Board of Directors public 27 September 2017 - all documents

This page has been left blank

Harrogate and District NHS Foundation Trust

**The meeting of the Board of Directors held in public will take place on Wednesday 27 September 2017 Boardroom, Harrogate District Hospital, HG2 7SX**

**Start: 8.30am Finish: 12.30pm**

| | AGENDA | | |
|---|---|---|---|
| **Item No.** | **Item** | **Lead** | **Paper No.** |
| **8.30am-9.00am** | | | |
| **Patient Story** | | | |
| **9.00am – 10.50am** | | | |
| **1.0** | **Welcome and Apologies for Absence**<br>*To receive any apologies for absence: Ms Laura Robson* | Mrs S Dodson, Chairman | - |
| **2.0** | **Declarations of Interest and Register of Interests**<br>*To declare any interests relevant to the agenda and to receive any changes to the register of interests* | Mrs S Dodson, Chairman | 2.0 |
| **3.0** | **Minutes of the Board of Directors meetings held on 26 July 2017**<br>*To review and approve the minutes* | Mrs S Dodson, Chairman | 3.0 |
| **4.0** | **Review Action Log and Matters Arising**<br>*To provide updates on progress of actions* | Mrs S Dodson, Chairman | 4.0 |
| **Overview by the Chairman** | | Mrs S Dodson, Chairman | - |
| **5.0** | **Report by the Chief Executive Including the Integrated Board Report**<br>*To receive the report for comment* | Dr R Tolcher, Chief Executive | 5.0 |
| **6.0** | **Report by the Finance Director to include:**<br>– **Financial Recovery Plan Monitoring**<br>– **CIP Quarterly Update**<br>*To receive the report for comment* | Mr J Coulter, Deputy Chief Executive/ Finance Director | 6.0 |
| **6.1** | **Treasury Management Policy**<br>*To receive and approve* | Mr J Coulter, Deputy Chief Executive/ Finance Director | 6.1 |
| **10.50am – 11.00am – Break** | | | |
| **11.00am – 12.30pm** | | | |
| **7.0** | **Report from the Chief Operating Officer**<br>*To receive the report for comment* | Mr R Harrison, Chief Operating Officer | 7.0 |
| **7.1** | **Emergency Preparedness, Resilience and Response (EPRR) Report**<br>*To receive the report for comment* | Mr R Harrison, Chief Operating Officer | 7.1 |

| | | | |
|---|---|---|---|
| **8.0** | **Report by the Director of Workforce and Organisational Development**<br>*To receive the report for comment* | Mr P Marshall, Director of Workforce & Organisational Development | 8.0 |
| **9.0** | **Report from the Chief Nurse**<br>*To receive the report for comment* | Mrs J Foster, Chief Nurse | 9.0 |
| **9.1** | **Freedom to Speak Up Guardian Update**<br>*To receive the report for comment* | Mrs J Foster, Chief Nurse | 9.1 |
| **10.0** | **Report from the Medical Director**<br>*To receive the report for comment* | Dr D Scullion, Medical Director | 10.0 |
| **10.1** | **Medical Revalidation and Appraisal Statement of Compliance**<br>*To receive the report for comment* | Dr D Scullion, Medical Director | 10.1 |
| **10.2** | **Learning from Deaths Policy**<br>*To approve the policy* | Dr D Scullion, Medical Director | 10.2 |
| **11.0** | **Oral Reports from Directorates**<br>*11.1 Planned and Surgical Care*<br>*11.2 Children's and County Wide Community Care*<br>*11.3 Long Term and Unscheduled Care* | Dr K Johnson Clinical Director<br>Dr N Lyth, Clinical Director<br>Mr A Alldred, Clinical Director | -<br>-<br>- |
| **12.0** | **Committee Chair Reports**<br>*12.1 To receive the report from the Finance Committee meeting held 5 September 2017.*<br>*12.2 To receive the reports from the Quality Committee meetings held 2 August 2017 and 6 September 2017.*<br>*12.3 To receive the report from the Audit Committee meeting held 7 September 2017.* | Mrs Maureen Taylor, Non-Executive Director/chair of the Finance Committee<br>Mrs L Webster, Non-Executive Director / Quality Committee Chair<br>Mr C Thompson, Non-Executive Director / Audit Committee Chair | 12.1<br>12.3 |
| **13.0** | **Council of Governors minutes of the meeting held 3 May 2017**<br>*To receive the minutes for comment* | Mrs S Dodson, Chairman | 13.0 |
| **14.0** | **Other matters relating to compliance with the Trust's Licence or other exceptional items to report, including issues reported to the Regulators**<br>*To receive an update on any matters of compliance:* | Mrs S Dodson, Chairman | |
| **15.0** | **Any other relevant business not included on the agenda**<br>*By permission of the Chairman* | Mrs S Dodson, Chairman | - |
| **16.0** | **Board Evaluation** | Mrs S Dodson, Chairman | - |
| **Confidential Motion – the Chairman to move:**<br>*Members of the public and representatives of the press to be excluded from the remainder of the meeting due to the confidential nature of business to be transacted, publicly on which would be prejudicial to the public interest.* | | | |

Harrogate and District 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 Company Secretary

| 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 | 1. Specialist Adviser to the Care Quality Commission<br>2. Member of NHS Employers Policy Board (Vice Chair).<br>3. Harrogate Ambassador on behalf of Harrogate Convention Centre |
| Mr Jonathan Coulter | Deputy Chief Executive/ Finance Director | None |
| Mrs Jill Foster | Chief Nurse | None |
| Mr Robert Harrison | Chief Operating Officer | 1. Appointed Voluntary Member of the Strategy and Resources Committee of the Methodist Church<br>2. Charity Trustee of Acomb Methodist Church, York |
| Mr Phillip Marshall | Director of Workforce and Organisational Development | 1. Member of the Local Education and Training Board (LETB) for the North |
| Mr Neil McLean | Non-Executive Director | Director of:<br>- Northern Consortium UK Limited (Chairman)<br>- Ahead Partnership (Holdings) Limited<br>- Ahead Partnership Limited<br>- Swinsty Fold Management Company Limited<br>- Acumen for Enterprise Limited |
| Laura Robson | Non-Executive Director | None |

| | | |
|---|---|---|
| Dr David Scullion | Medical Director | 1. Member of the Yorkshire Radiology Group |
| Mrs Maureen Taylor | Non-Executive Director | None |
| Mr Christopher Thompson | Non-Executive Director | 1. Director – Neville Holt Opera<br>2. Member – Council of the University of York |
| Mr Ian Ward | Non-Executive Director | 1. Non-Executive Director of :<br>• Charter Court Financial Services Limited,<br>• Charter Court Financial Services Group Limited,<br>• Exact Mortgage Experts Limited,<br>• Broadlands Finance Limited<br>• Charter Mortgages Limited.<br>In respect of the five companies above, Mr Ward is Chairman of the Remuneration Committee and Chairman of the Nominations Committee. Also, for each of them, he is a member of the Board Risk and Audit Committees.<br>2. Non-Executive Director of Newcastle Building Society and a member of the Group Risk Committee. Also, he is Chairman of its subsidiary company, Newcastle Systems Management Limited and a Director of Newcastle Financial Advisers Limited.<br>3. Member, Leeds Kirkgate Market Management Board |
| Mrs Lesley Webster | Non-Executive Director | None |
| Mr Andrew Alldred | Clinical Director LTUC | None |
| Dr Kat Johnson | Clinical Director PSC | None |
| Dr Natalie Lyth | Clinical Director CCCC | 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 of W & OD | None |
| Mr Jordan McKie | Deputy Director of Finance | 1. Familial relationship with NMU Ltd, a company providing services to the NHS |
| Mrs Alison Mayfield | Deputy Chief Nurse | None |
| Mr Paul Nicholas | Deputy Director of Performance and Informatics | None |

**July 2017**

Harrogate and District
NHS Foundation Trust

**Report Status: Open**

**BOARD OF DIRECTORS MEETING**

Minutes of the Board of Directors' meeting held in public on
Wednesday 26 July 2017 9.00am in the Boardroom at Harrogate District Hospital.

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

**In attendance:**
Mr Andrew Alldred, Clinical Director for Long Term and Unscheduled Care
Dr Kat Johnson, Clinical Director Planned and Surgical Care
Dr Natalie Lyth, Clinical Director for Children's and County Wide Community Services
Mrs Katherine Roberts, Company Secretary (minutes)



## 1.0 Welcome and Apologies for Absence

Mrs Dodson noted that apologies had been received from Mrs Maureen Taylor, Non-Executive Director.

Mrs Dodson welcomed observers to the meeting, this included Mr Paul Widdowfield (Communications and Marketing Manager), Mr Tony Dovestone (Public Governor) and Collette Black, (Health Care Assistant).

## 2.0 Declarations of Interest and Board Register of Interests

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

Dr Tolcher reported two amendments to her declared interests; she had been appointed as Vice Chair of the NHS Employers Policy Board, in addition she had become a Harrogate Ambassador on behalf of Harrogate Convention Centre.

Mr Ward noted some minor amendments to the interests he had included on the register of interests.

**ACTIONS:**

- **Register of Interests to be updated to reflect new interests for Dr Tolcher and Mr Ward.**

### 3.0 Minutes of the meetings of the Board of Directors on 28 June 2017

The draft minutes of the meetings held on 28 June 2017 were approved with no amendments.

**APPROVED:**
**The Board of Directors approved the minutes of the meeting held on 28 June 2017 as an accurate record of proceedings.**

### 4.0 Review of Action Log and Matters Arising

4.1 Completed actions were noted. In addition an update was provided regarding an outstanding action 36; proposed inclusion of the World Health Organisation (WHO) checklist within the new theatre dashboard. It was reported this had been explored and it had been concluded that it would not be appropriate to include the WHO checklist within the checklist. It was agreed this action was therefore closed.

4.2 There were no other matters arising.

**APPROVED:**
**The Board of Directors agreed action 36 was closed.**

### Overview by the Chairman

Mrs Dodson explained she expected the meeting would be challenging for all members of the Board of Directors. The Trust had not met the planned financial trajectory and this would be a concern for the Board. During the meeting the attention of the Board would remain on financial recovery, however it would be important to contextualise this and remember that overall performance was very good; the Trust was a high performing organisation delivering high quality and safe services.

Mrs Dodson noted income and expenditure was under-performing by nearly £1m per month. Discussions during the meeting would focus on how the Trust planned to control costs and recover income. She commented the Board needed granular insight into the financial position in order to agree a clear realistic recovery trajectory; this process would commence immediately and would therefore require the Board to have an additional private meeting in August.

She highlighted teams across the organisation were working hard and implementing actions to aid the financial recovery plan. It would be important to have honest and transparent conversations about what the Trust would be able to achieve and how this should be communicated to staff. It was noted the Clinical Directors would be key to supporting these conversations and giving teams clarity about the Board's expectations.

### 5.0 Report by the Chief Executive

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

5.2 Dr Tolcher explained overall financial performance was a great concern, she provided reassurance that all the Executive Directors were focused on the issue on a daily basis and would make this the main focus of her report.

5.3 Despite challenging financial performance, the Trust continued to perform well and the month saw an improving position, in particular an improving trajectory on the safety thermometer score.

5.4 The Trust continued to work in partnership with health and social care organisations to support a reduction in delayed transfers of care (DTOC). Dr Tolcher referred to the additional iBCF (improved Better Care Fund) funds which had been allocated to local authorities to fund a range of measures including support to reduce DTOC. National guidance, including indicative metrics, had been issued on 4th July. Dr Tolcher fed back on a meeting of the North Yorkshire Health and Wellbeing Board in the previous week. The Health and Wellbeing Board had decided not to accept indicative metrics included within the guidance pending further work which would be completed before the September deadline. It was noted that based on initial prioritisation, a substantial part of the iBCF funding would be used to underwrite existing cost pressures in adult social care. This would enable current schemes which were already supporting measures to reduce DTOCs to be sustained. The national target was for no more than 3.5% of beds to be used for DTOCs by September. This target was considered unattainable with the available resources in the timescale mandated. It was unclear what the implications of not accepting the indicative metrics would be. DTOCs continued to rise contributing to high occupancy rates at the Trust. The Trust's planned bed reductions could not be enacted while occupancy rates were high and this was one of the drivers of pay overspending.

5.5 The first national dashboard of Sustainability and Transformation Partnerships (STPs) had been publicised. West Yorkshire were in the 'making progress' category. Dr Tolcher noted the first tranche of capital funding had been awarded to those STPs who were rated as outstanding or advanced; West Yorkshire had not therefore received any capital funding which was very disappointing.

5.6 National ratings for CCGs had been published. Five CCGs in West Yorkshire were rated as 'requires improvement', this included Harrogate and Rural Districts CCG, it was unclear what implications this would have.

5.7 Dr Tolcher reported a 'stop the clock' day had been held to consider progress with the Integrated Response Service. The event had produced a very constructive dialogue, with many common views. It had been recommended a Harrogate community board should be established. Dr Tolcher noted she anticipated there would be slippage on publication of the commissioner's strategy for integrated community services.

5.8 Concerns were noted about the workforce capacity and demands faced by the community teams, however it was reported actions implemented by the Trust were starting to have an impact. Dr Tolcher confirmed referrals were reducing as the scope of community services had been clarified, and therefore the caseload for individuals had begun to reduce. Colleagues working in the teams however remained under extreme pressure.

5.9 Mr McLean sought further information about why there was a lack progress on the West Yorkshire and Harrogate STP; why had this occurred and what could be done? Dr

Tolcher said she had received no feedback since the rating was published. She reflected there was a conflict between the local approach and the national 'top down' style; systems with ambitious reconfiguration plans had featured more prominently in the outstanding and good categories. Mr McLean asked if there would be potential consequences for the West Yorkshire and Harrogate STP. Dr Tolcher noted that this was unclear at this stage. Mr Coulter suggested that if in future performance of the STP would determine how capital was allocated, the Board would need to consider how best to align the Trust. Mr Thompson suggested it appeared to be counter-intuitive to invest in a way which resulted in the best areas getting better and those areas which were struggling to be left to help themselves. Mr Harrison said he felt the STP had not effectively sold the local context and narrative; a great deal of historic work to reconfigure services had already been undertaken and therefore the West Yorkshire and Harrogate STP had a different starting point from other areas. Dr Tolcher noted the need for the STP to develop a whole system strategic vision and clinical strategy and to describe this consistently. This process was not helped because West Yorkshire and Harrogate was not a logical unit on which to build plans. Mrs Dodson confirmed the STP was the right configuration for the Trust to be involved within. She noted other local STPs were in the lowest category of STP; "needs most improvement".

5.10 Mrs Webster commented on the CCG annual assessment, and queried the implications because a number of CCGs in the area were rated as 'requires improvement'. Mr Coulter drew attention to the importance of financial position in determining the CCG rating. Dr Tolcher commented CCGs were coalescing into clusters, for example in Leeds and Bradford. It was noted the STP had commissioned YHEC (York Health Economics Consortium) to prepare a plan for the West Yorkshire and Harrogate STP. Mrs Dodson remarked reconfiguration plans in Calderdale and Huddersfield had been referred by the Local Authorities to the Secretary of State for Health and it would be interesting see the outcome.

5.11 Dr Tolcher moved on to report on the Trust's financial position. She provided an overview of the current position; the June in-month deficit was £613k resulting in a year-to-date deficit of £2.8m. This was £3m adverse of the planned financial position. The run rate in June 2017 had been largely the same as May 2017, if it continued for the full financial year the Trust would be £11.8m variance to plan. At the June 2017 meeting Dr Tolcher said she had provided the Board with reassurance that all relevant issues were known by the Executives and were being addressed. The next stage would be to provide assurance about what could be achieved and the implications of this for the Trust. Dr Tolcher confirmed she could not yet provide assurance. The original plan was for a £2.1m surplus which would also secure a further £3.8m sustainability and transformation funding. Although schemes were in place, the total sum did not take the final year position back to the original plan. If all schemes delivered in full, with no unexpected variances, a surplus of £896k would be achieved. In this scenario sustainability and transformation funding would not be provided, and therefore Dr Tolcher could not provide assurance the Trust would deliver the original 2017/18 plan in full.

