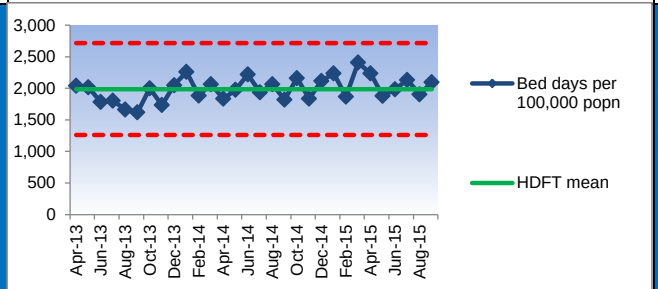
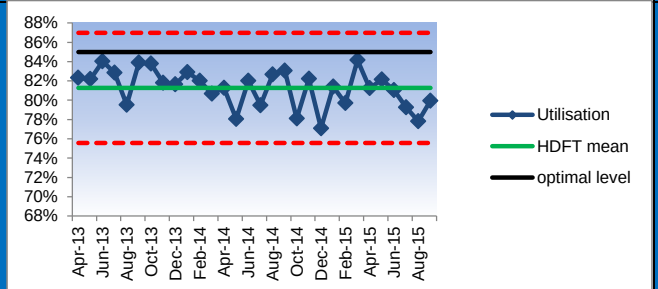
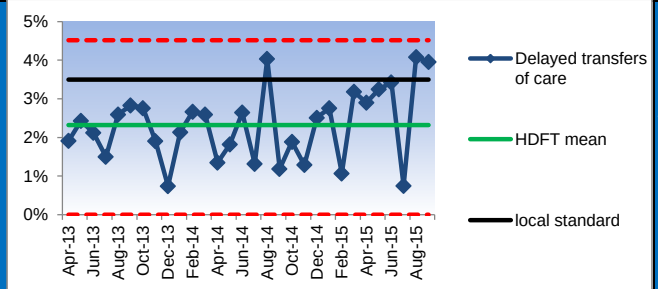
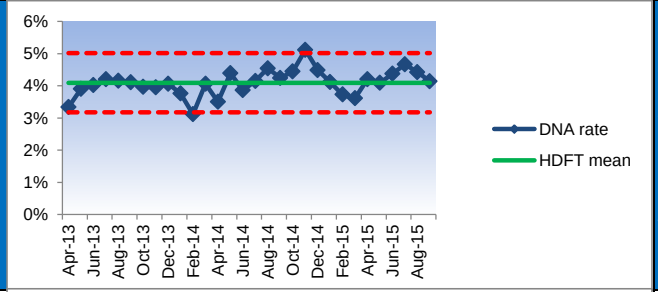
# Quality - September 2015

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Temporary staffing expenditure - medical/nursing /other** | The chart shows staff expenditure per month, split into contracted staff, overtime and additional hours and temporary staff. Lower figures are preferable. |  | The proportion of spend on temporary staff during 2015/16 to date is 7.1%, compared to 7.5% in the same period in 2014/15. |
| **Staff turnover rate** | The chart shows the staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts.<br>Data from the Times Top 100 Employers indicated a turnover rate norm of 15%, i.e. the level at which organisations should be concerned. |  | The staff turnover rate was at 12.7% in August 2015. HDFT's turnover rate has generally increased over the last two years but has levelled off during 2015/16 and remains below the turnover norm of 15%.<br>Exit questionnaires are received by the Human Resources Department where they are reviewed. Any patterns identified prompt investigating further and on occasion departmental stress risk assessments may be conducted. |
| **Research internal monitoring** | The Trust internally monitors research studies active within the Trust. The department mirrors the MHRA categorisation of critical, major and other findings (departures from legislative or GCP requirements). The department has set a standard of no critical and no more than four major findings per annum. Major and other findings are non-notifiable and dealt with locally. |  | There were no critical or major findings reported in the year to date. |

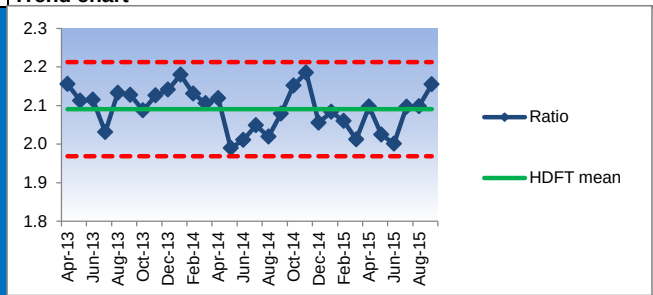
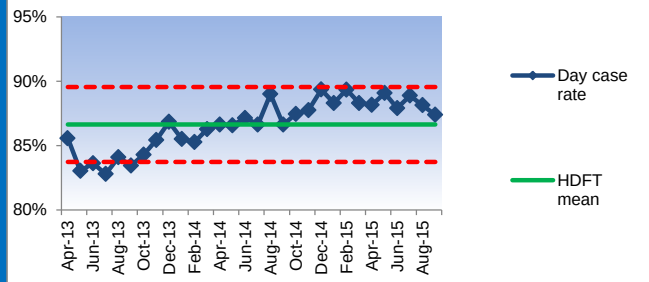
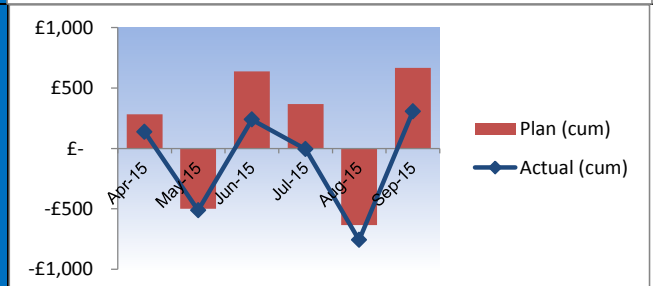
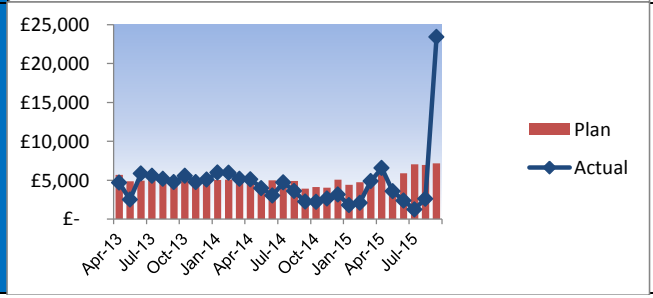
# Finance and Efficiency - September 2015

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Readmissions** | % of patients readmitted to hospital as an emergency within 30 days of discharge (PbR exclusions applied). To ensure that we are not discharging patients inappropriately early and to assess our overall surgical success rates, we monitor the numbers of patients readmitted. A low number is good performance.<br>This data is reported a month behind so that any recent readmissions are captured in the data. |  | The number of readmissions within 30 days is increasing. However when expressed as a % of all emergency admissions (black line on the chart), there has been no significant change over the last two years.<br>Data collection for the readmissions case note audit has commenced with a clinical proforma attached to notes of patients who have been readmitted to support the data capture. |
| **Readmissions - standardised** | This indicator looks at the standardised readmission rate within 30 days. The data is standardised against various criteria including age, sex, diagnosis, comorbidites etc. The standardisation enables a more like for like comparison with other organisations. The national average is set at 100. A low rate is good - rates below 100 indicate a lower than expected readmission rate and rates above 100 indicate higher than expected readmission rate. |  | *There is no update of this data this month.*<br>The standardised readmission rate for HDFT for May-15 (latest data available) was 97.8. This is below the national average and a reduction on the previous month. |
| **Length of stay - elective** | Average length of stay in days for elective (waiting list) patients. The data excludes day case patients.<br>A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay. |  | The average elective length of stay for Sep-15 was 2.7 days, no change on the previous month.<br>A focus on sustainably reducing this through the Planned Care Transformation programme is underway, which includes reducing the number of patients admitted the day before surgery. |
| **Length of stay - non-elective** | Average length of stay in days for non-elective (emergency) patients.<br>A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay. |  | The average non-elective length of stay for Sep-15 was 5.7 days, a slight decrease on the previous month.<br>There is a focus on patient flow and discharge through the Unplanned Care Transformation Programme which is looking to optimise internal efficiencies to minimise length of stay. |

# Finance and Efficiency - September 2015

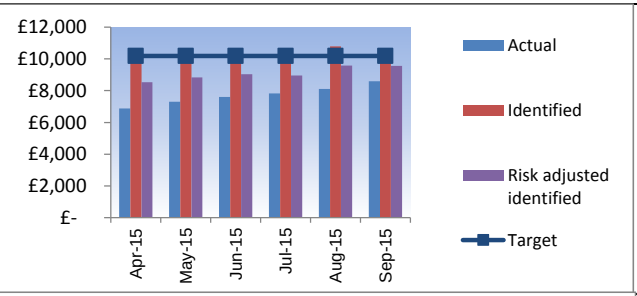
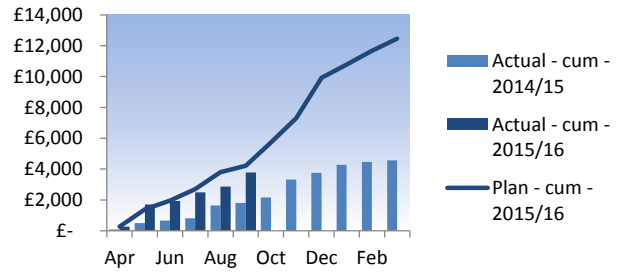
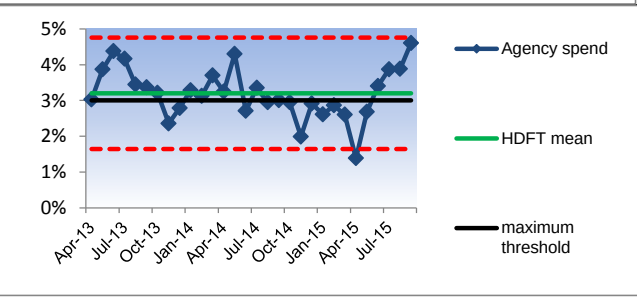
| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Non-elective bed days** | The charts shows the number of non-elective (emergency) bed days at HDFT for patients aged 18+, per 100,000 population. The chart only includes the local HARD CCG area. A lower figure is preferable. |  | As can be seen, the number of non-elective bed days for patients aged 18+ has remained fairly static over the last two years. Further analysis of this new indicator will be completed to look at the demograghic changes during this period and the number of admissions for this group will assist in understanding this further. |
| **Theatre utilisation** | The percentage of time utilised during elective theatre sessions only (i.e. those planned in advance for waiting list patients).<br>A higher utilisation rate is good as it demonstrates effective use of resources. A utilisation rate of around 85% is often viewed as optimal.<br>*Caution should be exercised when interpreting this indicator as there are data quality issues with the reported data.* |  | Theatre utilisation increased in September 2015 to 80.0%. The Elective Care Directorate are continuing to review the utilisation of theatres and will be working with the anaesthetic team to ensure that the impact on elective theatre lists of gaps in the anaesthetic rota is minimised.<br>The utilisation calculation is being reviewed to ensure that it correctly handles lists that are cancelled in advance. |
| **Delayed transfers of care** | The proportion of patients in acute hospital beds who are medically fit for discharge but are still in hospital. A low rate is preferable.<br>A snapshot position is taken at midnight on the last Thursday of each month. The maximum threshold shown on the chart (3.5%) has been agreed with the CCG. |  | Delayed transfers of care were at 4.0% when the snapshot was taken in September. This is a decrease on the previous month but above the maximum threshold of 3.5% set out in the contract.<br>The discharge liaison team are working closely with North Yorkshire and Leeds local authorities to improve the position. |
| **Outpatient DNA rate** | Percentage of new outpatient attendances where the patient does not attend their appointment, without notifying the trust in advance.<br>A low percentage is good. Patient DNAs will usually result in an unused clinic slot. |  | The DNA rate for outpatient first attendances in Sep-15 was 4.0%, a decrease on the previous month.<br>DNA rates at outreach clinics are being monitored to ensure that they are not significantly higher than clinics on the main site. During Q2, the DNA rate for first outpatient appointments at outreach clinics was 5.2%, compared to 4.3% on the main Harrogate site. Directorate teams will be asked to focus on why offsite rates are higher if this persists. |

# Finance and Efficiency - September 2015

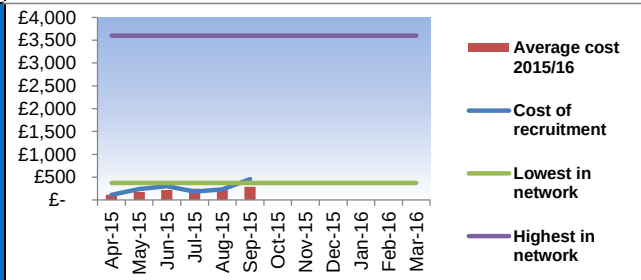
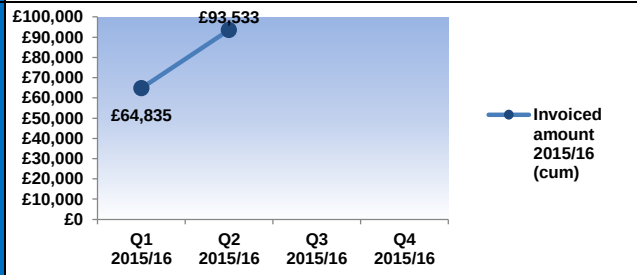
| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Outpatient new to follow up ratio** | The number of follow-up appointments per new appointment. A lower ratio is preferable. A high ratio could indicate that unnecessary follow ups are taking place. |  | The new to follow up ratio was 2.15 in September 2015, an increase on the previous month.<br>The Deputy Director of Performance & Informatics is leading a review with the CCG of patients who wait longer than 6 months for a follow up appointment. Changes to the PAS system have enabled the Trust to record clinical conditions for each follow up attendance and reports have been developed and shared to analyse this. |
| **Day case rate** | The proportion of elective (waiting list) procedures carried out as a day case procedure, i.e. the patient did not stay overnight.<br>A higher day case rate is preferable. |  | The elective day case rate in September was 86.6%. As can be seen from the chart, the day case rate steadily increased during 2013/14 and 2014/15 and has now levelled off during 2015/16.<br>Through the Day Surgery Transformation group, a number of new patient pathways have been assessed and setup recently. Work is ongoing to review and support developments of Best Practice Tariff and the directorate has agreed a cross specialties 'default to day surgery' list of procedures. |
| **Surplus / deficit and variance to plan** | Monthly Surplus/Deficit (£'000s). In some months, a deficit is planned for. This indicator reports positive or adverse variance against the planned position for the month. |  | The Trust reported a surplus of £306k in September, £361k behind plan. There was a significant adverse variance in relation to income of £513k in month. The Trust year to date deficit therefore reduced to £591k, £1,410k behind plan.<br>Expenditure continues to be ahead of plan with a significant adverse variance to date of £890k. Three key issues continue to require focus - medical staffing expenditure; nursing expenditure, particularly in relation to 1-1 care and delivery of CIP.<br>The Trust position reflects the need to ensure recovery plans are in action, putting into place the work that has been identified by directorates to reduce expenditure while bringing activity back to planned levels. |
| **Cash balance** | Monthly cash balance (£'000s) |  | The cash balance at the end of September was a significant improvement on previous months. This is a result of the agreement in relation to cash profiles with HARD CCG, as well as a catch up payment following contract agreement. The Trust is yet to invoice for overtrades in 2015/16.<br>The increase in cash in positive, however, it should be noted that following payment in November, there will be no more monthly contract payments in relation to the acute contract, only overtrade payments which are yet to be finalised. |

Harrogate and District NHS
NHS Foundation Trust

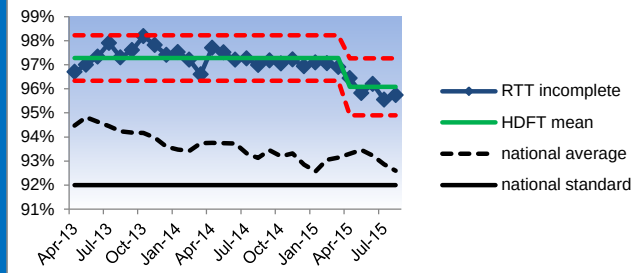
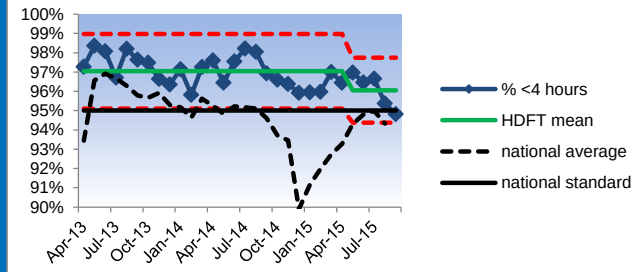
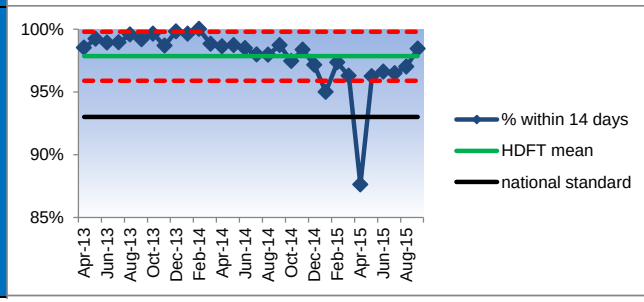
# Finance and Efficiency - September 2015

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Monitor continuity of services risk rating** | The Monitor Continuity of Services (CoS) risk rating now includes four components, as illustrated in the table to the right. An overall rating is calculated ranging from 4 (no concerns) to 1 (significant concerns). This indicator monitors our position against plan. | **Element** / **Plan** / **Actual**<br>Capital Service Capacity rating: 4 / 3<br>Liquidity rating: 4 / 3<br>I&E Margin rating: 3 / 2<br>I&E Margin Variance rating: 2 / 2<br>**Financial Sustainabiltiy Risk Rating: 3 / 3** | The Trust will report a risk rating of 3 for the year to September. This is in line with the Trust plan following the introduction of the new metrics previously discussed.<br><br>Despite still being a 3, the Trust's current position means this is weaker than initially planned. |
| **CIP achievement** | Cost Improvement Programme (CIP) performance outlines full year achievement on a monthly basis. The target is set at the internal efficiency requirement (£'000s). This indicator monitors our year to date position against plan. |  | 85% of plans have been actioned by directorates. A further 9% of plans are in place at present following risk adjustment. |
| **Capital spend** | Cumulative Capital Expenditure by month (£'000s) |  | Capital Expenditure is behind plan. This is due to a delay in relation to the Carbon Energy Fund Scheme. All other schemes are on plan. |
| **Agency spend in relation to pay spend** | Expenditure in relation to Agency staff on a monthly basis as a percentage of total pay bill. The Trust aims to have less than 3% of the total pay bill on agency staff. |  | Agency expenditure remains high, with September expenditure greater than at any point over the past 2 years. Agency and Locum costs remain the significant contributor to this position. |

# Finance and Efficiency - September 2015

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Research - Cost per recruitment** | Cost of recruitment to NIHR adopted studies. The Research department has a delivery budget of £69,212 per month. A low figure is preferable. |  | In 2014/15, the range across the network for recruitment cost was £372 to £3599, HDFT achieved a figure of around £375. HDFT's average cost per recruitment remains low. |
| **Research - Invoiced research activity** | Aspects of research studies are paid for by the study sponsor or funder. |  | As set out in the Research & Development strategy, the Trust intends to maintain its current income from commercial research activity and NIHR income to support research staff to 2019. Each study is unique. Last year the Trust invoiced for a total of £223k. |

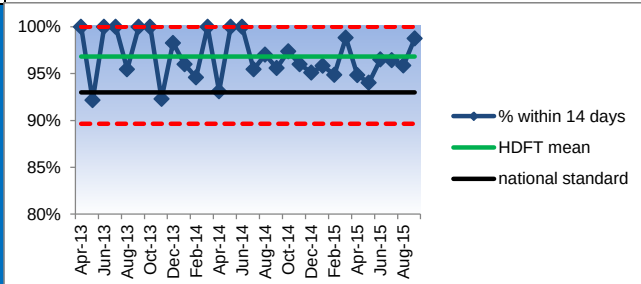
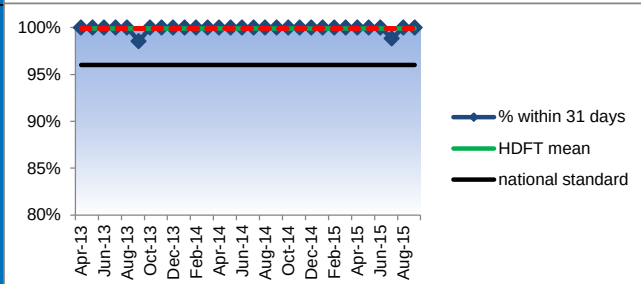
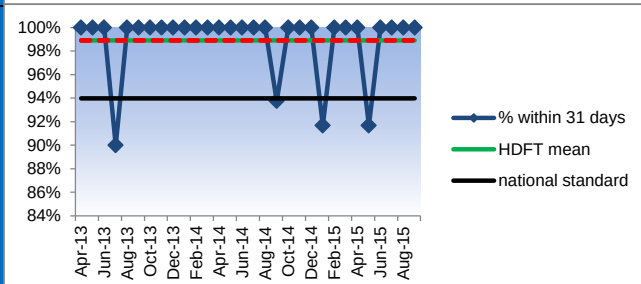
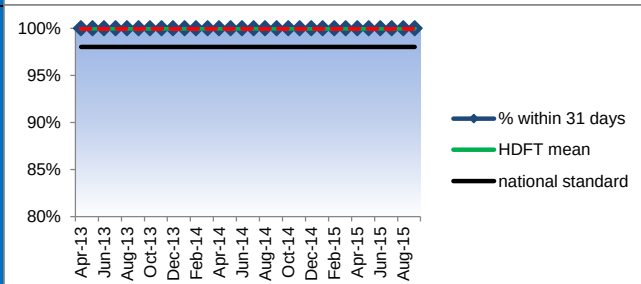
# Operational Performance - September 2015

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Monitor governance rating** | Monitor use a variety of information to assess a Trust's governance risk rating, including CQC information, access and outcomes metrics, third party reports and quality governance metrics. The table to the left shows how the Trust is performing against the national performance standards in the "access and outcomes metrics" section of the Risk Assessment Framework. An amended Risk Assessment Framework was published by Monitor in August 2015 - updated to reflect the changes in the way that the 18 weeks standard is monitored. | | HDFT's governance rating for Q2 is Green.<br>The Trust reported 16 cases of hospital acquired C. difficile year to date at end September. 6 of these cases have been agreed with HARD CCG to not be due to lapses in care and therefore these would be discounted from the trajectory for 2015/16. |
| **RTT Incomplete pathways performance** | Percentage of incomplete pathways waiting less than 18 weeks. The national standard is that 92% of incomplete pathways should be waiting less than 18 weeks.<br>A high percentage is good. |  | 96.0% of patients were waiting 18 weeks or less at the end of September.<br>There has been a deterioration in performance over the last few month but HDFT consistently performs above national average and above the required national standard of 92%. |
| **A&E 4 hour standard** | Percentage of patients spending less than 4 hours in Accident & Emergency (A&E). The operational standard is 95%.<br>The data includes all A&E Departments, including Minor Injury Units (MIUs). A high percentage is good. Histroical data for HDFT included both Ripon and Selby MIUs. In agreement with local CCGs, York NHSFT are reporting the activity for Selby MIU from 1st May 2015. |  | HDFT's overall trust level performance for September 2015 was 94.8%, below the required 95%. This includes data for the Emergency Department at Harrogate and Ripon MIU. However the overall Trust performance for Q2 was above the standard at 95.6%.<br>Performance in this area continues to be monitored daily and the Clinical Director for Urgent, Community and Cancer Care is leading on the work to ensure we sustainably deliver this standard as an organisation. |
| **Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals** | Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%.<br>A high percentage is good. |  | Provisional performance for Q2 to date is above the required standard at 97.8%.<br>Whilst the Trust achieved the required 93% for each quarter of 2014/15, there was a deterioration in performance during the year as illustrated in the trend chart. There has been a significant increase in the number of 2 week wait referrals received by the Trust since Q4 2014/15, partly due to the impact of several national and local cancer awareness campaigns. |

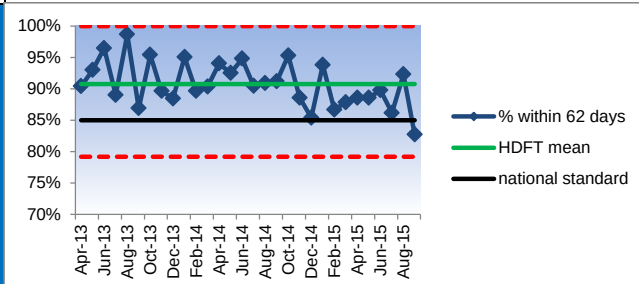
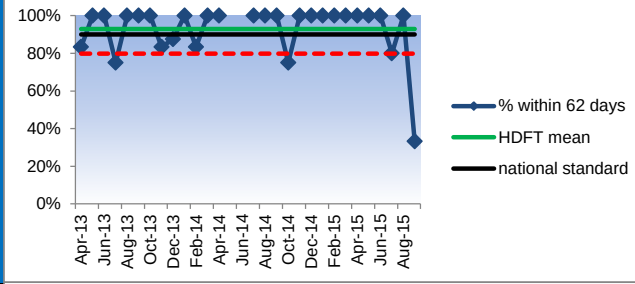
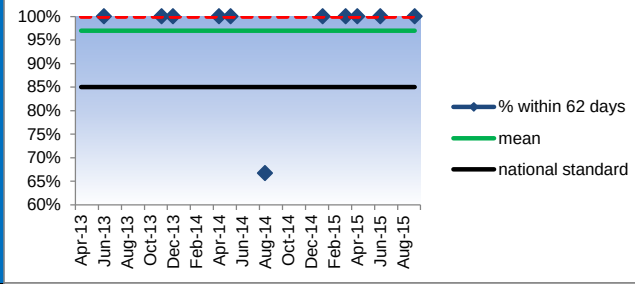
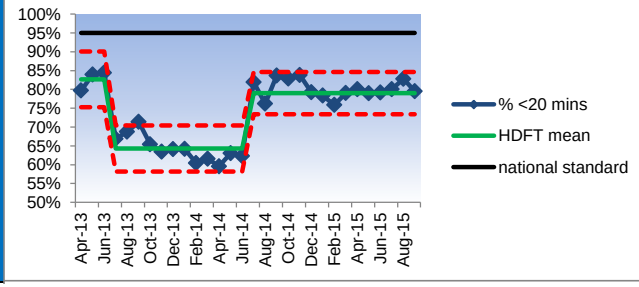
**Trend chart**

| Indicator | Q2 score | Indicator | Q2 score |
|---|---|---|---|
| 18 weeks - incomplete | 0.0 | Cancer - 14 days | 0.0 |
| A&E - 4 hour standard | 0.0 | Cancer - 14 days - breast symptoms | 0.0 |
| Cancer - 62 days to treatment | 0.0 | C-Difficile | 0.0 |
| Cancer - 62 days to treatment - screening | | MRSA | 0.0 |
| Cancer - 31 day subsequent treatment - surgery | 0.0 | Compliance with requirements regarding access to healthcare for patients with learning disabilities | 0.0 |
| Cancer - 31 day subsequent treatment - drugs | | Community services data completeness - RTT information | 0.0 |
| Cancer - 31 day subsequent treatment - radiotherapy | N/A | Community services data completeness - Referral information | 0.0 |
| Cancer - 31 day first treatment | 0.0 | Community services data completeness - Treatment activity information | 0.0 |

# Operational Performance - September 2015

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Cancer - 14 days maximum wait from GP referral for symptomatic breast patients** | Percentage of GP referrals for breast symptomatic patients seen within 14 days. The operational standard is 93%. A high percentage is good. |  | The Trust consistently achieved the 93% standard throughout 2014/15 and 2015/16 to date with performance at 98.8% in September 2015. |
| **Cancer - 31 days maximum wait from diagnosis to treatment for all cancers** | Percentage of cancer patients starting first treatment within 31 days of diagnosis. The operational standard is 96%. A high percentage is good. |  | Recurrent achievement of this standard. Ongoing monitoring. No new actions identified. |
| **Cancer - 31 day wait for second or subsequent treatment: Surgery** | Percentage of cancer patients starting subsequent surgical treatment within 31 days. The operational standard is 94%. A high percentage is good. |  | Only a small number of patients at HDFT are covered by this target which explains the variability in performance for some months. However the Trust was above the required 94% standard for Q1 2015/16 and for Q2 to date. |
| **Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug** | Percentage of cancer patients starting subsequent drug treatment within 31 days. The operational standard is 98%. A high percentage is good. |  | Recurrent achievement of this standard. Ongoing monitoring. No new actions identified. |

# Operational Performance - September 2015

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Cancer - 62 day wait for first treatment from urgent GP referral to treatment** | Percentage of cancer patients starting first treatment within 62 days of urgent GP referral. The operational standard is 85%. A high percentage is good. |  | Provisional performance for September 2015 is below the operational standard of 85%. However the Q2 performance is above the standard at 87.7%.<br>Of the 11 cancer sites treated at HDFT, 6 had performance above 85% in September and 5 had performance below 85% - colorectal (1 breach), gynaecological (0.5 breach), haematological (1 breach), head and neck (1.5 breach) and lung (1.5 breach). |
| **Cancer - 62 day wait for first treatment from consultant screening service referral** | Percentage of cancer patients starting first treatment within 62 days of referral from a consultant screening service. The operational standard is 90%. A high percentage is good. |  | Only a small number of patients at HDFT are covered by this target which explains the variability in performance for some months. However the Trust has been above the required 90% standard for each month where the number of pathways reported has been above the de minimis level for reporting performance. |
| **Cancer - 62 day wait for first treatment from consultant upgrade** | Percentage of cancer patients starting first treatment within 62 days of consultant upgrade. The operational standard is 85%. A high percentage is good. |  | Only a small number of patients at HDFT are covered by this target which explains the variability in performance for some months. However the Trust has been above the required 85% standard for each month where the number of pathways reported has been above the de minimis level for reporting performance. |
| **GP OOH - NQR 9** | NQR 9 (National Quality Requirement 9) looks at the % of GP OOH telephone clinical assessments for urgent cases that are carried out within 20 minutes of call prioritisation.<br>The data presented excludes Selby and York as these do not form part of the HDFT OOH service from April 2015. A high percentage is good. |  | Performance in September 2015 was at 79.6%, below the 95% standard.<br>The local NHS 111 service started in July 2013. From July 2014, the performance data was amended to correctly show the start time as the time that the case is passed to OOH service, as opposed to the initial call to NHS 111. It is not possible to re-work the historical data so this trend anomaly will remain. |