5.12 Income variances were highlighted, these related primarily to tariff-based income including activity shortfalls, a reduced acuity of case mix and the impact of the new funding calculation, called HRG4+.

5.13 Dr Tolcher reported planned recovery actions totalling £6.8m were being assessed through a risk adjustment process. The remaining £1.2m shortfall had been allocated as additional Cost Improvement Plans (CIPs) and apportioned to directorates. She

confirmed this explained why the percentage of CIP attainment had reduced; because the required total had increased.

5.14 Dr Tolcher reminded the Board there remained nine months in which to recover the financial position, this would be possible if there was no further variance. However it was not possible to provide assurance the plan would be delivered in full by 31 March 2017 until more detailed schemes were confirmed and assessed for quality impact.

5.15 Mr Ward said he felt Dr Tolcher's report included a change in emphasis from June 2017. He quoted from section 5.13 of the June 2017 minutes; 'Dr Tolcher had said the Trust's financial position was recoverable' but she could no longer provide this assurance. Mr Ward noted actions being taken to reduce the deficit, and yet the deficit had increased month on month. It was therefore difficult to consider the plan would be achievable, and he had concerns about where this would leave the Trust. Mr Coulter agreed it would become trickier with each month a deficit was made, more schemes would be required in order to achieve plan.

5.16 It was agreed Mr Coulter should present his finance report at this point in the meeting. He reported a discussion with NHS Improvement to enquire whether it would be possible to alter the Trust's plan. NHS Improvement had confirmed it would not be possible to amend the financial plan.

5.17 As a result of the current position the Trust's financial risk rating was three, not two as planned. There had not been any contact from NHS Improvement as a result of this deterioration. Mr Coulter confirmed the next quarterly meeting with NHS Improvement would take place on 4 August 2017.

5.18 Mr Coulter reported a number of planned actions reported to the Board in June 2017 had been put into place. Changes to the Long Term and Unplanned Care (LTUC) directorate establishment had been implemented. CIP schemes had been re-assessed, and £1.1m had been re-allocated. Of this figure, £400k was genuinely new CIP; the remainder was re-allocated following the inability of LTUC to implement planned bed closures. Dr Scullion and Mr Coulter had held a meeting with clinical leads and attended the July 2017 meeting of the Consultant Forum. The focus of these meetings had been on recovering income and there were helpful suggestions from the consultants in attendance. A recovery plan had been developed to re-build orthopaedic capacity, this was because, unlike other specialties, the level of activity was behind 2016/17. Mr Coulter confirmed progress to recruit new staff to theatres. There had been an amendment to the general surgery consultant of the week model. Finally, Mr Coulter noted work to identify the potential financial benefits of an Alternative Service Delivery Model (ASDM).

5.19 Mr McLean asked whether other parts of the system were experiencing problems with the new HRG4+ funding formula. Mr Coulter confirmed there was concern across other WYAAT Trusts; however each Trust was seeing different issues. Mr Harrison confirmed an action plan was in place; however he reflected that he was concerned the Trust had not changed anything related to coding process and therefore the change was starting to feel real and the Trust may not therefore be able to fully mitigate the apparent impact of HRG4+.

5.20 Mr Harrison explained that under the Trust's coding system HRG4+ limits the number of co-morbidities to 12, the acuity of the most complex patients receiving care is

therefore under-reported. The CCG had indicated they were minded to pay the Trust for this element, which would result in around £250k. The Trust has raised this issue with the PAS provider Silverlink. Other Trusts are similarly affected. Mr Thompson expressed concern that although the CCG may agree to meet this cost the CCG's financial situation would prevent them paying for this activity. Mr Coulter reflected that as long as activity continued to arrive at the Trust the CCG was required to account for this activity. However he noted the timing of the cash settlement would be more difficult. The Trust had received notification from the CCG that NHS England was instructing CCGs to pay Trusts in twelfths. This approach would be counter to the contract agreed between the Trust and HaRD CCG; it had been agreed payment would be in tenths. The issue would be discussed further at a meeting in early August 2017.

5.21 Mr Alldred agreed nothing had changed with regards to the Trust's clinical coding processes; therefore the case-mix change was starting to feel real. Work was underway between clinicians and coders to ensure all information was correctly recorded.

5.22 Dr Tolcher reflected on the Trust's DTOC position and the rising number of non-elective admissions, she asked whether it felt like the Trust was admitting a lower acuity of patients. Mr Alldred confirmed feedback from clinicians did not reflect the patient case-mix changing. Mr Harrison explained in preparation for the implementation of HRG4+ data sets had been put through a test system provided by NHS Improvement. This work did not suggest a marked impact of the introduction of HRG4+ for the Trust. It was suggested recent data would be run through the test system to identify if there was any difference for the Trust. Mr Harrison noted that although this would not alter the actual position, it would help to provide clarity on the impact and position for the remainder of the year. Dr Tolcher reminded the Board HRG4+ was the cost to the commissioner not the true cost to the system; it was an arbitrary not an actual cost. Mr McLean expressed a note of caution, that should the CCG be short on monies, they would come under pressure to only pay what they were contractually bound to pay.

5.23 Mr Coulter provided further detail about actions being undertaken to address income levels. Mr Harrison confirmed after lengthy discussions it had been agreed the Trust would advertise for a locum arthroplasty orthopaedic consultant to start work from September 2017. If however the Trust's orthopaedic team was able to present a credible plan to cover the additional shifts, the advert would be withdrawn.

5.24 It was noted the sterile services department would be located offsite for a total of eight, rather than six weeks. Mr Harrison confirmed this timeline was in line with the original plan; the additional two weeks were a contingency period.

5.25 Mr Ward and Mr McLean sought assurance that the reduced theatre capacity had been taken into account within the revised financial projections. Mr Coulter confirmed yes this position was reflected in his report. Mrs Foster noted Band 5 staffing vacancies in theatres would reduce from 50% to 20% in September 2017, she reflected this was a very positive step forward but noted to improve productivity levels and culture change was required within the theatres team.

5.26 Mr McLean drew attention to the challenge of embedding new teams; he asked how the theatres department planned to address this within the timelines outlined. Dr Johnson explained the theatres' strategy had been shared with all staff, and initial medical feedback was very positive. The strategy would reconfigure teams and change the way some staff were banded. In particular consultants would be paired with a specific team,

each of which would have a Band 7 lead. It was expected this would provide surgeons with confidence and increase productivity. Dr Johnson agreed culture was not easy to change. The speed with which productivity would increase would partly depend on the speed at which teams were reconfigured. Mr Harrison concurred, he said feedback he had received suggested confidence was returning and the strategy had gone down well with staff, and this in itself had boosted morale. Dr Tolcher noted real time information was available about the productivity of each theatre list, and many were finishing early and starting late, therefore the time available was not being maximised, this was a key message for consultants.

5.27 Mr Marshall and Dr Scullion provided feedback about progress to review the Trust's approach to managing professional leave. Dr Johnson noted concern from the Royal Colleges about Trusts reducing professional leave. It was agreed a clear process and governance support to professional leave was required. In light of this proposal concerns were raised about the sum allocated to professional leave within the revised financial plan, Mrs Webster suggested the action should be re-forecast to show a best and worst case scenario. Mr Thompson asked how other Trusts within WYAAT approached professional leave; Dr Scullion said there was no consistency of approach between Trusts. He noted changes would be met with a certain amount of cultural resistance. In conclusion Mrs Dodson reflected professional leave was worthy work, but it should not be an invisible cost to the organisation.

5.28 With regards to access for extra endoscopy sessions at Wharfedale hospitals, Mrs Dodson offered to intervene and escalate the issue to the chair at Leeds Teaching Hospitals Trust. Mr Harrison thanked Mrs Dodson for this offer, but confirmed he was confident the issue would soon be resolved.

5.29 Mr Coulter explained actions taken in relation to managing expenditure. The amendment to the nursing establishment in LTUC had been implemented. Mr Alldred noted this had required manual adjustments to the rotas which had already been published. Recruitment of care support workers was ongoing, and the Trust was working with NHS Professionals to have up to 20 care support workers available on a bank.

5.30 Mr Thompson commented the Trust were consistently under the required number of registered nurses. Following the revision to the nurse establishment for LTUC, he queried whether the staffing targets needed to be re-set. Mrs Foster confirmed the Trust had a 98% fill rate which was a good level, although some wards have been re-set. Mr Harrison noted the assessment of nurse numbers took into account bed closures being sustained.

5.31 Mr Coulter confirmed a Trust medical bank was on track for establishment; a business case was currently being developed. Mr Marshall explained the new model would result in the Trust making savings on VAT and would help to increase fill rates.

5.32 Mr Coulter noted the challenges faced by community services teams, current levels of demand meant reducing costs to meet the contract value would be difficult. There was high sensitivity about this area.

5.33 Mrs Webster commented the overall plan presented did not outline a best case and worst case scenario for the Trust; each action should be risk adjusted. Mr Coulter agreed this would be presented in August 2017, he noted the importance of supporting Quality Impact Assessments.

5.34 Mrs Dodson emphasised the view of the Non-Executive Directors that the financial recovery should focus on income and expenditure, rather than amendments to accounting methodology. Mr Coulter agreed that although there would be a number of 'one offs' which could be recognised within 2017/18, the Trust's income and expenditure must be balanced recurrently.

5.35 Mr McLean noted when the original budget was set it didn't take into account the proposed 'one off' items, the Board should not mislead themselves about the impact of these specials. In effect the Trust had under-performed on the trading position, and the trading position should remain the focus. Mr Harrison noted development of an ASDM had been part of original 2017/18 plan. Mrs Dodson remarked this item was commercial in confidence and would be considered in the private section of the meeting.

5.36 Mr McLean sought further information about annual leave accrual; Mr Coulter explained the Trust's accounts included a provision for annual leave time owed to staff. The Trust's policy has been altered and the ability to carry leave between years had been removed. This amendment would be a pure one off financial adjustment. Mr Thompson confirmed he was happy with this position which would be subject to audit.

5.37 Mrs Webster expressed concern about release of the Board contingency; she asked if this fund had been allocated to anything particular. Mr Coulter explained the fund had not been allocated anything specific – it was set aside to mitigate unforeseen risks. Dr Tolcher said it could be argued the deficit was due to one off items. It was agreed this fund should be released at an appropriate point in the year. Mr Thompson advocated the Trust should look to create a Board contingency in 2018/19.

5.38 Drawing this section of the meeting to a conclusion, Mrs Dodson noted some actions were more risky than others. Mr Ward welcomed the range of actions planned, but noted if there were any unexpected issues the financial position would slip away. He acknowledged the seriousness of the Trust's position. Mr Thompson said he left the meeting with greater confidence about the realism in place. He remarked on the number of queries raised by directors which had provided additional granularity, and confirmed a responsible and realistic approach had been adopted.

5.39 Mr Marshall reflected his frustration that an organisation which was able to demonstrate strong performance was unable to access capital because it was now linked to an STP. Mrs Dodson agreed but commented the STP system was not something the Trust was able to change.

5.40 Mr McLean reflected the case-mix issue was still not fully understood; there was a high level of demand and yet the Trust's income was not at the level expected. Although he was aware it was provocative, Mr McLean said it could be suggested the Trust was not being run properly, he queried whether too much management capacity was being pulled away to focus on the wider NHS system. Mr Coulter responded this was something to reflect on. He noted the need to engage with the STP in order to access system rewards. A significant amount of time had been spent on the local CCG; this was disproportionate to the services commissioned. Dr Tolcher said she endorsed Mr Coulter's description. She agreed the Trust was not achieving the operational efficiency necessary to make the margin required.

5.41 In conclusion Dr Tolcher said that although she could provide reassurance

regarding diagnosis of the issues and plans to resolve these, she could not yet give assurance that the original plan would be delivered. Work was underway to objectively forecast the plan on a risk adjusted methodology. It was essential all Trust staff were working and optimising their own performance.

**APPROVAL:**
**The Board of Directors noted the strategic and operational updates.**
**The Board of Directors noted progress on risks recorded in the BAF and Corporate Risk Register and confirm that progress reflects the current risk appetite.**
**The Board of Directors agreed to convene a private meeting of the Board in August**

**6.0 Integrated Board Report**

6.1 The report had been circulated in advance of the meeting and was taken as read. Mrs Dodson invited comments and questions.

6.2 Mrs Webster sought further information about the case of Carbapenemase-Producing Enterobacteriaceae *(CPE).* Mrs Foster confirmed the patient had been successfully transferred to Leeds and in response to the situation, a programme of cleaning had been undertaken and other patients had been re-located. A lesson learned exercise was ongoing. Mrs Foster paid credit to the staff in the intensive care unit and the facilities and estates staff who had worked very hard to get the unit back up and running quickly.

6.3 Mrs Webster asked for further information about actions to improve the number of staff who has completed an annual appraisal. Mr Marshall confirmed he had discussed the issue with the Trade Unions and sought their help to drive performance. He also noted the development of a new 'appraisal on a page' approach which had been circulated to staff for consultation. It was noted the appraisal figure was slightly skewed because it had been agreed the Children's and Countywide directorate would be able to complete appraisals over a rolling 12 month period.

6.4 Mr Thompson expressed his congratulations for the significant improvement in publication of rosters. Mrs Foster thanked Mr Thompson for his comment; she noted the huge effort from all staff involved, it was clear the team was now getting traction to resolve this issue.

6.5 Mr Thompson moved on to comment on the exit interviews pilot project and queried why this was not being used across all areas as a priority. Mr Marshall confirmed exit interviews already took place across the Trust, the pilot was testing interviews with staff before they decided to leave the Trust in an effort to retain staff, this was focused on nurses and registered care support workers.

6.6 Mr Thompson drew attention to agency spending; he queried whether the Trust should re-set the 3.5% ceiling. Mr Marshall confirmed he was working with Mr Coulter to re-assess the agency spend line. Work to establish an internal medical bank was noted, it was anticipated this would result in a fall in agency spending. The Trust was working with other providers across WYAAT to offer a common rate across WYATT.

6.7 Mr Coulter remarked the Trust's performance across NHS England performance measures was almost all green. Mr Harrison noted final verification of figures for the cancer screening measure had confirmed the Trust had achieved the target of 92%. Mrs

Dodson reflected the importance of remembering this context; the Trust was a high performing organisation.

**APPROVED:**
**The Board of Directors received and noted the contents of the report.**

**7.0 Report by the Finance Director including CIP update**

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

7.2 It was noted the report had been considered within agenda item 5. Members of the Board confirmed there was no further comment or questions about the CIP update.

7.3 It was agreed authority would be delegated to the Finance Committee to approve the submission of the 2016/17 reference costs to NHS Improvement.

**APPROVED:**
**The Board of Directors received and noted the contents of the finance report.**
**The Board of Directors delegated authority to the Finance Committee to approve the submission of the 2016/17 reference costs to NHS Improvement.**

**8.0 Report from the Chief Operating Officer**

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

8.2 Mr Harrison highlighted Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) had paused their new development at Cardale Park. As a result it had been confirmed TEWV would continue to occupy the Briary Wing until 2020. Although this was disappointing, it did mean the Trust would continue to receive rent and the costs of the site would be covered. Following a question from Mr Thompson, Dr Tolcher confirmed TEWV had provided a letter to indicate their intention but had not given notice on the Briary Wing. Mr Harrison noted the Trust had been subject to increased rent reviews on property occupied outside Harrogate, as a result the Trust would review rent charged for occupancy of its properties.

8.3 It was acknowledged TEWV were reviewing their clinical strategy to ensure patients were treated in the right setting. HDFT clinicians were engaging with TEWV to comment on the revised approach. Dr Tolcher suggested if there was no on-site mental health expertise there was a risk this could impact on the Trust's ability to manage patients with mental health illness. It was important mental health patients did not end up in medical beds unnecessarily.

8.4 In light of the two week delay to the SSD programme, Mr Thompson expressed surprise the associated risk had been removed from the corporate risk register. Dr Tolcher said the mitigations to address this risk had been judged to be sufficiently strong and therefore the risk had been removed. Mr Harrison remarked the timeline for the SSD project had always covered eight weeks; the two week contingency had been deployed. Mr Coulter added this had moved to be an issue which was being managed operationally, rather than a risk.

8.5 Mrs Webster asked for further information about inter-provider transfer performance, she queried why there were two measures. Mr Harrison explained the

historic inter-provider rules meant any breach was shared equally between providers. New rules, based on a pilot in Greater Manchester, would mean any provider transferring a patient by day 38 would not receive a breach, would apply from 2018/19. However each area had been given local discretion to develop their own approach, therefore there were three methodologies being applied. Mrs Dodson welcomed the new methodologies which provided more transparency about patient care. Mrs Webster suggested future reports should present the three methodologies in a chart format. Mr Harrison explained historically the new measurement would have benefited HDFT, but this had not been the case during the month or quarter.

8.6 Concerns were expressed by Mr McLean about the Trust's performance against the cancer measures. Mr Harrison noted the number of patients included were very small in number. Mr Alldred provided reassurance that the Trust's cancer pathways were very good, resilient and reliable. This was evidenced by green performance against other cancer measures and the results of the Macmillan cancer survey.

**APPROVED:**
**The Board of Directors received and noted the contents of the report.**

**ACTIONS:**
- **Present inter-provider transfer data in a chart format.**

**9.0 Report by the Director of Workforce and Organisational Development to include an update on the Clinical Workforce Strategy**

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

9.2 Mr Marshall drew attention to the tea party on 24 July for staff to mark both Celebrating Success Awards and Long Service Awards. The 'Growing Healthy' bus was the overall winner.

9.3 The latest job planning figures had shown an increase; Mr Marshall expressed his thanks to the directorates for their support in achieving this. It was noted implementation of Schedule 15 sanctions, whereby doctors who have not completed an appraisal, a Job Plan and their Mandatory and Essential training, would not be allowed to take their annual pay progression. He commented this was likely to have a positive effect on Job Planning rates. The HR team were liaising with consultants who had not returned the necessary paperwork.

9.4 The recruitment process for the new Chair was progressing well. Twelve applications had been received and a longlisting meeting would take place during the afternoon of 26 July 2017.

9.5 The Global Health Exchange Programme was demonstrating positive results, the Trust had interviewed, and conditionally offered jobs to 17 international nurses, taking the current project total to 19.

**APPROVED:**
**The Board noted and commented on the update on matters specific to Workforce, Training and Education, Service Improvement and Innovation and Organisational Development.**

**10.0 Report from the Chief Nurse**

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

10.2 Mrs Foster said she was pleased that following recent director inspections, all wards visited were green. She noted the detail included within her report about recent patient safety visits, she said it was important to recognise the valuable actions the Trust has taken as a result of these visits.

10.3 Mrs Foster noted concerns had been reported to the Board previously about potential delays to patients as a result of a referral management service commissioned by the CCG. She explained an interim report and audit had been received from the CCG regarding the service which was provided by About Health. The conclusion of the audit was that out of 5,200 patients referred by GPs, 52 people had been deemed to have been subject to a delay due to the referral management process. These 52 patients were being monitored by CCG, and all but one had now received an appointment. The Trust's team were working hard to get this patient an appointment. The CCG were working to assess any impact of the delay on the outcome for these patients. Mrs Foster confirmed she had pushed the CCG to secure assurance about future safety netting mechanisms. Following a question from Mrs Dodson, Mrs Foster confirmed the CCG has declared the issue as a Serious Incident, and had undertaken to provide a copy of the concluding report to the Trust. The investigation had been undertaken by About Health; Mrs Webster queried whether assurance could be drawn from the findings if the provider had undertaken the investigation themselves. It was noted this was the usual process for NHS investigations. Mr Harrison said he was assured the CCG had taken all necessary steps. Dr Tolcher agreed the Board needed to trust the CCG's governance process.

10.4 Dr Tolcher noted a separate but related issue regarding compliance by the Trust with national guidance about measurement of 18 week targets, due to the referral management service (RMS). Mr Harrison said the Trust was working with the CCG to resolve this issue; currently the Trust was unable to technically report performance within the national rules. NHS Improvement and NHS England were both aware of this technical breach which is likely to also be affecting our systems where a RMS was operating.

10.5 It was noted section 2.3 of the report was incorrect, Mrs Foster confirmed Littondale ward were now rated as green, not red.

10.6 Mrs Foster drew attention to the UNICEF Baby Friendly initiative; the Trust had held the accreditation for a number of years. Mrs Foster said she had received confirmation that the Durham and Darlington service had been successfully re-accredited, other services would be re-assessed in August 2017.

**APPROVED:**
**The Board of Directors:**

- **Confirmed they were assured by the monitoring of nurse recruitment and retention and the governance process for assuring safe staffing levels;**
- **Noted the results and changes to the reporting of Director Inspections;**
- **Noted the decrease in numbers of complaints received by the Trust in June 2017;**
- **Noted the update regarding the Referral Management Service;**
- **Acknowledged the work to improve standards for mothers and babies.**

**11.0 Report from the Medical Director and Report from the Guardian of Safer Working**

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

11.2 Dr Scullion thanked Dr Hall for preparing the report. He noted an amendment to the report; Dr Scullion was the executive lead for the Yorkshire and Humber Genomic Medicine Centre, assisted by Dr Daniel Scott.

11.3 Dr Scullion referred to the Guardian of Safe Working report. He confirmed the internal issues highlighted by the report were being dealt with. However he reflected the general wider messages about the health system were quite alarming; junior doctor recruitment rates were an issue across the NHS. Mr Marshall said he was working to address these gaps as part of the North Locality Partnership Board. Concerns about trainee gaps had been shared with Health Education England (HEE), Mr Marshall advocated a move to a local solution driven by local employers. It had been agreed by HEE the issue would be added to the HEE corporate risk register, it was therefore hoped further clarity about the associated solutions would be provided.

11.4 Mr McLean referred to Dr X and the issue being investigated by the Yorkshire Deanery, he asked whether this would be prejudicial to the Trust. Dr Scullion agreed this was a serious issue and could potentially mean the Trust would receive prejudicial treatment. However he confirmed HDFT was generally held in good standing by the Deanery, assurance had been provided that the Trust was taking the concerns seriously.

11.5 Mr Thompson welcomed the crude mortality graph and asked how the Trust should be performing against the data. Dr Scullion remarked the data was showing a positive trend, but did not tell the Board very much. He noted updated SHMI and HSMR data would be available in September 2017. Mrs Dodson suggested it was good for the Board to receive the data on an annual or bi-annual basis. The data demonstrated under-lying improvement, and was helpful in the context of SHMI and HSMR measures.

**APPROVED:**
**The Board of Directors:**

- **Received and noted the contents of the report.**
- **Considered the points raised in the conclusion of the safe working report.**

**12.0 Oral Reports from Directorates**

**12.1 Planned and Surgical Care Directorate**

12.1.1 Dr Johnson reported the sterile services department were currently operating off-site due to planned ongoing refurbishment of the Trust's facilities. The resulting reduction in theatre activity had been factored into forecast activity levels. However Dr Johnson noted there was some nervousness within the team about the impact of this reduced activity. She confirmed the directorate were working to add extra activity in the autumn 2017 period.

12.1.2 Dr Johnson said gastroenterology remained a 'hot spot'. A recent recruitment process had failed to identify any suitable consultant candidates, and it was noted the Trust already employed a long-term locum. Recruitment in the specialty was a national issue with other Trusts reported to have paid 'golden handshakes' to

recruit consultants. This staffing issue was causing an issue with activity; the team were reviewing all follow-ups not seen. Dr Johnson suggested the Trust's long-term strategy in this area required further discussion by the Executive Team, she confirmed a strategic review of the gastroenterology service had already started. It was agreed the Senior Management Team would consider this issue further and updates would be provided to the Board through Dr Johnson's verbal update to the Board.

12.1.3 It was reported there had been instances of consultant sickness, these were for valid reasons, and the directorate had picked up the work without the need to engage support from agencies.

12.1.4 Dr Johnson concluded by sharing details of funding received by the maternity department from the Department for Health to provide 'human factors' training. It was suggested this training would be helpful for the Board at a future development session.

**ACTIONS:**

- **Strategic review of the gastroenterology service to be completed and considered by the Senior Management Team. Further updates would be provided to the Board through Dr Johnson's verbal update to the Board**
- **Add 'human factors' training to a future Board development session.**

**12.2 Children's and County Wide Community Services Directorate**

12.2.1 Dr Lyth noted the UNICEF re accreditation for Durham and Darlington, as reported by Mrs Foster.

12.2.2 Dr Lyth explained many of the directorate's contracts were 'block' contracts which meant the team could not increase activity to bring additional income. The directorate was therefore undertaking reviews to ensure commissioned services were being delivered efficiently. In some instances this work was being undertaken in partnership with the commissioners. It was however noted not all services were supported by detailed service specification, and there had been instances where new service specifications developed by CCGs did not fit with what the Trust currently delivered.

12.2.3 The directorate were being asked for an increasing amount of performance data. Services were gradually moving onto SystmOne which would facilitate preparation of data. Dr Lyth reported the team were gathering data to support a neonatal review.

12.2.4 A draft copy of the CQC CLAS (Children Looked After and Safeguarding) report for North Yorkshire had been received and was being checked for factual accuracy. It appeared the report mirrored the verbal feedback received following the inspection. Implementation had commenced on a follow-up action plan prepared following the inspection.

**12.3 Long Term and Unscheduled Care Directorate**

12.3.1 Mr Alldred noted the Board had already discussed a number of issues relating to the directorate, he would therefore focus on matters not already discussed.

12.3.2 It was disappointing that the acute oncology consultant locum engaged to support from September 2017 had confirmed they were no longer able to work for the Trust. Dr Alldred explained the service was fragile and the Trust continued to work with Leeds and York to develop a long term solution for the service.

12.3.3 Harrogate Commissioners had confirmed their intention to test the market in relation to the GP Out of Hours service. The directorate was considering how the Trust should respond.

12.3.4 Mr Alldred said the Community Care Teams were under continued pressure and therefore remained a focus for the directorate. There was however evidence that measures implemented to manage demand had started to have an impact and there had been a reduction in demand.

12.3.5 A consultant neurologist had been appointment and would start with the Trust in late January 2018; this would support the service to be resilient.

**13.0 Committee Chair Reports**

Mrs Dodson welcomed reports from the Board's committees.

**13.1 Report from the Quality Committee meeting held on 5 July 2017**

13.1.1 Mrs Webster confirmed the Quality Committee had met on 5 July 2017. The report had been circulated in advance of the meeting and was taken as read. There continued a focus on cannula care.

13.1.2 Mrs Webster noted an action from the Board Strategy day on 20 July, which related to concerns about end of life care. The Committee would work with Mrs Foster to consider this matter further.

**ACTION:**

- **Quality Committee to seek assurance about concerns raised about end of life care services.**

**14.0 Other matters relating to compliance with the Trust's Licence or other exceptional items to report, including issues reported to the Regulators**

14.1 Mrs Dodson noted the refreshed annual updated of the third party schedule. The report had been circulated in advance of the meeting and was taken as read.

**RECOMMENDATION:**

- **The Board received the updated Third Party Schedule.**

**15.0 Any other relevant business not included on the agenda**

15.1 Mrs Dodson noted the next public meeting of the Board would be on 27 September 2017. She noted a private meeting of the Board would take place in August 2017; this meeting would include consideration of strategy which was commercial in

confidence and further oversight of the Trust's finances.

## 16.0 Board Evaluation

Mrs Dodson reflected that the meeting had focused on finance and issues within and that other areas had been touched upon appropriately.

Members of the Board confirmed the meeting had included the right use of time and there had been fair and reasonable challenge.

Dr Tolcher acknowledged the meeting was unusually skewed to focus on finance. It was hoped this would not continue once detailed analysis of the financial position was complete in August 2017.

Mrs Webster noted that in the private session the Board would also consider new business opportunities as another way to build financial resilience.

Mr McLean reflected the Board had not discussed the consequences and implications for the organisation if the financial position did not improve. Mrs Dodson said it was crucial the Board should delve into the detail of the financial issues facing the Trust. Future meetings would need to include open and difficult discussions about the consequences if performance did not improve.

Dr Tolcher remarked although the meeting was in public there had been open, truthful and transparent discussions. The Trust's financial positon would be reflected in the regular briefing to the Trust's stakeholders.

## 17.0 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 12.27pm.

Harrogate and District NHS Foundation Trust

# HDFT Board of Directors Actions Schedule as at September 2017
# Completed Actions

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

| Item Description | Director/ Manager Responsible | Date of completion/ progress update | Confirm action Complete |
|---|---|---|---|
| To include a bi-annual report on progress against the Clinical Workforce Strategy action plan to the Board on the Board Forward Plan | Dr R Tolcher, Chief Executive | February 2017 | Complete – included at Board to Board on 31 May 2017 |
| Update on the standardised readmissions | Mr R Harrison, Chief Operating Officer | February 2017 | Complete – included in Chief Operating Officer report in May 2017 |
| A report on absconding patients to be brought back to the Board after review by SMT. | Mrs J Foster, Chief Nurse | April 2017 | Complete – included within Chief Nurse report May 2017 |
| A report on progress against the implementation of the Stroke Improvement Plan to be received by the Board | Mr R Harrison, Chief Operating Officer | May 2017 | Complete – included in Chief Operating Officer report in May 2017 |
| Terms of Reference for the Board of Directors to be amended and brought back to the board for Approval | Mr B Courtney, Interim Company Secretary | May 2017 | Complete – approved by the Board in May 2017 |
| BAF to be reviewed in order to ensure the risk of cyber-attacks was appropriately reflected. | Mr R Harrison, Chief Operating Officer & Katherine Roberts, Company Secretary | June 2017 | Complete –BAF reviewed during June 2017, no amendments were required |
| Views would be sought from the Director of Infection Prevention and Control about suspending the rolling programme of additional deep cleaning during 2017/18 | Dr R Tolcher, Chief Executive | June 2017 | Complete – meeting held 1 June 2017 |
| Consider the Trusts financial position in further detail and consider the format of the finance report (including a rolling forecast). | Finance Committee | June 2017 | Complete – discussed at meeting on 19 June 2017 |
| Additional information on learning from cases of C. Diff and associated action planning during 2015/16 to be included in the annual report (6.3) | Mrs J Foster, Chief Nurse | February 2017 | Complete June 2017 |
| A report of the effectiveness of Quality of | Mrs J Foster, Chief Nurse | June 2017 | Complete June 2017 |

| Item Description | Director/ Manager Responsible | Date of completion/ progress update | Confirm action Complete |
|---|---|---|---|
| Care Teams to be brought to the Quality Committee in three months | | | – reported in May Quality Committee report |
| Review measures to ensure safer staffing levels were better linked to levels of ward activity | Chief Nurse, Jill Foster | June 2017 | Complete June 2017 |
| IBR would be amended to ensure that future reports would only include validated data for Children's services measures | Mr R Harrison, Chief Operating Officer | June 2017 | Complete June 2017 |
| Provide feedback to the Board following the 'Getting It Right First Time' meeting on 22 June 2017. | Dr Scullion, Medical Director | June 2017 | Complete June 2017 |
| Provide an update on progress with regard to actions associated with Corporate Risk Register CR8: risk of ophthalmology patients being lost to follow up (6.13) | Dr K Johnson, Clinical Director | April 2017 | Complete June 2017 |
| Further update on progress of the Care of Frail Older People Strategy (11.2.3) | Mr A Alldred, Clinical Director | May 2017 | Complete July 2017, part of Board Strategy Day on 20/07/2017 |
| Update on the programme of work to reduce hospital admissions (9.3) | Mr A Alldred, Clinical Director | May 2017 | Complete July 2017, part of Board Strategy Day on 20/07/2017 |
| Update on progress of internal and system wide work to improve discharge planning to *Board Strategy Day* (7.4) | Mr R Harrison, Chief Operating Officer | May 2017 | Complete July 2017, part of Board Strategy Day on 20/07/2017 |
| • Re-admission rates to be the subject of a deep dive at the Board Strategy Day on 15 March 2017.<br>• Benchmarking data on re-admissions to be shared with the Board prior to 15 March. | Mr R Harrison, Chief Operating Officer | May 2017 | Complete July 2017, part of Board Strategy Day on 20/07/2017 |
| Proposals for a revised format for the Strategic KPI Report to be brought back to the Board Strategy Day | Dr R Tolcher, Chief Executive | July 2017 | Complete July 2017, part of Board Strategy Day on 20/07/2017 |
| Board strategy day to include consideration of the Board's vision for the future Trust and a focus on ways to drive up productivity within the organisation | Dr R Tolcher, Chief Executive | July 2017 | Complete July 2017, part of Board Strategy Day on 20/07/2017 |
| A meeting of the Board of Directors would be held in August 2017. | Mrs S Dodson, Chairman / Mrs K Roberts, Company Secretary | August 2017 | Complete –meeting of the Board to be |