Harrogate and District NHS
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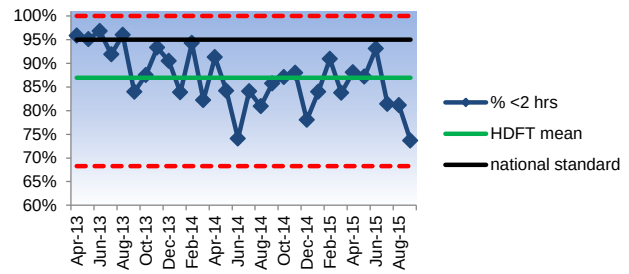
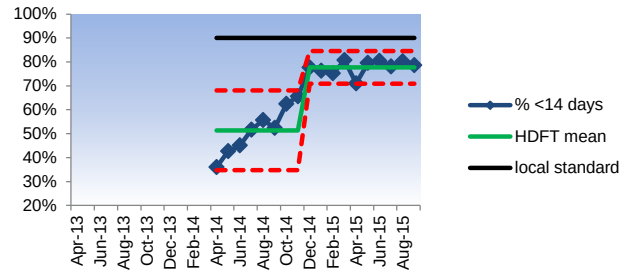
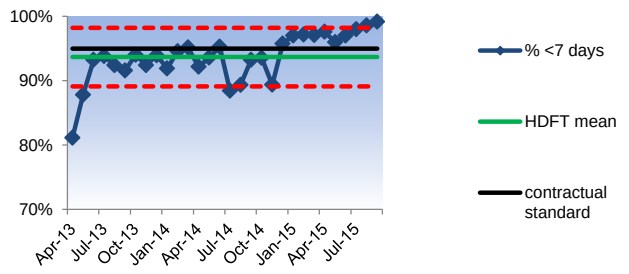
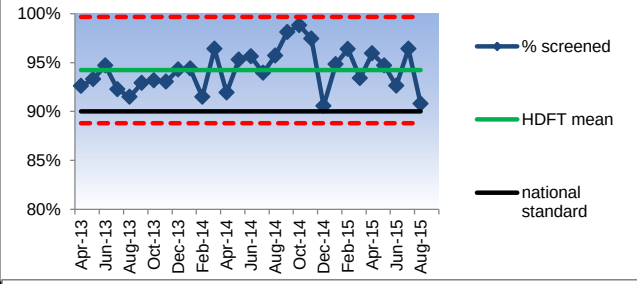
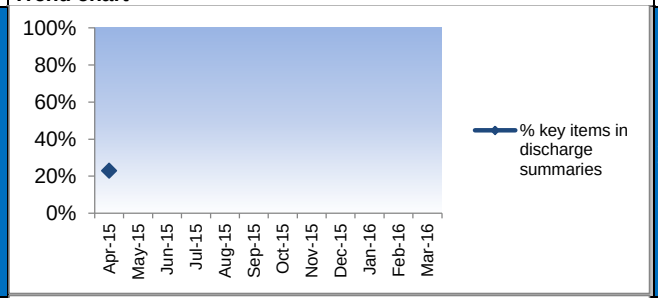
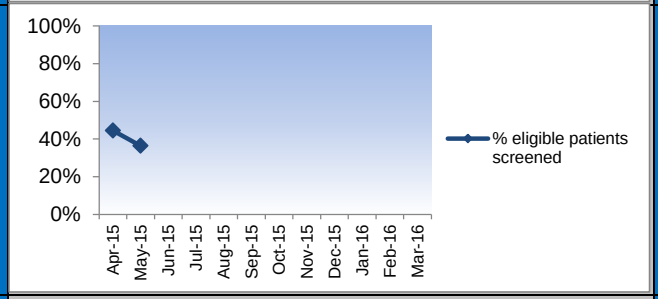
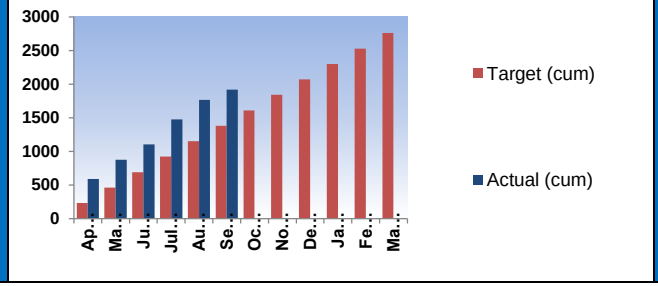
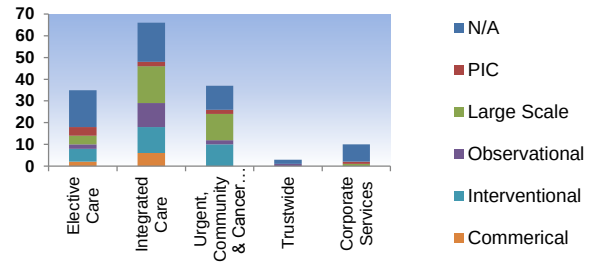
# Operational Performance - September 2015

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **GP OOH - NQR 12** | NQR 12 (National Quality Requirement 12) looks at the % of GP OOH face to face consultations started for urgent cases within 2 hours. The data presented excludes Selby and York as these do not form part of the HFT OOH service from April 2015. A high percentage is good. |   | Performance in September 2015 was at 73.7%, a reduction on last month and below the 95% standard. |
| **Health Visiting - new born visits** | The number of babies who had a new born visit by the Health Visiting team within 14 days of birth. Data is not available for 2013/14. A high percentage is good. |   | As can be seen from the chart, the performance on this metric improved significantly during 2014/15 - this was partly due to improved data capture over this period. In September 2015, 78.6% of babies had a new born visit within 14 days of birth. |
| **Community equipment - deliveries within 7 days** | The number of standard items delivered within 7 days by the community equipment service. A high percentage is good. |   | In September 2015, 99.2% of standard items were delivered within 7 days, above the 95% contractual requirement and an increase on recent months. In addition, 100% of priority items were delivered within 24 hours and 100% of urgent items were delivered within 6 hours. |
| **CQUIN - dementia screening** | The proportion of emergency admissions aged 75 or over who are screened for dementia within 72 hours of admission (Step 1). Of those screened positive, the proportion who went on to have an assessment and onward referral as required (Step 2 and 3). The operational standard is 90% for all 3 steps. A high percentage is good. |   | Recurrent achievement of this standard. Ongoing monitoring. No new actions identified. |

# Operational Performance - September 2015

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **CQUIN - Acute Kidney Injury** | Percentage of patients with Acute Kidney Injury (AKI) whose discharge summary includes four defined key items.<br>The aim of this national CQUIN is to improve the provision of information to GPs for patients diagnosed with AKI whilst in hospital. The target for the CQUIN is to achieve at least 90% of required key items included in discharge summaries by Q4 2015/16. A high percentage is good. |  | *There is no update on this data this month - Q2 data will be reported in next month's report.*<br>In line with national guidance, the Trust performed a baseline audit of a sample of patients who were diagnosed with AKI in April 2015. The audit results showed that 23% of key items were included in discharge summaries for the sampled patients.<br>These results now form the baseline position and the Trust need to agree an improvement trajectory with the CCG to ensure delivery of the required 90% compliance by Q4. |
| **CQUIN - sepsis screening** | Percentage of patients presenting to ED/other wards/units who met the criteria of the local protocol and were screened for sepsis. A high percentage is good. |  | *There is no update on this data this month - Q2 data will be reported in next month's report.*<br>In line with national guidance, the Trust performed a baseline audit during April and May 2015 which showed that 44% of eligible patients in April and 36% in May were screened for sepsis using the established local screening protocol.<br>These results now form the baseline position and the Trust need to agree an improvement trajectory with the CCG to ensure delivery of the required 90% compliance by Q4. |
| **CQUIN - severe sepsis treatment** | Percentage of patients presenting to ED/other wards/units with severe sepsis, Red Flag Sepsis or Septic Shock and who received IV antibiotics within 1 hour of presenting. A high percentage is good. | | *This data will be reported quarterly from next month.* |
| **Recruitment to NIHR adopted research studies** | The Trust has a recruitment target of 2,750 for 2015/16 for studies adopted onto the NIHR portfolio. This equates to 230 per month. A higher figure is good. |  | Recruitment has been good to date. Currently recruitment stands at 540 over its target year to date. |

# Operational Performance - September 2015

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

**Indicator traffic light criteria**

| Section | Indicator | Further detail | Proposed traffic light criteria | Rationale/source of traffic light criteria |
|---|---|---|---|---|
| Quality | Safety thermometer - harm free care | % harm free | Blue if latest month >=97%, Green if >=95% but <97%, red if latest month <95% | National best practice guidance suggests that 95% is the standard that Trusts should achieve. In addition, HDFT have set a local stretch target of 97%. |
| Quality | Pressure ulcers - hospital acquired | No. grade 3 and grade 4 avoidable hospital acquired pressure ulcers | Green if no. avoidable cases is below local trajectory year to date, red if above trajectory year to date. | A maximum threshold of 14 avoidable cases during 2015/16 has been locally agreed. This reflects a 50% reduction on last year's figure. |
| Quality | Pressure ulcers - community acquired | No. grade 3 and grade 4 community acquired pressure ulcers | tbc | tbc |
| Quality | Falls | IP falls per 1,000 bed days | Blue if YTD position is a reduction of <=50% of HDFT average for 2014/15, Green if YTD position is a reduction of between 20% and 50% of HDFT average for 2014/15, Amber if YTD position is a reduction of up to 20% of HDFT average for 2014/15, Red if YTD position is on or above HDFT average for 2014/15. | |
| Quality | Falls causing harm | IP falls causing moderate harm, sever harm or death, per 1,000 bed days | | Locally agreed improvement trajectory based on comparison with HDFT performance last year. |
| Quality | Infection control | No. hospital acquired C.diff cases | Green if below trajectory YTD, Amber if above trajectory YTD, Red if above trajectory at end year or more than 10% above trajectory in year. | NHS England, Monitor and contractual requirement |
| Quality | Avoidable admissions | The number of avoidable emergency admissions to HDFT as per the national definition. | tbc | tbc |
| Quality | Reducing readmissions in older people | The proportion of older people 65+ who were still at home 91 days after discharge from hospital into rehabilitation or reablement services. | tbc | tbc |
| Quality | Mortality - HSMR | Hospital Standardised Mortality Ratio (HSMR) | Blue = better than expected (95% confidence interval), Green = as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval). | |
| Quality | Mortality - SHMI | Summary Hospital Mortality Index (SHMI) | | Comparison with national average performance. |
| Quality | Complaints | No. complaints, split by criteria | Blue if no. complaints in latest month is below UCL, Green if below HDFT average for 2014/15, Amber if above HDFT average for 2014/15, Red if above UCL. In addition, Red if a new red rated complaint received in latest month. | Locally agreed improvement trajectory based on comparison with HDFT performance last year. |
| Quality | Incidents - all | Incidents split by grade (hosp and community) | Blue if latest month ratio places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25% | Comparison of HDFT performance against most recently published national average ratio of low to high incidents. |
| Quality | Incidents - SIRIs and never events | SIRI and never events (hosp and community) | Green if latest month =0, red if latest month >0. | |
| Quality | Friends & Family Test (FFT) - Staff | % staff who would recommend HDFT as a place to work | Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%. | |
| Quality | Friends & Family Test (FFT) - Staff | % staff who would recommend HDFT as a place to receive care | | Comparison with performance of other acute trusts. |
| Quality | Friends & Family Test (FFT) - Patients | % recommend, % not recommend - combined score for all services currently doing patient FFT | Green if latest month >= latest published national average, Red if < latest published national average. | Comparison with national average performance. |
| Quality | Safer staffing levels | RN and CSW - day and night overall fill rates at trust level | Green if latest month overall staffing >=100%, amber if between 95% and 100%, red if below 95%. | The Trusts aims for 100% staffing overall. |
| Quality | Staff appraisal rate | Latest position on no. staff who had an appraisal within the last 12 months | Annual rolling total - 85% green. Amber between 65% and 85%, red<65%. | Locally agreed target level based on historic local and NHS performance |
| Quality | Mandatory training rate | Latest position on the % staff trained for each mandatory training requirement | Blue if latest month >=95%; Green if latest month 75%-90% overall, amber if between 65% and 75%, red if below 65%. | Locally agreed target level - no national comparative information available until February 2016 |
| Quality | Staff sickness rate | Staff sickness rate | Green if <3.9%, amber if between 3.9% and regional average, Red if > regional average | HDFT Employment Policy requirement. Rates compared at a regional level also |
| Quality | Temporary staffing expenditure - medical/nursing/other | Expenditure per month on staff types. | Green if spend on temporary staff < last YTD, red if > last YTD. | Comparison with HDFT performance last year. |
| Quality | Staff turnover | Staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. | Green if remaining static or decreasing, amber if increasing but below 15%, red if above 15%. | Based on evidence from Times Top 100 Employers |
| Quality | Research internal monitoring | No. critical or major findings reported | Green if <1 per quarter (cumulative) | Locally agreed target. |
| Finance and efficiency | Readmissions | No. emergency readmissions (following elective or non-elective admission) within 30 days. | Green if latest month < HDFT average for 2014/15, Red if latest month > HDFT average for 2014/15. | Locally agreed improvement trajectory based on comparison with HDFT performance last year. |
| Finance and efficiency | Readmissions - standardised | Standardised emergency readmission rate within 30 days from HED | Green = better than expected or as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval). | Comparison with national average performance. |
| Finance and efficiency | Length of stay - elective | Average LOS for elective patients | Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%. | |
| Finance and efficiency | Length of stay - non-elective | Average LOS for non-elective patients | | Comparison with performance of other acute trusts. |
| Finance and efficiency | Non-elective bed days for patients aged 18+ | Non-elective bed days at HDFT for HARD CCG patients aged 18+, per 100,000 population | Improvement trajectory to be agreed. | Improvement trajectory to be agreed. |
| Finance and efficiency | Theatre utilisation | % of theatre time utilised for elective operating sessions | Green = >=85%, Amber = between 75% and 85%, Red = <75% | A utilisation rate of around 85% is often viewed as optimal. |

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

| **Report to the Trust Board of Directors:** 28 October 2015 | **Paper No:** 7.0 |
|---|---|

| | |
|---|---|
| **Title** | Financial Position |
| **Sponsoring Director** | Director of Finance |
| **Author(s)** | Finance Department |
| **Report Purpose** | Review of the Trusts financial position |

**Key Issues for Board Focus:**

1. The Trust reported a surplus in September of £306k, reducing the year to date deficit to £591k. Despite this improvement, performance in month was £361k behind plan, increasing the adverse variance to date to £1,410k.

2. Performance against the cost improvement programme continues to improve with £8.8m of plans actioned. It is important that work continue in order to achieve the full £10.2m plan as funding is now in place for a number of service pressures.

3. The Trust will report a continuity of services risk rating of 3. Although this is at planned levels, the current I&E position means that it is a weaker 3 than planned.

Note - The information in this report supports the financial information contained in the Integrated Board Report (Paper 6.0).

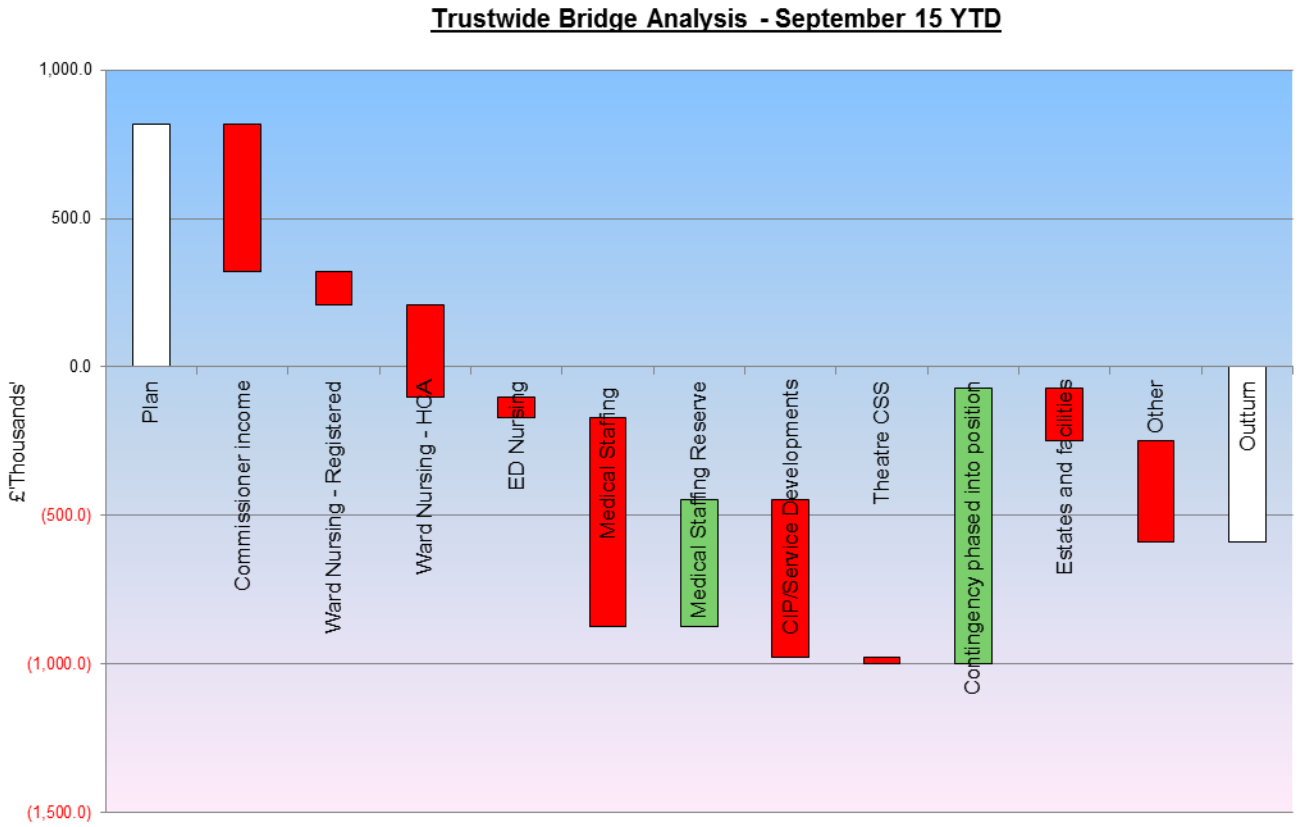
| **Related Trust Objectives** | |
|---|---|
| 1. To deliver high quality care | Yes |
| 2. To work with partners to deliver integrated care | Yes |
| 3. To ensure clinical and financial sustainability | Yes |

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

**Action Required by the Board of Directors**

The Board of Directors is asked to note the contents of this report and approve the submission of the Monitor return and Continuity of Services rating of 3 for Quarter 2.

# Trust wide Bridge Analysis



# Overview Income & Expenditure Position

| 2014/15 Actual £000 | | Budget Annual Budget £000 | Budget Proportion To Date £000 | Actual To Date £000 | Cumulative Variance £000 | Change in Variance £'000 |
|---|---|---|---|---|---|---|
| | **INCOME** | | | | | |
| | **NHS Clinical Income (Commissioners)** | | | | | |
| 127,628 | NHS Clinical Income - Acute | 133,574 | 65,955 | 65,370 | (585) | (520) |
| 38,756 | NHS Clinical Income - Community | 37,594 | 18,951 | 19,065 | 114 | 13 |
| 3,459 | System Resilience & Better Care Funding | 1,400 | 350 | 468 | 119 | 10 |
| | **Non NHS Clinical Income** | | | | | 0 |
| 1,606 | Private Patient & Amenity Bed Income | 1,854 | 920 | 837 | (83) | (20) |
| 438 | Other Non-Protected Clinical Income (RTA) | 523 | 261 | 173 | (88) | (42) |
| | **Other Income** | | | | | 0 |
| 13,747 | Non Clinical Income | 11,658 | 6,327 | 6,238 | (90) | 46 |
| 486 | Hosted Services | 119 | 119 | 119 | 0 | (0) |
| **186,119** | **TOTAL INCOME** | **186,722** | **92,883** | **92,270** | **(612)** | **(513)** |
| | **EXPENSES** | | | | | |
| | **Pay** | | | | | |
| (128,850) | Pay Expenditure | (124,683) | (62,999) | (63,964) | (964) | 7 |
| | **Non Pay** | | | | | 0 |
| (13,605) | Drugs | (8,705) | (7,013) | (7,021) | (8) | 74 |
| (18,493) | Clinical Services & Supplies | (16,566) | (8,778) | (8,955) | (177) | (79) |
| (18,307) | Other Costs | (16,124) | (8,180) | (9,275) | (1,095) | (172) |
| | | | | | | 0 |
| | | | | | | 0 |
| 0 | **Reserves :** Pay | (3,228) | (425) | 0 | 425 | 0 |
| 0 | Pay savings targets | 0 | 0 | 0 | 0 | 0 |
| 0 | Other Reserves | (3,705) | (930) | 0 | 930 | 250 |
| 0 | High Cost Drugs | (4,506) | 0 | 0 | 0 | 0 |
| 0 | Non Pay savings targets | 42 | 0 | 0 | 0 | 0 |
| (11) | **Other Finance Costs** | (18) | (9) | (10) | (1) | 1 |
| (543) | **Hosted Services** | (127) | (127) | (127) | 0 | 0 |
| (179,810) | **TOTAL COSTS** | (177,619) | (88,462) | (89,352) | (890) | 82 |
| **6,309** | **EBITDA** | **9,102** | **4,420** | **2,918** | **(1,502)** | **(432)** |
| (34) | Profit / (Loss) on disposal of assets | 0 | 0 | (2) | (2) | 0 |
| (4,092) | Depreciation | (4,763) | (2,381) | (2,284) | 97 | 83 |
| (55) | Interest Payable | (59) | (29) | (26) | 4 | 0 |
| 20 | Interest Receivable | 20 | 10 | 13 | 3 | 0 |
| (2,530) | Dividend Payable | (2,500) | (1,200) | (1,318) | (118) | (20) |
| (381) | **Net Surplus/(Deficit) before donations and impairment** | **1,800** | **819** | **(699)** | **(1,518)** | **(367)** |
| 392 | Donated Asset Income | 0 | 0 | 108 | 108 | 6 |
| (587) | Impairments re Donated assets | 0 | 0 | 0 | 0 | 0 |
| 0 | Impairments re PCT assets | 0 | 0 | 0 | 0 | 0 |
| **(577)** | **Net Surplus/(Deficit)** | **1,800** | **819** | **(591)** | **(1,410)** | **(361)** |
| (102) | Consolidation of Charitable Fund Accounts | 0 | 0 | 0 | 0 | 0 |
| **(679)** | **Consolidated Net Surplus/(Deficit)** | **1,800** | **819** | **(591)** | **(1,410)** | **(361)** |

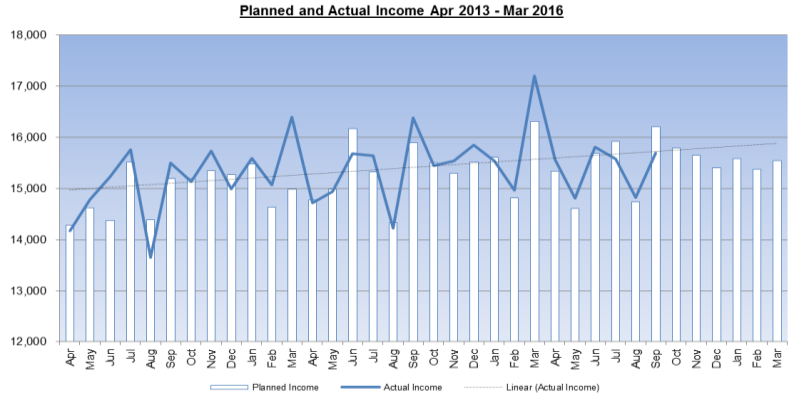
**Negative sign under variance indicates an UNDER-recovery of forecast income, or an OVER-spending against budget**

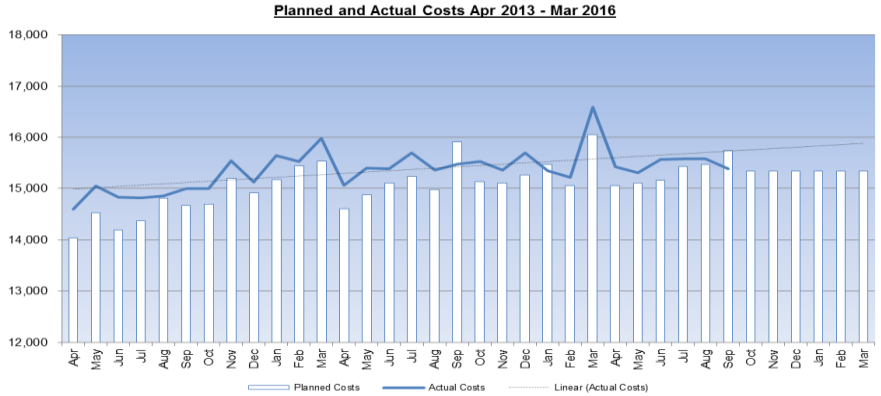
# Overview Total Directorate Position

**For the month ending 30th September 2015**

| 2013/14 Actual £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 | Non-Comissioner Income | 1,234 | | | | 103 | 70 | (33) | 743 | 694 | (48) |
| (36,721) | Pay | (32,054) | 818.62 | 794.60 | 774.99 | (2,754) | (2,875) | (121) | (16,230) | (16,882) | (652) |
| (9,172) | Non-Pay | (5,875) | | | | (772) | (787) | (15) | (4,563) | (4,656) | (93) |
| **(43,724)** | **Total Integrated Care Directorate** | **(36,695)** | **818.62** | **794.60** | **774.99** | **(3,422)** | **(3,592)** | **(169)** | **(20,050)** | **(20,844)** | **(793)** |
| 3,180 | Non-Comissioner Income | 3,145 | | | | 308 | 324 | 16 | 1,809 | 1,810 | 2 |
| (29,388) | Pay | (32,081) | 754.67 | 696.66 | 686.22 | (2,833) | (2,715) | 118 | (16,163) | (16,155) | 8 |
| (12,671) | Non-Pay | (10,343) | | | | (943) | (1,076) | (133) | (6,184) | (6,755) | (571) |
| **(38,879)** | **Total Acute & Cancer Care Services Directorate** | **(39,279)** | **754.67** | **696.66** | **686.22** | **(3,468)** | **(3,468)** | **0** | **(20,539)** | **(21,100)** | **(561)** |
| 1,360 | Non-Comissioner Income | 1,506 | | | | 125 | 114 | (11) | 754 | 737 | (17) |
| (43,027) | Pay | (42,195) | 907.49 | 867.38 | 852.65 | (3,685) | (3,632) | 54 | (21,553) | (21,826) | (273) |
| (13,347) | Non-Pay | (12,114) | | | | (1,120) | (1,080) | 40 | (6,780) | (7,094) | (313) |
| **(55,014)** | **Total Elective Care Directorate** | **(52,804)** | **907.49** | **867.38** | **852.65** | **(4,680)** | **(4,598)** | **82** | **(27,580)** | **(28,183)** | **(603)** |
| **(19,852)** | **Corporate (Clinical)** | **(16,435)** | **451.42** | **427.70** | **442.72** | (1,353) | (1,416) | (64) | (8,101) | (8,291) | (189) |
| (157,469) | **Total Clinical Spend** | (145,213) | 2932.20 | 2786.34 | 2756.58 | (12,923) | (13,074) | (150) | (76,270) | (78,417) | (2,147) |
| **(7,626)** | **Corporate (inc. CNST)** | (11,845) | **149.93** | **143.56** | **144.54** | (1,014) | (979) | 35 | (5,765) | (5,896) | (131) |
| **(27,478)** | **Total Corporate Position** | **(28,279)** | **601.35** | **571.26** | **587.26** | **(2,366)** | **(2,395)** | **(29)** | **(13,867)** | **(14,187)** | **(320)** |
| 165,503 | **Commissioner Income** | 171,168 | | | | 14,973 | 14,476 | (497) | 85,255 | 84,889 | (367) |
| (388) | **Central** | (12,311) | | (20.63) | (21.63) | (368) | (117) | 251 | (2,401) | (1,275) | 1,126 |
| **21** | **Total before donations & impairments** | **1,800** | **3,082.13** | **2,909.27** | **2,879.49** | **668** | **306** | **(361)** | **819** | **(699)** | **(1,518)** |
| 5,297 | **Donations for Capital Expenditure** | 0 | | | | | | 0 | 0 | 108 | 108 |
| (3,340) | **Impairments on Donated assets** | 0 | | | | | | 0 | 0 | 0 | 0 |
| (1,305) | **Impairments on PCT assets** | 0 | | | | | | 0 | 0 | 0 | 0 |
| **672** | **Trust reporting position** | **1,800** | **3,082.13** | **2,909.27** | **2,879.49** | **668** | **306** | **(361)** | **819** | **(591)** | **(1,410)** |
| 457 | **Charitable funds consolidation** | 0 | | | | | | 0 | 0 | 0 | 0 |
| **1,129** | **Total Trust reported position** | **1,800** | **3,082.13** | **2,909.27** | **2,879.49** | **668** | **306** | **(361)** | **819** | **(591)** | **(1,410)** |

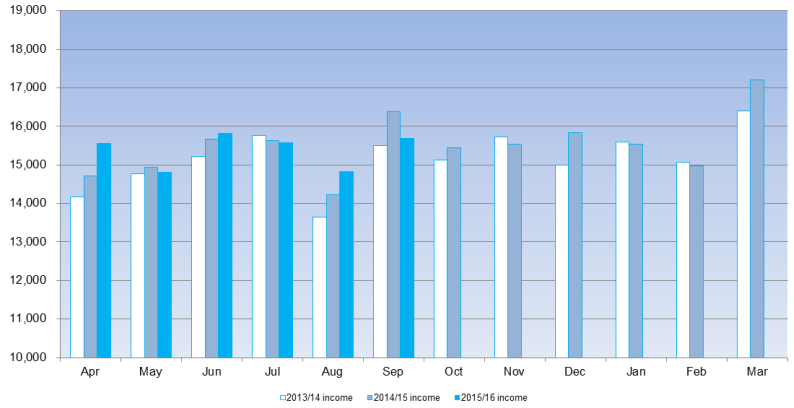
# Income & Expenditure Run Charts

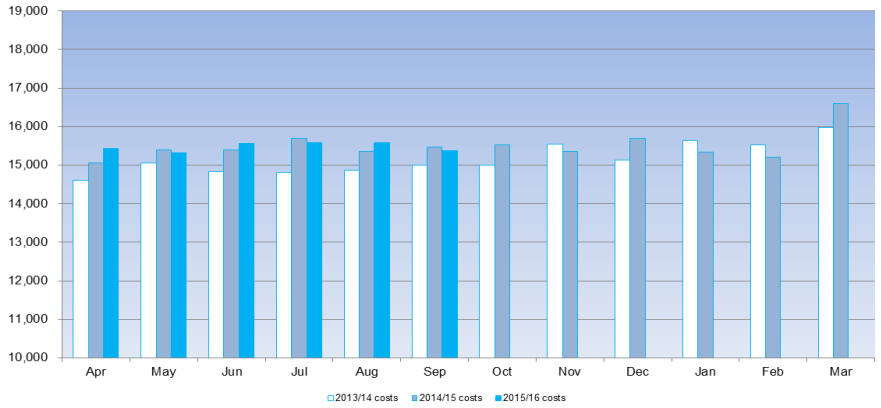


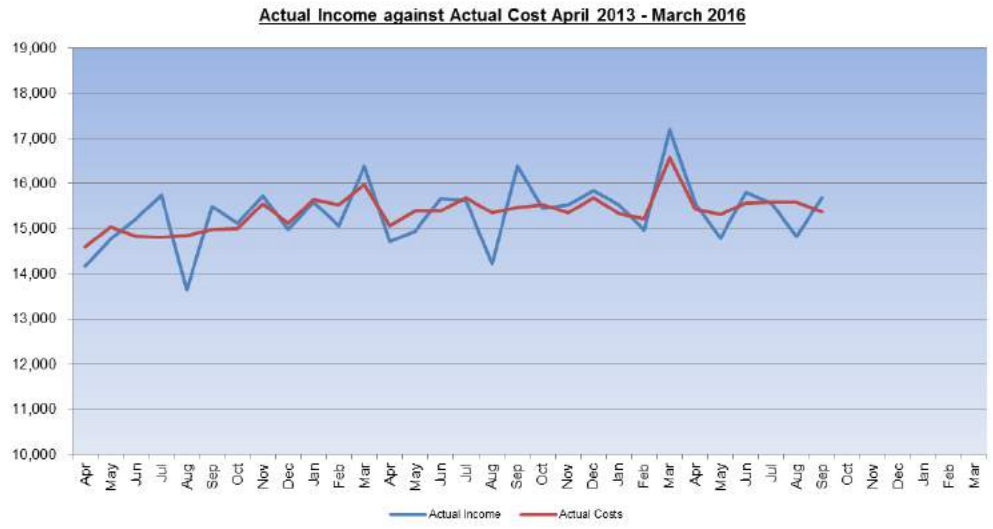

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2013/14 income plan | 14,287 | 14,617 | 14,369 | 15,513 | 14,383 | 15,188 | 15,199 | 15,349 | 15,277 | 15,473 | 14,637 | 14,978 |
| 2013/14 income actual | 14,171 | 14,778 | 15,227 | 15,755 | 13,653 | 15,502 | 15,130 | 15,731 | 14,987 | 15,588 | 15,073 | 16,395 |
| **2013/14 variance** | **-116** | **161** | **858** | **242** | **-730** | **314** | **-69** | **382** | **-290** | **115** | **436** | **1,417** |
| 2013/14 % variance | -0.8% | 1.1% | 6.0% | 1.6% | -5.1% | 2.1% | -0.5% | 2.5% | -1.9% | 0.7% | 3.0% | 9.5% |
| | | | | | | | | | | | | |
| 2014/15 income plan | 14,779 | 14,981 | 16,165 | 15,325 | 14,332 | 15,901 | 15,506 | 15,293 | 15,523 | 15,606 | 14,809 | 16,305 |
| 2014/15 income actual | 14,717 | 14,945 | 15,674 | 15,637 | 14,221 | 16,388 | 15,451 | 15,533 | 15,845 | 15,539 | 14,967 | 17,201 |
| **2014/15 variance** | **-62** | **-36** | **-491** | **312** | **-111** | **487** | **-55** | **240** | **322** | **-67** | **158** | **896** |
| 2014/15 % variance | -0.4% | -0.2% | -3.0% | 2.0% | -0.8% | 3.1% | -0.4% | 1.6% | 2.1% | -0.4% | 1.1% | 5.5% |
| | | | | | | | | | | | | |
| 2015/16 income plan | 15,335 | 14,610 | 15,683 | 15,920 | 14,739 | 16,202 | 15,788 | 15,646 | 15,404 | 15,578 | 15,370 | 15,544 |
| 2015/16 income actual | 15,564 | 14,802 | 15,810 | 15,578 | 14,826 | 15,689 | | | | | | |
| **2015/16 variance** | **229** | **192** | **127** | **-342** | **87** | **-513** | | | | | | |
| 2015/16 % variance | 1.5% | 1.3% | 0.8% | -2.1% | 0.6% | -3.2% | | | | | | |