| Item Description | Director/ Manager Responsible | Date of completion/ progress update | Confirm action Complete |
|---|---|---|---|
| | | | held in private scheduled for August 2017 |
| Research succession plan to be presented to the Board | Dr R Tolcher, Chief Executive | July 2017 | Complete – details included in Medical Director report July 2017 |
| Explore option to include WHO checklist within new theatre dashboard. | Mr Coulter, Director of Finance | July 2017 | Complete – closed by Board in July 2017, option explored and found not to be viable. |
| Additional information to be included in the IBR relating to readmissions of older people.<br>Update on reducing readmissions in older people to be submitted to the September Board meeting (8.9) | Mr A Alldred, Clinical Director | July 2017 | Complete – Revised IBR presented in September 2017 |
| IBR to be reviewed by a small group post April 2017. | Mrs S Dodson, Chairman | July 2017 | Complete – Revised IBR presented in September 2017 |
| Consider how the Integrated Board Report would capture improved efficient within theatres | Mr Coulter, Director of Finance &<br>Mr R Harrison, Chief Operating Officer | July 2017 | Complete – Revised IBR presented in September 2017 |
| Review KPIs included within the Integrated Board Report. | Non-Executive Directors, Mr Coulter, Director of Finance &<br>Mr R Harrison, Chief Operating Officer | July 2017 | Complete – Revised IBR presented in September 2017 |
| Financial plan to be risk assessed and be re-presented to Board meeting in July. | Mr Coulter, Director of Finance | July 2017 | Complete – presented to the Board in private session in August 2017 |
| Register of Interests to be updated to reflect new interests for Dr Tolcher and Mr Ward. | Katherine Roberts, Company Secretary | August 2017 | Complete – interests added in August 2017 |
| Add ‘human factors’ training to a future Board development session. | Katherine Roberts, Company Secretary | September 2017 | Complete – session planned for autumn 2017 |

NHS
Harrogate and District
NHS Foundation Trust

# HDFT Board of Directors Actions Schedule – Outstanding Actions as at September 2017

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

| Ref | Meeting Date | Item Description | Director/Manager Responsible | Completion date | Detail of progress |
|---|---|---|---|---|---|
| 4 | November 2016 | A recommendation paper to be submitted to Board on the Trust's substantive nursing workforce requirements. | Mrs J Foster – Chief Nurse | September 2017 | **Update included in Chief Nurse report** |
| 46 | May 2017 | During the planned Finance Committee self-assessment, consideration would be given to the committee's terms of reference and ensuring an appropriate balance of focus on short term financial management and longer term strategic issues | Mrs Maureen Taylor, Chair – Finance Committee | December 2017 | |
| 49 | June 2017 | Sentinel Stroke National Audit Programme; following completion of 'hot spot' review, action plan will be presented. | Mr R Harrison, Chief Operating Officer | October 2017 | |
| 50 | June 2017 | Assurance to be provided to July meeting of the Board that fire risk assessments are up to date for all sites occupied by the Trust. | Mr R Harrison, Chief Operating Officer | July 2017 | **Partially complete**<br><br>**Details included in Chief Operating Officer report; assurance awaited from NHS Property Services.** |
| 52 | July 2017 | Chief Operating Officer report should inter-provider transfer data in a chart format | Mr R Harrison, Chief Operating Officer | September 2017 | |
| 53 | July 2017 | Strategic review of the gastroenterology service to be completed and considered by the Senior Management Team. Further updates would be provided to the Board through Dr Johnson's verbal update to the Board. | Dr Kat Johnson, Clinical Director Planned and Surgical Care | October 2017 | |
| 55 | July 2017 | Quality Committee to seek assurance about concerns raised about end of life care services. | Lesley Webster, Non Executive Director / Jill Foster, Chief Nurse | September 2017 | |

NHS
Harrogate and District
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Date of Meeting:** | 27 September 2017 | **Agenda item:** | 5.0 |
| **Report to:** | Board of Directors | | |
| **Title:** | Report from the Chief Executive | | |
| **Sponsoring Director:** | Dr Ros Tolcher, Chief Executive | | |
| **Author(s):** | Dr Ros Tolcher, Chief Executive | | |
| **Report Purpose:** | **Decision** ✓ **Discussion/ Consultation** **Assurance** **Information** ✓ | | |
| **Executive Summary:** | There was no public Board of Directors meeting in August and this report therefore covers the last two months of operation.<br>• The Trust reported a deficit of £5.2m at the end of August. The run rate has improved and expenditure in month 5 was largely on plan. Actions to recover income have commenced and impact will build incrementally.<br>• All four of the key operational metrics of the NHSI Single Oversight Framework have been achieved year to date.<br>• Bed occupancy rates remain high and workforce gaps present significant challenges | | |

| **Related Trust Objectives** | | | | | |
|---|---|---|---|---|---|
| **To deliver high quality care** | ✓ | **To work with partners to deliver integrated care:** | ✓ | **To ensure clinical and financial sustainability:** | ✓ |

| **Key implications** | |
|---|---|
| **Risk Assessment:** | Strategic and operational risks are noted in section 7. Risks associated with this report are reflected in the Board Assurance Framework: BAF 14: risk to deliver of integrated models of care; BAF 15: misalignment of partner strategic plans; and BAF 9; failure to deliver the operational plan. |
| **Legal / regulatory:** | There are no legal/regulatory implications highlighted within the report. |
| **Resource:** | There are no resource implications highlighted within the report. |
| **Impact Assessment** | Not applicable |
| **Conflicts of Interest:** | None identified. |
| **Reference documents:** | • Improved Better Care Fund / DTOC: https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/<br>• Single Oversight Framework Consultation: https://improvement.nhs.uk/resources/updating-single-oversight-framework-share-your-views/<br>• Freedom to Speak Up Guardian Survey www.cqc.org.uk/sites/default/files/20170915_freedom_to_speak_up_guardian_survey2017.pdf |

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

- The Board is requested to **note** the strategic and operational updates
- The Board is asked to **note** progress on risks recorded in the BAF and Corporate Risk Register and **confirm** that progress reflects the current risk appetite.
- The Board is requested to **endorse** use of the Trust's seal as detailed in the report.

## 1.0 MATTERS RELATING TO QUALITY, PATIENT EXPERIENCE AND PERFORMANCE

### 1.1 Operational Performance

In Quarter 2 to date the Trust has achieved all four of the operational key metrics of the NHS Improvement (NHSI) Single Oversight Framework, however the deteriorating trend in respect of RTT (referral to treatment times) has continued and this standard is at risk for this quarter. Actions to correct this position must be taken in parallel with actions to achieve a sustainable financial run rate.

The Trust continues to run with some significant gaps in our registered workforce, particularly ward based nurses and acute service medical staff. These staffing challenges and the continued increase in medical non-elective (NEL) admissions reported in prior months mean that services are working exceptionally hard in order to sustain safe care and a good patient experience in the face of high occupancy rates.

Reducing reliance on high cost agency staffing remains a key objective for the Trust with steps being taken to both fill gaps with substantive appointments and reduce bed numbers to current establishments. Non elective activity year to date is 3% above plan and 4.5% above the same period last year. A sustained increase in Delayed Transfers of Care (averaging 6-8% compared to a contract standard of 3.5%) and high rates of medically fit for discharge patients in acute beds are further contributing to relatively high occupancy rates. A number actions designed to ensure a clinically appropriate length of stay have been taken, however our mean NEL length of stay at 5.3 days remains above the national average and peer benchmarks.

A cost improvement plan based on seasonal bed reductions has been partially successful with 20-30 beds closed for most of the period to date.

There is a growing concern from global data that influenza rates will be higher this winter and that this will further impact on demand and workforce. A ‘flu vaccination campaign will commence shortly.

### 1.1 Financial Recovery Plan

The Trust has a Financial Recovery plan in place designed to correct the adverse performance year to date and to make sustainable changes to how services operate so that a new balance is achieved. There is an ongoing dialogue with NHSI and a further meeting with NHSI has been scheduled.

Actions taken during Month 5 achieved at £319k run rate improvement against a planned improvement of £466k. Further actions initiated should achieve a more substantial improvement in month 6 and beyond. Further details are contained in section 4 of this report and the report from the Finance Director.

The Trust is also working with our main commissioner, Harrogate and Rural District Clinical Commissioning Group on a joint financial recovery plan due to be submitted to NHSI/NHS England at the end of September.

## 2.0 STRATEGIC UPDATE

### 2.1 West Yorkshire and Harrogate Health and Care Partnership (STP) and West Yorkshire Association of Acute Trusts (WYAAT) update

The West Yorkshire and Harrogate Sustainability and Transformation Partnership has been renamed the West Yorkshire and Harrogate Health and Care Partnership, in line with a national directive.

A memorandum of understanding between all organisations involved in the West Yorkshire and Harrogate Health and Care Partnership is being developed. This will be an opportunity to strengthen mutual accountability arrangements and provide a level of assurance to NHS England / NHSI which would facilitate greater control of funding within West Yorkshire and Harrogate, and potentially to establish the risk/reward approach for a single system control total.

A meeting of the WYAAT Committee in Common took place on 10 August 2017. The meeting received an update from Ian Holmes (STP Programme Director). The region's STP has been rated as 'making progress' in the National Dashboard. He explained the rating was largely based on national Key Performance Indicators with an element influenced by leadership. West Yorkshire and Harrogate is an outlier on hospital acquired infections, emergency bed days, NELs and extending access in primary care. As a result of this rating, no first round capital funding would be available for West Yorkshire and Harrogate. It was recognised more work was required to align the narratives from the STP and WYAAT. Furthermore it was agreed additional work should be undertaken on the mission and vision of WYAAT and a supporting medium term clinical strategy to deliver this vision.

The Committee received an update on work streams. Positive progress on the procurement work stream was noted. There was an update on efforts to form a single network for vascular services, it is expected this will be agreed by April 2018. The elective care project initiative document was supported. The pharmacy supply chain and imaging collaborative cases for change were approved.

Matt Graham has commenced in the role of WYAAT Programme Director following the departure of Caroline Griffiths (Interim Programme Director).

Plans are underway for a workshop for Foundation Trust governors from organisations across the West Yorkshire and Harrogate Health and Care Partnership to take place in autumn 2017. This event will provide governors with further information about the West Yorkshire and Harrogate Health and Care Partnership and WYAAT and consider the role of governors in these new partnerships.

Two WYAAT facilitated development session have been held. The first session was for WYAAT CEOs and the second, held on 19 September included the full executive team of each WYAAT Trust. These sessions explored the case for collaboration and the areas in which collaboration would offer benefits in terms of care quality, equity and financial sustainability. Further work will be undertaken to describe potential areas for collective decision making and the principles on which such decision could be made.

NHSI hosted a Leadership Seminar in York on 15 September at which a number of speakers described progress in other STP areas. The predominant model emerging from the trailblazers is one of Accountable Care Systems (ACS) in which health and care providers and commissioners come together to take responsibility for outcomes and financial balance. Approximately 20% of the population of England is now covered by

these ‘ACS’ areas. NHSI/NHSE are describing a phased handover of responsibilities and resources so that the focus of ACS development shifts from the current state (dominated by partnerships and planning) to a future state of ACSs taking responsibility for performance and delivery. An incremental devolution of resources will operate in parallel. ACS should ensure that commissioner and provider plans are completely aligned and that some enduring challenges eg wider determinants of health, and workforce constraints are owned and tackled a ‘place’ level. The governance models of ACS’s vary with no one size fits all.

The West Yorks and Harrogate Health and Care Partnership approach aligns with the evolution of ACSs elsewhere, including local ‘place’ based plans or Accountable Care Partnerships. The position in the Harrogate ‘place’ is still developing.

## 3.0 WORKING IN PARTNERSHIP

### 3.1 Better Care Fund (BCF) and Delayed Transfers of Care (DTOC)

In July 2017 the Department of Health and the Department for Communities and Local Government published a detailed policy framework for the implementation of the Better Care Fund (BCF) in 2017-18 and 2018-19. North Yorkshire County Council has been allocated £19.6m non-recurrent funding over three years (£9.3m, £6.9 and £3.4m for 2017-18; 2018-19 and 2019-20 respectively). The grant must be used to address the following:

a. Adult Social Care pressures
b. Stabilising the market
c. Reducing Delayed Transfers of Care

The guidance clarified each BCF area should set a target for reducing DTOC to no more than 3.5% of occupied bed days by September 2017. National Condition 4 requires that health and social care partners in all areas work together to implement the High Impact Change Model for Managing Transfers of Care. Nationally the ambition is to ensure that DLOC account for no more than 9.4 in every 100,000 adults nationally which would free up the equivalent of 2,000-3,000 beds (3.5%).

Many Local Authorities, including North Yorkshire County Council (NYCC) expressed concern that the national target was unachievable in the prescribed timescale. The issue was discussed at the July and August meetings of the North Yorkshire Health and Well-being Board and at this stage the local target has not been agreed by NYCC. Further work is to be undertaken at each local Accident and Emergency Delivery Board. The issue is compounded by differing counting and reporting arrangements between health and care systems. In order to achieve the target for September 2017, the sum of all delayed days across North Yorkshire would need to reduce from 2281 in February to 1371 in September 2017. The Harrogate system consistently has the highest DTOC rate in North Yorkshire. A DTOC rate of 3.5% equates to approximately 10 beds at HDFT.

### 3.2 Pathology Networks

In early September 2017 NHSI wrote to all Trusts setting out proposals to establish 29 pathology networks across England. These are broadly based on existing ‘hubs’ and emerging collaborative systems. The proposition is that centralisation via a ‘hub and spoke’ model will drive out unwarranted variations across England and improve efficiency. The network approach is designed to preserve essential laboratory services relevant to each hospital *on site*, whilst centralising within each the performance of both high volume

and more complex tests. The proposed model for HDFT mirrors the WYAAT footprint, and includes Leeds as a 'hub' organisation and Harrogate as one of five 'spokes'.

NHSI has set key milestones for the development of these new pathology networks. Following consideration by the Board, an update must be provided to NHSI confirming the Trust's agreement to establish the proposed network by 30 September 2017.

By the end of October the Trust must ensure executive level attendance at an NHSI facilitated workshop. It is expected this workshop will deliver agreement between network partners about the timeline and project approach to rapidly deliver the new model.

By late January 2018 the Trust is required to provide written confirmation to NHSI that the Board has formally agreed on a partnership or outsourcing model with the aim of rationalising pathology services.

This proposal has been discussed by WYAAT CEOs and a verbal update on local conversations will be provided to the meeting.

### 3.3 Harrogate Health Transformation Board (HHTB)

NHS England have announced quarters three and four funding for vanguard programmes will be dependent on NEL admissions and an expectation that growth will be at least 3% less than NEL growth in the rest of England. National growth in non-vanguard sites stands at 3.9% so this target will not be achieved in the Harrogate system, where NEL from all providers has grown by 4.5%. Any withdrawal of funding mid-year would present an additional cost pressure to the Trust and local partners and further compromise financial recovery. Final decisions on funding allocations are likely to rest with the STP and the Trust and local partners are in dialogue with the STP leadership team regarding this.

The consultation with staff affected by change in the community teams is underway in order to ensure that staff in post reflects the budgeted establishment by 31 March 2018.

Significant operational pressures continue within the Community Care teams which have been at OPEL level 3 or 4.

## 4.0 FINANCIAL POSITION

Financial performance continues to be a high risk to the Trust, with a deficit of £5.2m reported for the year to August and a Use of Resources metric rating of 3 (compared to plan of 2). While expenditure in Month 5 is on plan, income remains behind plan and concerted effort will be required throughout the remainder of the year to correct this position.

The Financial Recovery plan (FRP) was for a run rate improvement of £466k in Month 5 of which £319k was achieved. Additional in month pressures of £100k mean that the overall improvement was £219k. The robustness of FRP schemes and existing Cost Improvement Plans has been further challenged. If all schemes achieve in full and no further unexpected variances arise then the forecast position at year end is a surplus of £2.4m against a control total (excluding STF) of £2.2m. The risk adjusted total currently stands at a deficit of £350k. Work continues to improve confidence in plans and ensure that all actions are completed within the timescales agreed. The early indications are that September's elective activity is within 1% of plan. The Sterile Services Department (SSD), which have been off-site since July to enable capital works, will re-open on site this month enabling a return to usual rates of theatre productivity. Additional sessions have been scheduled which will further improve income recovery.

Adverse financial performance has triggered a formal request to meet and review plans with NHSI on 10th October, and follows meetings already held between NHSI and the Finance Director during September. The Trust continues to report a forecast outturn to NHS Improvement that achieves the original plan and control total set for the Trust.

## 5.0 SENIOR MANAGEMENT TEAM (SMT) MEETING

The SMT met on 20 September 2017. The following key areas are for noting:

- An update on the recent readmissions audit was presented. Eight out of 41 cases reviewed were considered to be potentially avoidable. The historical agreement with commissioners on withholding of funds in respect of readmissions should be revised in the Trust's favour on this basis.
- It was noted that falls have increased this year compared to last year. Targeted actions have been agreed to understand cause and improve prevention. The downward trend in pressure ulcers continues.
- Financial performance and progress on agreed FRP actions was scrutinised in detail.
    - A locum T&O Consultant surgeon will commence work early in November
    - Gastro capacity at Wharfedale has increased with impact due in October
    - Some general surgeons will commence additional outpatient sessions during their on call week, others remain in dialogue
    - Topical cataract surgery lists will commence early in October
    - Ten additional orthopaedic lists have been scheduled in the next two months, with more planned thereafter.
    - The risk adjusted CIP plan has improved to 90%
- Staffing on wards is a daily challenge with staff becoming increasingly tired.
- Out-patient activity in August was 9% below plan. This was due to annual leave taken to coincide with SSD being off site, staffing gaps and an unusually high rate of Did Not Attends in some areas.
- Work continues to explore alternative options for medically fit for discharge patients, those who are non-weight bearing and people choosing Nursing Home placements.
- A detailed update on actions to improve End of Life care and the recommendations of the Care Quality Commission's inspection in 2016 was received and noted.
- A number of new tenders have been submitted and the high workload associated with bidding activity was acknowledged, thanks were given to all involved.
- It was noted that Stroke patients are currently being diverted to York Hospital due to workforce gaps in respect of thrombolysis. A long term solution is being sought as an urgent priority.

## 6.0 COMMUNICATIONS RECEIVED AND ACTED UPON OR TO NOTE

### 6.1 NHS Improvement (NHSI) Single Oversight Framework

NHS Improvement (NHSI) have consulted Trusts about proposed changes to the Single Oversight Framework, including changes to some of the metrics and triggers used by NHSI to identify support needs. Material changes include:

- The CQC rating trigger has been changed from 'inadequate' or 'requires improvement' against any of the safe, effective, caring or responsive key questions to CQC rating of 'inadequate' or 'requires improvement' in *overall* rating.
- Hospital Standardised Mortality Ratio – Weekend has been removed.

- *Escherichia coli* (E. coli) bacteraemia bloodstream infection rate has been added to the metric list in addition to Methicillin-resistant *Staphylococcus aureus* and *Clostridium difficile.*
- Addition of a measure of dementia assessment and referral.
- 62 day wait for first treatment from NHS cancer screening service has been removed to align with STF performance improvement trajectories.
- The operational performance triggers have been amended so they are linked to quarterly Sustainability and Transformation Fund (STF) trajectories for A&E performance only.

Further detail is available at: https://improvement.nhs.uk/resources/updating-single-oversight-framework-share-your-views/. It is expected the outcome of the consultation will be published in October 2017.

### 6.2 Emergency Preparedness

Following a suspected terrorist incident in London on 15 September, the Joint Terrorism Analysis Centre raised the UK Threat Level from SEVERE (an attack is highly likely) to CRITICAL (an attack is expected imminently). NHS providers were asked to enact the actions required within the NHS Emergency Preparedness Resilience and Response protocol at this time. The threat level has since been stepped down again.

### 6.3 Review of Whistleblowing Arrangements

The National Freedom to Speak Up Guardian wrote to all Chief Executives in September 2017 to outline her recommendations based on the findings of the first survey of Freedom to Speak Up Guardians.

The recommendations for the role include:

- Ring-fenced time to enable guardians properly to meet the needs of workers;
- All workers, particularly the most vulnerable, should have effective routes to enable them to speak up; and
- Boards need to hear regularly from their guardian, in person.

## 7.0 BOARD ASSURANCE AND CORPORATE RISK

### 7.1 Board Assurance Framework (BAF)

No new risks have been added to the BAF this month. Six risks are currently assessed as having achieved their target risk score. The strategic risks are as summarized as follows:

| Ref | Description | Risk score | Progress score | Target risk score reached |
|---|---|---|---|---|
| **BAF 1** | Risk of a lack of medical, nursing and clinical staff | *Red 12 ↔* | *Moved to 1* | |
| **BAF 2** | Risk of a high level of frailty in the local population | *Amber 8 ↔* | *Unchanged at 1* | ✓ |
| **BAF 3** | Risk of a failure to learn from feedback and Incidents | *Amber 9 ↔* | *Improved to 2* | |
| **BAF 4** | Risk of a lack of integrated IT structure | *Amber 8 ↓* | *Unchanged at 1* | ✓ |
| **BAF 5** | Risk of maintaining service sustainability | *Amber 9 ↑* | *Unchanged at 1* | |
| **BAF 9** | Risk of a failure to deliver the Operational Plan | *Red 16 ↑* | *Reduced to 2* | |
| **BAF 10** | Risk of breaching the terms of the Trust's Licence to operate | *Yellow 5 ↔* | *Unchanged at 1* | ✓ |

| | | | | |
|---|---|---|---|---|
| **BAF 12** | Risk of external funding constraints | *Red 12 ↔* | *Unchanged at 1* | ✓ |
| **BAF 13** | Risk of a reduced focus on quality | *Yellow 4 ↔* | *Unchanged at 1* | ✓ |
| **BAF 14** | Risk of delivery of integrated models of care | *Red 12 ↔* | *Moved to 1* | |
| **BAF 15** | Risk of misalignment of strategic plans | *Red 12 ↔* | *Moved to 1* | |
| **BAF 16** | Risk that the Trust's critical infrastructure is not fit for purpose | *Amber 8 ↓* | *Unchanged at 1* | ✓ |
| **BAF 17** | Risk to senior leadership capacity | *Amber 9 ↔* | *Unchanged at 1* | |

## 7.2 Corporate Risk Register (CRR)

The CRR was reviewed at the monthly meeting of the Corporate Risk Review Group on 8 September 2017. The Corporate Risk Register contains 10 risks.

**Corporate Risk Register Summary**

| Ref | Description | Current risk score | Risk movement | Current progress score |
|---|---|---|---|---|
| CR2 | Risk to the quality of service delivery in Medicine due to gaps in rotas following the Deanery allocation process | 12 | ↔ | 2 |
| CR5 | Risk to service delivery due to the lack of experienced registered nurses due to national labour market shortage | 16 | ↔ | 2 |
| CR12 | Risk to financial sustainability from failure to deliver the Clinical Transformation Programme at pace and scale | 12 | ↔ | 2 |
| CR13 | Risk to urgent care system due to a lack of capacity in the out of hospital services | 12 | ↔ | 2 |
| CR14 | Risk of financial deficit and impact on service delivery due to failure to deliver the Trust annual plan by having excess expenditure or a shortfall in income. | 16 | ↔ | 2 |
| CR17a | Risk of patient harm as a result of being lost to follow-up as a result of current processes | 12 | ↔ | 2 |
| CR17b | Risk of patient harm as a result of being lost to follow up as a result of historic processes | 12 | ↔ | 4 |
| CR18 | Risk to provision of service and not achieving national standards in cardiology due to potential for lab equipment breaking down | 12 | ↔ | 2 |
| CR19 | Risk to patient safety due to lack of provision of Acute Oncology, CUP, Breast and Urology Oncology services. | 9 | ↓ | 1 |
| CR24 | Risk to patient safety, quality, experience, reputation, staff wellbeing and and associated effect on timely discharge from the reduction to baseline (2011) funding capacity | 15 | ↔ | 2 |

**Risks added to the corporate risk register**
None

**Risks removed from corporate risk register**
CR19: Risk to patient safety due to lack of provision of Acute Oncology, CUP, Breast and Urology Oncology services.

**Risks with amended target dates or target scores**
CR12: Risk to financial sustainability from failure to deliver the engagement for, and the pace and scale of, transformation required through the Clinical Transformation programme

***Progress key**

1 = fully on plan across all actions

2 = actions defined - most progressing, where there are delays, interventions are being taken

3 = actions defined - work started but behind plan

4 = actions defined but largely behind plan

5 = actions not yet fully defined

## 8.0 DOCUMENTS SIGNED AND SEALED

The following documents have been signed and sealed during the month.

7 August 2017 Consultants Appointment; deed with developer (edp Consulting Limited) for development of Endoscopy Suite

**Common Seal Number 061**

7 August 2017 Consultants Appointment; Deed with developer (Slater Jackson) for development of Endoscopy Suite

**Common Seal Number 062**

7 August 2017 Consultants Appointment; Deed with developer (P+HS) for development of Endoscopy Suite

**Common Seal Number 063**

9 August 2017 Deed of Guarantee with Essci Limited regarding Carbon Energy Fund (note this was a replacement for the document sealed in March 2017 which had been mislaid)

**Common Seal Number 064**

31 August 2017 Lease with Airwave Solutions Limited for roof space at Harrogate Hospital for emergency services telecoms, renewal for a further 15 years.

**Common Seal Number 065**

Dr Ros Tolcher
Chief Executive
September 2017

This page has been left blank

Harrogate and District NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Date of Meeting:** | 27th September 2017 | **Agenda item:** | 5.0 |
| **Report to:** | Board of Directors | | |
| **Title:** | Integrated Board Report | | |
| **Sponsoring Director:** | Dr Ros Tolcher, Chief Executive | | |
| **Author(s):** | Ms Rachel McDonald, Head of Performance & Analysis | | |

**Report Purpose:**

| Decision | | Discussion/ Consultation | ✓ | Assurance | ✓ | Information | ✓ |
|---|---|---|---|---|---|---|---|

**Executive Summary:**

The Trust is required to report its operational performance to NHS Improvement and to routinely submit performance data to NHS England and Harrogate and Rural District CCG. The Board of Directors are asked to note that:

- The Trust reported a rating of 3 (where 1 is best) for NHS Improvement's Use of Resource Metric in August, against an expected rating of 2, and is a result of the variance from plan for income and expenditure.
- In Quarter 2 to date, HDFT is above the required level for all four key operational performance metrics in NHS Improvement's Single Oversight Framework.
- Four new metrics have been introduced this month looking at activity against plan. Elective admissions and outpatient activity are both behind plan.

**Related Trust Objectives**

| To deliver high quality care | ✓ | To work with partners to deliver integrated care: | ✓ | To ensure clinical and financial sustainability: | ✓ |
|---|---|---|---|---|---|

**Key implications**

| | |
|---|---|
| **Risk Assessment:** | Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF 4: risk of a lack of interoperable systems across New Care Models partners; BAF 9: risk of a failure to deliver the operational plan; BAF 10: risk of a breach of the terms of the NHS Provider licence; BAF 16: risk to delivery of integrated care models. |
| **Legal / regulatory:** | None identified. |
| **Resource:** | Not applicable. |
| **Impact Assessment:** | Not applicable. |
| **Conflicts of Interest:** | None identified. |
| **Reference documents:** | None. |

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

The Board of Directors are asked to receive and note the content of the report.

This page has been left blank

# Integrated board report - August 2017

## Key points this month

1. The Trust reported a rating of 3 (where 1 is best) for NHS Improvement's Use of Resource Metric in August, against an expected rating of 2. This is a result of the variance from plan for income and expenditure. The Trustwide position to August was a deficit of £5,213k. The Trust remains focused on achieving the planned outturn and recovery plans are outlined in more detail in the finance paper.

2. In Quarter 2 to date, HDFT is above the required level for all 4 key operational performance metrics in NHS Improvement's Single Oversight Framework. However delivery of the 18 weeks standard is becoming increasingly challenging with the Trust reporting a performance of 92.0% in August, in line with the minimum performance standard.

3. The number of hospital acquired pressure ulcers fell for the 4th successive month with 11 reported in August. Community acquired pressure ulcers also reduced. However the number of inpatient falls increased.

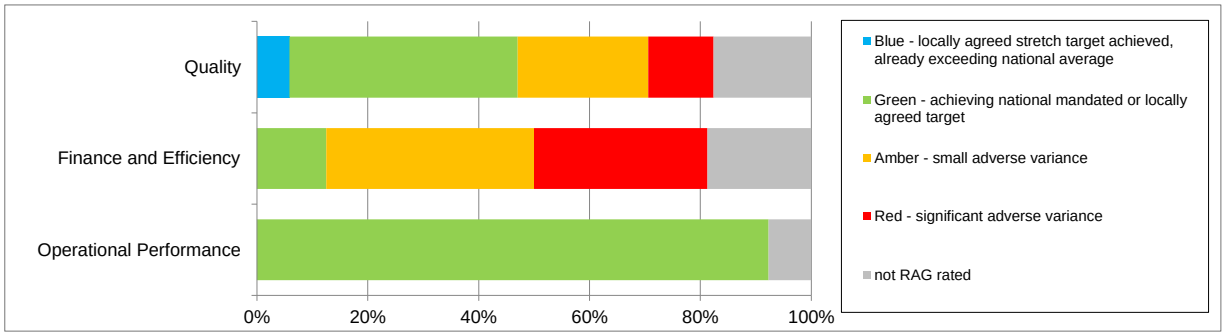
4. The number of complaints increased to 22 in August, above the monthly average reported in 2016/17 (17 per month).

5. Four new metrics have been introduced this month looking at activity against plan. Elective admissions and outpatient activity are both behind plan. A number of actions are being undertaken to address this and these are reported in detail in the Chief Operating Officer's report.

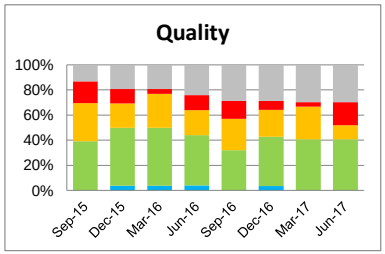
6. Delayed transfers of care decreased to 6.0% when the snapshot was taken in August but remain above the maximum threshold of 3.5% set out in the contract.