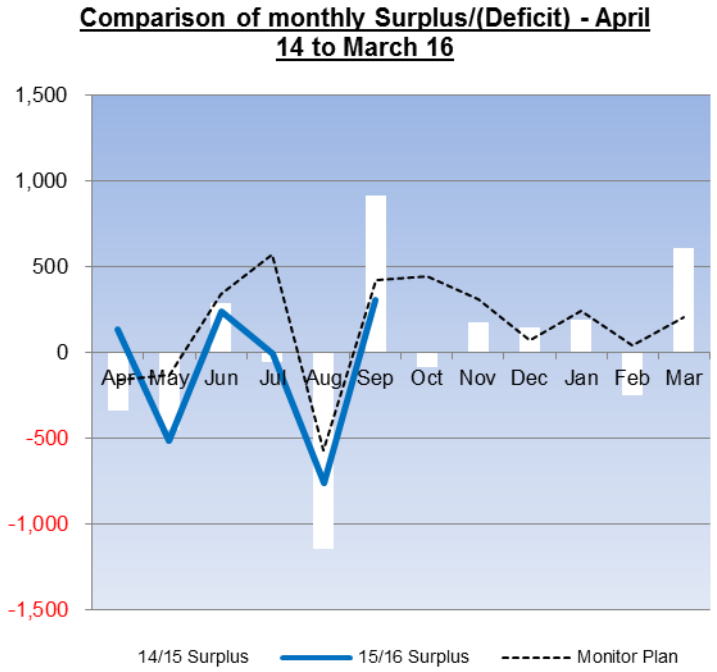
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2013/14 expenditure plan | 14,039 | 14,523 | 14,197 | 14,368 | 14,808 | 14,665 | 14,700 | 15,203 | 14,908 | 15,172 | 15,450 | 15,535 |
| 2013/14 expenditure actual | 14,598 | 15,051 | 14,825 | 14,814 | 14,861 | 14,994 | 15,001 | 15,546 | 15,126 | 15,641 | 15,530 | 15,983 |
| **2013/14 variance** | **559** | **528** | **628** | **446** | **53** | **329** | **301** | **343** | **218** | **469** | **80** | **448** |
| 2013/14 % variance | 4.0% | 3.6% | 4.4% | 3.1% | 0.4% | 2.2% | 2.0% | 2.3% | 1.5% | 3.1% | 0.5% | 2.9% |
| | | | | | | | | | | | | |
| 2014/15 expenditure plan | 14,602 | 14,875 | 15,107 | 15,236 | 14,983 | 15,912 | 15,128 | 15,105 | 15,268 | 15,465 | 15,052 | 16,051 |
| 2014/15 expenditure actual | 15,058 | 15,394 | 15,387 | 15,695 | 15,362 | 15,476 | 15,533 | 15,358 | 15,695 | 15,346 | 15,214 | 16,591 |
| **2014/15 variance** | **456** | **519** | **280** | **459** | **379** | **-436** | **405** | **253** | **427** | **-119** | **162** | **540** |
| 2014/15 % variance | 3.1% | 3.5% | 1.9% | 3.0% | 2.5% | -2.7% | 2.7% | 1.7% | 2.8% | -0.8% | 1.1% | 3.4% |
| | | | | | | | | | | | | |
| 2015/16 expenditure plan | 15,052 | 15,109 | 15,164 | 15,429 | 15,466 | 15,747 | 15,342 | 15,342 | 15,342 | 15,342 | 15,342 | 15,342 |
| 2015/16 expenditure actual | 15,427 | 15,314 | 15,572 | 15,584 | 15,584 | 15,384 | | | | | | |
| **2015/16 variance** | **375** | **205** | **408** | **155** | **118** | **-363** | | | | | | |
| 2015/16 % variance | 2.5% | 1.4% | 2.7% | 1.0% | 0.8% | -2.3% | | | | | | |



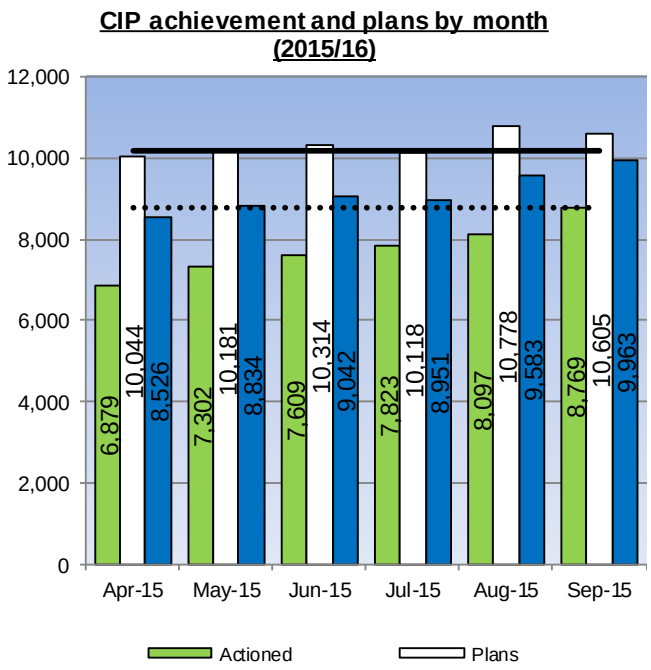
# Income & Expenditure Run Charts



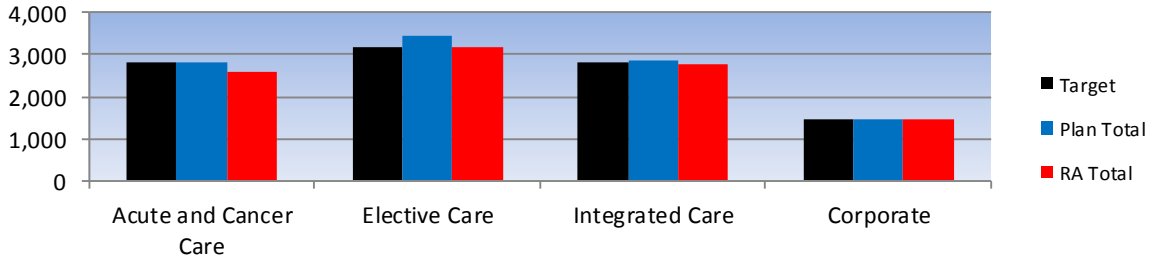




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2013/14 income | 14,171 | 14,778 | 15,227 | 15,755 | 13,653 | 15,502 | 15,130 | 15,731 | 14,987 | 15,588 | 15,073 | 16,395 |
| 2014/15 income | 14,717 | 14,945 | 15,674 | 15,637 | 14,221 | 16,388 | 15,451 | 15,533 | 15,845 | 15,539 | 14,967 | 17,201 |
| 2015/16 income | 15,564 | 14,802 | 15,810 | 15,578 | 14,826 | 15,689 | 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 | 15,314 | 15,572 | 15,584 | 15,584 | 15,384 | 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 | -512 | 238 | -6 | -758 | 305 | | | | | | |

# Efficiency Programme




| Summary | Target | Actioned | Low | Medium | High | Total | % | Risk Adjust | % |
|---|---|---|---|---|---|---|---|---|---|
| Acute Care | 2,823,600 | 2,486,630 | 38,963 | 22,289 | 275,718 | 2,823,600 | 100% | 2,596,620 | 92% |
| Elective Care | 3,165,500 | 2,773,100 | 266,150 | 81,069 | 338,100 | 3,458,419 | 109% | 3,158,418 | 100% |
| Integrated Care | 2,800,200 | 2,148,800 | 317,000 | 393,932 | 0 | 2,859,732 | 102% | 2,765,096 | 99% |
| Corporate | 1,463,600 | 1,360,660 | 0 | 102,840 | 0 | 1,463,500 | 100% | 1,442,932 | 99% |
| **Total** | **10,179,000** | **8,769,190** | **622,113** | **600,130** | **613,818** | **10,605,251** | **104%** | **9,963,065** | **98%** |
| | | | | | | | | | |
| Target | | 10,179,000 | | | | 10,179,000 | | 10,179,000 | |
| | | | | | | | | | |
| **Variance** | | **-1,409,810** | | | | **426,251** | **104%** | **-215,935** | **98%** |
| Target less ETO benefit | | 8,779,000 | | | | 8,779,000 | | 8,779,000 | |
| | | | | | | | | | |
| **Variance** | | **-9,810** | | | | **1,826,251** | **121%** | **1,184,065** | **113%** |




- Trustwide CIP performance is outlined above. Plans to meet the majority of the Trust external target (£8,779k) have been actioned, with a further 14% required to achieve the internal target. Plans are in place to achieve this.

- Achievement of the external target is extremely positive, however, funding has now been put in place for a number of service pressures, the impact of which is £900k in 2015/16. It is therefore important that directorates continue to implement plans for 2015/16.

# Continuity of Services Risk Rating

- 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** | **3** | **3** | **3** | **3** |
| Actual Rating – Capital Service Cover | 3 | 3 | | | |
| Actual Rating – Liquidity | 4 | 3 | | | |
| Actual Rating – I&E Margin | N/A | 2 | | | |
| Actual Rating – I&E Margin Variance | N/A | 2 | | | |
| **Actual Rating – Consolidated Rating** | **4** | **3** | | | |

- The Board is asked to approve the submission of the Monitor return and CoS of 3 for quarter 2.

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

- The I&E elements of the risk rating were not applicable in quarter one as the changes to the risk rating were under consultation. If they had been in place the Trust would have reported a rating of 3.

Harrogate and District NHS
NHS Foundation Trust

| **Report to the Trust Board of Directors:** 28 October 2015 | **Paper No:** 7.1 |
|---|---|

| | |
|---|---|
| **Title** | CIP Planning - 2016/17 |
| **Sponsoring Director** | Director of Finance |
| **Author(s)** | Finance Department |
| **Report Purpose** | For information |

**Key Issues for Board Focus:**

1. The Trust financial plan for 2016/17 will require the delivery of a surplus for investment in the capital programme. Given the current financial environment, a significant cost improvement programme (CIP) will be required.

2. Directorate plans currently amount to 92% of the indicative target.

3. Further work is required to develop and implement these plans, as well as ensure a robust quality impact assessment has taken place.

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

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

**Action Required by the Board of Directors**

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

## 1. Background

A key objective of the organisation is to manage resources effectively, and the financial plan for 2016/17 will require the delivery of a surplus for investment in the capital programme. Given the financial environment, in order to deliver the financial plan a significant Cost Improvement Programme (CIP) will be required whilst ensuring that the quality of care that we offer as an organisation is maintained.

Directorates have been asked to update CIP schedules in order to assess what is planned for 2016/17. This paper summarises the work undertaken so far.

In deriving the CIP for the year, a Quality Impact Assessment will be undertaken. The process for this is similar to previous years, with directorates undertaking an initial assessment before the Medical Director and Chief Nurse review assessed schemes.

## 2. Financial Assumptions & Targets

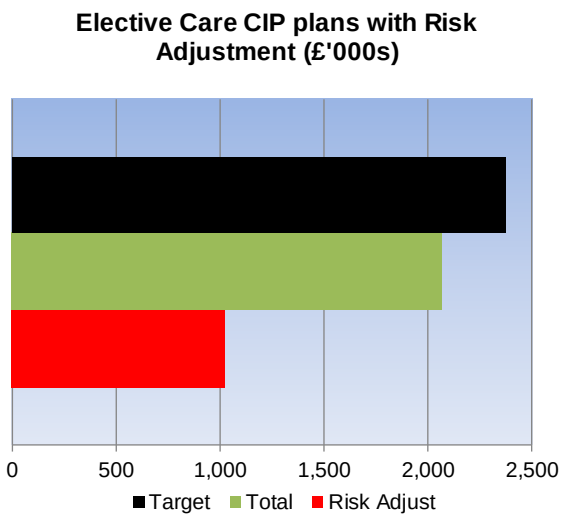
At present, the Trust financial plan for 2016/17 is in the early stages of development. In the coming months service pressures, cost pressures, activity plans and quality requirements will be developed and finalised, outlining the efficiency requirement for the year ahead. Planning and tariff guidance is also yet to be released, however, a draft financial plan will be in place by December 2015, discussed across the organisation during January and February before being subsequently finalised at the Board in March 2016.

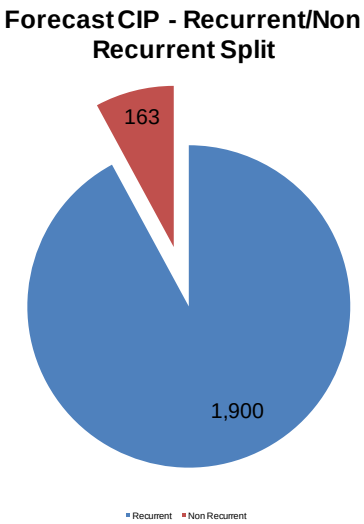
Directorates are currently working to Cost Improvement Programme (CIP) targets for 2016/17 based on the target for 2015/16 plus any non-recurrent or unachieved CIP from 2015/16. These assumptions will be updated as further information is available through the planning process. The table below outlines these targets, as well as an additional amount that reconciles to the figures presented as part of the growth strategy at the board timeouts in 2014/15.

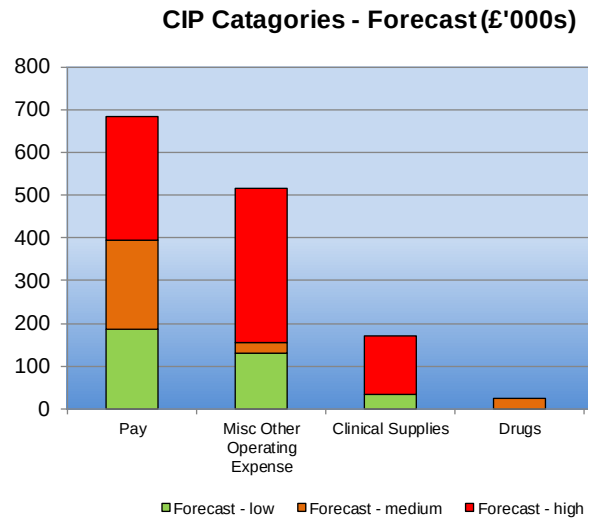
| Directorate | In year target (£'000s) | Non recurrent/ unachieved (£'000s) | Total (£'000s) | % of total |
|---|---|---|---|---|
| Corporate Services | 994.00 | 656.10 | 1,650.10 | 18% |
| Elective Care | 2,000.00 | 372.36 | 2,063.36 | 26% |
| Integrated Care | 1,320.80 | 1,181.57 | 2,502.37 | 27% |
| Urgent, Community and Cancer Care | 1,334.00 | 1,286.30 | 2,620.30 | 28% |
| Amount required from Board timeout for £1.9m surplus | 151.20 | 0.00 | 151.20 | 2% |
| **Subtotal** | **5,800.00** | **3,496.33** | **9,145.33** | |

## 3. Elective Care

| Summary (£'000s) | Target | Actioned | Low | Medium | High | Total | Total %age | Risk Adjust | Risk Adj %age |
|---|---|---|---|---|---|---|---|---|---|
| Elective Care | 2,372 | 0 | 527 | 352 | 1,183 | 2,063 | 87% | 1,019 | 43% |



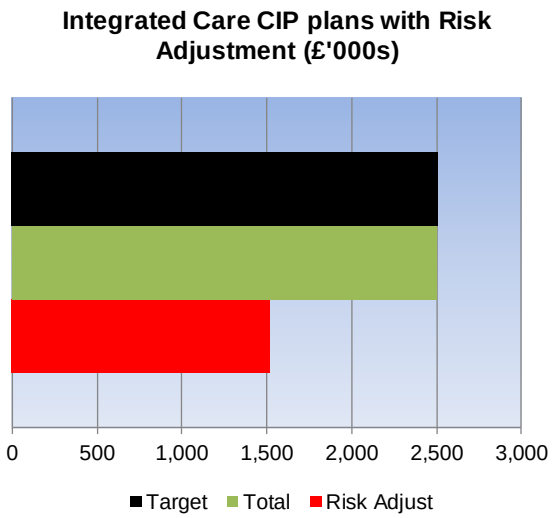



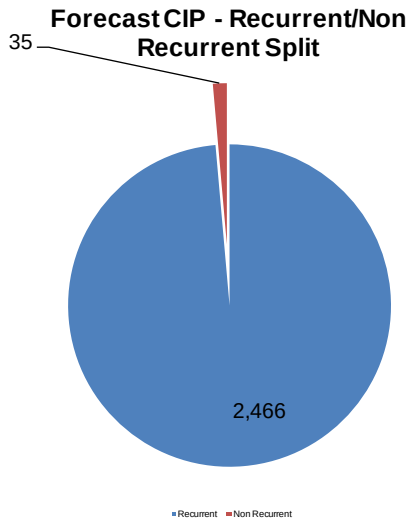



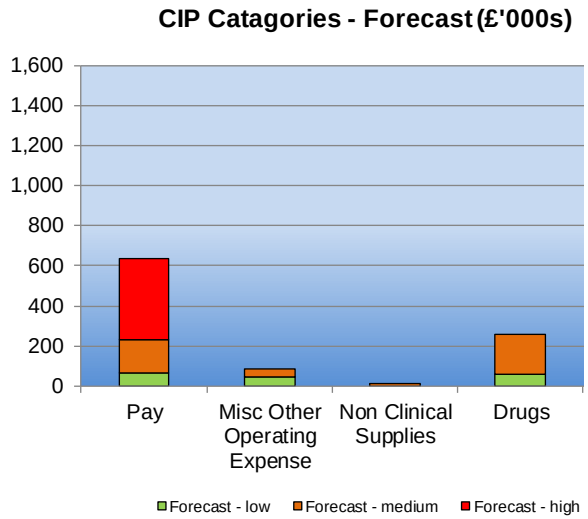

| Scheme Name | Risk | QIA | Forecast |
|---|---|---|---|
| Cost savings / change in practice through SLR (10% of worst 10) | High | 1 | 310,000 |
| Business Development C | High | 1 | 200,000 |
| Theatre utilisation (£184k less already actioned in 15/16) | High | 1 | 139,000 |
| Contribution from 7th General Surgery bus case | Low | 1 | 128,000 |
| Theatres stock system - non pay savings this would bring | High | 1 | 120,000 |

## 4. Integrated Care

| Summary (£'000s) | Target | Actioned | Low | Medium | High | Total | Total %age | Risk Adjust | Risk Adj %age |
|---|---|---|---|---|---|---|---|---|---|
| Integrated Care | 2,502 | 0 | 595 | 954 | 952 | 2,501 | 100% | 1,519 | 61% |



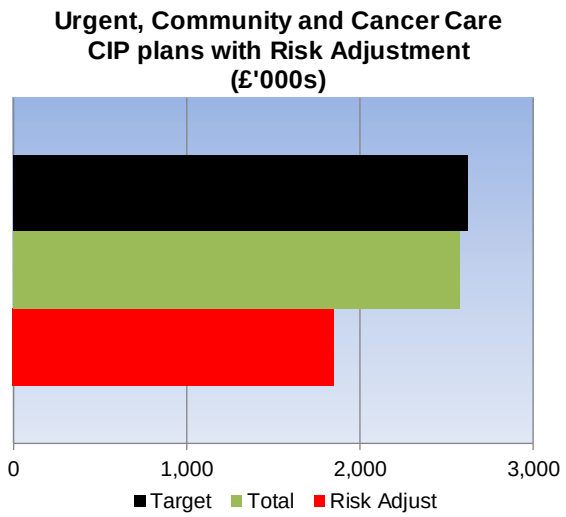



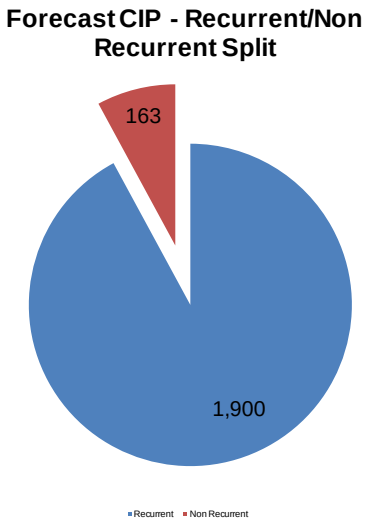



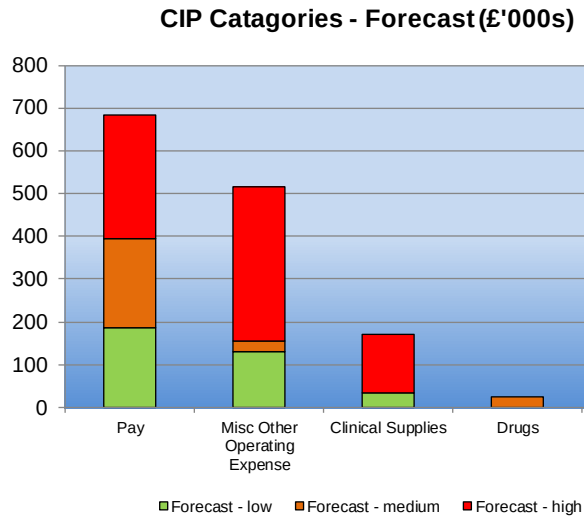

| Scheme Name | Risk | QIA | Forecast |
|---|---|---|---|
| Business Development A | High | TBC | 450,000 |
| Respiratory & Cardiology Outpatient Review | Low | TBC | 300,000 |
| Review Inpatient Workstream | High | TBC | 252,300 |
| Business Development B | Medium | TBC | 220,000 |
| Biosimilar Change – Rheumatology | Medium | TBC | 200,000 |

## 5. Urgent, Community and Cancer Care

| Summary (£'000s) | Target | Actioned | Low | Medium | High | Total | Total %age | Risk Adjust | Risk Adj %age |
|---|---|---|---|---|---|---|---|---|---|
| Urgent, Community and Cancer Care | 2,620 | 0 | 938 | 1,053 | 580 | 2,571 | 98% | 1,849 | 71% |



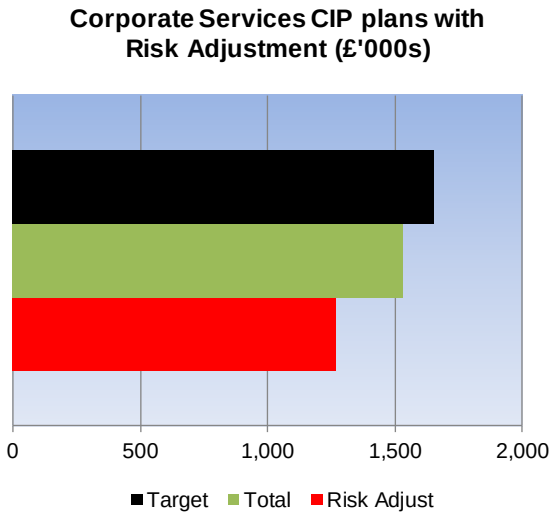



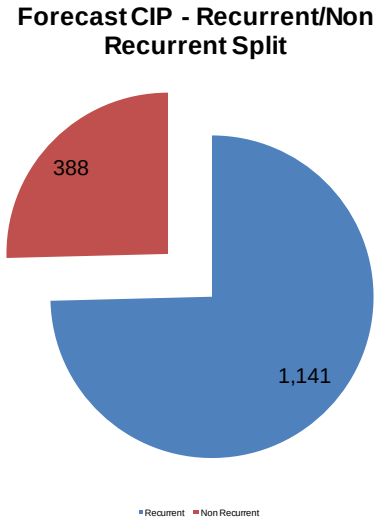



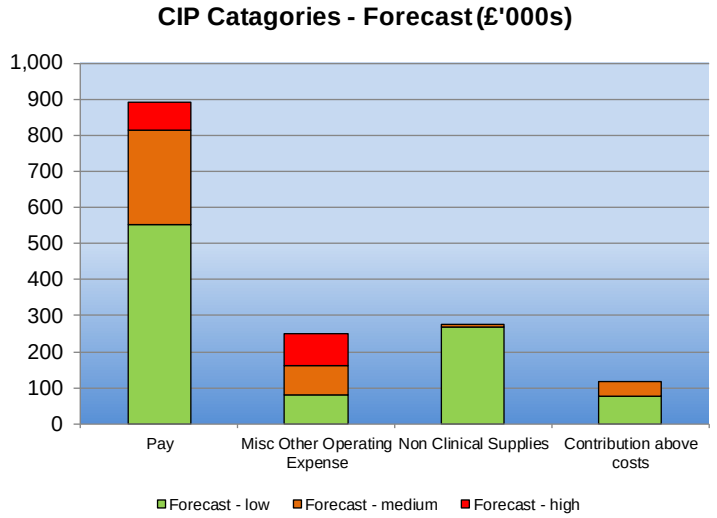

| Scheme Name | Risk | QIA | Forecast |
|---|---|---|---|
| Staffing Reviews/Skill Mix Savings 5% of Pay/Reduce GP Spend | Medium | TBC | 330,000 |
| Locum Reduction | High | TBC | 260,000 |
| Drug Savings | Low | TBC | 150,000 |
| 1st Managed Contract additional 2nd year savings | Low | TBC | 145,000 |
| Non Pay Review | Low | TBC | 131,500 |

## 6. Corporate Services

| Summary (£'000s) | Target | Actioned | Low | Medium | High | Total | Total %age | Risk Adjust | Risk Adj %age |
|---|---|---|---|---|---|---|---|---|---|
| Corporate Services | 1,650 | 0 | 971 | 390 | 168 | 1,529 | 93% | 1,268 | 77% |




| Scheme Name | Risk | QIA | Forecast |
|---|---|---|---|
| Carbon Energy Fund | Low | 1 | 266,000 |
| Review of overheads | Low | TBC | 226,500 |
| Single Sign in | Medium | TBC | 150,000 |
| Estate Rationalisation | High | TBC | 90,000 |
| Review of procedures | Low | TBC | 85,700 |

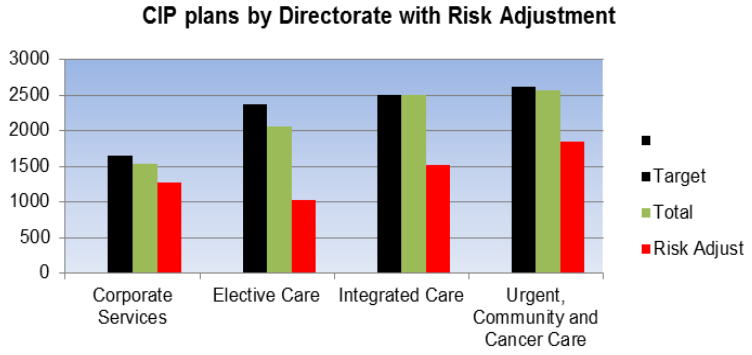
## 7. Trustwide Summary

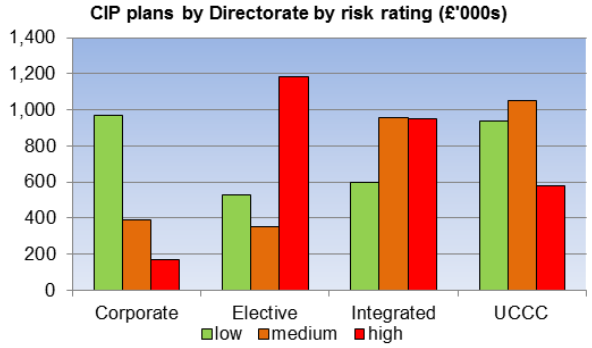
Plans developed so far equate to 95% of the provisional Cost Improvement Target prior to risk adjustment.

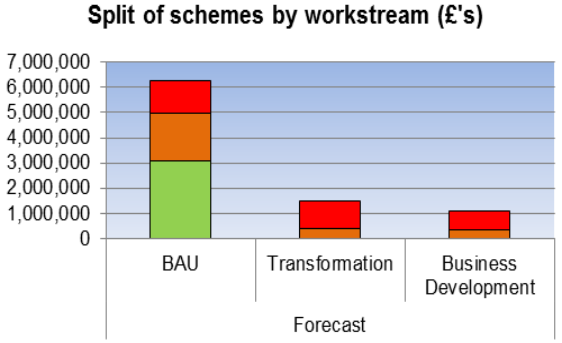
| Summary | Target | Actioned | Low | Medium | High | Total | Total %age | Risk Adjust | Risk Adj %age |
|---|---|---|---|---|---|---|---|---|---|
| Corporate Services | 1,650 | 0 | 971 | 390 | 168 | 1,529 | 93% | 1,268 | 77% |
| Elective Care | 2,372 | 0 | 527 | 352 | 1,183 | 2,063 | 87% | 1,019 | 43% |
| Integrated Care | 2,502 | 0 | 595 | 954 | 952 | 2,501 | 100% | 1,519 | 61% |
| Urgent, Community and Cancer Care | 2,620 | 0 | 938 | 1,053 | 580 | 2,571 | 98% | 1,849 | 71% |
| **Trustwide Total** | **9,145** | **0** | **3,030** | **2,750** | **2,884** | **8,664** | **95%** | **5,656** | **62%** |
| | | **% age of target** | 33% | 30% | 32% | | | | |

It should be noted that at this point in the development of plans for 2015/16 only a small number of schemes had been costed. By February 2015, schemes were in place for 84% of the Trust target.