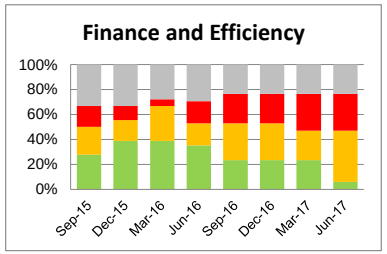
*Following a review of the indicators presented in this report during Summer 2017, a number have been removed from the report - either because they are no longer relevant, are not a robust metric or are reported to board via an alternative mechanism. In additon, four new activity related indicators have been added, as detailed above.*

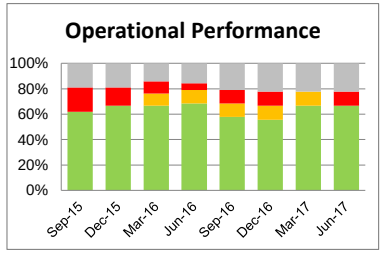
## Summary of indicators - current month



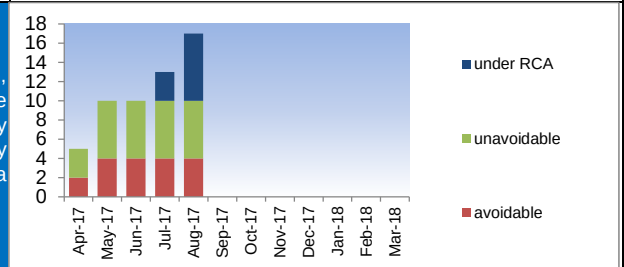
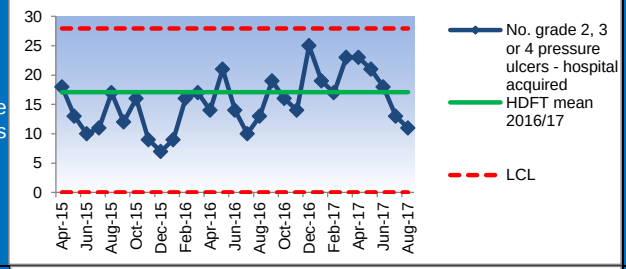
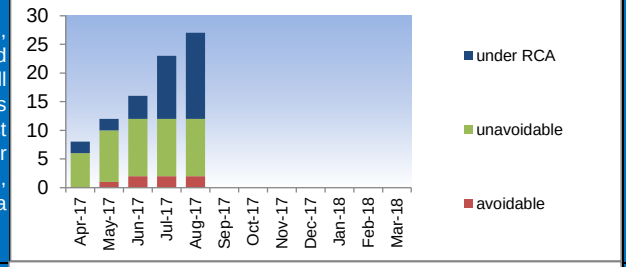
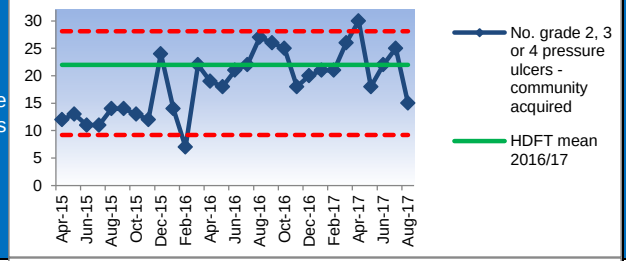

## Summary of indicators - recent trends



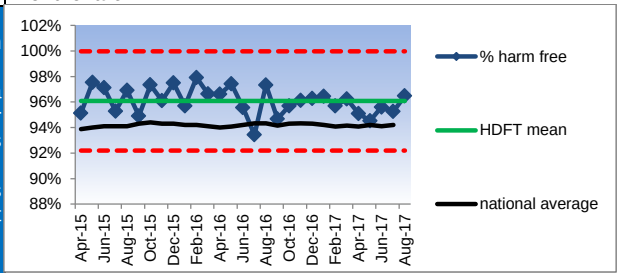
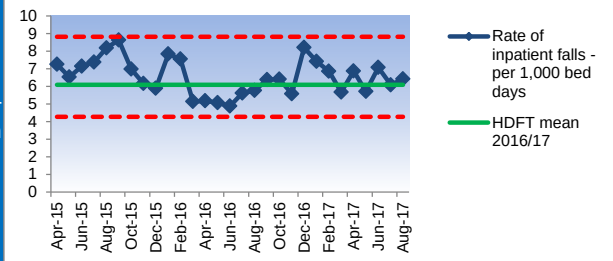
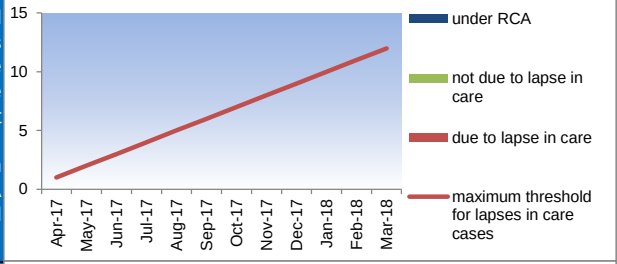
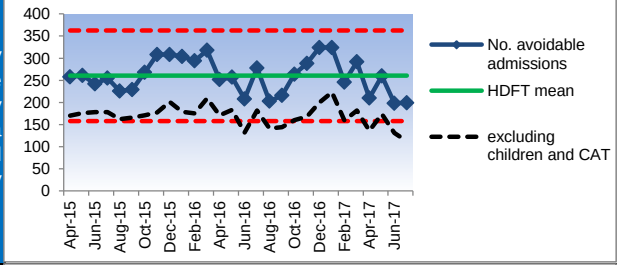



## Quality - August 2017

| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| Pressure ulcers - hospital acquired | The chart shows the cumulative number of category 3, category 4 or unstageable hospital acquired pressure ulcers in 2017/18. The Trust has set a local trajectory for 2017/18 to reduce the number of avoidable category 3, category 4 or unstageable pressure ulcers. The data includes hospital teams only. |  | There were 4 hospital acquired unstageable or category 3 pressure ulcers reported in August, with the year to date total now at 17. Of these, 7 are still under root cause analysis (RCA), 4 have been assessed as avoidable and 6 as unavoidable. No category 4 hospital acquired pressure ulcers have been reported in 2017/18 to date.<br><br>In 2016/17, 33 hospital acquired category 3 or unstageable pressure ulcers were reported. Of these, 19 were deemed to be avoidable. |
| | The chart includes category 2, 3 and 4 and unstageable hospital acquired pressure ulcers. The data includes hospital teams only. |  | The number of hospital acquired category 2-4 (or unstageable) pressure ulcers reported in August was 11, compared to 13 last month. This is the fourth month in a row in which we have seen a reduction. |
| Pressure ulcers - community acquired | The chart shows the cumulative number of category 3, category 4 or unstageable community acquired pressure ulcers in 2017/18. This metric includes all pressure ulcers identified by community teams including pressure ulcers already present at the first point of contact. The Trust has set a local trajectory for 2017/18 to reduce the number of avoidable category 3, category 4 or unstageable pressure ulcers. The data includes community teams only. |  | There were 4 community acquired category 3 (or unstageable) pressure ulcers reported in August, bringing the year to date total to 27. Of these, 15 are still under root cause analysis (RCA), 2 have been assessed as avoidable and 10 as unavoidable. No category 4 community acquired pressure ulcers have been reported in 2017/18 to date.<br><br>In 2016/17, 79 community acquired category 3 or 4 or unstageable pressure ulcers were reported (including 3 category 4 cases) of which, 42 were deemed to be avoidable. |
| | The chart includes category 2, 3 and 4 and unstageable community acquired pressure ulcers. The data includes community teams only. |  | The number of community acquired category 2-4 (or unstageable) pressure ulcers reported in August was 15 cases, compared to 25 last month. |

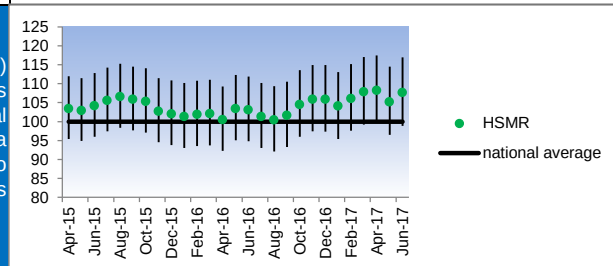
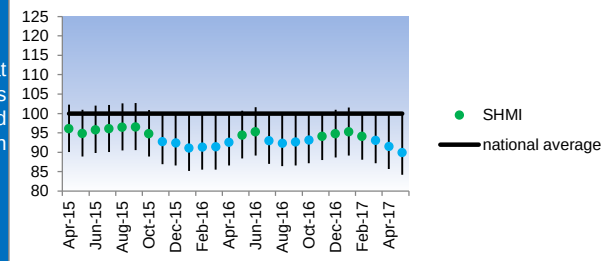
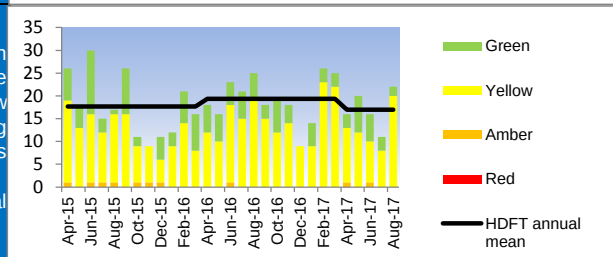
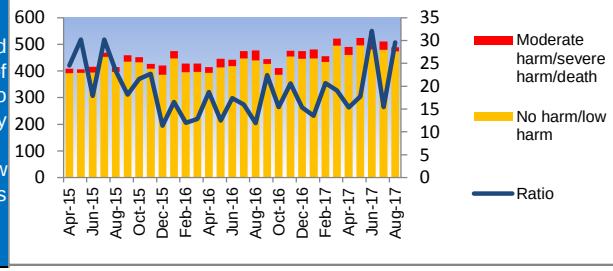
## Quality - August 2017

Harrogate and District NHS Foundation Trust

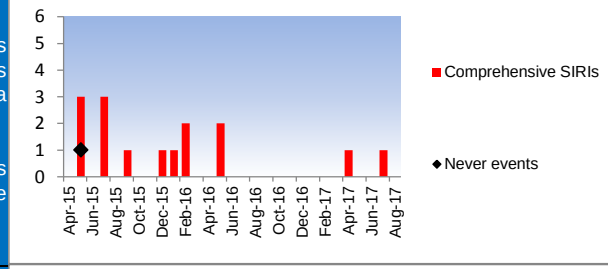
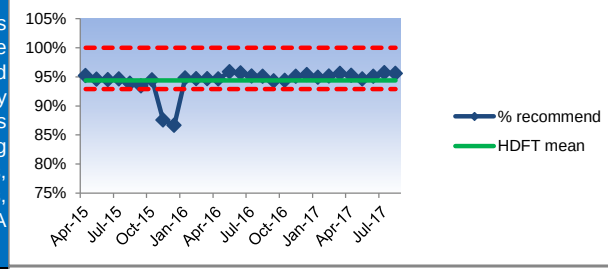
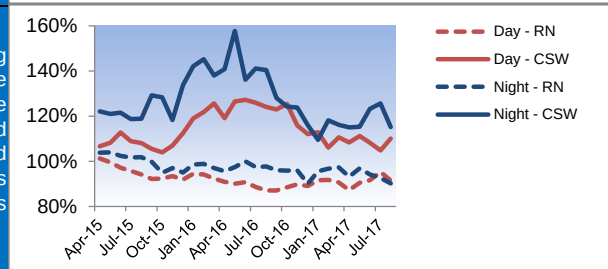
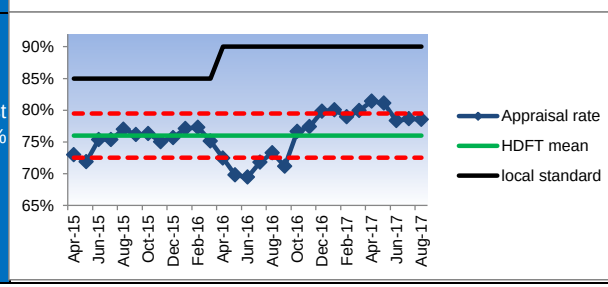
| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Safety Thermometer - harm free care** ✓ | Measures the percentage of patients receiving harm free care (defined as the absence of pressure ulcers, harm from a fall, urine infection in patients 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. |  | The harm free percentage for August was 96.5%, an improvement on recent months and remaining above the latest national average. |
| **Falls** ✓ | The number of inpatient falls expressed as a rate per 1,000 bed days. The data includes falls causing harm and those not causing harm. A low rate is good. |  | The rate of inpatient falls was 6.41 per 1,000 bed days in August, an increase on last month and above the average HDFT rate for 2016/17. There were 3 falls causing moderate harm in August (1 last month), all of which resulted in a fracture.<br><br>In 2016/17, 697 inpatient falls were reported (including those not causing harm), a 14% reduction on the number of inpatient falls reported in the previous year. |
| **Infection control** ✓ | The chart shows the cumulative number of hospital apportioned C. difficile cases during 2017/18. HDFT's C. difficile trajectory for 2017/18 is 12 cases, no change on last year's trajectory. Cases where a lapse in care has been deemed to have occurred would count towards this.<br>Hospital apportioned MRSA cases will be reported on an exception basis. HDFT has a trajectory of 0 MRSA cases for 2017/18. The last reported case of hospital acquired MRSA at HDFT was in Oct-12. |  | There were no cases of hospital apportioned C. difficile reported in 2017/18, as at the end of August (the period covered by this report). Hwever there were 2 hospital acquired case reported in early September - these will be reported in next month's report.<br><br>No hospital apportioned MRSA cases have been reported in 2017/18 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 a hospital admission. Conditions include pneumonia and urinary tract infections in adults and respiratory conditions in children. |  | There were 199 avoidable admissions in July, no change on last month. This metric is seasonal with less avoidable admissions in the summer compared to the winter months. However this is significantly below the level reported in July last year (279) and equates to 6.4 avoidable admissions per day.<br><br>Adult admissions (excluding CAT attendances) also decreased signficantly this month and are now at the lowest level since this metric was introduced in 2014. |

# Quality - August 2017

Harrogate and District NHS Foundation Trust

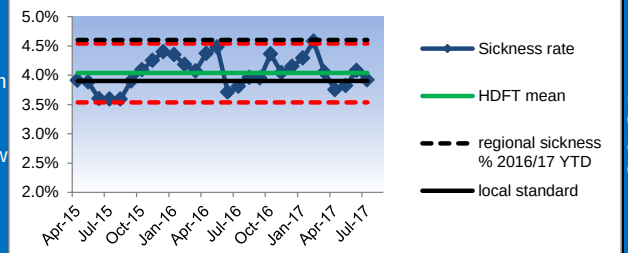
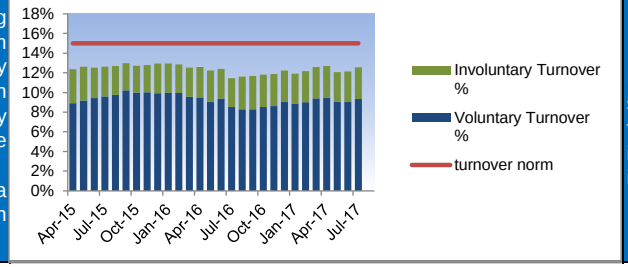
| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Mortality - HSMR** ✓ | The Hospital Standardised Mortality Ratio (HSMR) looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises 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 to 107.6 for the rolling 12 months ending June 2017 but remains within expected levels.<br><br>At specialty level, one specialty (Geriatric Medicine) continues to have 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. |  | HDFT's SHMI decreased to 89.9 for the rolling 12 months ending May 2017, remaining below expected levels.<br><br>At specialty level, two specialties (Geriatric Medicine and Gastroenterology) continues to have a standardised mortality rate above expected levels. |
| **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. |  | 22 complaints were received in August, compared to 11 last month, with no complaints classified as amber or red. The main subjects referenced in the complaints received in August were communication and attitude and delay / failure or dispute over diagnosis. There were also complaints about the discharge process and post-treatment complications.<br><br>For the complaints received in 2017/18 to date, 21% are still under investigation. Of those completed, 61% were upheld and 39% were not upheld. |
| **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 |  | The latest published national data (for the period Apr - Sep 16) shows that Acute Trusts reported an average ratio of 37 no harm/low harm incidents for each incident classified as moderate harm, severe harm or death (a high ratio is better). HDFT's local reporting ratio for the same period was 18 which placed the Trust in the bottom 25% nationally. The focus going forward is to improve our incident reporting rate particularly encouraging staff to report no harm/ near miss incidents. Options to improve the Datix system to simplify the incident reporting process are being explored. |