The risk adjusted total reflects how many schemes are in early stages of development, as well as a more risk averse approach to some of the schemes being developed through transformation and business development. Business development has been outlined in this way as the majority of work has yet to have tender submitted.



## 8. Quality Impact Assessment

The QIA process is underway in each of the Directorates, with the identified schemes undergoing review by clinical leads. The Clinical Director will sign off the QIA and the Directorate Team will then meet with the Chief Nurse and Medical Director to present the assessments.

Meetings are being arranged during November for the Chief Nurse and Medical Director to review each Directorate's programme, and a report will then be submitted to the Board of Directors documenting the outcome of the QIA. The intention is to have the process fully complete before Christmas.

The efficiency programme, and particularly the QIA process, will also be shared with the CCG to provide assurance to our commissioners in relation to the quality of care that we deliver.

## 9. Monitoring

Moving forward the CIP will be specifically monitored through:

- Monthly Finance and Activity meetings with Directorates
- Quarterly report to Finance Committee and Board of Directors

This is in addition to the routine monitoring of the monthly financial position and the monthly monitoring of the transformation programme through the clinical transformation board.

| | |
|---|---|
| **Report to the Trust Board of Directors: 28 October 2015** | **Paper No: 7.2** |

| | |
|---|---|
| **Title** | **Business Plan 2016/17** |
| **Sponsoring Director** | Jonathan Coulter |
| **Author(s)** | Jonathan Coulter /Angela Gillett |
| **Report Purpose** | For Information |

**Key Issues for Board Focus:**

- Forward planning environment, both nationally and locally.
- Financial context within which the Business Plan is to be developed.
- Key actions that need to be taken forward.
- Timeline for developing the Business Plan

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

| | |
|---|---|
| **Risk and Assurance** | Quality, finance and performance risks are addressed through the development of the Business Plan. |
| **Legal implications/ Regulatory Requirements** | Guidance is awaited from Monitor, however the Trust is developing the Business Plan for March 2016 in readiness for the new financial year. |

**Action Required by the Board of Directors**

- Note the work that is ongoing with the development of the Business Plan for 2016/17.
- Note the planning process and the timescales for agreement of the Business Plan for 2016/17.

## 1. Introduction

1.1 The purpose of this paper is to:-

- Outline the forward planning environment, both nationally and locally;
- Outline the financial context within which the Business Plan is to be developed;
- Update the Board on the key actions that need to be taken forward; and
- Detail the timeline for developing the Business Plan.

## 2. Vision, Mission and Strategic Objectives

2.1 Discussions are currently taking place with regard to refining the vision and mission of the Trust. A session to discuss and progress this further is taking place following the Board of Directors' meeting.

2.2 At the Board of Directors meeting in September, the strategic objectives of the organisation were reviewed and a revised set of objectives were agreed as follows:-

- Deliver high quality care;
- Work with partners to deliver integrated care; and
- Ensure clinical and financial sustainability.

2.3 As part of the agreement of the Operational Plan for 2015/16, it was agreed that a set of KPIs should be developed to assess the delivery of our strategic objectives. This work has now been completed and developed into a dashboard which is attached for information at **Appendix A**.

## 3. National and Local Planning context – key planning issues

3.1 The national context is underpinned by the Five Year Forward View that was released last autumn. This, alongside the financial environment that will be set out as part of the Autumn Statement, is the key national policy driver for the NHS.

3.2 As part of the Five Year Forward View a number of strands of work are underway, including the development of New Models of Care. These models of care are being developed through a number of Vanguard programmes, and alongside our local partners we are developing our bespoke model for the Harrogate area.

3.3 In relation to the national financial environment within which the NHS will be planning going forward, it is clear that the challenges will be some of the most significant in the history of the NHS, with a large provider deficit combined with a historically limited funding increase going forward.

3.4 As part of the financial challenge, a number of national initiatives will inform our planning into the future. These include:

- Carter Review, which will outline opportunities for operational efficiency for each organisation
- Pay restraint, with a cap on total pay increases of 1%
- Agency costs, with a cap on the rate of payment to agency staff
- Revised staff contracts, in particular relating to medical staff

3.5 A further key policy driver relates to the standards in relation to 7 day provision. We will need to respond to the policy requirements as and when they are defined and the timescales confirmed.

3.6 The national regulatory environment is changing, with the merging of Monitor with the Trust Development Agency (TDA) to form NHS Improvement. The impact of this change upon the service will need to be assessed. The Risk Assessment Framework has already been amended during 2015/16, with a tightening of the financial assessment now in place. We need to be mindful that the framework for 2016/17 may change again as a result of the new organisation being formed which will potentially have a different regulatory approach.

3.7 At a local level, the commissioning environment remains relatively stable this year, although there is an increasing role for Local Authorities in commissioning services which we need to influence and respond to. Over the long term, the potential development of Accountable Care Organisations, new approaches to contracting, extension of the DevoManc concept, and the potential pooling of commissioning budgets, will potentially require a new commissioning approach. This will be considered as part of our Vanguard work in the first instance and then brought into our Business Plan as and when it is appropriate to do so.

3.8 The remainder of this paper will consider the more operational detail and how the planning process will be undertaken this year.

## 4. Financial Planning

4.1. The financial environment within the NHS remains extremely challenging, and it is clear that significant efficiency savings will be required over the planning period.

4.2 Our current understanding is that due to the importance of the Autumn Statement and the current financial complexities that Monitor has to consider, that the consultation on the national tariff will not be issued until January 2016, with a final tariff not agreed until the end of March 2016. In previous years, the tariff has been issued for consultation in November, with a confirmed position early in the calendar year at the latest. Whilst this timescale is not particularly helpful, in terms of our planning we will simply need to plan using reasonable assumptions about the future tariff whilst discussion continues nationally.

4.3 The planning assumptions that need to be taken into account include:-

- Continued tariff reduction of 1.5% year on year
- Cost pressures within the service of around 2.5% per year, creating a minimum efficiency requirement of 4%
- No change in tariff rules in respect of the Marginal Rate Emergency Tariff (MRET) being set at 70% of full tariff price, with discussion with Commissioners in relation to reinvestment in services to reduce non-elective activity.
- Specific pressures being experienced in relation to medical staffing and in particular the cost of locum and agency staff.
- CCG allocations that will be flat in real terms.
- The tighter regulatory requirement in respect of the Continuity of Services rating, and the commitment we will need to make as a Board in relation to our confirmation or otherwise that we will have a risk rating of at least three for the following 12 months.

- The level of surplus generated to deliver a capital programme that will be required to achieve the Trust's strategic objectives.
- The impact of CIP not delivered in 2015/16 or delivered non-recurrently only.

4.4 In terms of process, the financial issues locally that will require to be addressed include:-

- The level of activity and associated income.
- The principle of no new investment that does not contribute to efficiency improvements or safeguarding patient safety.
- The balance between capital and revenue and the timing of capital investments in line with CIP delivery.
- Our approach to the medical staffing cost pressure in particular and the level of risk that we build into our plan.
- The need to rebuild our current cash position to provide financial resilience over the planning period.
- The allocation across Directorates of the efficiency challenge which at this stage in the planning process can be assumed to be around 5%.

## 5. Contracting

5.1 As the Board is aware, the contracting round for 2015/16 was significantly extended beyond the desired timescale. A feedback session is being organised with the CCG to understand the process and the difficulties we experienced this year so that we can learn from that experience.

5.2 The national timetable for agreeing contracts has not been issued, but best practice clearly would suggest that the contract should be agreed before 1st April 2016. How this reconciles with the current indication from Monitor about the release of the final tariff for 2016/17 needs to be worked through with the CCG.

## 6. Capital

6.1 Work has started to review the Trust's capital estates strategy for the hospital site. A workshop was held on the 29th September with the representatives from across the Trust to consider the future needs and identify the options for how the site is developed over the next ten years. This event generated a number of ideas which are now being collated and developed into a series of options for further consideration. Further updates on the development of the capital strategy will be given to the Board over the coming months.

6.2 With regard to the agreement of the capital priorities, the following principles will be adopted: -

- Strategic capital schemes related to our business development strategy will be funded centrally, with borrowing an option considered
- Replacement (or 'maintenance') capital spend should be funded through our depreciation resource
- Allocations should be linked to the equipment replacement requirements
- A separate estates fund will be protected related to building depreciation
- Funding will be allocated to Directorates for prioritisation

- Release of funding against an agreed programme will be linked to achievement of financial plan in each directorate
- Phasing of the programme each year protects the trust's cash position and allow adjustment dependent upon in year financial performance
- Over-delivery of Directorate financial plan will enable additional capital resource to be released
- The directorates will prioritise this allocation and construct a programme for 2016/17, with the phasing being a maximum of 25% in Q1 and a further 25% in Q2.

## 7. Process

7.1 Business Planning meetings have now commenced and the group, including representatives from each of the Clinical and Corporate Directorates, will meet fortnightly over the coming months. These meetings will focus on agreeing activity plans, efficiency programmes and reviewing the service and capital initiatives included in the Five Year Strategic Plan to re-affirm the initiatives to be taken forward in 2016/17 and beyond.

7.2 Business development activity will be incorporated within the planning process to ensure that bid opportunities and development opportunities are captured.

7.3 Capacity and activity modelling is underway with a view to completing the activity and capacity plans by the end of November.

7.4 The identification of CIP savings through Directorates is well advanced with approximately 95% identified for 2016/17 totalling £8.7m. (Using our risk adjusted methodology these figures reduce to 62% identified totalling £5.7m). A detailed paper in relation to our CIP for 2016/17 is reported elsewhere on the Board agenda.

7.5 Work will clearly continue in the coming weeks to agree the CIP programme, and Quality Impact Assessments (QIA) are already commencing through the Directorate governance process. These will be documented and recorded through further review by the Chief Nurse and Medical Director who will report to the Board of Directors. This will include greater transparency and audit trail in relation to proposals that are rejected or amended in the light of the QIA process.

7.6 Discussions will continue over the coming weeks with Directorates to identify the service pressures that need addressing as part of the plan going forward. These will include existing pressures as well as future challenges, such as the requirement to meet 7 day standards.

## 8. Timetable and Engagement with Board of Directors and Council of Governors

8.1 We still await the planning guidance nationally that will outline the deadlines for submission of our plan to Monitor (NHS Improvement) and also the timetable for tariff information and contract negotiations. Internally however, we have organised our timetable to deliver an agreed business plan by March 2016– this could need adjusting for external submission but internally it is clearly important to have our own plan in place before the start of the new financial year.

8.2 Meetings are taking place on a fortnightly basis across Directorates to ensure that the information required is produced and discussed, and in addition discussions are being held within Directorates and individual Directorate plans are developed.

8.3 A paper updating the Board of Directors will be presented each month until the plan is agreed. This will include regular updates in relation to working with our Commissioners to agree service contracts. We will have dedicated planning sessions with the Board in December and February and the Board meeting in March will be required to approve our plan for 2016/17 including the associated budgets for Directorates.

8.4 The Finance Committee will meet in January, February and March, with the latter two meetings specifically in place to discuss the progress in developing the financial plan for 2016/17.

8.5 The Quality Committee meets monthly and part of the agenda will be a discussion about the quality priorities for 2016/17 which will need to be factored into our planning process.

8.6 The Governor group concerned with the operational plan has already met and will continue to do so throughout the planning process.

8.7 The Council of Governors meeting in February will also provide an opportunity for engagement and discussion with all Governors.

8.8 A timeline for agreeing the 2016/17 Business Plan is detailed at **Appendix B.**

## 9. Conclusion

9.1 The Board is asked to:-

- Note the ongoing work with the development of the Business Plan for 2016/17 onwards.
- Note the planning process and the timescales for agreement of the Business Plan for 2016/17 onwards.

Harrogate and District NHS
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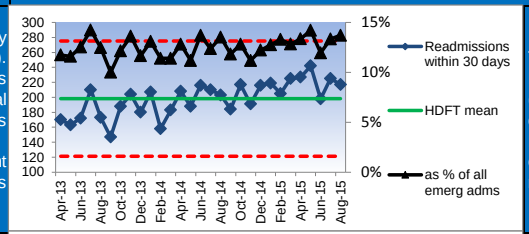
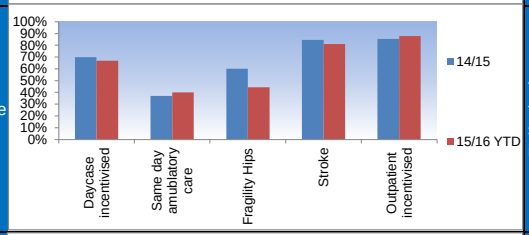
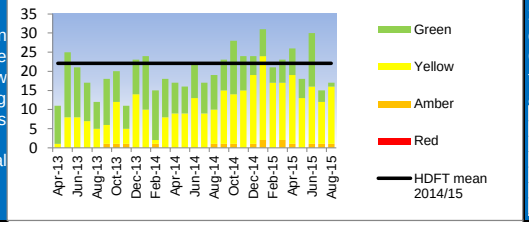
## Delivering High Quality Care - October 2015

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Strategy for frail elderly in place, with milestones agreed** | This narrative describes progress in relation to the development of the strategy for frail elderly and associated milestones | A briefing paper detailing the development of the strategy for older people with frailty at HDFT has been written for presentation to the Board of Directors on 20th October 2015. The paper contains some of the headlines that that the finalised strategy will encompass. | |
| **Reduction in avoidable emergency readmissions within 30 days** | % of patients readmitted to hospital as an emergency within 30 days of discharge (PbR exclusions applied). To ensure that we are not discharging patients inappropriately early and to assess our overall surgical success rates, we monitor the numbers of patients readmitted. A low number is good performance.<br>This data is reported a month behind so that any recent readmissions are captured in the data. A low figure is good. |  | The number of readmissions within 30 days is increasing. However when expressed as a % of all emergency admissions (black line on the chart), there has been no significant change over the last two years.<br>Data collection for the case note audit has commenced with a clinical proforma attached to notes of patients who have been readmitted to support the data capture. |
| **Proportion of Best Practice Tariff achieved** | The chart compares each key area of Best Practice Tariffs achieved/monitored from 2014/15 to 2015/16 |  | The achievement in Best Practice Tariff has decreased 16% in fragility hips and slightly in daycase incentivised procedures and stroke. Whilst there have been slight increases in outpatient incentivised procedures and same day amublatory care. |
| **Reduction in number of complaints per 1000 contacts referencing communication** | The number of complaints received by the Trust, shown by month of receipt of complaint. The criteria define the severity/grading of the complaint with green and yellow signifying less serious issues, amber signifying potentially significant issues and red for complaints related to serious adverse incidents.<br>The data includes complaints relating to both hospital and community services. |  | 26 complaints were received in September, but none were classified as amber or red.<br>Complaints are only categorised upon resolution/closure, the table below details those which referenced 'Communication' as a category in the complaint:<br>2015 04: 15<br>2015 05: 6<br>2015 06: 13<br>2015 07: 8<br>2015 08: 6<br>2015 09: 2<br>Totals: 50 |

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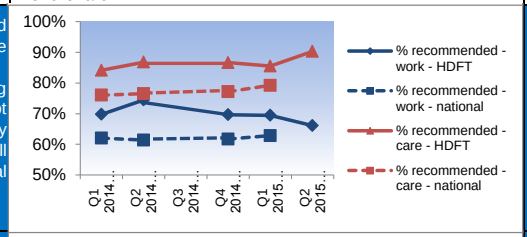
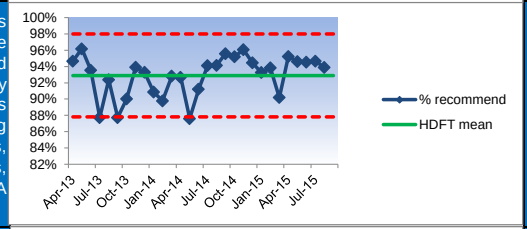
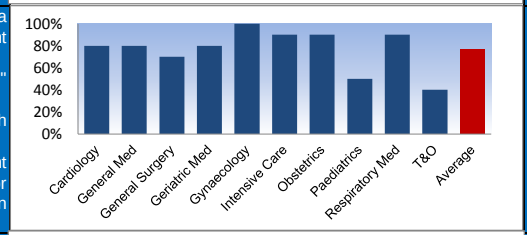
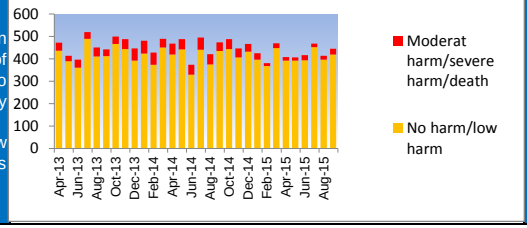
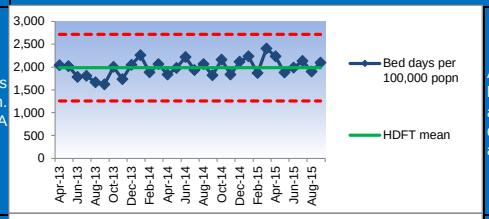
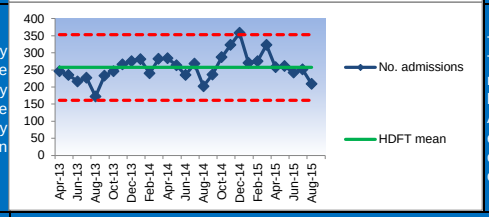
## Delivering High Quality Care - October 2015

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Friends and Family Test (FFT) for staff (% that would recommend HDFT)** | The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organsation they work in.<br>Trusts were only required to carry out the survey during Q1, Q2 and Q4 2014/15 so data for Q3 2014/15 is not available. HDFT surveyed all staff for each survey during 2014/15. During 2015/16, a proportion of staff will be surveyed each quarter, which is in line with national guidance.<br>A high percentage is good. |  | In Q2 2015/16, staff from Elective Care Directorate and some staff from the Corporate Directorate were surveyed. 90.3% of staff surveyed would recommend the Trust as a place to receive care.<br>The latest available national data is for Q1 2015/16. HDFT's score for Q1 was above the national average and placed the Trust 39 out of 149 acute trusts. |
| **Friends and Family Test (FFT) for patients (% that would recommend HDFT)** | The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of hospital and community services including inpatients, day cases, outpatients, maternity services, the emergency department, some therapy services, district nursing, community podiatry and GP OOH. A high percentage is good. |  | The chart shows the overall score (% patients who would recommend the service) for all HDFT services currently participating in the FFT survey. 93.9% of the 5,700 patients surveyed in August would recommend the service to friends and family. The number of patients participating in August reduced when compared to July, but this is partly due to reduced activity during the summer period. Response rates vary between services but the Clinical Directorates are working on maximising these. |
| **Senior patient reviews within 14 hours** | All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant within 14 hours of arrival at hospital.<br>- All patients to have "National Early Warning Score" established at time of admission;<br>- Consultant involvement for patients considered "high risk";<br>- All patients admitted during period of consultant presence on the ward seen and assessed by a doctor promptly and seen and assessed by a consultant within 6 hours. |  | The Trust undertook a manual case note review of ten sets of case notes against each specialty. These were emergency patients admitted within June, July and August 2015, with 5 sets of case notes covering weekend days. The Trust average compliance with senior review within 14 hours was 77% achievement. |
| **Proportion of high/low risks. Reporting culture. Total no incidents, % that are high** | The chart shows the number of incidents reported within the Trust each month. It includes all categories of incidents, including those that were categorised as "no harm". The data includes hospital and community services.<br>A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture |  | There were 425 incidents reported in September 2015. The number of incidents reported each month remains fairly static but the proportion classified as moderate harm, severe harm or death has reduced during 2015/16.<br>The latest published national data (for the 6 month period to end March 2015) showed that acute (non-specialist trusts) reported an average ratio of 25.0 no harm/low harm incidents for each incident classified as moderate harm, severe harm or death. HDFT's reporting ratio for 2015/16 is 22.7. |

## Working with partners to deliver integrated care - October 2015

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Agreed service model in place, milestones identified, contractual arrangements in place** | The narrative describes progress in relation to the development of the joint service model and associated milestones for the New Models of Care | The Value proposition and work of the New Models of Care Task and Finish Groups provides the outline of the model and the work for early implementation and mobilisation has commenced. Contractual arrangements to be developed and agreed. | |
| **Harrogte residents NEL bed days/1000 (over 65s) reduced** | The charts shows the number of non-elective bed days at HDFT for patients aged 18+, per 100,000 population. The chart only includes the local HARD CCG area. A lower figure is preferable. |  | As can be seen, the number of bed days for patients aged 18+ has remained fairly static over the last two years. Further analysis of this new indicator will be completed to look at the demograghic changes during this period and the number of admissions for this group will assist in understanding this further. |
| **Reduced avoidable admissions** | The chart shows the number of avoidable emergency admissions to HDFT as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require admission. Conditions include pneumonia and urinary tract infections in adults and respiratory conditions in children. |  | The number of avoidable admissions reduced in August 2015. The chart demonstrates some seasonality with this metric with more avoidable admissions occurting over the winter months last year.<br>An admission avoidance/urgent care project group has been established and the Trust is working with HARD CCG to develop care models and pathways that support patients to stay in their own home and reduce the risk of hospital admissions. |
| **Joint IT strategy agreed with agreed milestones** | This narrative describes the progress in relation to the development of the joint IT strategy in conjunction with our partners in the Health Community | An IT workstream project group has been established and is being led by Jason Westwood with representatives from each organisation. A number of meetings have been held and are scheduled on a weekly basis going forward. Work has commenced to develop a strategy covering how information will be shared and accessed by all organisations. | |
| **Formal alliances in place** | Formal alliances in place (LTHT, YHFT, AHFT) with governance arrangements and workplan agreed | LTHT - Alliance Board meetings scheduled and held regularly. Strategic Workshop 16th November to develop a series of workstreams and work programmes to be implemented.<br>YTHT - Clinical Alliances well established. Alliance Board meetings scheduled and held regularly. Number of work programmes being taken forward across a range of specialities. Good examples of collaborative working in place with areas of Best Practice shared across both organisations.<br>ATHT - Alliance Board meetings scheduled 6 monthly. Focus on sharing areas of good practice and joint learning. | |
| **Patient satisfaction of new model of care** | This is not available as yet, will be developed as the Vanguard Project progresses | | |

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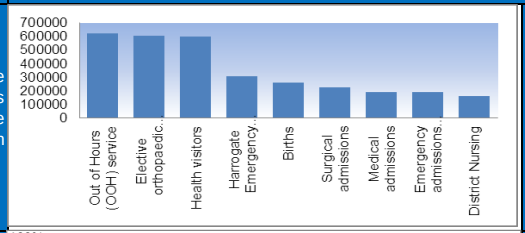
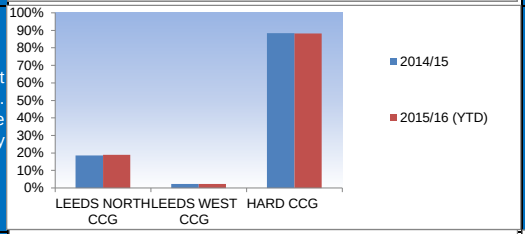
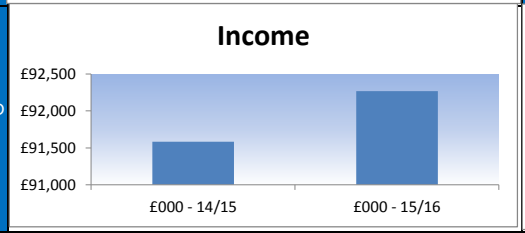
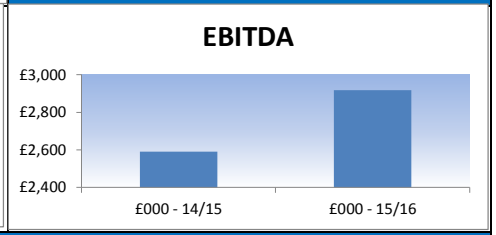
## Clinical and Financial sustainability - October 2015

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Sustainable service strategy refreshed with milestones agreed** | The narrative describes progress with regard to the sustainable service strategy and associated milestones | The Trusts Business Plan for 15/16 sits within the 5 year strategic plan which sets out the Trusts Clinical and Financial Sustainability plan, including the development of Emergency Surgery, Elderly Care, Paediatrics, Maternity and community services to deliver care closer to home. The Board also set out the intention to grow the Trusts revenue by £30m over the 5 years, with the business development plan setting out how this will be achieved through a mixture of growth in elective work, demographic growth, successful tender bids and development of private patient work. | |
| **Sufficient catchment population for key specialites of maternity, paediatrics and emergency surgery** | This narrative describes progress in relation to the development of catchment areas for the key specialities of maternity, paediatrics and emergency surgery. The chart shows populations served by HDFT services in 2013. |  | Work has progressed to develop catchment areas for Maternity, Paediatrics and Emergency Surgery, with new developments in community midwifery outreach into Leeds, development of Endoscopy services in Wharfedale and Surgical Outpatients in Yeadon, changes in provision of Paediatrics and Maternity to the north of Harrogate and development of Paediatric outpatient services into Leeds. |
| **Increased share of HaRD CCG, Leeds North CCG and Leeds West CCG referrals** | The chart shows the proportion of first outpatient attendances from each locality that are seen at HDFT. The data is sourced from the HED (Healthcare Evaluation Data) benchmarking system and only includes specialties for which HDFT run services. |  | HDFT's market share in 2015/16 year to date is 88% in HARD CCG, 19% in Leeds North CCG and 2% in Leeds West CCG. |
| **Income and EBITDA** | The charts show the growth in income and EBITDA YTD 2014/15 vs 2015/16 |  |  |
| **CCG/Commissioners survey undertaken** | CCG/Commissioners survey undertaken and actions taken in response | A survey has been circulated to HARD and Leeds CCGs, and feedback is awaited. | |

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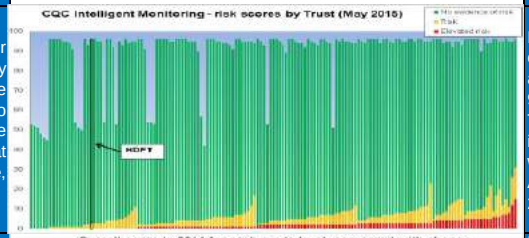
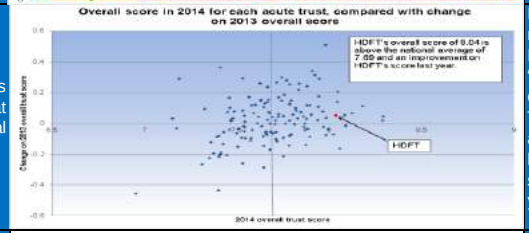
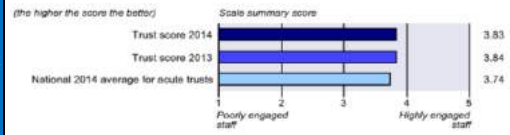
## External Monitoring - October 2015

| Indicator | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Monitor continuity of services risk rating** | The Monitor Continuity of Services (CoS) risk rating is made up of two components, liquidity and capital service cover. An overall rating is calculated ranging from 4 (no concerns) to 1 (significant concerns). This indicator monitors our position against plan. | **Element** / **Plan** / **Actual**<br>Capital Service Capacity rating: 4 / 3<br>Liquidity rating: 4 / 3<br>I&E Margin rating: 3 / 2<br>I&E Margin Variance rating: 2 / 2<br>**Financial Sustainabiltiy Risk Rating: 3 / 3** | The Trust will report a risk rating of 3 for the year to September. This is in line with the Trust plan following the introduction of the new metrics previously discussed.<br><br>Despite still being a 3, the Trusts current position means this is weaker than initially planned. |
| **CQC Intelligent Monitoring reports** | CQC published the most recent update of their Intelligent Monitoring Reports for each Trust in May 2015. The reports include around 100 indicators and are used by CQC as part of the new inspection process to raise questions about the quality of care and were chosen by CQC to reflect the five key questions that they will ask of all services – are they safe, effective, caring, responsive and well led? |  | For the latest publication, HDFT was given an overall banding of 6, the lowest risk banding. HDFT had no indicators assessed as “elevated risk” and 3 indicators assessed as “at risk”, out of 96 applicable indicators. This places HDFT joint 20th out of 155 Trusts as illustrated by the chart to the left. This is an improvement on the previous publication in December 2014, when HDFT was ranked joint 50th.<br>A CQC inspection of the Trust is due to take place in February 2016. |
| **Patient Survey** | The national adult inpatient survey for 2014 was published by CQC in May 2015. 461 patients treated at HDFT responded in the survey this year - a local response rate of 56%, the same as last year. |  | HDFT had 7 questions rated "better than average" and the remaining 53 questioons rated "about the same as average". For the fourth consecutive year, HDFT had no questions rated “significantly worse than average”, placing us 5th nationally out of 140 Trusts .<br>The chart below shows how each acute trust scored in 2014 and plots this against the change on their 2013 score. As can be seen, HDFT is in the top right quadrant indicating an overall score that is above average and an improved position on last year’s results. |
| **Staff Survey (Top 20%)** | The results shown are taken from the 2014 National NHS Staff Survey. The 2015 NHS Staff Survey is currently being undertaken and the results are not yet available. | OVERALL STAFF ENGAGEMENT- 2014<br>  | The figure opposite shows how HDFT compares with other acute trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged with their work, their teams and their Trust) and 5 indicating that staff are highly engaged. The Trust's score of 3.83 was in the highest (best) 20% when compared with trusts of a similar type. |

**Appendix B**

**OPERATIONAL PLAN 2016/17 - TIMELINE:**

| Date | Actions/discussions |
|---|---|
| **Oct 15** | • Introduce the Annual Business Planning Process for 2016/17<br>• Agree process for capital priorities<br>• Introduce the capacity and activity plans for completion<br>• Initial meeting with Governors<br>• Receipt of capacity and activity plans<br>• First cut of Efficiency Programme<br>• BoD meeting paper |
| **Nov 15** | • Discuss activity and capacity plans<br>• Identify potential service developments<br>• Identify potential capital developments<br>• Identify quality priorities<br>• QIA Completed with Directorate, Medical Directors and Chief Nurse<br>• BoD meeting paper to update progress |
| **Dec 15** | • Sign off activity and capacity plans (ALL)<br>• Efficiency programme update<br>• Tariff and planning guidance to be issued after Christmas discuss in January<br>• Sign off capital and service priorities<br>• 16 December 2015 BoD timeout to discuss amongst other things the Business Plan<br>• Meeting with Governors |
| **Jan 16** | • Submission of Directorate business plans for inclusion in Trust's first draft of the operational plan for Board of Directors to consider<br>• Tariff and planning guidance to be issued<br>• Financial templates to be issued<br>• Extended SMT to agree content<br>• Update on agreement of Efficiency Programmes<br>• Outline key messages to be included in the plan<br>• Meeting with the Governors |
| **Feb 16** | • BoD timeout<br>• 1st Draft of the plan to SMT, BoD and CoG for consideration<br>• Finance Committee review<br>• Finalise CIP plans<br>• Budgets signed off and financial plans finalised<br>• Sign off Directorate business plans<br>• Sign off quality priorities<br>• SMT review of progress<br>• BoD meeting paper to update progress<br>• Meeting with the Governors |
| **Mar 16** | • Final draft of business plan to SMT, BoD for approval and CoG for endorsement<br>• Finance Committee review<br>• Quality Committee review and confirmation of priorities<br>• Sign off business plan for submission to Monitor<br>• Submit business plan to Monitor 1st April 2016<br>• Meeting with Governors<br>• Develop Summary Annual Plan |

# Quality Committee
# Minutes
## Wednesday 2 September 2015, 2.00 – 4.00 pm, The Boardroom, Trust HQ

**Members present:**

| | |
|---|---|
| Mrs L Webster | Non-Executive Director (Chair) |
| Mr N McLean | Non-Executive Director |
| Dr R Tolcher | Chief Executive |
| Mr P Marshall | Director of Workforce and Organisational Development |
| Mrs J Foster | Chief Nurse |
| Dr K Johnson | Clinical Director, Elective Care Directorate |
| Ms K Barnett | Operational Director, Integrated Care (rep. Dr Lyth) |
| Mrs J Crewe | Operational Director, Urgent, Community & Cancer Care (rep. Mr Alldred) |
| Dr D Scullion | Medical Director |
| Dr S Wood | Deputy Director of Governance |
| Ms S Keogh | Head of Midwifery and Lead Nurse, Elective Care |

**In attendance:**

| | |
|---|---|
| Ms S Blackburn | Public Governor |
| Mrs S White | Corporate PA (minutes) |

| No | Item | Actions |
|---|---|---|
| 1. | Welcome and apologies<br>Apologies were received prior to the meeting by the record taker from Mr A Alldred, Clinical Director, Urgent, Community and Cancer Care Directorate, Mr R Harrison, Chief Operating Officer, Mrs A Leng, Head of Risk Management, Dr N Lyth, Clinical Director, Integrated Care Directorate and Professor S Proctor, Non-Executive Director.<br><br>Mrs Webster welcomed Sally Blackburn, Public Governor, to the meeting to observe and ask questions.<br><br>Dr Johnson reported significant pressure in Obstetrics & Gynaecology and that she may be called away therefore Sarah Keogh, lead nurse for the Directorate, had accompanied her and would deputise if necessary. | |
| 2. | Minutes of the Last Meeting and Matters Arising<br>The minutes of the meeting held on 5 August 2015 were approved as a correct record subject to the following amendments being made:<br><br>• Dr Wood clarified under item 9, Log of Reports; previously reports went through the Standards Group but these are now received, logged centrally and disseminated. The log of reports comes to Quality Committee for information and for members to seek further information or assurance.<br>• Dr Tolcher's name was misspelt in a couple of instances.<br><br>There were no matters arising. | |

2.1 Action Log

The outstanding actions of the schedule were reviewed and the following updates given:

4. Integrated Dashboard – lack of information around Community Services – outstanding. Action should be Mr Harrison. To remain on Action Log
4. Integrated Dashboard lack of information on Maternity Services and Community Services. There are some community indicators but these are not available as a dashboard report. Agreed to discuss with Mr Nicholas and Ms McDonald which indicators could be incorporated into the Integrated Dashboard. Proposal to be taken to next SMT to be held in September.
4. Maternity Services information was provided just before this meeting. Agreed that a recommendation of information suitable to be included in the Integrated Dashboard would be discussed and agreed at next SMT and brought to this Committee then.
4. Ms Wixey working on both documents. Dr Wood agreed to clarify the timescale for completion and ratification but suggested aiming for the November meeting.
7. CQC Assurance Framework – self assessment process – agenda item for next SMT. To remain on Action Log
4. Dashboard – RAG ratings, outstanding action – this is an agenda item for next SMT and feedback should be available for the October Quality Committee. To remain on Action Log
4. Dr R Hobson unable to attend today's meeting but would attend October's meeting to present a paper around the action plan for C.difficile. Quality Committee members to advise Mrs White if they had anything they wished to raise so Dr Hobson could be briefed in advance.
4. Integrated Dashboard – Family and Friends Test consideration for increasing the number of forms completed– outstanding. To remain on Action Log

The following actions were closed:

6. GP OOHs – report received.
9. Log of reports received – to be discussed under respective item.

Mrs Webster referred to item 6, Patient Flow, and suggested it would be helpful to look at these three reports in depth before proceeding to talk about CQC self-assessment and then move on to review the dashboards. All agreed.

2.2 Quality Improvement - Communication

The paper from Integrated Care was received and taken as read; there were no questions from the Quality Committee.

3. Dashboards

3.0 Integrated Dashboard

The dashboards were received and taken as read.

In response to a query raised at the previous meeting regarding occupational health services, Mr Marshall advised that free staff counselling services are available to all

staff, initially six sessions per individual, and staff may be referred for more in depth counselling if necessary. In terms of numbers, an average of 100 members of staff per year use this service. The main reason for referral was stress, anxiety or depression, including personal trauma. Hotspot areas were identified. A charge of £5 per session had been considered but trade union colleagues had not been supportive of this. An annual report from the service is received showing cause and effect, number of working days lost and reason. There can be a long wait for a GP referral for counselling and the Trust is able to offer immediate referral. Mrs Webster noted that the number of staff using the service was relatively small given the current demands on the organisation. Mr Marshall commented that it was important to sustain and maintain the service.

Mr McLean commented that he did not feel the narrative provided in the Integrated Dashboard had improved, the comments largely repeated those in the first column and did not provide adequate explanations or details of action being taken in relation to the results.

Dr Tolcher reported that the thresholds for RAG ratings were being considered. Also considering how to ensure that the Friends and Family Test was more uniformly completed. Any comments or suggestions would be welcomed. Mrs Foster advised that work was on-going looking at how we target people who use our outpatient services and other things to improve on the response rate from patients and staff, to capture and use feedback and to address where no feedback is being received.

There were no further comments.

3.1 Quality and Safety Dashboard

It was noted that reports from patient safety visits are not received at Quality Committee and it was considered whether these should be heard here. It was confirmed that these are received at the Senior Management Team (SMT); actions identified are shared with the directorate concerned and monitored by SMT. A six-monthly report is also received at the Board of Directors' meeting. Therefore consensus was, there was no need for these to be heard at the Quality Committee.

Mr McLean referred to maternity services and Family and Friends narrative, data on reduced performance is provided but does not explain what the issues are and what is being done to address this. Ms Keogh confirmed that maternity – particularly in relation to the community has a poor response rate.

Mrs Webster referred to the section about staff completing the Family & Friends test, the percentage of staff saying they would not recommend seems to be quite high if this was representative of the whole workforce. It was commented that the results were substantially better than the national average, but on reflection it was suggested that a stretch target could be considered and be introduced.

It was noted that if staff are engaged and happy then patients are likely to be much happier about their care. Positive data from the staff Family and Friends Test would be useful to include in recruitment campaigns.

4. New Items and Hot Spots

There were no new items or hot spots to be brought to the attention of the Quality

Committee.

5. Patient Experience and Incident Report & (5.1)
Risk Management Aggregated Annual Report 2014/15

It was noted that the Patient Experience and Incident Report was presented in a new format. For the first time providing a comprehensive report on patient experience rather than a report just on complaints, and feedback was requested from the Quality Committee on whether it provided the information they wished to see. It was felt that it would be helpful to have more time to review this report and it was agreed to consider and discuss at October's meeting, when Mrs Leng was present. *All*

The Risk Management Aggregated Annual Report was also deferred to the next meeting.

6. Quality Improvement Priority Update – Patient Flow

6.1 Elective Care Directorate

Dr Johnson presented this paper and noted that it featured contributions from many areas within the Directorate and gave a flavour of some of the things that were happening in relation to patient flow. Some of the work being taken forward included:-

- Looking at acute and elective patient flow in outpatients and orthopaedic outpatients to address issues of DNAs and whether review visits were absolutely necessary. Work was also on-going to ensure appropriate coding and capturing follow-ups to make sure we are fully and appropriately reimbursed.
- Looking at ways to try and reduce people coming in for suture removal, for example encouraging more use of dissolvable stitches. Implemented suture removal being undertaken in Occupational Therapy to reduce patients travelling between appointments.
- Surgical wards – Littondale and Nidderdale – middle grade doctors in gynaecology now taking the phone calls from GPs, providing advice and reducing unnecessary admissions to hospital.
  Mr McLean asked if conversations are documented by middle grades and Dr Johnson said they should ask the GP to document on the patient's notes that are held at the Surgery. He asked if we were satisfied that this happens. Dr Johnson confirmed that it was expected the GP would record advice given. In the maternity department there is a system for documenting advice given – a proforma is completed and goes in notes when the patient comes in and this works really well. Mrs Foster asked if the initiative had made a difference to the number of patients being admitted and it was noted no record of calls is maintained by the Trust. Most attendees are ward attendees and do not stay.
- Development of an afternoon Clinical Assessment Team (CAT) for Nidderdale is underway, run by a Care Support Worker, who starts paperwork for patients, records observations and calls relevant doctor, but there is a cost implication.
- Working with gastro team to provide more frequent rounds on Nidderdale and Litttondale wards.
- Looking at use of discharge lounge – Harlow do not really utilize.
- Trying to encourage doctors to complete patient discharge letters with "to take out" medicines (TTOs) in advance. However from October 2015 Nidderdale will

be trialling pharmacists writing TTOs to help speed up discharge.

- Orthopaedics have been working to enhanced recovery guidelines for some time, and the directorate is looking at applying these in other areas. Ensuring patients are in the best condition before and after surgery means they recover more quickly, and using different anaesthetics enables earlier mobilization. This has been started for patients having caesarian-sections.
- Woodlands ward – a business case is being written for the implementation of a clinical assessment unit which would prevent some admissions.
- Ophthalmology – a number of actions were underway to address the large volume of patients waiting for follow-up appointments or new appointments, including looking at how clinics work and taking paper records out of the department to try and speed up/work differently.
- Endoscopy – demand continues to increase and a new build was awaited to provide additional space and capacity, which would improve the patient journey. Patients awaiting ERCP are now invited at a specific time and also being pre-assessed, which is reducing waiting times.
- Pre-Admissions Assessment Unit – trialling a PAAU assessment service at Yeadon and Ripon clinics to allow patients to be seen closer to home and in doing so creating additional capacity for the PAAU to admit patients on the morning of surgery and reduce the need for inpatient stay.
- Physiotherapy – a number of initiatives had been introduced, including focusing on recruitment to fill vacancies which are resulting in long waits for outpatient assessments.
- Chronic pain – there is currently a significant waiting list and a number of actions are taking place to help reduce this including looking at leaner ways of working.
- Maternity refurbishment complete – official opening date 9 October – all very welcome.
- Volume of paperwork in maternity is enormous and the department would welcome steps towards going paperless as it would make a huge difference to time available to care for patients.
  Mr McLean asked what the barriers to going paperless were and Dr Johnson explained several: investment in technology, a significant time element, requirement to interface with other areas of the hospital. It was noted that there is a master plan for the organisation within the IT strategy. Agreed to add this to the agenda for the next meeting – to look at where it is in the list of priorities. Noted the Corporate Risk Register should flag this up if appropriate. *S White*
- Day Surgery Unit – a paediatric day that avoids patients being admitted to Woodlands ward had been introduced. A review of procedures that can be carried out as day cases to avoid any unnecessary admissions had also been undertaken.
- ITU are looking to introduce a High Observation Bay (HOB) on the wards that would reduce admissions and length of stay on ITU.

Dr Johnson summarized that in improving patient flow she felt three things were key to this:

- Differing use of discharge lounge – need to understand what is behind this, challenge and set some clear markers
- Writing up TTOs and use of planned date of discharge
- Are we satisfied that we have enough grip and in encouraging staff to make changes.

It was noted that Ms Barnett is leading on discharge and all three issues are part of

the discharge improvement plan. Dr Tolcher noted a timescale was needed for this work.

Mrs Webster noted the use of the discharge lounge was not included in the Integrated Care dashboard and questioned whether sight of this had been lost with the new reporting system. It was confirmed it was seen at operational level, possibly not at board level. The Quality Committee considered how it could be confident the discharge lounge was being used to an appropriate level. Dr Tolcher suggested length of stay could be used although not a good indicator of patient flow. Mrs Webster noted that feedback on the discharge lounge was that it was not the most comfortable place to spend any time and this may be a reason for Harlow not utilising it for its patients.

Mrs Webster thanked Dr Johnson for a very comprehensive report. Dr Johnson then left the meeting.

6.2 Urgent, Community and Cancer Care Directorate

The paper from this Directorate was received and taken as read. Mrs Crewe advised that the report had been prepared by Michelle Milnes and she highlighted the key messages, noting that a lot of the narrative describes on-going work similar to that taking place in Elective Care. Some measurable indicators of what was being aimed for would be included in the next update:-

- Cancer Services and Psychology resource – work taking place to understand the demand on psychology services for patients; to understand what the true demand is for this.
- Acute oncology – a number of improvements had taken place to this service and the success of these could be evidenced from surveys that relate to cancer and audits.
- GP Out of Hours – included on the risk register – some issues in relation to patient access and patient experience – work was on-going in this area.
- Community equipment breakdowns out of hours – not commissioned and is an issue that comes up often and impacts on patient experience. Discussing with commissioner the need to provide a more robust out of hours service. Risk mitigated by Fast Response team having access to equipment. No engineer available 24/7. Community teams can also rent equipment, at additional cost, such as in the case of a bed malfunction to avoid admittance to hospital.
- As in Elective Care, pharmacy to commence trialling writing up TTOs.
  Mrs Webster enquired whether pharmacists were happy with the new arrangements instead of doctors doing this and Mrs Crewe advised that she had not heard anything to the contrary and it is a pharmacy led initiative. Dr Scullion confirmed all were happy with the new arrangements. Mrs Webster asked if patients were prescribed drugs they already take and have at home or just new drugs. Mrs Crewe confirmed patients are encouraged to bring in their own medication, which is kept in their lockers. If necessary they would be provided with a top up at discharge, but pharmacy tries to be as efficient as possible.
- Lack of adequate Clinical Nurse Specialist (CNS) resources impact on cancer services and provision of timely CNS support.

Mr McLean noted that there was a lot of detailed information around on-going actions but no projected timescales, and these should be included. Mrs Webster agreed that these could be used when reviewing progress going forward.

6.3 Integrated Care Directorate

The report from this Directorate was received and taken as read. As the directorate responsible for managing the inpatient medical wards, patient flow is an area of particular focus and a number of activities were in place to support the achievement of improvements in patient flow:-

- Inpatient flow - A large number of projects were underway at the moment – the biggest one being the Fountains/Bolton FLIP – to redesign the space and patient pathways within Fountains, Bolton and the Clinical Assessment Team and improve patient flow. The project was over three phases with capital investment required in the later phase. The initial phase was due to take place at the beginning of October. An update on this would be received at November's meeting.
- Outpatient flow – Dermatology and Gastroenterology are both high users of outpatients. In Dermatology, to meet increased demand, daily two week wait clinics have recently been set up and work has been undertaken to change how clinics are managed and how many patients need to come back for follow-ups. In Cardiology a lot of work had been undertaken in relation to pathways and a one stop atrial fibrillation clinic had commenced in August to improve access and provide a more comprehensive service.

Mr McLean noted that his personal experience of dermatology services had been very positive; he had found it to be well organised with good patient flow in spite of the enormous number of patients. Mrs Webster asked if there were any lessons here that could be used in ophthalmology services. Ms Barnett said there may be but the patient mix is very different.

It was noted that metrics and targets would be required so that progress and overall improvement could be reviewed at the end of the year. This had been discussed when identifying the priorities at the start of the year and the spread sheet would be reviewed to see if the common metrics defined were still relevant.

It was agreed that the reports were very helpful, talking about care not just looking at data. However they did not prioritise per directorate what the key issues are and critical timing or biggest impact on patients. The Quality Committee could focus on these, tracking and escalating if required. It was agreed it was reassuring to see such a lot of activity, lots of small things making an impact, improving patient flow and decreasing length of stay. Ideally the FLIP project would result in a reduction in the amount of escalation beds this winter.
The Quality Committee would be keen to see some metrics to see if successful, for example a reduction in escalation beds.

7. CQC Assurance Framework – assessment of readiness:
Question 1: Is the service safe?

The Quality Committee considered whether the organisation was CQC ready.
It had received reports on a significant number of initiatives; and the question of whether the organisation felt ready, would staff be comfortable to answer all the CQC's questions, The area particularly related to questions on safety was considered and whether there was anything the Quality Committee could do to help make a difference.

Mrs Crewe noted the reports provide a lot of details at department level about what is important to make services better for patients and meaningful in the department. Directorates were also striving to ensure better engagement with staff so that the CQC assurance process is owned locally and staff are able to answer the questions.

Mrs Foster reminded the committee that a lot of improvements are underway not because the Trust is providing unsafe services, or there are concerns, but because it wishes to improve and be more efficient.

Mrs Webster asked if there were any areas that were felt to be unsafe or where there were concerns.

Ms Keogh, for Elective Care, confirmed there were no areas to flag up and she did not think anyone would say anything was unsafe, the issue was capacity.

Ms Barnett, for Integrated Care, confirmed that whilst services are safe, there are safety concerns relating to gaps in medical and nurse staffing which could impact on the delivery of the high quality care we want to provide. There have been gaps in the latest cohort of junior doctors, although this will improve in October. Gaps are covered with locums or through NHSP, but this comes at a cost. Agency staff are less familiar with Trust processes and there is a greater risk than with substantive staff. This is included in the Risk Register.

Dr Scullion noted that the safety of the service had been tested by the CQC in 2013 and not found to be unsafe and he did not believe the services would be found to be unsafe today, however there would always be room for improvement.

Ms Barnett advised that in Integrated Care, staff are aware of the assurance framework and discuss this at Board and Governance meetings. Departments look at different areas and self-assess to identify any gaps and on the whole she felt that the service would be able to give a reasonable response. A new matron would be commencing in October, from a Trust recently inspected, so their experience would be very helpful. Also many staff were employed when the last CQC inspection took place so are aware of the process.

Mrs Foster highlighted the recent changes to the Mental Capacity Act and Deprivation of Liberty safeguards (DOLs) where there were issues regarding staff training. Action to remedy this was being taken forward.

Mrs Crewe, for Urgent, Community and Cancer Care, reported that she was assured there were no glaring concerns, with mitigated risks in the community and she did not feel there was a safety issue. From an assurance framework perspective, facilitated discussions would be taking place with different services/departments so feedback from staff is captured, especially where they feel there are gaps. Information would be triangulated and any concerns raised with the Quality Committee. To focus on is the service effective? prior to the next Quality Committee meeting.

Dr Tolcher referred to the CQC's five domains and noted the amount of good work that had taken place in relation to these. However she did not feel the Trust would get the result it deserved unless it could demonstrate the evidence base behind this. Mrs Webster asked if the evidence was physical reports/documents and Dr Tolcher

said evidence of good systems and process is required and that these are being followed. The CQC also look at hard data, staff surveys, NHSLA claims, NHS inspections, etc. A huge amount of work is provided in order for them to pursue key lines of enquiry and test policies. Staff need to be engaged and be aware of and understand policies. Information that is relevant needs to be accessible when the inspectors ask for it.

In relation to policies, it was noted that the Trust has in excess of 1000 documents classified as policies on the intranet, and not all are up-to-date.

Work had commenced in relation to the well led review, and other work around making sure documents/leaflets are up-to-date, utilised and accessible. Mrs Webster asked if there were adequate resources to do this work in the timescale. Dr Wood advised that the majority of this would be at directorate level. Mr Marshall advised that the well led review provides assurance about what is in place. As in the previous inspection, briefings would be provided in advance for staff to encourage them to be frank and open.

Mrs Webster asked if the Quality Committee felt assured in relation to the elements and activity towards preparation for the CQC visit. The members confirmed they did, both in actions going forward and in respect of safety.

The next question to be considered would be “how effective is the service we provide?”

8. 8.0 Forward Plan

The forward plan had been circulated with the agenda for information, for awareness of what is expected at future meetings and to track receipt. The plan was being populated with names of those responsible and date report, etc expected at Quality Committee. Dr Wood had contacted Ms Wixey and reported that the Clinical Effectiveness Policy is out for consultation at the moment and it was proposed that November would be a good time to receive this and the Clinical Effectiveness Strategy.

8.2 Policies Review

Dr Wood advised work had commenced in relation to reviewing policies. It had been suggested groups established within the organisation identify policies and strategy they have responsibility for and monitor when due for review - ensuring someone is identified to have overall responsibility for the work. It had recently been identified that a lot of policies were out-of-date, some owners having left the organisation, and there was quite a bit of work to be done in relation to this.

The policies log would be reviewed on a quarterly basis, to ensure items are completed or followed up. Mr McLean suggested it would be useful to include a target date column and Dr Wood agreed to add this. *Dr Wood*

9. New Reports Received

Following on from the previous meeting when a question had been asked about four items shown in ‘red’, Dr Wood explained that the report comprised outstanding action plans from the previous database used by the Standards Group, and new

reports received since Standards Group was decommissioned. The four items had been found on the old database as outstanding, but had not been followed up by Standards Group. Further review revealed that all referred to notification of audits that were to happen, not to reports received. Therefore these were no longer relevant and had been removed.

It was noted the Quality Committee would need to agree how they wish to use this report to gain assurance that reports have been actioned going forward. It was suggested that the Audit Committee could consider an audit of the effectiveness of the new process.

It was agreed the Quality Committee would not wish to receive a detailed report; it just needs to see that reports are received and allocated to the appropriate group, gaining assurance by receiving the log of reports. Dr Wood suggested that the Quality Committee could just see a log of new reports received since the previous meeting, on a monthly basis. This would enable members of the Committee to highlight any reports received that were not on the central log. This was agreed. *Dr Wood*

10. Items to escalate to Board of Directors

There were no items to be escalated to the Board of Directors.

11. Any Other Business

There were no further items of business.

12. Reflection on Meeting

- The agenda had been altered to take reports early on and lots of questions had arisen from these. All agreed this had been useful.
- Mr McLean felt it had been really helpful to talk about quality and care issues so that the Committee can really drive quality issues.
- Dr Scullion felt that time had been spent where it was needed.
- Agreed it was valuable having clinicians in the room.
- It was felt that the discussions provided an assurance on the safety and fitness of our services and on compliance with governance issues.
- Dr Tolcher suggested it might be helpful to include some initial timings on the agenda and Mrs Webster advised that she had allocated timings on her own copy of the agenda.
- Dr Wood commented that the Committee was still finding its way, but she felt it was focusing on the appropriate subjects.
- It was noted that a number of reports were due to be received at the next meeting and it was suggested that 2.5 hours might be required.
- It was agreed the Quality Priority reports are really helpful and would be very useful when writing the Quality Account. Mrs Webster commented that she did not want to create work for the Directorates in writing reports and it was noted that these reports also go to the Directorate Board meetings. Progress reports would no doubt be much shorter reports.

13. Next meeting
Wednesday 7 October 2015, 2.00 pm, Boardroom, Trust HQ

Harrogate and District NHS
NHS Foundation Trust

| | |
|---|---|
| **Report to the Trust Board of Directors: 28 October 2015** | **Paper No: 10.0** |

| | |
|---|---|
| **Title** | Report from the Medical Director |
| **Sponsoring Director** | Dr David Scullion, Medical Director |
| **Author(s)** | Dr David Scullion, Medical Director |
| **Report Purpose** | To update the Board on clinical matters for the month of October 2015 |

**Key Issues for Board Focus:**

- Training on case note review of mortality cases
- Publication of 7-day services self-assessment data
- An NHSE external investigation following a murder by a patient
- Improved NRLS reporting data

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

| | |
|---|---|
| **Risk and Assurance** | The paper provides a measure of assurance on clinical issues to the Board. |
| **Legal implications/ Regulatory Requirements** | None |

**Action Required by the Board of Directors**:

The Board is recommended to **consider and comment on** the report and appendix

1. **Mortality**

At the time of writing, I do not have the latest mortality indices. The Mortality Review Group is about to embark on a more structured form of case note review. The training for this will be led by Professor Allen Hutchinson on behalf of the regional work being led by the Improvement Academy. Due to Prof. Hutchinson's busy schedule, it is anticipated training with him will take place in the New Year. Diaries are being aligned. This will bring HDFT into line with the process already being rolled out in a number of acute provider organisations across the region.

2. **7-Day services self-assessment tool**

A response to the Trust data collection exercise has been received from NHSIQ. It is anticipated that the data collected from all Trusts will be published on the MyNHS website on 27 October. The following is a summary of the data that is likely to be published:

| **Harrogate & District NHS Foundation Trust** | | | |
|---|---|---|---|
| **Inpatients seen by a Consultant within 14 hours** | **Diagnostic services available seven days per week** | **Interventional services available seven days per week** | **Seven day services; ongoing review of patients by consultants** |
| 4 out of 10<br>Relevant clinical areas the Trust reports patients are seen within 14 hours 90% or more of the time | 11 out of 14<br>Diagnostic services are available all week | 9 out of 9<br>Consultant directed interventions are available week | 12 out of 14<br>Specialties meet the standard |

There is a possibility that the publication of such data will attract media interest. Next steps will be communicated in writing. At the time of going to press, this communication has yet to be received. This baseline position will act as a starting point against which progress can be measured.

3. **NHSE investigation**

The Trust has been contacted by NHSE regarding a forthcoming external review, following a widely publicised murder of a Harrogate resident which took place in 2000. The perpetrator subsequently confessed and has now been convicted. At the time of the incident he was under the care of the Psychiatric service in Harrogate, a service that was at the time provided by the Trust. The investigation is in its early planning stages. Important information from a learning and reputational perspective will be fed back to Board as necessary when it is made known. As yet the timescales for the investigation are unknown.

4. **HDFT haemato-oncology peer review update**

The MDT is well-led with disciplines working cohesively across a number of hospital sites and a culture of team working embedded into clinical practice. The Team has made significant strides to ensure equity of patient care across this wide geographical area. No immediate risks were identified. Issues of attendance compliance by Consultant staff have been addressed and agreed. Outstanding recommendations relate to Clinical Nurse Specialist resource within York Teaching Hospital NHS Foundation Trust. This has been acknowledged in a CEO response and is being addressed through the business planning process and restructuring of the Scarborough CNS job plan.

5. **West Yorkshire Stroke Summit**

A summary of the recent stroke summit meeting on 11 September is attached as an Appendix for interested readers. Both providers and commissioners are adopting a collaborative approach, centred around stroke prevention and workforce planning. Challenges face all providers including HDFT. There needs to be an improvement in some key metrics and a focus on long term sustainability. I did not get a sense from the discussions that there was a regional appetite for centralisation of hyperacute stroke services. Follow up progress meeting planned for March 2016.

6. **Closure of Bootham Park Hospital**

Following a recent inspection, the CQC took action to withdraw the registration of Bootham Park Hospital at short notice. This is despite a programme of improvement work totalling almost £1.5 million since February 2014. The contract for service provision has recently passed from Leeds and York Partnership to TEWV. Arrangements are in place to provide alternative accommodation for all in patients. One potential impact for HDFT is the closure of the place of safety facilities in Bootham, with potential transfer of cases to Harrogate. So far the impact has been negligible, but we are watching this carefully, given that only one place is currently available in Harrogate. In other respects I hope the impact will be minimal.

7. **NRLS reporting data**

The most recent reporting rate summary data from NRLS has been released for the period beginning October 2014 to end of March 2015. The current data confirms a reporting rate of 34.51 per 1000 bed days against a previous rate of 28.84. This places the Trust within the middle of the middle group of reporters (i.e. in the middle). The indicators are moving in a positive direction, both in terms of timeliness of reporting and overall profile of incidents, and with a very high low: high harm ration (only 0.2% “severe” or “death”). We are higher than the national average for moderate harm reporting. There is more to do. The recent appointment of a Patient Safety Manager, Philippa Cooper, and the planned appointment of an Incident Co-ordinator will facilitate proactive educational effort within the Directorates.

8. **Dr Michael Toop**

It is with great sadness that I have to announce the recent, sudden and unexpected death of Dr Mike Toop. Mike was a Consultant Biochemist in the Trust for many years prior to his retirement. He was a fine colleague and a good servant to the Trust and wider community. Following retirement he served as a NED at Airedale NHSFT. Our sympathies and condolences go to his family.

Appendix:
West Yorkshire Stroke Summit – summary presentation

HEALTHY FUTURES

Better health for all across the West Yorkshire region

# Stroke Programme

## West Yorkshire Leadership Summit

### Summary Report

*11th September 2015*

NHS

# 1. Executive Summary of Discussions

## Context

The first phase of the Healthy Futures stroke programme comprised of a review of the resilience of the current Hyper Acute Stroke Service configuration in West Yorkshire. Work has been initiated on improving the management of patients with atrial fibrillation and hypertension as primary prevention initiatives but the predicted growth in population and demand for services will put significant pressure on the current capacity. In addition there are significant workforce issues that impact on both the current and future resilience of services.

Nationally , there remains significant variation in access to stroke professionals across the week, a lack of medical and therapy workforce, significant pressures on the service as a result of acute medicine and financial pressures. Experience suggests that to run efficient services and provide a high quality service there should be a minimum of 600 stroke admissions per year through the service and a maximum of 1,500. the breakeven financial figure based on best practice tariff is 900 admissions per year.

Within West Yorkshire there are a number of services outwith the suggested minimum requirements and the quality of services as demonstrated by the SSNAP outcome indicators is variable with many below the national average suggesting a poorer quality of service. The providers and commissioners of West Yorkshire were therefore invited to consider whether to (1) Do Nothing (2) Invest in all hyper acute services to improve outcomes to at least the national average or (3) Develop further alliances and reduce the number of Hyper Acute services.

## Workforce Considerations

Workforce challenges is a major limiting factor in being able to build resilience across all stroke services. A flexible approach to training is required with a wider contribution from other specialities allowing the stroke workforce to be developed on a competency based model. Leeds are looking to pilot this model in neurology advocating a core curriculum for disparate specialties. The SCN have supported the development of core competencies for nurses. Training will be developed and the opportunity to offer regional placements to escalate skills and competence development was identified. There was consensus amongst the group that there should be HR consistency across the region to avoid destabilisation due to incentivising posts and that the West Yorkshire Association of Chief Executives should be requested to endorse standardisation of competencies and bandings for stroke nurses.

# 1. Executive Summary of Discussions (cont.)

## Provider Aspirations

Each provider was invited to outline their aspirations regarding stroke services and considerations regarding further alliances to secure a more sustainable future.

**Airedale:** The HASU service has been relinquished and consolidated at Bradford. All other stroke services have been retained and the providers operate on a single service model with a clinical lead across both sites. The financial arrangements were undertaken within the existing financial envelope against a principle that no one Trust would suffer an increase percentage financial loss as a result. The alliance is considered successful in terms of offering safer services , improved quality and promoting recruitment.

**Bradford:** The alliance with Airedale has been successful with the model driving specialists to work together. Both providers clearly articulated the impact of not addressing these issues. Executive discussions have been initiated with Calderdale. There is potential to further increase capacity if required. Future plans would be to increase the number of HASU Beds and to undertake further collaboration (CHFT).

**Calderdale:** The service is across two sites, with out of hours shared with HDFT & BTHT. Discussions are underway regarding the reconfiguration of A&E services with a vision to consolidate A&E services on one site. This is an integral part of the future of the hospital. There are collaborative discussions underway with Bradford. There is a wish to build on the stroke service, nursing investment last year enabled standards to be met and a wish for future investment in the medical workforce. The Trust would welcome alliances that promotes maintenance and consolidation of the HASU service.