# Quality - August 2017

| Indicator name / data quality assessment | 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.<br><br>Only comprehensive SIRIs are included in this indicator, as concise SIRIs are reported within the presure ulcer / falls indicators above. |  | There were no comprehensive SIRIs or Never Events reported in August. There have been 2 comprehensive SIRIs and no Never Events in 2017/18 to date. |
| **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. |  | 95.6% of patients surveyed in August would recommend our services, no change on last month and remaining above the latest published national average (94%).<br><br>Around 4,200 patients responded to the survey this month. |
| **Safer staffing levels** ✓ | Trusts are required to publish information about staffing levels for registered nurses/midwives (RN) and care support workers (CSW) for each inpatient ward. The chart shows the overall fill rate at HDFT for RN and CSW for day and night shifts. The fill rate is calculated by comparing planned staffing with actual levels achieved. A ward level breakdown of this data is published on the Trust website. |  | Overall staffing compared to planned was at 98.8% in August, a decrease on last month. Care Support Worker staffing remains high compared to plan - this is reflective of the increased need for 1-1 care. Whilst safer staffing levels for registered nurses remains below 100%, the staffing level achieved still enables the delivery of safe care. Achieving safe staffing levels remains challenging and requires the increasing use of temporary staff through the nurse bank and agencies. |
| **Staff appraisal rates** ✓ | The chart shows the staff appraisal rate over the most recent rolling 12 months. The Trusts aims to have 90% of staff appraised. A high percentage is good. |  | This is the final month for the appraisal period and the Trust has remained at 78% compliance for appraisals over the last twelve months. HR Business Partners continue to monitor compliance through the Directorate meetings. A review of the appraisal period will be undertaken in October to determine how effective it has been and develop a plan for 2018/19.<br>The new "appraisal on a page" document has been launched following ratification at the Workforce and OD steering group in August. The aim is to provide managers with the flexibility to identify the most appropriate approach for their teams and hence improve appraisal completion before the end of the appraisal period. |

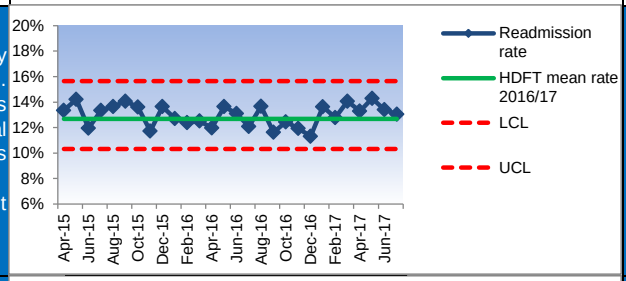
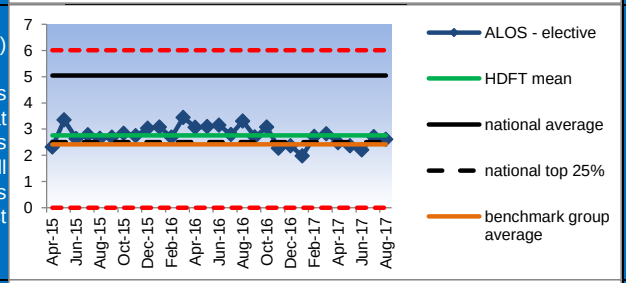
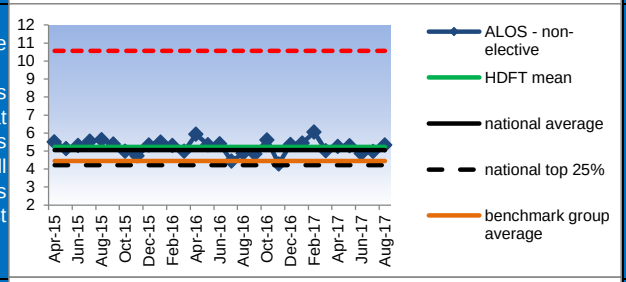
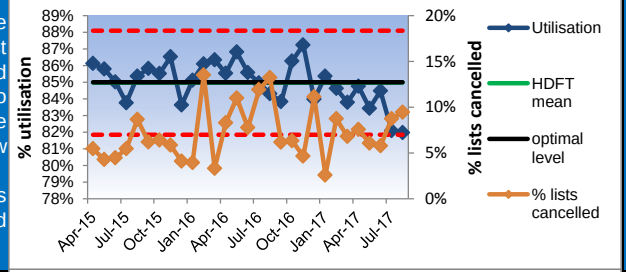
## Quality - August 2017

Harrogate and District NHS Foundation Trust

| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Mandatory training rates** ✓ | The table shows the most recent training rates for all mandatory elements for substantive staff. | See table below | The data shown is for the end of August and includes the staff who were TUPE transferred into the organisation on the 1st April 2016. The overall training rate for mandatory elements for substantive staff is 88 %.<br><br>The new follow up procedure is now in place for Directorates to use and we hope to see a positive impact on compliance going forward. |
| **Sickness rates** ✓ | Staff sickness rate - includes short and long term sickness.<br><br>The Trust has set a threshold of 3.9%. A low percentage is good. |  | Sickness absence has reduced in month to 3.92%. The hot spot areas continue to be a focus alongside long term absence. 27 long term absence cases were closed in July with 23 individuals returning to work, 2 commencing maternity leave and 2 leavers. |
| **Staff turnover rate** ✓ | The chart shows the staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. The turnover figures include both voluntary and involuntary turnover. Voluntary turnover is when an employee chooses to leave the Trust and involuntary turnover is when the employee unwillingly leaves the Trust.<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. |  | Labour turnover remains static at 12.55%. This is the final month for the save/exit interview pilot. A report will be produced in October detailing the feedback from the interviews and themes as appropriate. This will report into the nurse recruitment and retention group and will be incorporated into the plan for the year ahead. |

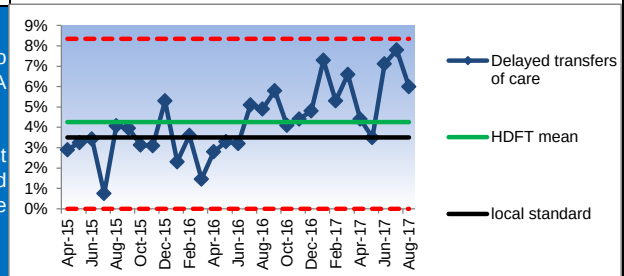
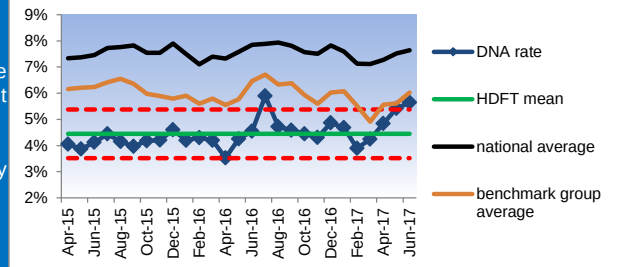
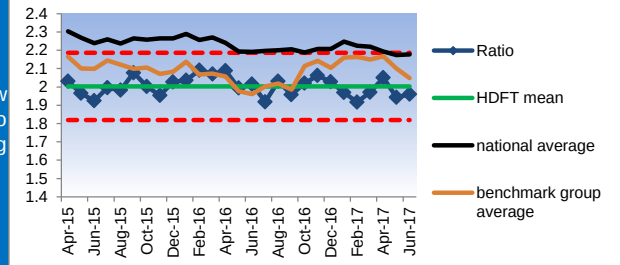
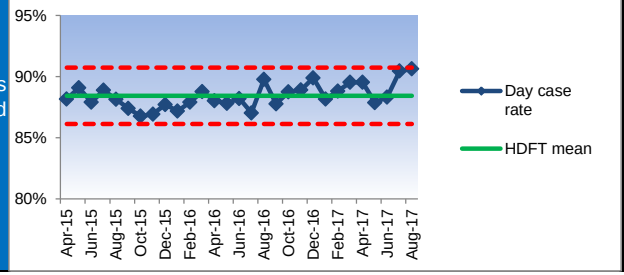
| Competence Name | % Completed |
|---|---|
| Equality, Diversity and Human Rights - Level 1 | 89 |
| Fire Safety Awareness | 76 |
| Infection Prevention & Control (Including Hand Hygiene) 1 | 100 |
| Infection Prevention & Control (Including Hand Hygiene) 2 | 78 |
| Data Security Awareness | 83 |
| Prevent Basic Awareness (December 2015) | 100 |
| Safeguarding Children & Young People Level 1 - Introduction | 94 |

# Finance and Efficiency - August 2017

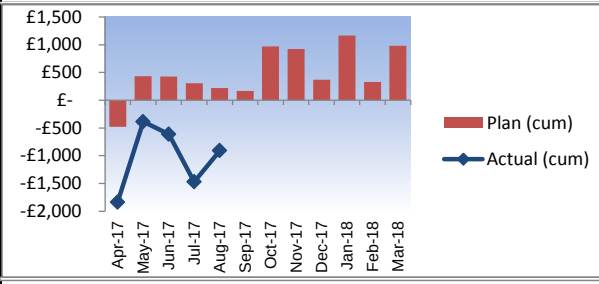
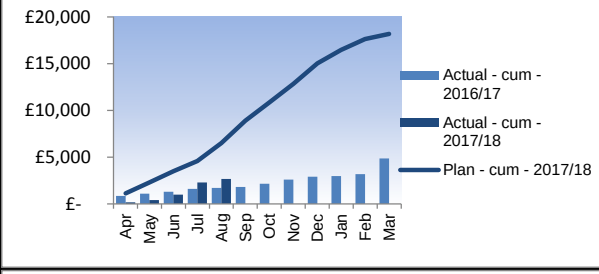
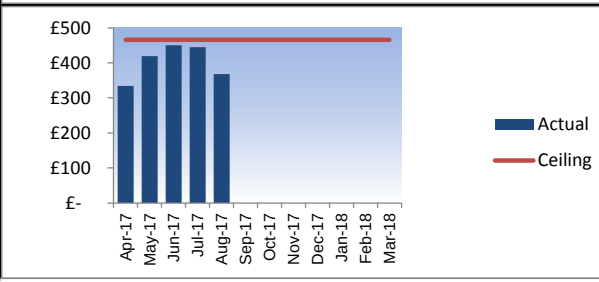
| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Readmissions** ✓ | % of patients readmitted to hospital as an emergency within 30 days of discharge (PbR exclusions applied). To ensure that we are not discharging patients inappropriately 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 decreased in July, when expressed as a percentage of all emergency admissions but remains just above the HDFT average rate for 2016/17.<br><br>The review undertaken with HARD CCG has still be be finalised and the changes to the readmissions reimbursement agreed. This is very important to ensure that the Trust is appropriately paid for patients who are readmitted appropriately. |
| **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 August was 2.6 days, a decrease on the previous month but remaining just above the benchmark group average. |
| **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 July was 5.3 days, above both the benchmark group average and the national average.<br><br>The implementation of the SAFER care bundle, which supports discharge processes is now being supported by a live information dashboard, which enables ward level length of stay, morning discharges and use of planned discharge dates to be monitored at the daily bed meeting. Directorates are then progressing with targeted reductions in length of stay by ward area. |
| **Theatre utilisation** △ | The percentage of time utilised during elective theatre sessions (i.e. those planned in advance for waiting list patients). The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. An extra line has been added to the chart to allow monitoring of this.<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. |  | Theatre utilisation decreased to 82.0% in August and the number of cancelled sessions increased to 9.5% (compared to 8.8% last month). As anticipated, the temporary relocation of sterile services off site (which commenced in late July) is impacting on theatre utilisation. Alterations have been made to lists to ensure that kit is available for the procedures booked. In addition to this, annual leave was encouraged to help manage this period and as a result of this, a high number of clinical staff had significant leave which also impacted on the volume of activity. It is essential that this returns to above the levels expected from when sterile services returns onsite, which is now planned for 27th September. |

## Finance and Efficiency - August 2017

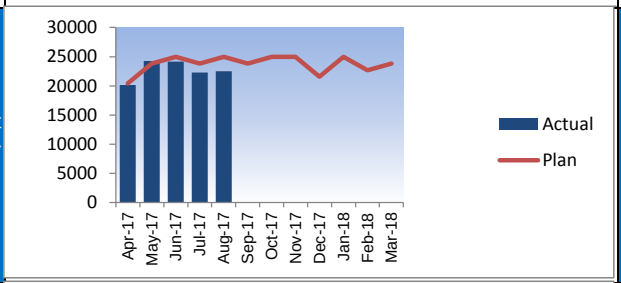
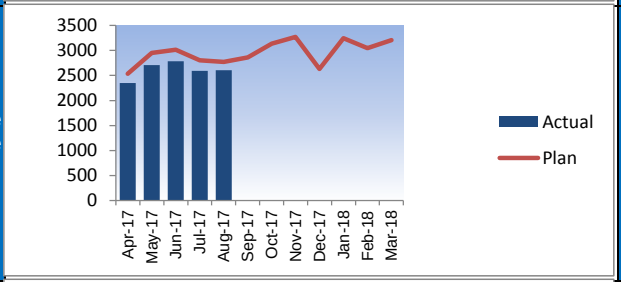
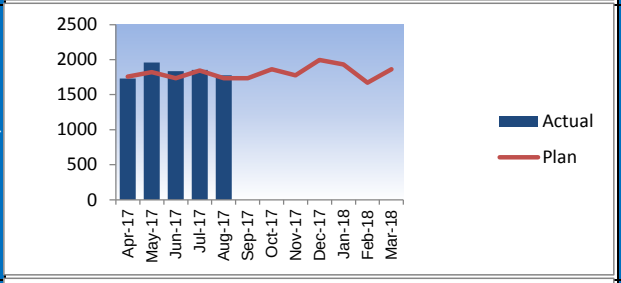
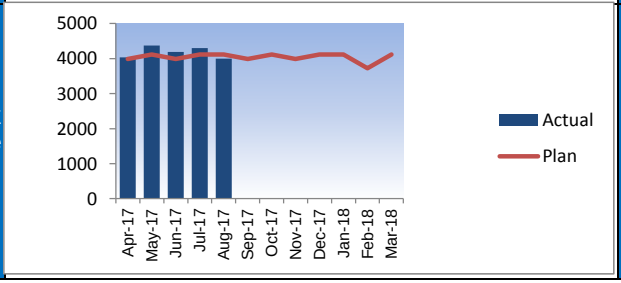
Harrogate and District NHS Foundation Trust

| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **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><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 decreased to 6.0% when the snapshot was taken in August, but remain significantly above the maximum threshold of 3.5% set out in the contract.<br><br>This remains a significant concern going into winter and is being raised again through the local A&E delivery Board to try and progress solutions to support a reduction to the national target of 3.5% in the first instance. |
| **Outpatient DNA rate** ✓ | Percentage of new outpatient attendances where the patient does not attend their appointment, without notifying the trust in advance.<br><br>A low percentage is good. Patient DNAs will usually result in an unused clinic slot. |  | HDFT's DNA rate increased again to 5.6% in June but remains below that of both the benchmarked group of trusts and the national average. A similar upward trend was seen in the same period last year with the DNA rate peaking at 5.9% in July 2016. Local data shows that the DNA rate reduces in July and August 2017 (benchmarking data is not yet available for this period). Work has now commenced at directorate level to review whether some clinics could have templates changed to increase the number of patients booked due to the increase in the number of patients who are not attending. This will reduce wasted slots on the day. However, it carries the risk of delaying patients if all patient do attend. |
| **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. |  | Reducing the number of follow ups is a major part of HARD CCG's financial recovery plan. HDFT's new to follow up ratio was 1.96 in June, remaining below both the histroical average for HDFT and also below both the national and benchmark group average. As part of the financial recovery plan, outpatient clinic templates are being adjusted to increase the number of new slots where changes can be made to reduce the number of patients being booked for follow up. It remains essential that the Clinical Directorate teams monitor the waiting times for patients booked for follow up to ensure that they receive timely care where they do need to return. |
| **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><br>A higher day case rate is preferable. |  | The day case rate was 90.6% in August, remaining above the historical average. |