**Mid Yorkshire:** Following consultation in 2013 Pinderfields became the central acute site. The Trust is in the 2nd year of a 3 year reconfiguration programme. There is an internal improvement programme and aspirations to re-size HASU capacity. Challenges remain due to acute pressures, staffing ratios and therapy support. The rehabilitation model is not finalised but offers opportunities re bed base and co-location. High level discussions are underway with Barnsley that could be extended to include Calderdale. The Trust would welcome support with Modelling.

**Harrogate:** The Trust maintain a current service on a single site with 3 site telemedicine Out of Hours. Acknowledge their vulnerability regarding the number of consultants (4) and the number of strokes. Threats to the service articulated as 1. Telemedicine & 2. Manpower. Consider that aspirations will be determined by external factors and would accommodate an agreed network model on the basis of either improved sustainability or alliance. Discussions have been initiated with Leeds.

**Leeds:** Centralisation to the LGI site improved services. However there is a very intense work load with large stroke numbers. An increasing volume of mimics is putting a stress on the system and creates a threat to capacity. Improved discharge processes are required to ensure efficient utilisation of the existing capacity (decreasing length of stay). There is an ongoing challenge with regards to the medical workforce. Alliance discussions are underway.

# Next Steps / Actions

| Ref# | Next Steps | Owner | Due | Action |
|---|---|---|---|---|
| 1 | **Improving Outcomes:** A watching brief will be maintained on SSNAP quality outcomes to review whether the existing resilience plans are effective. A further meeting will be scheduled for 6 months to review. | SCN | April 16 | Set up a follow on meeting in 6 months time (aligned to release of Oct-Dec 2015 SSNAP data) to review performance; progress on resilience plans and next steps |
| 2 | **Review of Resilience Plans:** CCG and Providers to conduct a review of local resilience plans. | CCGs | By Dec 16 | CCG to ensure a review of action plans as part of annual peer review process |
| 3 | **Workforce: SCN to facilitate exploration of;**<br>• Developing a regional stroke workforce<br>• Nurse competencies/ HR standardisation / opportunities for escalation of skill development & training – e.g. placement<br>• Sharing Best Practice models<br>• Medical Workforce Planning and training opportunities<br>• Mimics: Educational tools for primary care & A&E<br>• Stroke Rehabilitation / ESD and developing links with social care<br>• Intra-arterial Interventions (clot retrieval) | JC/AB/RC | By Dec 16 | Jon Cooper, Alistair Bailey & SCN team |
| 4 | **Modelling Cross Boundary Implications;**<br>SCN to support modelling and discussions with Mid Yorkshire, Calderdale and Barnsley | JJ | By Dec 16 | Liaise with Working Together Programme and establish meetings. |
| 5 | **Programme Next Steps**<br>Stroke will be moved under the umbrella of Urgent & Emergency<br><br>Follow on meeting in 6 months to review progress - 18th March 2016, 1430-1630, Leeds venue (TBC). | PC/JJ | By Oct 16 | Establish a meeting to align programmes<br>All to note |

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| **Report to the Trust Board of Directors: 28 October 2015** | **Paper No: 11.0** |

| | |
|---|---|
| **Title** | Chief Nurse Report |
| **Sponsoring Director** | Chief Nurse |
| **Author(s)** | Jill Foster, Chief Nurse |
| **Report Purpose** | To provide the Board of Directors with an update on matters affecting care quality, patient safety and patient experience within the Trust |

**Key Issues for Board Focus:**
This paper sets out the position for defined aspects of care quality, patient safety and patient experience within the Trust. There is particular focus on local and national nursing and midwifery issues including actual versus planned nurse staffing levels and an update on nurse recruitment. There is also information for the Board a review into the effectiveness of Quality in Care Team meetings.

| **Related Trust Objectives** | |
|---|---|
| 1. To deliver high quality care | Yes by improving patient safety, the effectiveness of care and patient experience |
| 2. To work with partners to deliver integrated care | Yes |
| 3. To ensure clinical and financial sustainability | 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**

The Board of Directors is asked to receive this report on the progress with care quality patient safety and patient experience.

**Patient Safety Visits**

Since the last report to Board there has been Patient Safety Visits to Day Surgery on the 25/09/15 and Littondale Ward on the 07/10/15.

Unfortunately due to staff pressures caused by high levels of sickness a visit to Selby MIU on 01/10/15 was cancelled. This has been rearranged for 11/12/15.

**Nurse Recruitment**

On Thursday 24th September alongside the Trust Open Event a recruitment evening was held for registered nurses and care support workers. There was a high level of attendance and interviews were held on the night and 20 conditional offers of employment were made, 10 to registered nurses and 10 to care support workers.

A further event is planned on Thursday 12th November which will incorporate recruiting for New Models of Care.

**Midwifery Supervision**

I have received responses from the Chief Nursing Officer for England and the Nursing and Midwifery Council regarding removing midwifery supervision from statute. The Chief Nursing Officers from Wales, Scotland and Northern Ireland are working together with Jane Cummings on proposals to change the system of supervision. New guidelines and advice are being developed and a national working group is being convened.

**Actual versus Planned Nurse Staffing Levels – Inpatient Areas**

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

| | Sep-2015 | | | |
|---|---|---|---|---|
| | 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 | 90% | 99% | 143% | 118% |
| AMU-Fountains | 87% | 101% | 98% | 110% |
| Byland | 89% | 105% | 92% | 169% |
| Farndale | 100% | 104% | 100% | 115% |
| Granby | 112% | 121% | 100% | 158% |
| Harlow | 107% | 75% | 100% | - |
| ITU/HDU | 95% | - | 94% | - |
| Jervaulx | 82% | 117% | 77% | 187% |
| Lascelles | 83% | 113% | 100% | 100% |
| Littondale | 98% | 110% | 97% | 157% |
| Maternity Wards | 86% | 130% | 101% | 183% |
| Nidderdale | 100% | 95% | 117% | 72% |
| Oakdale | 97% | 104% | 97% | 153% |

| | | | | |
|---|---|---|---|---|
| Special Care Baby Unit | 92% | 84% | 100% | - |
| Trinity | 95% | 103% | 100% | 130% |
| Wensleydale | 83% | 89% | 100% | 92% |
| Woodlands | 95% | 88% | 105% | 83% |
| **Trust total** | **92%** | **105%** | **100%** | **129%** |

**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 Fountains and Byland wards where the (RN) fill rate was less than 100% against planned; this reflects current Band 5 RN vacancies and some sickness. The Trust is actively recruiting to fill vacancies.

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

On Harlow Suite the daytime care staff hours in September were less than planned due to vacancies; however this was compensated for in RN hours as required.

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

On Jervaulx ward the day and night duty RN hours were less than planned due to RN vacancies, however the ward occupancy levels fluctuated in September and an assessment was undertaken on a shift by shift basis to ensure that the planned staffing matched the needs of the patients. Additional care support workers were deployed to support the ward as required.

The actual daytime RN hours on the Lascelles Unit were less than planned in September due to vacancies 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 (maternity wards) have been combined from March 2015 to reflect the close working relationship of these two areas and the movement of staff between the wards in response to fluctuating occupancy and activity levels.

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

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

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

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

The staffing complement for the children's ward, Woodlands, is designed to reflect varying levels of occupancy. Although the daytime RN and care support staffing levels are less than 100% in September, the ward occupancy levels vary considerably which means that particularly in this area the number of planned and actual nurses is kept under constant review.

**Quality of Care Team Meetings**

The Quality of Care Teams, formerly known as local Risk Management Teams have been in place in HDFT since 2003. The aim of these multi-disciplinary teams is to ensure that quality and safety is discussed as a matter of priority at the local level. The groups look at delivery of the service including patient safety, incidents, complaints, alerts, audits and assessment of risk. They maintain a departmental risk register. The aim is to ensure multi-disciplinary teams are actively addressing quality and safety issues, managing risk, sharing good practice and experience, and that there is evidence of this.

Each clinical directorate is responsible for identifying the local Quality of Care Teams and monitoring their effectiveness through the Directorate Governance Groups / Quality Boards. The number of Quality of Care teams is determined by the Directorate. There has been feedback received and concerns raised about the effectiveness of Quality of Care Teams. The Trust has changed considerably since the Quality of Care Team model was established and it was considered appropriate to review the model.

The review showed there is considerable variability in the Quality of Care Teams across the organisation. The multi-disciplinary contribution is variable, with some meetings demonstrating good representation, attendance and participation, and others struggling to meet at all, often due to the difficulty in getting staff released from other duties.

Some good practice has been identified, and there has been considerable effort put into establishing and supporting some of the Quality of Care Teams, with significant improvement in some areas and some useful outcomes, however there is significant variation in the effectiveness of these meetings.

The detailed findings have been discussed and actions agreed to address the shortcomings at Senior Management Team on 21 October 2015. The result of actions being undertaken is expected to be reported back to the Senior Management Team in December 2015.

Harrogate and District NHS
NHS Foundation Trust

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|---|---|
| **Report to the Trust Board of Directors: 28 October 2015** | **Paper No: 11.1** |

| | |
|---|---|
| **Title** | Quarterly Claims Report October 2015 |
| **Sponsoring Director** | Dr David Scullion |
| **Author(s)** | Andrea Leng, Head of Risk Management |
| **Report Purpose** | For Information |

**Key Issues for Board Focus: To note the activity in civil claims over Q2 and the increase in the number of open cases. A theme experienced across other Trusts within the NHS.**

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

| | |
|---|---|
| **Risk and Assurance** | This report provides a level of assurance to the Board that claims are appropriately processed. |
| **Legal implications/ Regulatory Requirements** | None |

**Action Required by the Board of Directors**
The Board is recommended to consider the report for comment

## QUARTERLY CLAIMS REPORT OCTOBER 2015

## Quarter 2 (July-September 2015)

### Total Number of Claims

- 175 claim files open and investigated, 68 progressed to formal claim compared with 65 at time of last report and a total of 160 cases. 13 new cases opened in Q1.

| | Number Open | | | | Proceeded to formal | | | | New cases Opened 2015 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Q3 | Q4 | Q1 2015 | Q2 | Q3 | Q4 | Q1 2015 | Q2 | Q3 | Q4 | Q1 2015 | Q2 |
| Clinical Negligence Claims | 129 | 134 | 138 | 151 | 42 | 49 | 50 | 52 | 12 | 12 | 10 | 18 |
| Employers Liability | 10 | 12 | 13 | 15 | 10 | 12 | 8 | 9 | 1 | 2 | 1 | 2 |
| Personal Injury | 5 | 8 | 8 | 9 | 5 | 8 | 6 | 7 | 0 | 3 | 2 | 1 |
| Property Expenses Scheme | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

The attached summary details the claims data of the Trust compared with the data held by the National Health Service Litigation Authority (NHSLA) up to Q2. This is broken down into Clinical negligence Schemes for Trusts (CNST) and Liabilities to Third Parties (LTPS) which covers Employers Liability and Personal Injury Claims. Data is held of the claims that have been reported to the NHSLA.

The NHSLA holds the financial liabilities in respect of the Trust CNST claims and the details are as follows:-

Annual statement at 31 March 2015: £31,128,000
Quarter 1 report: £27,657,000
Quarter 2 report: £21,975,412

### Clinical Negligence Claims

- 151 clinical negligence cases open at end of Q2 (previous report in Q1 there were 138).
- Of the 151, 52 have progressed to a formal claim (previously were 50 formal claims open)
- Top 3 specialties with most open claims are the same as reported in last three quarters:-
  - Orthopaedics/trauma (27)
  - Emergency Department (24)
  - Obstetrics (15).

- 18 new cases opened in Q2 (16 new requests for disclosure of notes / notification of investigation by claimant's solicitors and 2 letters of claim).
- 4 cases closed in Q2
    - 2 cases settled and damages paid by NHSLA (1 in gynaecology and the other in cardiology)
    - 2 cases closed - either out of time or withdrawn.

**Employers Liability Cases (EL)**

- 15 cases open at end of Q2
- 2 new cases opened in the period relating to injury from fall and a moving and handling incident.

**Public Liability Cases (PL)**

- 9 cases open at end of Q2
- 1 new case opened in the period relating to a burn.

**Property Expenses Scheme**

No claims received in period.

**Monitoring of Claims Policy**

In all cases, key stakeholders have been given copies of new claims and asked for comments.

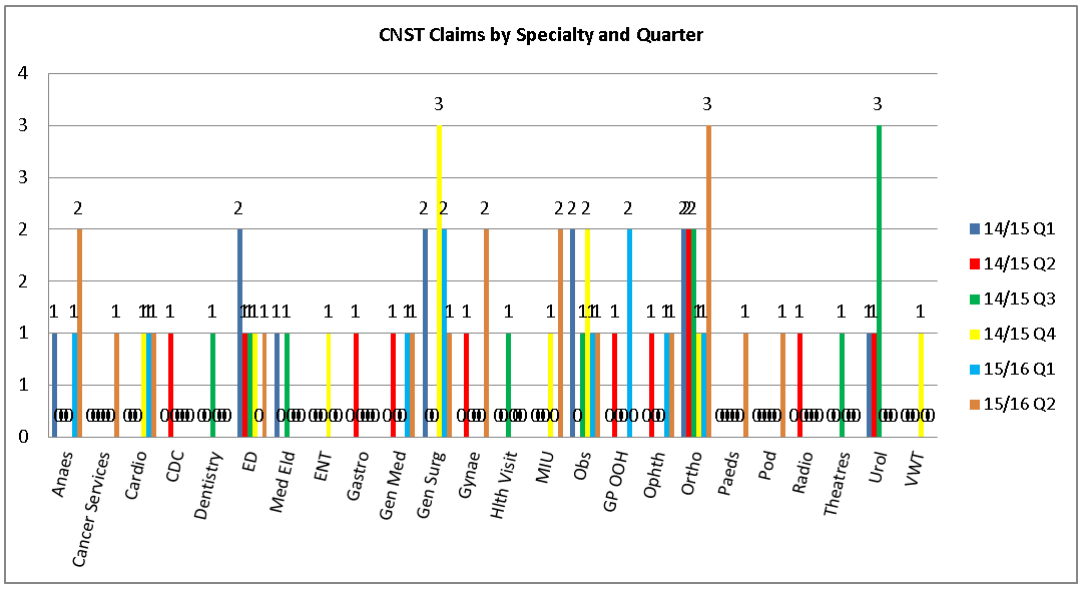
- All CNST cases where letters of claim received have been forwarded to the NHSLA.
- All disclosure requests are under investigation and will be risk assessed to determine liability.
- The new EL and PL cases were reported to the RPST section in accordance with the 21 day reporting deadline.
- Where letters of claim or proceedings have been issued, these have been forwarded to the NHSLA in accordance with their reporting timescales and staff informed and consulted.

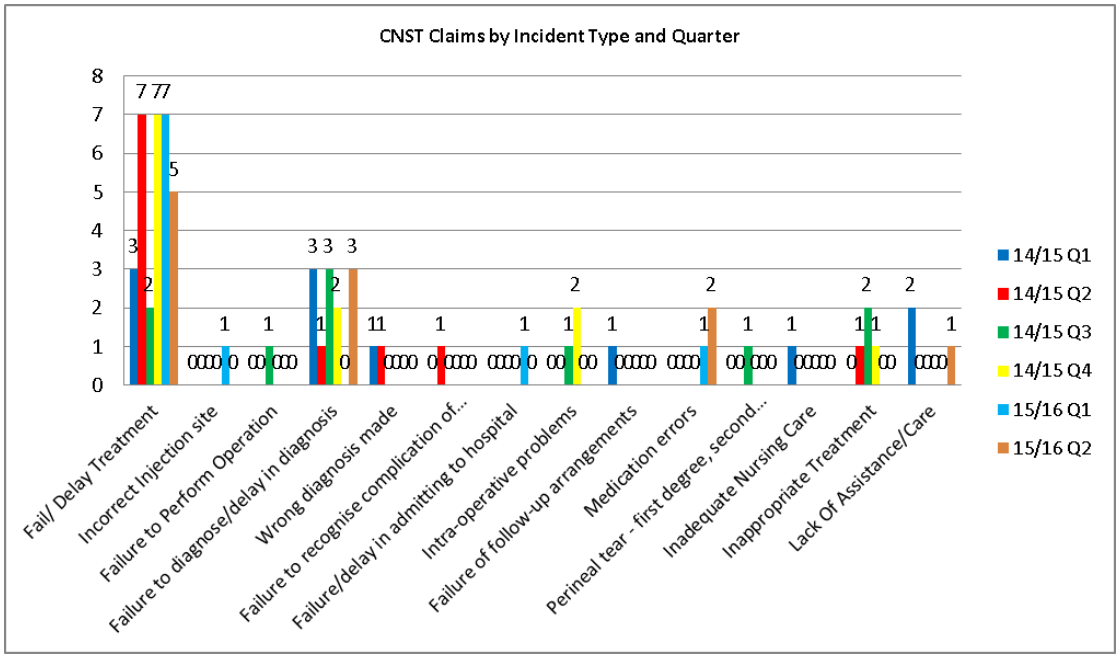
**Risk Management Issues**

- 11 out of the 21 new cases have previously been investigated in accordance with the complaints procedure and / or incident reporting procedure and resulting actions implemented.
- 15 CNST cases and 3 EL/PL cases are being handled by DAC Beachcroft Solicitors – it is noted that claims are increasing nationally and the NHSLA have 1000 new claims reported per month.
- In Q2 there have been no risk management actions highlighted following review of the claims.

## DATA ANALYSIS SUMMARY

## 1. Clinical Negligence Claims



All CNST Claims Open as at 30/09/15

| | ANAE | CANCER | CARD | CAT | CDC | DENTAL | DERM | DIABET | ED | ELDER | ENDO | ENT | GAST | GEN MED | GEN SUR | GYNAE | HAEM | HVSCH | MIU | NEUR | OBS | OOH | OPHTH | ORTHO | PAED | PRISON | RAD | THEAT | UROL | VWT | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Fail/ Delay Treatment | 1 | 0 | 3 | 1 | 0 | 0 | 0 | 0 | 10 | 0 | 0 | 1 | 0 | 2 | 6 | 3 | 0 | 0 | 2 | 0 | 1 | 2 | 4 | 7 | 0 | 1 | 2 | 0 | 2 | 2 | 50 |
| Incorrect Injection site | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Failure to Perform Operation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 |
| Fail to Monitor 2nd Stg Labour | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Bacterial Infection | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| Failure to diagnose/delay in diagnosis | 0 | 2 | 0 | 0 | 1 | 0 | 0 | 1 | 12 | 1 | 1 | 1 | 1 | 0 | 2 | 3 | 1 | 1 | 3 | 2 | 1 | 1 | 0 | 7 | 1 | 0 | 1 | 0 | 0 | 0 | 43 |
| Failure to Perform Tests | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| Wrong diagnosis made | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |
| Failure/delay in admitting to hospital | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Operate on the wrong patient/wrong body part | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Surgical Foreign Body Left in Situ | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Intra-operative problems | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 10 |
| Failure to warn (informed consent) | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Failure of follow-up arrangements | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Failure to carry out adequate post-operative observations | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Medication errors | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 |
| Failure to correctly interpret USS - follow up or act on | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Failure to adequately monitor the first stage of labour | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| Perineal tear - first degree, second degree, third degree | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| Inadequate Nursing Care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Inappropriate Treatment | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 3 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 2 | 0 | 9 |
| Lack Of Assistance/Care | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |
| Totals: | 5 | 2 | 3 | 1 | 1 | 1 | 1 | 1 | 24 | 2 | 1 | 3 | 2 | 3 | 13 | 9 | 1 | 1 | 7 | 2 | 14 | 4 | 4 | 24 | 1 | 1 | 3 | 1 | 4 | 2 | 141 |

nb 10 out of 151 cases allegations yet to be confirmed

## 2. Employers Liability (EL) Claims by type and location as at Q2

| | ED | Endo | Jerv | Nidd | OOH | Trinity | Other | Total |
|---|---|---|---|---|---|---|---|---|
| Asbestosis | | | | | | | 1* | 1 |
| Moving and handling | | 2 | | 2 | | 1 | 1 | 6 |
| Assault on staff member by patient | 1 | | 1 | | | | | 2 |
| Staff slip/trip/fall | | | | | 1 | | 4 | 5 |
| Work related stress | | | | | | | 1 | 1 |
| Totals | 1 | 2 | 1 | 1 | 1 | 1 | 6 | 15 |

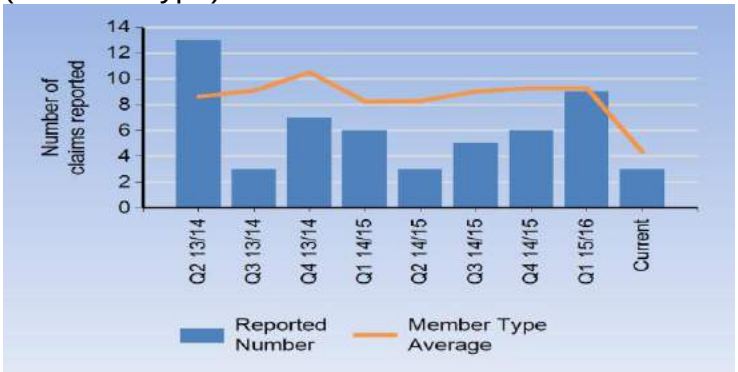
* is pre RPST scheme so handled via NHS England

## 3. Public Liability (PL) Claims as at Q2

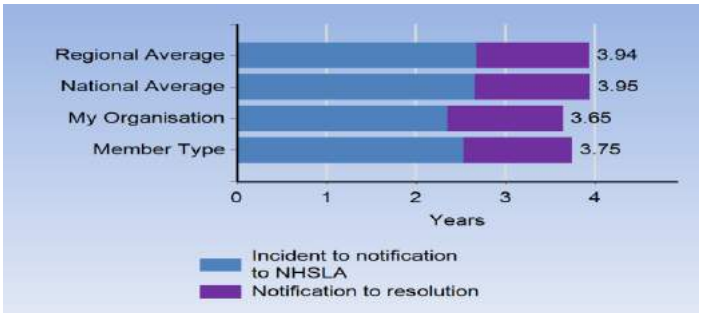
| PL Claims by Incident type and Location | Main Entrance | Emergency Dept | Labour Ward | Nidderdale Ward | Wensleydale Ward | Prison (Northallerton) | Other | Total |
|---|---|---|---|---|---|---|---|---|
| **Pt/visitor slip/ trip/fall** | 2 | 1 | 1 | | 1 | | 1 | 6 |
| **Wheelchair faulty** | | | | | | | 1 | 1 |
| **Medication Incident** | | | | | | 1 | | 1 |
| **Burn from hot drink** | | | | 1 | | | | 1 |
| **Totals** | 2 | 1 | 1 | 1 | 1 | 1 | 2 | 9 |

## 4. NHSLA Reported Cases as at September 2015

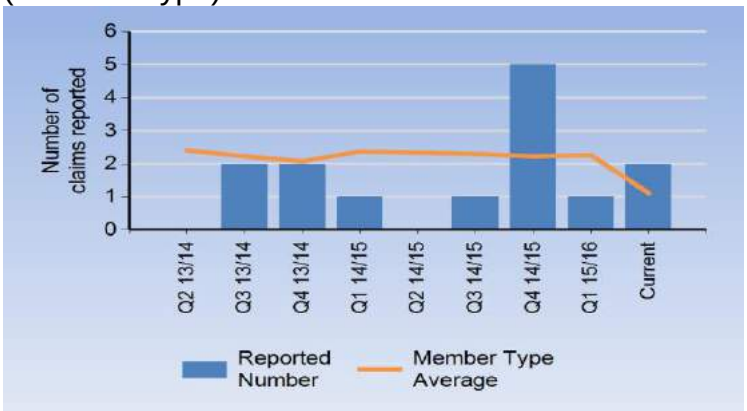
Number of CNST Claims Reported by HDFT Compared to Small Acute Trust (Member Type)



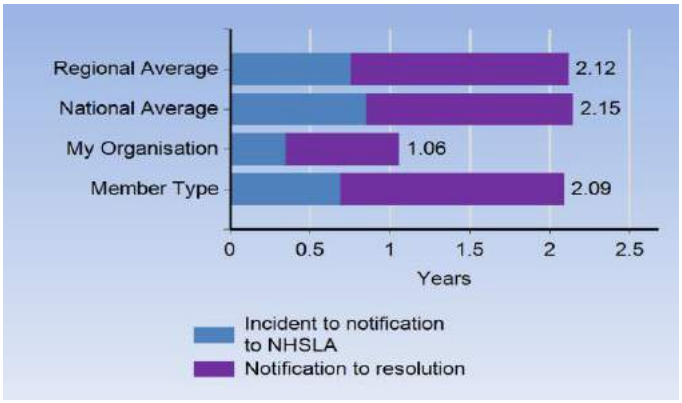

CNST Claims Time To Resolution




Number of LTPS Claims Reported by HDFT Compared to Small Acute Trust (Member Type)




LTPS Claims Time To Resolution



| | |
|---|---|
| **Report to the Trust Board of Directors: 28th October 2015** | **Paper No: 12.0** |

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

**Key Issues for Board Focus:**

- Medical staffing vacancies in Integrated Care.
- FLIP project update.
- Actions to address Emergency Department performance standards.

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

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

**Action Required by the Board of Directors**

That the Board of Directors note the information provided in the report and approve the submission of the Midyear Information Governance Toolkit submission and the Monitor RAF Governance compliance for Quarter 2.

## 1.0 FLIP PROJECT

The Acute Medical Team has been developing a new model to the delivery of acute medicine, named the FLIP project (Improving Flow across Acute Floor). The first significant change went live in October with the transition of the acute wards Fountains and Bolton to their new designation Clinical Assessment Triage and Treatment (CATT) Unit and the Acute Medical Unit (AMU).

Medical admissions are now admitted through the CATT Unit. This has brought the medical admissions and the clinical assessment team patient flows together, with the resulting improved access to senior medical opinion and further developing the ambulatory care model. The Executive Team have approved additional resource to the acute floor to support clinical skills, discharge support and senior nursing support on each shift on both the AMU and CATT.

## 2.0 NATIONAL EMERGENCY DEPARTMENT PERFORMANCE STANDARDS

Following the significant decline in operational performance against the national performance standards for the Emergency Department, the Chief Operating Officer and Chief Nurse met with the clinical team to understand the issues and to seek to find ways to mitigate them. Three main areas were explored, bed capacity and flow through the department, ED staffing model and timely speciality reviews. As described above in section 1.0 work is ongoing to improve flow within the hospital and early signs of improvement have been noted following the change. There has positive progress with Speciality Clinical Leads in relation to agreeing standards regarding response times and handover to clinical teams outside the ED. In addition, the ED team provided detail of the establishment changes they had identified in relation to staffing which would have a positive impact on waiting times for assessment, this centred around the provision of additional senior nursing time and care support workers trained in completing ECGs, Cannulation and taking bloods. The Executive Team approved the changes and recruitment has commenced.

## 3.0 MEDICAL STAFFING VACANCIES

Medical staffing vacancies continue to be a challenge for Integrated Care Directorate with a number of middle grade shifts being covered by consultants acting down over night and at weekends. It was anticipated that the position should have improved with the latest rotation of Junior Doctors, however, 2.4 wte middle grade gaps on the on-call rota remain. Recruitment processes are at different stages to improve the position with forthcoming interview for the cardiology middle grade post, the commencement in January of a new starter in the new diabetes and endocrinology ST3+ post and a long term locum recruited for respiratory medicine starting in November. These actions should improve the situation but the current position continues to require a significant amount of management time and consultant support.

## 4.0 CHILD HEALTH INFORMATION SERVICE

NHS England have agreed to provide additional funding to support the development of a full Child Health Information Service (CHIS) across North Yorkshire. Work is progressing to agree the structure of the CHIS to meet the requirements.

## 5.0 SERVICE IMPROVEMENTS GASTROENTEROLOGY

The Gastroenterology service have been focussed in the last few months on ensuring they provide services in a way which support teaching and supervision of junior medical

staff along with providing the capacity to meet the significant increase in demand for elective outpatients and endoscopy work.

The work to improve training has included:

- Increased consultant presence on the wards - Monday to Friday.
- Protected registrar endoscopy sessions and clinic.
- Additional junior support.
- Reduced speciality cross-cover requirements.

The capacity demands of the service have been much more difficult to manage with a number of actions taken including:

- Increased clinic capacity via locum registrar which started in September 2015.
- Increase consultant capacity through external SLA with York Teaching Hospitals NHS Foundation Trust.
- Review of clinic templates, additional slots, review of follow-ups.
- Review of capacity at Wharfedale.

## 6.0 CARBON AND ENERGY FUND

Following the management buyout of Imtech in September the position of the project has now stabilised and the supply of the required materials and equipment recommenced. The project programme has now been revised taking into account the delays in equipment resulting in an overall eight week delay in the expected completion date which is now the end of July 2016. Due to the project delays the milestone payments dates have been revised and agreed with the Trust.

The work on site has seen some significant items of equipment delivered and installed on site most notably the first of the two new steam boilers together with new cooling plant which were installed in the boiler house on 20th October. The lighting replacement programme has seen work in the Trust HQ and medical records undertaken. Replacement of the external lighting is due to commence at the end of October.

## 7.0 INFORMATION GOVERNANCE TOOLKIT PEFORMANCE UPDATE

For the performance update 2015/16 the Trust remains at 83% of standards at Level 2 or above. The Trust is still working towards 95% of staff completing their Information Governance mandatory training to keep standard 112 at level 2.

## 8.0 SERVICE ACTIVITY

For 2015/16 to date at the end of September, elective admissions from all commissioners were 3.8% above plan, and new outpatient appointments (consultant and nurse-led) were 3% below plan. For Leeds North and West CCG new outpatient appointments were 3.5% below plan, follow-up outpatient appointments were 5.4% below plan, and elective admissions were 13.2% above plan for the year to date.

## 9.0 FOR APPROVAL

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

The Board is asked to approve the Quarter 2 Governance section of the Risk Assessment Framework as **Green** for submission to Monitor as detailed in the Integrated Board Report.

Harrogate and District NHS
NHS Foundation Trust

| | |
|---|---|
| **Report to the Trust Board of Directors: 28 October 2015** | **Paper No: 13.0** |

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

**Key Issues for Board Focus:**

This report provides information on the following areas:

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

| **Related Trust Objectives** | |
|---|---|
| 1. To deliver high quality care | Through the pro-active management of workforce matters, including recruitment, retention and staff engagement. |
| 2. To work with partners to deliver integrated care | By working with NHS England and the Yorkshire and Humber LETB on standards of education, training and leadership at the Trust. |
| 3. To ensure clinical and financial sustainability | By the delivery of multi-disciplinary learning and development interventions. Also, via service innovation and improvement initiatives.<br><br>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** and comment on the update on matters specific to Workforce, Training and Education, Service Improvement and Innovation and Organisational Development.

**Key Messages for October 2015**

## a) Schedule 15

Following a recent meeting of the Trust's Local Negotiating Committee, a local agreement has been reached regarding Schedule 15 of the Consultant and Specialty / Associate Specialist Doctors' Contracts. Schedule 15 requires the post holder to achieve criteria in order to progress through the annual pay thresholds. The criteria agreed in the local revision to Schedule 15 are; to complete an annual appraisal, a completed annual job plan (which includes achievement of agreed job plan objectives) and 100% mandatory and essential skills training completion.

From November 2015 colleagues will receive an email reminder of their impending increment/pay threshold (January 2016 increments). This process will be repeated for each consecutive month. A letter will be circulated to all medical staff describing the criteria that will be applied and the process that will be followed.

## b) Job planning

The latest job planning figures are shown below for Consultants and SAS Grades as at 16 October 2015.

| JOB PLANNING CENTRAL REPORT – CONSULTANTS – as at 07/10/15 | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Directorate** | **Number of Consultants** | **Job Plans within 12 months** | **%** | **Job Plans older than 12 months** | **%** | **Number of Consultant with no Job Plans recorded** | **%** |
| Urgent, Community and Cancer Care | 23 | 21 | 91% | 2 | 9% | 0 | 0% |
| Elective Care | 58 | 20 | 34% | 22 | 38% | 16 | 28% |
| Integrated Care | 37 | 14 | 38% | 8 | 22% | 15 | 40% |
| **Total** | **118** | **55** | **47%** | **32** | **27%** | **31** | **26%** |

| JOB PLANNING CENTRAL REPORT - SAS GRADES – as at 07/10/15 | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Directorate** | **Number of SAS Doctors** | **Job Plans within 12 months** | **%** | **Job Plans older than 12 months** | **%** | **Number of SAS Doctors with no Job Plans recorded** | **%** |
| Urgent, Community and Cancer Care | 7 | 2 | 29% | 0 | 0% | 5 | 71% |
| Elective Care | 41 | 5 | 12% | 2 | 5% | 34 | 83% |
| Integrated Care | 2 | 0 | 0% | 0 | 0% | 2 | 0% |
| **Total** | **50** | **7** | **14%** | **2** | **5%** | **41** | **81%** |

An audit regarding job planning was undertaken in Quarter 4 (2014/15) and the Trust was given limited assurance based on the number of job plans that had been completed specifically for Specialty Doctors across the Trust. A re-audit is due to take place in Quarter 3/4 of this financial year with an audit report to be published by 31 January 2016. Directorates have been asked to focus their attention on the completion of job plans for all Consultants and SAS doctors by 31 December 2015 at the latest and also on any outstanding audit recommendations related to this audit. It is hoped that the introduction of the Schedule 15 arrangements will act as an enabler and improve the timely completion of other job plans in the future. Directorates gave their commitment at the Senior Management Team meeting that took place on 21 October to achieve the 31 December 2015 target.

**c) Registered Nurse Recruitment**

In response to the increasing demand for Registered Nurses, the Trust has created a working group, led by the senior nursing team and HR. This group has been tasked with the implementation of a recruitment and retention action plan to support achievement of the required nursing establishments particularly within the inpatient wards.

On Thursday 24 September the Trust held a Registered Nurse and Care Support Worker open day. The event attracted a large number of applicants and interviews were held on the night to enable the applicant to leave with a conditional offer of employment. Following the event, ten Registered Nurses and ten Care Support Workers were offered conditional permanent contracts of employment.

The success of the evening has prompted a second open day to be held on Thursday 12 November. This event is being run alongside the Trust's attendance at a career's fair at Leeds Beckett University and will provide the opportunity to speak with a number of student nurses, qualified and non-registered nurses looking for a new role. Innovative recruitment work will continue to take place in order to try and fill all existing vacancies in the current challenging labour market for registered nurses. These conditions have recently been shrouded by the Government with the introduction of registered nurses onto the Shortage Occupation List. This means that NHS employers will not have to satisfy the resident labour market test before making offers of employment to registered nurses from overseas.

**d) Attendance**

Sickness absence across the organisation has stabilised at 3.6% which is below the Trust target and shows a relatively static position over the three month period June to August 2015. Absences due to musculoskeletal issues across the Trust are showing an increase, whilst those due to stress, anxiety and depression have stabilised following a decrease. This trend is, however, reversed in the Integrated Care Directorate where there remain high levels of absence. Work is taking place to focus efforts in the Elective Ward areas by the commencement of 'clinics' for managers to agree action plans to reduce absence.

There has been a net decrease in the numbers of staff in the attendance process and managers are continually reminded to ensure both compliance with the policy and accurate reporting of this to the HR team.

**e) NHS 2015 Staff Survey**

The National NHS Staff Survey went live on Tuesday 29 September 2015. The Trust constantly strives to provide the highest standards for its service users and the information provided by staff is invaluable to the Trust and its service users, staff and patients.

In light of feedback received last year, the survey has now been sent out to the vast majority of staff via email and staff without a Trust email account will have

received a paper copy. This has delivered significant efficiency savings.

This year the Directorate with the highest return rate will be awarded £1 per returned survey to spend on staff development and every opportunity is being taken to promote the staff survey at team meetings, departmental communication sessions and during handover, this is due to a potential risk of a lower participation rate with the move forward to more paper-free solutions.

Regular daily bulletin notices and posters including progress reports are being circulated around Trust sites.

**f) Health Education Yorkshire and the Humber (HEYH) Revisit in January 2016**

Due to ongoing issues reported by trainees in elderly medicine HEYH are going to re-visit the Trust in January 2016. HEYH have decided to re-open Condition 2 around work intensity, previously agreed following their last visit, which requires further attention. Appendix 1 shows the original visit report from February 2015 which was widely circulated at the time.

This condition must have an action plan and actions must be addressed and met before the visit in January 2016. HEYH will be including this re-opened condition in the Dean's report to the General Medical Council at the end of October. The Director of Medical Education, Medical Specialties Service Manager – Integrated Care and the Medical Education Centre Manager are meeting to ensure the actions are completed in time for the revisit.

**g) Junior Doctors contract negotiations**

The latest update over the proposed contract negotiations for Junior Doctors is that the Health Secretary wrote to the Chair of the British Medical Association's (BMA) Junior Doctors' Committee (JDC), Dr Johann Malawana on 8 October 2015, summarising the key discussion points following their meeting on 25 September 2015.

In his letter the Health Secretary makes a number of key assurances to the BMA JDC on the impact of the proposed reforms, in an attempt to address some of the concerns regarding a new contract. The letter makes some key assurances on:-

- overall cost of the pay bill - the introduction of Junior Doctors' contracts is not a cost-cutting exercise
- out of hours' payment
- working week - the new contract aims to reduce, not increase, the number of hours Junior Doctors work each week
- individual doctors' pay - the great majority of Junior Doctors will be as well paid as they are now
- GP trainees - they will not be disadvantaged.

The talks to try get the BMA to continue negotiations are still ongoing and any further update will be noted in next month's report.

**h) Team Development Task and Finish Group – New Models of Care**

The Team Development Task & Finish Group met for the first time on 24 September with all partners represented at the meeting.

At the meeting the terms of reference of the group were agreed – copy attached at Appendix 2.

As this is a newly formed team the group considered how they wanted to work together and 'be' as a team – the following list was the outcome of the discussion:-

- Passionate about supporting workforce to provide excellent care for patients and service users;
- Committed to the project, i.e attending meetings and following up on actions;
- Challenging technical roles - can do approach;
- Open minded;
- Responsiveness and willingness to engage;
- Honest and truthfulness;
- Listen to one another; and be
- Representative of Organisation's views and to feedback to Organisation.

**Implementation plan – prioritisation of deliverables**
The Calderdale Framework facilitation is the first step in the work of this team. A paper explaining the remit of the Calderdale Framework has been developed and circulated to the Programme Office, to ensure clarity about what is within the remit of this framework and what falls outside of it.

The next steps are that during November 2015 the Calderdale Facilitators will attend individual staff meetings to present the Framework and to raise awareness of the project. Following the awareness raising stage, the service analysis process will start in early December 2015 or earlier if possible. The work of this group will be closely linked to the work led by Dr Bruce Willoughby regarding Integrated Teams.

**i) Effective Rostering**

The business case presented for Oceans Blue has been approved. The aim of the business case is to improve and provide assurance that rostering in ward areas is safe, efficient and effective. A significant amount of work has been undertaken in this area already with the Trust performing well against our own safe staffing recommendations. However, a recent internal audit highlighted a number of areas which required improvement and provided limited assurance.

Directorates have implemented a number of changes, however there remains a gap in the information available to support the rostering process.

The Trust will be implementing a pilot for a system called Barnacles, supplied by Oceans Blue, to address this issue. The Barnacles system will ensure robust time balances, coherent information across RosterPro, the Trust's Electronic Staff Record System and budget reports as well as providing a greater level of management information. It also removes duplication in a number of areas.

It is estimated that the system will provide approximately £100k of actual savings against ward nursing expenditure. If these savings are achieved then the system could continue at ward level or be expanded to a number of areas across the Trust.

**j) Staff Friends and Family Test**

Each quarter staff are invited to complete the Staff Friends and Family Test. Scores are based on the number of staff who have chosen the options of extremely likely and likely to recommend the Trust as a place to work and the number of staff extremely unlikely and unlikely to recommend the Trust as a place to work.

The Trust remains above the quarter one national average of 63% for this indicator of those that would recommend the organisation as a place to work (61% average in Yorkshire and the Humber) with a score of 69% in quarter one and 66% in quarter two.

11% of staff were unlikely or extremely unlikely to recommend the Trust as a place to work in quarter one, placing the Trust below the national average of 18%, where a lower position is a positive. The number of staff who would not recommend the Trust as a place to work fell further in quarter 2 with 7% of staff extremely unlikely or unlikely to recommend the Trust as a place to work.

Quarter one and two focussed on different Directorates including Elective Care, Urgent, Community and Cancer Care and Corporate areas. Next quarter will see staff across all Directorates invited to take part with encouragement to participate with the message that the Trust is listening and taking action on feedback to drive forward improvements.

A review has been carried out where 20 employees from a cross section of clinical and office based staff were asked their five top reasons for continuing to work at HDFT. There were 14 replies in total and the breakdown was as follows:-

| Reason | Number Responded |
|---|---|
| Team camaraderie | 10 |
| Money | 9 |
| Locality | 9 |
| The work I do | 7 |
| NHS Pension Scheme | 5 |
| Patient care | 4 |
| Family friendly rostering | 4 |
| Annual leave entitlement | 3 |
| To work for the NHS | 3 |
| Equal Opportunities | 2 |
| National terms and conditions of employment (inc Salary) | 2 |
| Support solleagues | 2 |
| To be part of something important | 3 |
| Good sick pay | 1 |
| Promotional opportunities | 1 |
| Salary sacrifice schemes | 1 |
| Sense of duty | 2 |
| To improve the NHS | 1 |
| To use my skills | 1 |
| CPD | 0 |
| Leadership/Development | 0 |
| Living Wage from 01/11/15 | 0 |

**k) Military Health**

As part of the Trust's commitment to the Armed Forces Covenant, a small task and finish group has been working to ensure our services are compliant with the commitments of the Covenant. A process has been established to apply risk flags to serving personnel and veterans which will help to identify the armed forces community to HDFT staff. Medical Records have agreed to test the process during October and November, and the group will work with the Clinical Commissioning Group and GP practices to encourage better identification within referrals. The Covenant states that veterans should receive priority treatment,

subject to the clinical needs of others, in respect of treatment relating to a condition resulting from their service in the armed forces. Following discussions with the Deputy Director of Performance and Informatics, it was felt that it would not be appropriate to set rigid expectations for the triage and prioritisation of veterans. It has therefore been agreed that clinicians will be asked to consider prioritisation for veterans with a condition related to their service, and should they feel that there is cause for prioritisation, they will be supported to move the patient within the waiting list to the appropriate position. The group envisage that this principle will apply to a small number of patients, and this will be monitored as we start to track patients through the system via the risk flags.

The group have also undertaken an audit examining timely access to our services for serving personnel. The aim of the audit was to partially test compliance against the commitment that the armed forces community should enjoy the same standard of, and access to, healthcare as received by any other UK citizen in the area where they live. For serving personnel, the majority of contact with HDFT services are with the Emergency Department, Trauma and Orthopaedics and Dermatology. The audit therefore concentrated on 18 week compliance for serving personnel referred by a known military medical practice. The length of wait for this group was comparable to the rest of our patient population, helping to demonstrate that in terms of timely access to our services, there is no significant difference.

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:**<br>1) The Trust to examine consultant time on the ward with a view to increasing this. | | |
| **RAG Rating:** | **Timeline: 30/04/2015** | |
| **Evidence/Monitoring:**<br>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:**<br>1) The Trust to review current consultant supervision with regard to Workplace Based Assessments. | | |
| **RAG Rating:** | **Timeline: 31/7/2015** | |
| **Evidence/Monitoring:**<br>1. Job planning to allow consultants to perform work based assessments with their trainees. | | |

| **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.

In Gastroenterology undermining had been experienced by Trainees at a sub consultant level. 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:**<br>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**<br><br>**Name: Jon Hossain**<br>**Title: Associate Postgraduate Dean**<br>**Date: 07/04/15** | **Signed on behalf of Trust**<br><br>**Name: Helen Law**<br>**Position: Director of Medical Education**<br>**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*

Harrogate and District NHS
NHS Foundation Trust

# Finance Committee

## Minutes

## Friday 10 July 2015, 10:30 a.m.
## Board Room, Trust HQ

**Members present:**

Name: Mrs Maureen Taylor, Non Executive Director (Chair)
Mr Jonathan Coulter, Director of Finance
Mr Robert Harrison, Chief Operating Officer
Mrs Lesley Webster, Non Executive Director
Mr Chris Thompson, Non Executive Director
Mr Paul Nicholas, Deputy Director of Performance & Information
Mr Jordan McKie, Deputy Director of Finance

**In attendance:**

Name Mrs Catherine Gibson, Corporate PA (notes)

| No | Item | Actions |
|---|---|---|

1. **Welcome and apologies**
Mr Ian Ward, Non Executive Director

2. **Minutes of the last meeting held on 21 April 2015**
Minutes of the previous meeting were agreed as a true and accurate record.

3. **CIP Position and Progress**
Mr McKie updated the group regarding the current CIP position. The Trust has made a positive start to the financial year in relation to the efficiency programme with a significant number of plans identified and actioned. Work is continuing on the higher risk elements of the CIP. Some of the higher risk elements include:
   - the reduction in Integrated Care beds, which has not taken place as plan, due to the continued use of escalation beds
   - work to improve rostering
   - sickness absence is currently exceeding 3.9%

4. **New Business Development Opportunities**
Action notes from the Business Development Group meetings held on 19 May and 16 June 2015 were received and noted:

   - **Bid/No Bid Exercise: North Yorkshire Stop Smoking Service**

Mr Coulter to provide an update to Board of Directors in terms of an overview of the Bid/No Bid summary template of the 'attractiveness score of 1-10'. ***Mr Coulter***

Mrs Taylor stressed the importance of identifying new initiatives from the Business Development/Transformation work in order to put together a cost

improvement plan for 2016/17.

5. **Significant Projects – Carbon Efficiency Fund**

RH reported work is essentially well underway and over the course of the coming months work will be undertaken around the site, to include:

- New chilled water infrastructure, work has already commenced with pipework being installed on the roof.
- Installation of new electricity cables around the perimeter of the site between July and September. RH to provide an update at the next meeting. ***Mr Harrison***

6. **Contract Update**

Mr Coulter provided feedback following on from Dr Tolcher's meeting with Ms Dilani Gamble from the CCG. CCG is seeking to enhance the Community contract by £1m by making efficiencies elsewhere; specifically in the community,with examples:

- that the Acute Trust could offer savings by providing a prescription service for items such as wound care dressings.
- Accelerating the profile of cash payments to the Trust to reduce the overall cost
- seeking to cap the amount the CCG pay the Trust for elective activity.

Discussions are continuing on all these issues.

7. **New Models of Care Proposal**

HaRD 585-15 Letter to S Loseby – New Models of Care.
Mr Coulter shared a copy of the letter, purpose of the letter is two-fold. Firstly to respond to the points and queries raised in the feedback letter from the visit held on 16 June 2015 and secondly to update on the development of the Value Proposition case and confirm the level of support required in finalising this work.

- **Appendix 1 – New Structure**

Document received for information. Job descriptions and roles are being worked out.

- **Appendix 2 – Harrogate Health Transformation Governance**

Document received for information.

- **New Models of Care – Outcomes June 2015**

Document received for information.

8. **Monitor Risk Assessment Framework**

Comments have been submitted to Monitor nd now awaiting feedback.

9. **NHSP Contract Renewal**

Mr Coulter provided NHSP Providers feedback on Monitor consultation response. Renewal end of September 2015. It was noted a piece of work needs to be undertaken in terms of Rostering.

10. **Schedule of Meetings for rest of Financial Year**

Schedule of meetings for the rest of the financial year was discussed, it was agreed to change some dates of future meetings to accommodate Mr ***Mrs Gibson***

Harrison's diary. Mrs Gibson to update the table and re-circulate it to the Committee.

11. **Date and Time of next meeting**

It was agreed that a 30 minute meeting to review the quarterly position to go to Monitor will take place on Monday 20 July 2015, 3:30 p.m. Next Finance Committee will take place on Friday 9 October 2015, 1:00 p.m. held in Board Room, Trust HQ.

Harrogate and District NHS
NHS Foundation Trust

**MINUTES OF THE AUDIT COMMITTEE MEETING**
**Held on 21 May 2015**
**Farndale Meeting Room, Harrogate District Hospital**

| | | |
|---|---|---|
| **Present:** | Mr C Thompson | Non-Executive Director (Chair) |
| | Prof S Proctor | Non-Executive Director |
| | Mrs M Taylor | Non-Executive Director |
| **In Attendance:** | Mr J Coulter | Finance Director & Deputy Chief Executive, HDFT |
| | Mr A Forsyth | Interim Head of Corporate Affairs, HDFT |
| | Mr T Morrison | Head of Financial Accounts, HDFT |
| | Mr J McKie | Deputy Director of Finance, HDFT |
| | Dr S Wood | Deputy Director of Governance, HDFT |
| | Mr T Watson | Internal Audit Manager, NYAS |
| | Mr A Smith | Senior Manager, KPMG |
| | Mrs C Partridge | Director, KPMG. |
| | Miss K Anderson | Audit Committee Secretary, NYAS |
| | Dr R Tolcher | Chief Executive, HDFT [item 8(ii)] |

## 1 Apologies for Absence and Attendance

Apologies for absence were received from Mr Ward, Non-Executive Director, Mrs Kemp-Taylor, Head of Internal Audit, NYAS and Dr C Hall, Deputy Medical Director, HDFT.

Mr Thompson welcomed Mrs Taylor who has joined the Audit Committee in her capacity as new Non-Executive Director.

## 2 Declaration of Interests

No declaration of interests.

## 3 Minutes of Previous Meetings

### (i) Audit Committee Meeting held on 7 May 2015

Dr Wood requested re-wording on page 4 regarding the Quality Account to read 'Mr Ward enquired if there was any significant difference in the requirements for the Quality Account'

*The minutes of the 7 May 2015 Audit Committee meeting were approved as an accurate record of the meeting held subject to the amendment above.*

## 4 Action Points

See separate Action Point document for progress against actions.

## 5 Matters Arising

There were no matters arising from the minutes of the previous meeting.

## 6 Clinical Assurance

### (i) Quality Account

Dr Wood stated that the document had been through significant proof reading and additional areas

had been included in light of the comments raised by KPMG, to ensure it was an accurate document covering all aspects of Quality activity in 2014/15. She highlighted the additional information in terms of the outstanding Internal Audit control weaknesses, which are reflected in the Annual Governance Statement, work around community equipment and details on the ambulance handovers both requested by the CCG.A short section on the 2014 National Inpatient Survey results had also been included as the results have now being received. Dr Wood concluded that all outstanding indicator data had now been included.

Prof Proctor said the narrative was clear and commended Dr Wood and those involved. Mr Thompson agreed and formally thanked everyone involved in the Quality Account for their hard work in preparing the Report.

*The Quality Account was recommended to the Board of Directors.*

## 7 Governance

### (i) Review Staff Registers of Interests and Gifts and Hospitality

Mr Forsyth summarised that the Trust has a robust and proactive system of reporting interests and gifts and hospitality. He said that departments have been chased which has resulted in receiving retrospective declarations and added that people are aware of and compliant with the Standards of Business Conduct Policy. Mr Thompson agreed it is a very comprehensive report which provides assurance to the Audit Committee.

Prof Proctor enquired what the threshold for reporting declarations is. Mr Forsyth confirmed it is £50.

*The Staff Registers of Interests and Gifts and Hospitality was noted*.

### (ii) Review Audit Committee Annual Report (Final)

Mr Thompson stated that amendments had been made as per discussions held at the Audit Committee meeting held on 7 May and that delays in finalising the report were around ensuring there were appropriate consistency between the Audit Committee Annual report and the External Audits report. Mr Smith explained that the report is referred to in KPMGs audit report to state that it is consistent with their findings and opinion.

*The Audit Committee Annual report was approved*.

## 8. Financial Management

### (i) Consideration of going concern

Mr Thompson stated that the appropriateness of preparing the accounts on a going concern basis was formally considered at the March Audit Committee meeting and at the Accounts Review Meeting. He added that a paper regarding going concern would be taken to the end of May 2015 Board of Directors meeting next week.

Mr Coulter said the Trust had just submitted its annual plan and as part of that submission, statements were signed to say that the Trust will be financially stable for the next five years.

Mr Thompson proposed that the Audit Committee recommend the approval of Financial Statements and the Annual report on the basis of going concern.

### (ii) Review of Annual Report

Dr Tolcher summarised that the Annual Governance Statement (AGS) sets out arrangements and assurances the Trust has in place within its framework for internal control. It sets out everyone's responsibilities under the Trust's new governance framework and the groups that work within the

organisation to deliver on those responsibilities. She added that the document includes a summary of current key risks to the Trust, both strategic and corporate.

Dr Tolcher stated that the Trust had conducted a self-assessment against the Monitor Licence and CQC compliance requirements, which has shown the Trust to have robust systems in place for governance. Whilst no significant concerns to report have been highlighted in the AGS she asked the Audit Committee to note the caveats on the final page which flag up outstanding control weaknesses arising from the work undertaken by Internal Audit throughout the year. Dr Tolcher concluded that a considerable amount of work had been undertaken to close risks and that this will be followed up further.

Dr Wood noted that she was aware of an new risk on the Corporate Risk Register and asked whether the Annual Governance Statement should reflect that, given the risk had been escalated after the year end. Mr Smith confirmed that the document should reflect both current and future risks, therefore if the additional risk is considered significant then it should be included in the statement.

Mr Coulter added that the Chair and Chief Executives statements, tabled at the meeting, have been added to the Annual Report and that KPMG have conducted a review of the document. Mr Smith stated that the review is on-going and whilst the key areas have been reviewed and no issues have been identified the annual report is subject to a final full review. Mr Coulter added that an updated report including all areas of the annual report, including KPMG's full review would be available for next week's Board Meeting. He added that KPMGs audit opinion needs to be inserted into the Annual Report.

Mr Thompson sought and received approval to approve the Annual report, subject to agreed changes, and recommend to the Board of Directors for formal approval.

*Dr Tolcher and Dr Wood left the meeting.*

**(iii) Review of Final Trust & Charitable Annual Accounts**

Trust Accounts

Mr Thompson noted that the Trust Annual Accounts had been to the Audit Committee previously and had been discussed at length with all comments dealt now reflected.

*The Final Trust Annual Accounts were approved subject to the changes noted above.*

Charitable Accounts

Mr Morrison highlighted that he was waiting for confirmation from External Audit as to the correct act to note, this will now be changed to reference the Charities Act of 2011.

*The Final Charitable Annual Accounts were approved subject to the changes noted above.*

*Mr Mckie and Mr Morrison left the meeting.*

**(iv) Review of Losses and Special Payments**

Mr Coulter explained that a more detailed report, reconciliation and account categorisation were included in the paper this time. He went on to add that some of the losses are made up of a large number of items for example prescription charges; other balances mainly relate to dentures and glasses. He said that outstanding balances have been reconciled with the ledger. Mrs Taylor commented that the £26,000 total losses were minimal for a year.

*The Losses and Special Payments paper was noted.*

## 9. Internal Audit and Counter Fraud

### (i) Review of Counter Fraud Annual Report

Mr Moss explained that the self-review tool, which requires organisations to review compliance with provider standards, had been introduced last year. He added that overall the Trust scored as Green which is an improvement from last year's Amber score. The Trust had fully met 18 of the standards, partially met 5 of the standards and recorded a neutral response against one standard. He hoped that the work planned for the next year would ensure the Trust is fully compliant with all standards.

Mr Moss stated that various methods had been used throughout the year to inform and involve the Trust staff such as; face to face presentations, the Trust open event, an e-learning package and information on wage slips/staff bulletin.

During 2014/15 the Counter Fraud Team have liaised with a number of agencies to assist in countering fraud, including the Home Office, North Yorkshire Controlled Drug Local Intelligence Network, Regional Local Counter Fraud Specialists Forum and the Regional Counter Fraud Managers' Group meetings.

Mr Moss added that the Anti-Fraud, Bribery and Corruption Policy had been revised and includes additional information on the Fraud Act, Bribery Act and gives examples of frauds Trust staff may potentially encounter. He added that it is explicit in terms of the roles and responsibilities of staff.

Mr Moss stated that the Trust is undertaking the National Fraud Initiative (NFI) this year. He added that employees were notified about participation in the NFI via wage slips, Team Brief and the Intranet. The Trust was found to be compliant with the NFI Security policy's requirements with no duplicate payments found for the creditor exercise within the organisation. He said that they are currently reviewing the payroll matches which may lead to some investigation work.

Mr Moss explained that the Counter Fraud team had received twelve referrals, which is one more than last year. Working whilst on sick leave is the most prevalent fraud at the Trust and a trend across the NHS.

Mr Moss summarised two of the investigations listed in the report:

Prescribing Investigation – NYRT/12/00078
Mr Moss stated that this related to a Locum Doctor falsifying prescriptions and the LCFS' had provided witness statements to the General Medicine Council (GMC). A hearing will take place in August and the Trust's Medical Director is aware of the case.

Timekeeping Referral – 69565
Mr Moss explained that this case related to an employee who is alleged to routinely arrive late and leave early. This case has been referred back to HR and a disciplinary hearing is due to take place in June.

Prof Proctor enquired if Trust staff found to be working whilst on sick leave, were working elsewhere in Harrogate. Mr Moss confirmed they were found to be working mostly in Harrogate and Leeds. Prof Proctor asked what level of awareness there is across the Health sector, in particular care homes and also in the private sector. Mr Moss said that awareness was good in the public sector which should ensure any public sector cases are picked up. He explained that it is more difficult to identify staff who work within the private sector, because the private sector do not take part in the exercise.

Mr Thompson commented he was surprised that the NFI exercise was not run more frequently given the previous successes. Mr Moss said that the Cabinet Office are proposing real time matches, which will identify these issues on a regular basis.

Mr Thompson asked that after the recent Stepping Hill incident, and the individual providing false references, does Mr Moss expect a purge in this area. Mr Coulter replied that pre-employment

checks are part of the Internal Audit programme and that the Trust has a robust system in place. Prof Proctor commented that it will be at least two years until an independent review will be published, so for now the Trust should ensure that the pre-employment checks process is robust. Mr Watson confirmed that Pre-Employment checks had been covered this financial year and controls in place were generally operating well.

*The Counter Fraud Annual Report was approved.*

## 10. External Audit

### (i) External Audit ISA 260 report and Letter of Representation

Mr Thompson thanked the Finance team and voiced his appreciation for their hard work and dedication in completing the financial statements and Annual report. He also thanked KPMG for the work they had done.

ISA 260 Charity Accounts
Mr Smith stated that the audit of the charitable accounts had been completed and there were no audit differences or issues to note.

Mr Smith said that KPMG is satisfied with the Annual Report disclosures and confirmed there are no issues in financial statements therefore the charitable fund accounts have been given a clean opinion.

ISA 260 Trust Accounts
Mr Smith explained that an outstanding balance for Leeds North CCG had been highlighted in the report because of its material value. Mr Thompson stated that given the amount, he was surprised the Audit Committee were not previously made aware of it. Mr Coulter explained that all Trusts make estimates of income and expenditure and the difference of £0.8 million is in terms of the difference between the Trust's expectation of activity delivered and that of Leeds North CCG. He added that he is confident the amount is collectable, and discussions are being held with Leeds North CCG to resolve the issue. Mr Morrison added that differences on the agreement of balances only become apparent when the draft accounts are submitted centrally and the Trust is then made aware of differences with counterparts' estimates.

Mr Thompson requested the Audit Committee be updated for assurance purposes. Mr Coulter added that the Trust will have a more accurate picture by the July Board meeting and assured the Audit Committee that the Trust had followed the same year-end process as usual.

**ACTION: Mr Coulter to keep the Board informed of the progress with resolving the difference and to provide a summary of impact to the July Board Meeting.**

Mr Thompson sought reassurance that it was still appropriate for the Audit Committee to approve the accounts with this outstanding difference.

Mr Smith added that it would not be unusual for the Audit Committee to approve the accounts and assurance can be taken from KPMGs review of all material accounting estimates.

*The Audit Committee noted the outstanding balances.*

Mr Smith stated that in terms of use of resources, KPMG found no issues. They reviewed correspondence with Monitor and CQC, plus reports from external agencies and inspector bodies and the Annual Governance Statement. He concluded that based that work, KPMG are satisfied they can provide a clean use of resources conclusion.

Mr Smith said that KPMG will be issuing an unqualified opinion on the financial statements. He explained that KPMG had highlighted some presentational issues which have now been addressed and their review of the annual report is on-going. Work on the annual report would be concluded soon, and comments fed back to the Trust prior to the Board meeting.

Mr Smith concluded that KPMG are happy with the review of the Remuneration Report, Annual Governance Statement and the Annual Audit Committee Report.

Mrs Partridge thanked the Finance team for their co-operation and for providing information when required.

Letters of Representation

Mr Thompson sought and obtained approval from the Audit Committee to recommend and endorse the draft representation letters to the Board of Directors for signing.

**(ii) External Audit's Review of Quality Account**

Mr Smith stated that KPMG had reviewed the content of the report against Monitor's and the Department of Health requirements and that it had been checked for consistency against specified documentation. He added that a few items had been identified in the Board of Directors minutes which have now been included in the Quality Account

Mr Smith confirmed that regarding the indicator data, he was assured it was in line with the reported data. He commented that he had not had sight yet of the CQC Inpatient Survey as it had not yet been released to the Trust, the Quarter 4 Hospital Intelligence Monitoring Report or feedback from the Health and Wellbeing Board. Mr Smith stated that if they are unable to review these, it will not change their opinion, they will just have to state in their report that these areas were not covered as part of the review.

Mr Smith added that the Trust are required to publish Emergency Readmission data from the Health and Social Care Information Centre (HSCIC), but noted that the data is out of date and from 2013/14.

Incomplete pathways within 18 weeks
Mr Smith stated that KPMG had reviewed the data and were giving it a limited assurance opinion in respect of this indicator. He clarified that the limited assurance opinion meant there was limitation of scope and not areas of concern as you might find in a limited assurance Internal Audit opinion.

Mr Smith explained that the data reported by the Trust to NHS England is not strictly in line with National definition. He added that the Trust should be reporting unadjusted time for incomplete pathways however has been reporting an adjusted position. Analysis by the Trust has shown that this inflates performance by 0.5% and does not created a difference in reported performance.
Mr Coulter confirmed that reporting had been amended to report in line with national definitions from1st April 2015.

Emergency readmissions within 28 days of discharge
Mr Smith stated that although the indicator is supposed to be against 28 days, the Trust reports against 30 days which is the same for most providers. He explained that no issues were found and this indicator was given a limited assurance opinion. Mr Thompson enquired whether there would be a significant difference if the Trust reported against the 28 days. Mr Smith explained that the indicator comes from HSCIC and their information is up to 18 months out of date.

62 day Cancer Referrals
Mr Smith confirmed that no issues were found during testing and no opinion was needed as this was not a mandated indicator.

For clarity, Mr Coulter requested for KPMG to include a description of what a limited assurance opinion is in the narrative of the External Audit report.

**ACTION: Mr Smith to include a description of limited assurance opinion in the External Audits report on the Quality Account**.

**(iii) Review of External Audit's Representation Letter (Draft)**

**(iv) Confirmation of External Audit Independence**

Mr Thompson thanked KPMG for the declaration of objectivity (included under item 10(i) above). He agreed that KPMG have appropriate controls in place to ensure they are able to operate on an independent basis.

*External Audit's independence was noted.*

**11. Standing Items**

**(i) Audit Committee Timetable**

Prof Proctor said that as the Trusts' new governance structure comes into place in June, the Standards Group items will need a closure date of May, and the new groups will need adding to the timetable.

**ACTION: Mr Watson to liaise with Dr Wood regarding the new groups.**

Mr Thompson noted that Prof Proctor is a member of the new Quality Committee and asked whether it would still be appropriate for the Audit Committee to review the minutes to gain assurance on the overall governance structures in place across the Trust. Prof Proctor said that there will be a transition period, so it may be appropriate to receive the minutes for the September and December Audit Committee meetings and then review the position in the new financial year. Mr Thompson added that he expected the Quality Committee to review all sub committee meeting minutes, so that the Audit Committee would not need to. Prof Proctor confirmed the Quality Account would review sub committee minutes and would provide assurance to the Audit Committee over this process.

**12. Any Other Business**

There was no other business.

**13. Date, Time & Venue of Next Meeting**

8 September 2015 Farndale Meeting Room, Harrogate District Hospital

- 09.00 – 09.30 Pre-Meet for Audit Committee Members
- 09.30 – 12.30 Audit Committee

Harrogate and District NHS
NHS Foundation Trust

**Council of Governors**

Minutes of the public Council of Governors' meeting held on Saturday, 16 May 2015 at 10:45 hrs at St. Aidan's Church of England High School, Harrogate.

**Present:**

Mrs Sandra Dodson, Chairman
Ms Pamela Allen, Public Governor
Cllr. Bernard Bateman, Stakeholder Governor
Dr Sally Blackburn, Public Governor
Mrs Angie Colvin, Corporate Affairs and Membership Manager
Dr Sarah Crawshaw, Stakeholder Governor
Mrs Emma Edgar, Staff Governor
Mr Andrew Forsyth, Interim Head of Corporate Affairs
Mrs Jane Hare, Public Governor
Mrs Pat Jones, Public Governor
Mrs Sally Margerison, Staff Governor
Miss Polly McMeekin, Deputy Director of Workforce and Organisational Development
Mrs Joanna Parker, Stakeholder Governor
Prof. Sue Proctor, Non-Executive Director
Mrs Joyce Purkis, Public Governor
Dr Daniel Scott, Staff Governor
Dr David Scullion, Medical Director
Mr Chris Thompson, Non-Executive Director
Dr Ros Tolcher, Chief Executive
Mrs Lesley Webster, Non-Executive Director
Rev. Dr Mervyn Willshaw, Public Governor/Deputy Chair of Council of Governors
Mrs Fiona Wilson, Staff Governor
Dr Jim Woods, Stakeholder Governor

**In attendance:**

Mrs Liz Pugh, Human Resources Business Manager
2 members of staff and 10 members of the public

## 1. Apologies for absence and introductions

Apologies were received from Mr Michael Armitage, Public Governor, Mrs Carol Cheesebrough, Staff Governor, Mrs Cath Clelland, Public Governor, Mr Jonathan Coulter, Deputy Chief Executive/Finance Director, Mrs Liz Dean, Public Governor, Cllr John Ennis, Stakeholder Governor, Mrs Jane Farquharson, Stakeholder Governor, Mrs Jill Foster, Chief Nurse, Mr Robert Harrison, Chief Operating Officer, Mrs Jane Hedley, Public Governor, Mr Phillip Marshall, Director of Workforce and Organisational Development, Mr Peter Pearson, Public Governor, Mr Andy Robertson, Public Governor, Mrs Maureen Taylor, Non-Executive Director and Mr Ian Ward, Non-Executive Director.

In addition, Mrs Dodson confirmed apologies from Mr McLean, new Non-Executive Director, who was unable to attend the meeting due to a pre-existing commitment. Mrs Liz Pugh, Human Resources Business Manager was introduced as she was presenting the Trust's Values and Behaviours Framework under item 6.0 on the agenda.

Mrs Dodson offered a warm welcome to the members of the public and provided an overview of the meeting format.

## 2. Minutes of the last meeting, 4 February 2015

The minutes of the last meeting were agreed as a true and accurate record.

### 2.1 Minutes of the extra Council of Governor meeting, 17 April 2015 to approve the appointment of a new Non-Executive Director

The minutes of the extra Council of Governor meeting held on 17 April 2015 to approve the appointment of a new Non-Executive Director were agreed as a true and accurate record.

## 3. Matters arising and review of actions schedule

Updates on the schedule of actions outstanding were reported as follows:

Item 1 would remain ongoing and Governors would continue to be invited to future Consultant interview presentations.

Item 2 – Dr Tolcher provided the following update on the Ripon Partnership Project:

Representatives from the Trust, Harrogate and Rural District Clinical Commissioning Group (HaRD CCG), North Yorkshire County Council (NYCC) and Harrogate Borough Council (HBC) were working together to shape a new model of health and social care, supported housing, and leisure facilities for people in Ripon.

Dr Tolcher confirmed the project was making good progress and had reached a new milestone with the appointment of a management consultancy firm to examine the options for reprovision of the community hospital and other facilities. There would be ongoing involvement and consultation with the voluntary sector and other stakeholders throughout the project and Governors would continue to be kept up to date.

## 4. Declaration of interests

There were no declarations of interest.

### 4.1 Council of Governors' Declaration of Interests

In addition the Council of Governors' Declaration of Interests presented on Paper 4.1 at the meeting, Mrs Dodson confirmed that Mr Pearson had

recently been elected as a Councillor for Ripon City Council, representing Spa Ward.

## 5. Governor sub committees

Mrs Dodson clarified the role of the sub committees and thanked Governors for their commitment and involvement.

### 5.1 Volunteering and Education

The report from the Volunteering and Education Governor Working Group, chaired by Rev. Dr Willshaw, had been circulated prior to the meeting and was taken as read.

Rev. Dr Willshaw took the opportunity to provide an overview of the group for everyone in attendance at the meeting. Through the work of the group to monitor, promote, develop and support the Volunteer Programme, Work Experience and Education Liaison Programmes and relevant workforce issues, Rev. Dr Willshaw highlighted how the group engaged with Trust members, service users and members of the general public.

The Volunteering Programme had 567 active volunteers (378 volunteers over the age of 25 and 189 volunteers below the age of 25) providing a wide range of roles across the Trust including meal time assistance, hand hygiene champions and 'meet and greet' to name just a few. Some of the volunteers had served as much as 40 years service and Rev. Dr Willshaw talked about the annual celebration event and Long Service Awards. The Trust was incredibly proud and thanked all volunteers for their dedication to a programme which was managed with enthusiasm and energy by Mrs Fiona Tomlinson.

The award winning Education Liaison Programme provided a wide range of activities and engagement with all the secondary schools across Harrogate and District, some primary schools and Harrogate College. These activities included careers events, behind the scenes tours, annual mock interviews for students wanting to go into a medical or nursing career and the innovative 'Living Library', which involves members of staff to go into schools following a request to talk about their career route and particular specialist area. The Work Experience Programme offers placements to approximately 150 students per year with a third of these dedicated to medical placements, offering students across the district applying to study medicine at University the valuable experience of shadowing a medical team. The contract with North Yorkshire Business Education Partnership (NYBEP) to provide the education and work experience programmes would cease on 31 July, but both areas of work would continue to be managed by the Trust and overseen by the Governor Working Group.

Rev. Dr Willshaw was pleased to report that the Governor Working Group and the Volunteering, Work Experience and the unique Education Liaison Programmes were featured as a case study in a recent publication by Monitor, the sector regulator for health services in England.

Finally, Rev. Dr Willshaw reported that the group would be keen for more Governors to join and they would also be looking for a new Chair of the committee from 1 January 2016 as he would not be standing in the Governor elections for a third term.

Mrs Dodson reiterated the importance of the work of the group which provided an important link to the public and supported medical staff to engage with our future workforce.

**5.2 Membership Development and Communications**

The report from the Membership Development and Communications Governor Working Group, chaired by Ms Allen, had been circulated prior to the meeting and was taken as read. Ms Allen summarised the work of the group responsible for overseeing the delivery of the Foundation Trust's Membership Development Strategy including membership recruitment and engagement.

The group membership included both Public and Staff Governors along with Trust staff including the Chairman, Corporate Affairs and Membership Manager, Interim Head of Corporate Affairs and Communications and Marketing Manager.

The Trust continued to develop a representative and vibrant membership, offering innovative and active engagement across the organisation including a Foundation News magazine, letter from the Chairman and invitations to membership events and training sessions to name a few.

Mrs Dodson confirmed the importance in quality membership engagement and welcomed any feedback from the members of public present at the meeting in the break.

**5.3 Patient and Public Involvement**

Mrs Hare provided a verbal update and confirmed that following a Quality Governance Review to look at the governance structure and processes, the Quality of Experience Group (QEG) had been renamed Learning from Patient Experience and would be chaired by the Chief Nurse. Both Mrs Hare and Mrs Purkis, Public Governors, would remain on the group on behalf of the Council of Governors representing the interests of the membership and the general public.

Mrs Hare reported that following the meeting earlier in the week, the group agreed to widen the membership to include representation from Estates and Facilities, Communications, the voluntary sector and medical colleagues. The purpose of the group was to understand, monitor, challenge and seek to improve the quality of the experiences of the users of services provided by HDFT, both in hospital and in the community, taking into account the values of the NHS Constitution and the Trust's Values & Behaviours. The group would report to the Quality Committee, a sub-committee of the Board.

Dr Tolcher clarified that it was fundamental to listen to both positive and negative feedback from all groups, including the Trust's workforce, in order to continue to improve and provide the best quality of care.

### 5.4 Quality Account

Mr Forsyth outlined the purpose of the Quality Account document, an integral part of the Annual Report and Accounts which would be approved on 27 May by the Board and then submitted to be laid before Parliament. The Quality Account would be made available on the Trust website as it was a public document reflecting both the highest priorities of the Trust for the forthcoming year and reporting on progress made with the Trust's highest priorities in the past year. Mr Forsyth highlighted the importance of stakeholder engagement in producing the Quality Account and in accordance with the NHS Quality Accounts Regulations, the Trust had forwarded a copy of the draft Quality Account to Harrogate and Rural District Clinical Commissioning Group, Healthwatch North Yorkshire, North Yorkshire County Council Scrutiny of Health Committee, the Council of Governors and the Health and Wellbeing Board for comment prior to publication.

Ms Allen commented that her involvement in the Quality Account process had been very interesting and staff had worked extremely hard to pull the document together.

## 6. Presentation – 'At the heart of everything', the Trust's Values and Behaviours Framework

Mrs Dodson welcomed Mrs Pugh, Human Resources Business Manager to present the Trust's Values and Behaviours Framework.

Mrs Pugh summarised the background and ongoing progress of the Values and Behaviours Framework which defined the behaviours that Trust staff must demonstrate for the Trust to perform effectively. The framework was a statement of who we are, what our patients could expect from us and what we would expect from each other. This framework was at the heart of everything we do.

Mrs Pugh talked about the consultation process with staff and Trust members to identify the values: respectful, responsible and passionate. She explained how these values were in line with the NHS Constitution and how they could be used from the recruitment stage throughout the employment journey.

The framework would be embedded in to the culture of the Trust moving forward and rolled out to all staff through a variety of methods.

Mrs Dodson thanked Mrs Pugh for an interesting and informative presentation.

Dr Tolcher also thanked Mrs Pugh for an excellent presentation and her commitment to a thorough piece of work which was fundamental to the NHS. Dr Tolcher confirmed that at a Consultant interview that week, each candidate was in fact asked about their personal values as part of the interview process.

## 7. Update from the Chief Executive

Taking a look back at 2014/15, Dr Tolcher summarised the following highlights:

- The Trust achieved all access targets in all quarters in 2014/15 including cancer waiting targets and Emergency Department four hour access target;
- There were zero MRSA cases and nine cases of C.Difficile against a maximum allowable number of 15;
- The Trust's safety thermometer score, a national improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care, was consistently above 91% and above 95% in the last five months. The Trust had been focussing on this area as part of the Quality Account which Mr Forsyth referred to earlier in the meeting;
- The National Cancer Patient Experience Survey placed the Trust third nationally with 94% of patients rating their care as good or excellent; and,
- Positive ratings from the regulator Monitor.

Reflecting the activity trends for 2014/15 – 2015/16, Dr Tolcher confirmed that elective admissions were 9.5% higher in 2014/15 than they were in 2013/14 and face to face contacts had increased by 12% in the last six months in the District Nursing service.

In addition to the excellent results received from the Cancer Patient Survey, Dr Tolcher was pleased to provide a snapshot of other positive feedback. The Trust was ranked 14 out of 142 Trusts in the Adult Inpatient Survey 2013 with the 2014 results expected to be published in the next few months and the National Accident and Emergency Survey 2014 placed the Trust 13 out of 142 participating Trusts.

Dr Tolcher went on to talk about the year ahead and planning for success with four high level strategic objectives: driving up quality, working with partners, integrating care and growing our business. The Trust would continue to drive forward a total commitment to providing high quality care whilst working on new models of care and developing the business strategy.

The Trust had recorded a modest operating surplus of £10,000 for 2014/15. With a planned surplus of £1.8m for 2015/16, the finance challenges continued and a total of £10.2m savings were required. Dr Tolcher explained the importance of achieving a surplus in order to reinvest and maintain the organisation however, with increasing demand and less money to provide the same level of quality of care, delivering new models of care was imperative.

Dr Tolcher was pleased to report that the Trust had been chosen as one of NHS England's Vanguard Sites, meaning Harrogate and Rural District would lead the way in transforming care for local people and resulting in more responsive and co-ordinated health and social care services. Working alongside health and social care partners: Harrogate and Rural District Clinical Commissioning Group, North Yorkshire County Council, Tees Esk and Wear Valleys NHS Foundation Trust, Harrogate Borough Council and Yorkshire Health Network, the Vanguard programme would deliver access to preventative advice and information for individuals who find themselves needing support 24/7. The shared vision was for care to be centred on the needs of the individual and their carers, empowering people to take control of their health and independence.

Finally, Dr Tolcher summarised 2014/15 as a year of strong operational performance and sustained high quality care but a year of phenomenal challenge financially. The Trust's focus for the year ahead would be: new models of care and a new business model, retaining the culture, values and continuing to provide high quality care, retaining a strong grip on finances, improving engagement with service users, members and Governors and valuing, involving, and engaging with staff.

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

Before Mrs Dodson moved on to the questions which had been submitted prior to the meeting, she asked if there were any questions which related to any items on the agenda so far.

Following the presentation on the Trust's Values and Behaviours Framework, Mrs Parker, Stakeholder Governor asked how the Trust would embed the values and behaviours with the existing workforce and what would happen if these were not being demonstrated.

Mrs Pugh confirmed that a variety of methods would enable the Trust to educate and embed the framework culture across the organisation. As part of the consultation process, the values and behaviours identified were those that staff expected and therefore if someone failed to demonstrate what was expected, this would be dealt with in the appropriate manner.

Cllr. Bateman, Stakeholder Governor commented on poor discharge arrangements.

Dr Tolcher agreed that an inefficient discharge was not a good patient experience and acknowledged there were improvements to be made in this area. A recent bed audit confirmed that further work was required however, Dr Tolcher clarified that delays were not usually caused by Pharmacy as this was often the presumption. A task group would be focussing on improving the discharge process.

Mrs Hare, Public Governor expressed concerns regarding the scale of the cost improvement programme (CIP) and asked how the Trust aimed to deliver this.

Dr Tolcher confirmed how hard staff worked last year to deliver the CIP. Each year the Trust continued to face increased financial challenges and therefore a fundamental change in the whole health system was needed.

Mrs Dodson asked Non-Executive Directors to respond.

Mr Thompson, Chair of the Audit Committee commented that he understood Mrs Hare's concerns regarding the delivery of the CIP. He reiterated that the Trust had worked incredibly hard and directorate and finance teams had reviewed and challenged each CIP in detail on a regular basis in order to achieve the year end results. CIP progress was also discussed at regular finance and audit committee meetings.

Mrs Webster, Chair of the Finance Committee, confirmed that cost efficiencies had been scrutinised throughout the year and the committee would continue to review them in detail against the ongoing work towards the new models of care.

A member of the public asked how much it cost the NHS for a patient to be treated by a non-NHS provider.

Dr Tolcher confirmed that on occasions an NHS patient could be offered a non-NHS provider as a choice of where to receive treatment and this would incur the same cost to the NHS as it would for the patient to be treated in an NHS hospital.

Mrs Purkis, Public Governor asked Non-Executive Directors to comment on the Hospital Standardised Mortality Ratio (HSMR) reported in appendix 7.3.

Prof. Proctor assured Governors that the HSMR was included in every performance report submitted to the monthly Board meeting. The Mortality Review Group had reviewed the HSMR in depth over the last three to four months and provided ongoing guidance to the Non-Executive Directors in understanding the data and the risks.

Mr Thompson clarified the assurance that Non-Executives had received and commented that the guidance had provided them with a better insight to such a complex subject. Mrs Colvin agreed to circulate the guidance link to Governors.

***Action: Mrs Colvin***

Dr Scullion informed Governors that following a difficult winter he believed the HSMR had peaked and figures were beginning to improve, similarly to a national picture. The HSMR was an indicator of healthcare quality that measured whether the number of deaths in hospital was higher or lower than expected and the key message was that it could be a warning sign that things were going wrong. He confirmed that the Mortality Review Group had been reviewing a number of individual cases and were assured with the findings.

**Mrs T Lambert, a member of the public, had submitted the following question:**

**"Why is it taking so long to get gynaecological oncology at the Sir Robert Ogden Macmillan Centre?"**

In response, Dr Tolcher commented that the Trust was also disappointed that this service had not progressed but reassured Mrs Lambert that working was ongoing towards a solution. The opening of the Sir Robert Ogden Macmillan Centre had now provided the Trust with additional space to deliver local services however, transferring this type of service would need great care in order to make sure that the treatment regimens could be delivered safely and that any complications could also be managed safely. This required the commitment by commissioners and the availability of staff with the right skills to deliver the care. Originally it was anticipated that the process would take approximately a year from when the new centre opened, but there were some delays to the final steps. Dr Tolcher added that there was still the ongoing requirement to appoint another consultant for gynaecological cancers and the Trust remained in dialogue with partners about how best this could be achieved. Dr Tolcher apologised as patient expectations that the service would be in place by now had not been met, and agreed to provide Mrs Lambert with a written response to her question. In the meantime, care for these patients continued to be delivered safely in Leeds.

Dr Scullion clarified that more time was needed than anticipated to resolve this issue however, the current Consultant Oncologist was working hard to progress this service being provided in Harrogate.

***Action: Dr Tolcher***

**Mr William Scott, Trust member, had submitted the following question:**

**"Why does free car parking, given to person visiting next of kin with terminal illness, come off the ward allowance?"**

In response, Miss McMeekin explained that car parking concessions did not come off an individual ward's budget. The ability to authorise car parking concessions was given to ward sisters in June 2012 in order that discretion could be exercised as no set of guidance would cover every eventuality. The Trust offered an apology for the misunderstanding in the information provided and training would be provided on this issue.

**Mrs Christine Holmes, Trust member, had submitted the following question:**

**"Are there any plans to improve the situation at the Diabetes Resource Centre? If you need to go there it is difficult for the staff to find a consulting room that is free. If you have an appointment your appointment is constantly being interrupted by staff needing to use equipment or find something. These constant interruptions can leave patients feeling extremely uncomfortable. The staff in the Diabetes Resource Centre do a wonderful job but clearly need larger offices for their equipment and more consulting rooms."**

In response, Dr Tolcher was aware of this situation and agreed that it was unacceptable that a patient's consultation should be interrupted in this manner. The diabetes team had discussed the accommodation issues with management and a number of options were being reviewed including the potential for consultants to share an office or an alternative location for this service.

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

**Please could there be a review of the Referral Support Service (RSS) to establish it is has, or does deliver:**

- **improved referrals (in regard to process, timescales, communication, efficiency of resources);**
- **cost savings; and,**
- **the outcomes identified at the outset.**

**Also please could we have some statistics on Choose and Book, including:**

- **demographic age profiles of those using it as well as those invited to use it;**
- **how long does it take patients to get onto the Choose and Book system (from letter with password to their login to them securing an appointment and then the appointment being met); and,**
- **how many Trust treatments start with Choose and Book then opt out of it and why?"**

In response, Mrs Dodson confirmed that the RSS was a Clinical Commissioning Group (CCG) initiative and not run by the Trust and therefore this question would need to be redirected to the CCG.

Dr Scullion confirmed that the Choose and Book system was being replaced with a new e-referral system in June nationally and the Trust was working closely with them to ensure maximum benefits were gained for our users, administrative and clinical.

**Rev. Dr Mervyn Willshaw, Public Governor and Deputy Chair of the Council of Governors, submitted the following question:**

**"Are there any risks involved for the Trust being part of a Vanguard site?**

In response, Dr Tolcher outlined the huge opportunity for the Trust in being part of a Vanguard site however, this would bring its own risks and challenges to all partners involved including working differently, reputational and financial risks. The Trust would continue to deliver its day to day business alongside working towards new models of care and there would be lots to do in the year ahead. Dr Tolcher reassured Governors that she had total confidence in the health system and the leadership to take this work forward and added that there would be far more risks in not moving forward.

**Rev. Dr Mervyn Willshaw also asked:**

**Research shows that being a research active Trust improves quality of care. How assured are the Non-Executive Directors that the Trust has a strong enough research culture to benefit from this?"**

In response, Prof. Proctor confirmed that Dr Layton, clinical lead for the Trust's research activity, had presented a brief on research issues to the Board in March.

This brief outlined that having a successful research programme was essential to the quality of care provided by the Trust. Prof. Proctor was pleased to report that the Trust was the sixth highest recruiting trust in the region with particularly high numbers in areas such as diabetes, dermatology and dementia. There were currently 110 studies which were being actively recruited into and over 2000 patients for the year overall had been recruited.

Mrs Dodson applauded Dr Layton's leadership in research and assured Governors that the Board would continue to receive information on research performance on a regular basis.

**9. Any other business**

Mrs Dodson informed the Council that Rev. Dr Willshaw would be stepping down as a Governor at the end of the year and the end of his second term of office. This would leave a vacancy for a Public Governor for Harrogate and surrounding villages and also the position of Deputy Chair of Governors and Lead Governor. Mrs Dodson welcomed expressions of interest from existing Governors for the role of Deputy Chair of Governors and Lead Governor and Rev. Dr Willshaw would be happy to discuss the role further if requested.

## 10. Date and time of next meeting

The next Council of Governor meeting would take place on Wednesday, 29 July at 5.45 pm at Harrogate College, Hornbeam Park, Harrogate, HG2 8QT.

Harrogate and District NHS
NHS Foundation Trust

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|---|---|
| **Report to the Trust Board of Directors: 28 October 2015** | **Paper No: 16.1** |

| | |
|---|---|
| **Title** | Review of Treasury Management Policy |
| **Sponsoring Director** | Jonathan Coulter |
| **Author(s)** | Thomas Morrison |
| **Report Purpose** | Approval |

**Executive Summary**
The Trust's Treasury Management Policy has been reviewed by the Audit Committee (September 2015). The Audit Committee approved the policy and recommended onward approval by the Board.

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

| | |
|---|---|
| **Risk and Assurance** | NHS Foundation Trusts are required to manage their affairs in a way that ensures they remain 'going concerns' and have access to sufficient cash and other liquid assets to meet their financial obligations. A key element of this is having an effective policy for Treasury Management. |
| **Legal implications/ Regulatory Requirements** | Monitor requirement. |

**Action Required by the Board of Directors**
To approve the attached Treasury Management Policy.

Harrogate and District NHS
NHS Foundation Trust

# TREASURY MANAGEMENT POLICY

| Version | Date | Purpose of Issue/Description of Change | Review Date |
|---|---|---|---|
| 1 | June 2005 | Initial Issue | June 2006 |
| 2 | May 2006 | 12 month review of Policy | June 2007 |
| 3 | May 2007 | 12 month review of Policy | June 2008 |
| 4 | Aug 2008 | 12 month review of Policy | June 2009 |
| 5 | Sept 2009 | 12 month review of Policy | August 2010 |
| 6 | Sept 2010 | 12 month review of Policy | August 2011 |
| 7 | Sept 2011 | 12 month review of Policy | August 2012 |
| 8 | Sept 2012 | 12 month review of Policy | August 2013 |
| 9 | Dec 2013 | 12 month review of Policy | November 2014 |
| 10 | Sept 2014 | 12 month review of Policy | August 2015 |
| 11 | Sept 2015 | 12 month review of Policy | August 2016 |

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|---|---|---|
| **Status** | Open | |
| **Publication Scheme** | Document Library>>Policies | |
| **FOI Classification** | Release without reference to author | |
| **Function/Activity** | Treasury Management | |
| **Record Type** | Policy | |
| **Project Name** | **N/A** | |
| **Key Words** | Treasury, Management, Policy, Finance | |
| **Standard** | **N/A** | |
| **Scope / Location** | Trust-wide | |
| **Author** | Head of Financial Accounts | **Date** |
| **Approval and/or Ratification Body** | Board of Directors<br>Board of Directors<br>Board of Directors<br>Board of Directors<br>Board of Directors<br>Board of Directors<br>Board of Directors<br>Board of Directors<br>Board of Directors<br>Board of Directors | May 2005<br>May 2006<br>May 2007<br>Sept 2008<br>Sept 2009<br>Oct 2010<br>Sept 2011<br>Oct 2012<br>Feb 2014<br>Jan 2015<br>TBC |

**CONTENTS**

# 1 INTRODUCTION

NHS Foundation Trusts are required to manage their affairs in a way that ensures they remain 'going concerns' and have access to sufficient cash and other liquid assets to meet their financial obligations. A key element of this is having an effective policy for Treasury Management.

Treasury Management includes the management of:

- Cash flow (monitoring and forecasting).
- Working capital management.
- Banking.
- Money and capital market transactions.
- Optimising returns through investment.
- Reducing financial transaction and borrowing costs.
- Minimising financial and corporate risk.

Donated funds are regulated by the Standing Financial Instructions and other guidelines relating to Charitable Funds and decisions on investments are made by the Trust's Charitable Funds Investment Panel.

# 2 AIMS AND OBJECTIVES

The Treasury Management Policy aims and objectives are:

- To apply and develop professional standards and disciplines to the Treasury management function.
- To identify, manage, reduce and eliminate where possible, financial risk arising from operational and treasury management activities.
- To support the delivery of the Trust's objectives by ensuring short and long term availability of liquidity.
- To minimise costs by borrowing on flexible and competitively priced terms.
- To manage HDFT's liabilities and investment assets prudently ensuring commitments can be met as they fall due.

# 3 KEY RESPONSIBILITIES AND CONTROLS

The Chief Executive is Accountable Officer for the Trust and is charged, with the Board, in ensuring probity in the use of public money. Responsibility for the day to day management of the Trust's financial systems rests with the Finance Director.

The Finance Director is responsible for the following:

- Ensuring that controls and processes are sufficient to meet the aims and objectives of the Treasury Management policy.

- Making recommendations to the Trust Board for a system of delegated authority limits and implementing and reviewing those limits on a regular basis.

- Establishing strict limitations on the types of investments for deposits of surplus cash and the circumstances in which they may be used.
- Managing daylight exposure (a limit set by a bank on its foreign-exchange dealings in a given currency with a particular counterparty) in the use of agreed counter-party limits.
- Ensuring that all moneys due from maturing or sold assets are received on time by the Trust.

## 4 INVESTMENTS

Cash investment decisions will be aimed at ensuring security, safeguarding liquidity and maximising income to support the financial aims of the Trust.

The Trust will only invest cash in organisations or financial institutions that offer the maximum security for the investment, in line with Monitor's definition of a 'safe harbour' investment. The types of organisations that can provide this are:

- UK Government Departments and Agencies (excluding those contracted out to the private sector).
- Local Authorities.
- Banks, Building Societies and any similar institutions granted permission to trade by the FSA particularly those that are unlikely to fail).
- Approved Money Market Funds.
- Open ended investments such as unit trusts or bond funds where all elements of the investment meet Monitor safe harbour criteria.
- Revenue repurchase transactions where collateral is securities backed by the UK Government and the counterparty is a permitted institution under the Monitor definition.

## 5 APPROVED INVESTMENT INSTITUTIONS

The Department of Health has changed the methodology in calculating Public Dividend Capital (PDC) dividends from 2013 onwards, by excluding cash from the calculation based on average daily cleared balances as opposed to opening and closing cash balance. This will have the effect of increasing the amount of PDC dividend paid annually. As the UK bank base rate is currently 0.5% and that returns from short term investment is very low, the cost of the extra PDC dividends far outweighs the benefit earned from the short term investment.

For example, on £5m there is a 3.5% saving on PDC dividend which totals £175,000 pa. Any investment made at the present time within this policy, and whilst the UK bank base rate is 0.5%, are unlikely to yield 3.5%. Therefore, the Trust does not intend to place any investment until UK bank base rate rises to 3.5% or above. At that time, the Audit Committee will consider the Investment Policy again. It is likely that some financial institutions, whilst meeting the current definitions outlined in section 4 of this policy, would be excluded because of individual credit ratings or other information.

The Trust will keep all of its cash with the Government Banking Service (GBS) and the National Loan Fund (NLF) until such time where base rate goes above 3.5%.

## 6 LIMIT PER COUNTERPARTY

| | |
|---|---|
| GBS | Unlimited |
| NLF | Unlimited |

## 7 MAXIMUM INVESTMENT PERIOD

The maximum period of 12 months will be permitted for investments. For investments with a fixed period of up to 6 months Finance Director approval is required. Board of Director approval is required for investments with a fixed period between 6 and 12 months.

## 8 DELEGATION OF RESPONSIBILITY FOR BORROWING

Post implementation of the Risk Assessment Framework the Trust no longer has a Prudential Borrowing Limit set annually by Monitor. The Board will authorise the strategic use of all borrowing in advance; whilst delegating day-to-day responsibility for all borrowing to the Chairman and Chief Executive collectively.

One of any of the Non-Executive Directors can deputise for the Chairman. The Finance Director can deputise for the Chief Executive.

In order to carry out these duties, the Chairman and Chief Executive will request from the Finance Director as required reports on borrowing, including:-

- Performance monitoring.
- Review of borrowing requirements, funding plans and interest rate strategy.

The information included in the above reports will form part of the Trust's annual business planning process and the output of which will be approved by the Board of Directors.

## 9 AUDIT COMMITTEE

The Audit Committee is responsible for:

- Ensuring that public money is safeguarded and properly accounted for.
- Ensuring that the Trust's investment and borrowing strategy retains an appropriate risk profile.
- Ensuring that proper safeguards are in place for the security of the Trust's funds by agreeing the list of permitted institutions, setting investment limits for each institution and agreeing permitted investment types.
- Performing an annual review of this Policy and recommending approval to the Board of Directors.

## 10 APPENDICES

Appendix 1: Consultation Summary

### 10.1 Appendix 1: Consultation Summary

| | List Groups and or Individuals Consulted |
|---|---|
| **Those listed opposite have been consulted and comments/actions incorporated as required.**<br><br>The author must ensure that relevant individuals/groups have been involved in consultation as required prior to this document being submitted for approval. | Finance Director/Deputy Chief Executive |
| | Deputy Finance Director |
| | Audit Committee |
| | |
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