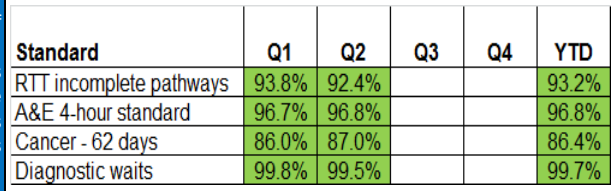
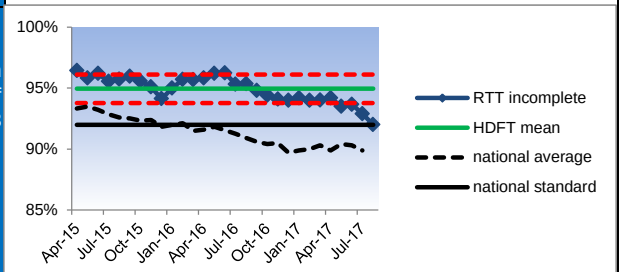
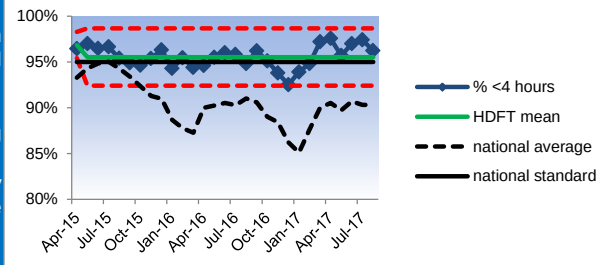
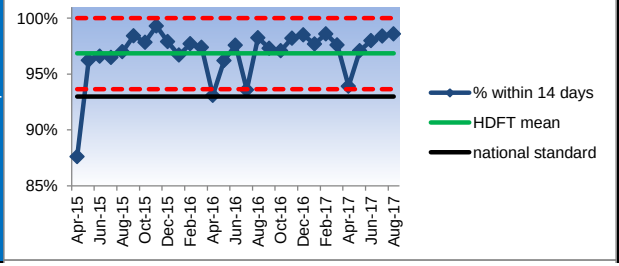
# Finance and Efficiency - August 2017

| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **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 Trustwide position to August was a deficit of £5,213k. As previously outlined this is significantly behind plan. Initial actions from the financial reecovery plan have had some impact, however this is less than the full amount planned. This remains a significant risk. |
| **NHS Improvement Single Oversight Framework - Use of Resource Metric** | From 1st October 2016, NHS Improvement introduced the Single Oversight Framework. As part of this this, Use of Resource Metric was introduced to replace the previous Financial Sustainability Risk Rating. This is the product of five elements which are rated between 1 (best) to 4. | **Element** / **Plan** / **Actual**<br>Capital Service Cover: 2 / 4<br>Liquidity: 2 / 1<br>I&E Margin: 1 / 4<br>I&E Variance From Plan: 1 / 4<br>Agency: 1 / 1<br>**Financial Sustainability Risk Rating: 2 / 3** | The Trust will report a rating of 3 for August. This is behind the plan of 2 and is a result of the variance from plan for income and expenditure. |
| **Capital spend** | Cumulative Capital Expenditure by month (£'000s) |  | Capital expenditure is behind plan. However it is anticipated that expenditure will increase to planned levels as the year progresses. |
| **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 was 2.9% of total employee expenses in August. Although this continues to be below the agency ceiling, there is still work underway to drive down agency usage and cost. This is being led through the Workforce Efficiency Group. Further controls for above cap booking for nursing staffing have reduced the level of bookings in late August. This is being managed daily to ensure that we maintain a minimum level of safe staffing. |

# Finance and Efficiency - August 2017

| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Outpatient activity against plan** ✓ | The chart shows the position against plan for outpatient activity. The data includes all outpatient attendances - new and follow-up, consultant and non-consultant led. |  | Outpatient activity was 9.9% below plan in the month of August and 4% below plan year to date. A number of actions are being undertaken by Planned & Surgical Care Directorate to improve this position. Further information is provided within the Chief Operarting Officer's Report. |
| **Elective activity against plan** ✓ | The chart shows the position against plan for elective activity. The data includes inpatient and day case elective admissions. |  | Elective activity was 5.9% below plan in the month of August and 7.4% below plan year to date. A number of actions are being undertaken by Planned & Surgical Care Directorate to improve this position. Financial recovery plans are also discussed in detail at Operational Delivery Group. Further information is provided within the Chief Operarting Officer's Report. |
| **Non-elective activity against plan** ✓ | The chart shows the position against plan for non-elective activity (emergency admissions). |  | Non-elective activity was 2.4% above plan in the month of August and 3.0% below plan year to date. Further information is provided within the Chief Operarting Officer's Report. |
| **A&E activity against plan** ✓ | The chart shows the position against plan for A&E attendances at Harrogate Emergency Department. The data excludes planned follow-up attendances at A&E. |  | A&E attendances were 2.9% below in the month of August but are 2.7% above plan year to date. |

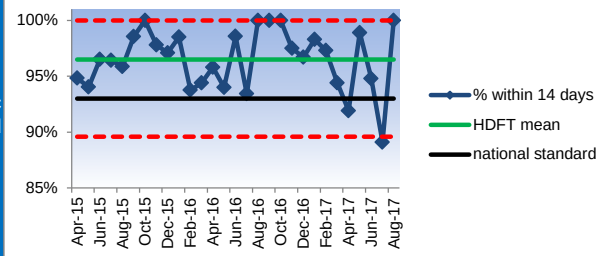
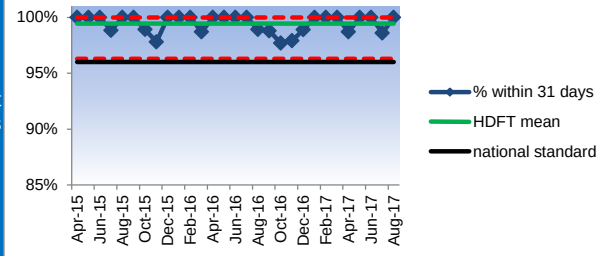
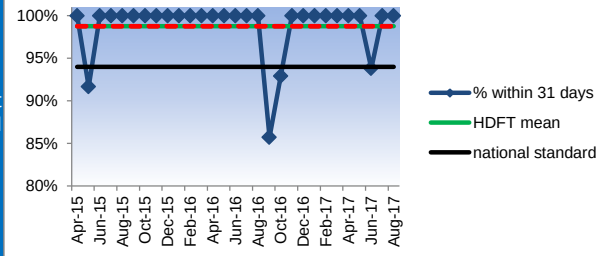
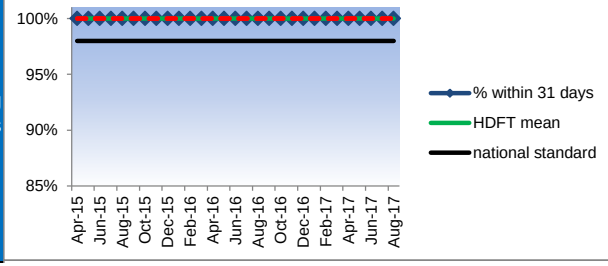
# Operational Performance - August 2017

| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **NHS Improvement Single Oversight Framework** ✓ | From October 2016, NHS Improvement use a variety of information to assess a Trust's governance risk rating, including CQC information, access and outcomes metrics, third party reports and quality governance metrics. The table to the right shows how the Trust is performing against the national performance standards in the "operational performance metrics" section. |  | In Quarter 2 to date, HDFT's performance is above the required level for all 4 key operational performance metrics. |
| **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><br>A high percentage is good. |  | 92.0% of patients were waiting 18 weeks or less at the end of August, a decrease on last month's performance. Performance has deteriorated significantly over the last 2 months with the Trust overall performance now at the minimum level of 92%.<br><br>At specialty level, Trauma & Orthopaedics, General Surgery and Ophthalmology were below the 92% standard. Operational Delivery Group reviews long waiting patients on a weekly basis to ensure that patients receive a date for treatment as soon as possible and the Trust maintains the national standard for RTT. Specialties with long waits are being targeted as part of the financial recovery plan and it is therefore planned to improve this position, along with income. |
| **A&E 4 hour standard** ✓ | Percentage of patients spending less than 4 hours in Accident & Emergency (A&E). The operational standard is 95%.<br><br>The data includes all A&E Departments, including Minor Injury Units (MIUs). A high percentage is good. Historical data for HDFT included both Ripon and Selby MIUs. In agreement with local CCGs, York NHSFT are reporting the activity for Selby MIU from 1st May 2015. |  | HDFT's Trust level performance for August was 96.2%, a reduction on last month but remaining above the required 95% standard. This includes data for the Emergency Department at Harrogate and Ripon MIU. Performance for Harrogate ED was also above the 95% standard at 95.4%.<br><br>HDFT's performance remains significantly above the national average. |
| **Cancer - 14 days maximum wait from urgent GP referral for suspected cancer referrals** ✓ | Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%. A high percentage is good. |  | Delivery at expected levels. |

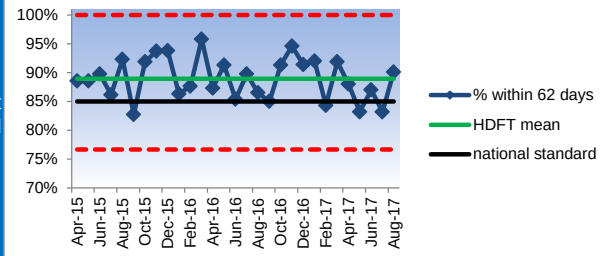
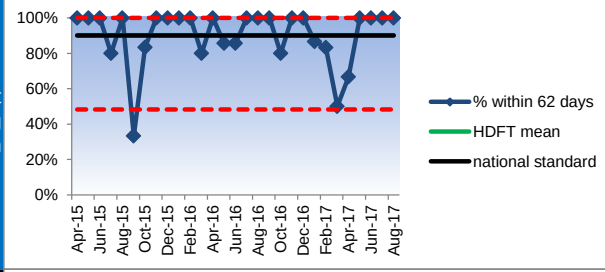
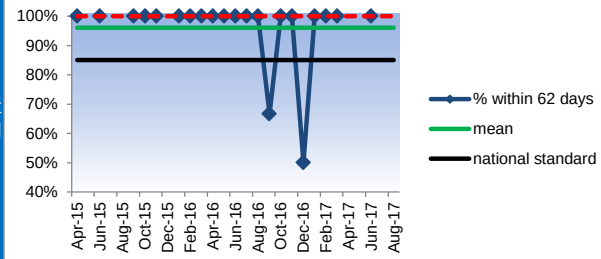
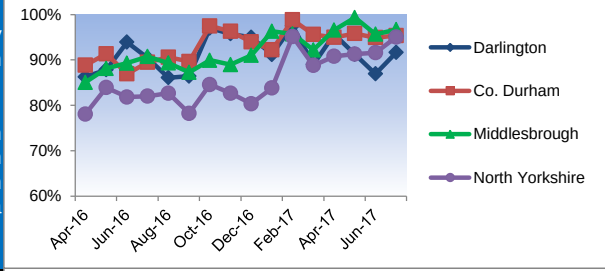


| Standard | Q1 | Q2 | Q3 | Q4 | YTD |
|---|---|---|---|---|---|
| RTT incomplete pathways | 93.8% | 92.4% | | | 93.2% |
| A&E 4-hour standard | 96.7% | 96.8% | | | 96.8% |
| Cancer - 62 days | 86.0% | 87.0% | | | 86.4% |
| Diagnostic waits | 99.8% | 99.5% | | | 99.7% |

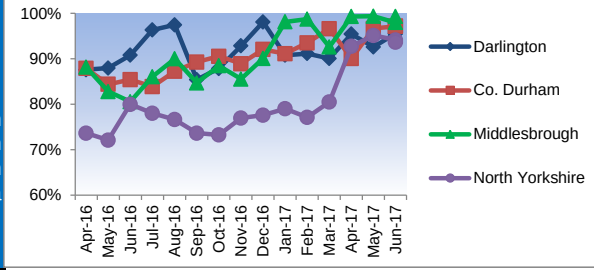
# Operational Performance - August 2017

| Indicator name / data quality assessment | 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. |  | Provisional performance is at 100% for August, an improvement on the July position. Performance for Quarter 2 to date is now above the required 93% standard. |
| **Cancer - 31 days maximum wait from diagnosis to treatment for all cancers** ✓ | Percentage of cancer patients starting first treatment within 31 days of diagnosis. The operational standard is 96%. A high percentage is good. |  | Delivery at expected levels. |
| **Cancer - 31 day wait for second or subsequent treatment: Surgery** ✓ | Percentage of cancer patients starting subsequent surgical treatment within 31 days. The operational standard is 94%. A high percentage is good. |  | Delivery at expected levels. |
| **Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug** ✓ | Percentage of cancer patients starting subsequent drug treatment within 31 days. The operational standard is 98%. A high percentage is good. |  | Delivery at expected levels. |

# Operational Performance - August 2017

| Indicator name / data quality assessment | 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 August is above the required 85% standard at 90.1% with 6 accountable breaches. Of the 11 tumour sites, only two had performance below 85% in August - upper gastrointestinal (1.5 breaches) and urological (2.5 breaches). Two patients waited over 104 days in August. The main reasons for the delays were delays in diagnostic tests and complex diagnostic pathways. |
| **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. |  | Delivery at expected levels. |
| **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. |  | There were no eligible pathways in August for this standard. |
| **Children's Services - 10-14 day new birth visit** ⚠ | The percentage of babies who had a new birth visit by the Health Visiting team within 14 days of birth. A high percentage is good.<br><br>Data shown is for the 0-5 Health Visiting Service in North Yorkshire and the Healthy Child Programme in Darlington, Co. Durham and Middlesbrough. A high percentage is good. The contract does not specify a required level. |  | In July, the validated performance position is that 95% of babies were recorded on Systmone as having had a new birth visit within 14 days of birth. The improvement in delivery across all localities should be noted, this has been a clear priority for all 0-19 services as part of the team's performance frameworks.<br><br>The data is reported a month in arrears so that the validated position can be shared. |

## Operational Performance - August 2017

| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Children's Services - 2.5 year review** | The percentage of children who had a 2.5 year review. A high percentage is good.<br><br>Data shown is for the 0-5 Health Visiting Service in North Yorkshire and the Healthy Child Programme in Darlington, Co. Durham and Middlesbrough. A high percentage is good. The contract does not specify a required level. |  | In July, the validated performance position is that 96% of children were recorded on Systmone as having had a 2.5 year review.<br><br>The data is reported a month in arrears so that the validated position can be shared. |

# Data Quality - Exception Report

Harrogate and District NHS Foundation Trust

| Report section | Indicator | Data quality rating | Further information |
|---|---|---|---|
| Quality | Pressure ulcers - community acquired - grades 2, 3 or 4 | **Amber**  | The observed increase in reported cases over the last two years may be partly due to improvements in incident reporting during the period. |
| Finance and efficiency | Theatre utilisation | **Amber**  | The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. An extra line has been added to the chart to allow monitoring of cancelled sessions. |
| Operational Performance | Children's Services - 10-14 day new birth visit | **Amber**  | Caution should be exercised as further work is required to understand the completeness and quality of this data. |
| Operational Performance | Children's Services - 2.5 year review | **Amber**  | Caution should be exercised as further work is required to understand the completeness and quality of this data. |

**Indicator traffic light criteria**

Harrogate and District NHS Foundation Trust

| Section | Indicator | Further detail | Traffic light criteria | Rationale/source of traffic light criteria |
|---|---|---|---|---|
| **Quality** | **Pressure ulcers - hospital acquired** | No. category 3 and category 4 avoidable hospital acquired pressure ulcers | tbc | tbc |
| **Quality** | **Pressure ulcers - community acquired** | No. category 3 and category 4 community acquired pressure ulcers | tbc | tbc |
| **Quality** | **Safety thermometer - harm free care** | % harm free | Blue if latest month >=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** | **Falls** | IP falls per 1,000 bed days | Blue if YTD position is a reduction of >=50% of HDFT average for 2016/17, Green if YTD position is a reduction of between 20% and 50% of HDFT average for 2016/17, Amber if YTD position is a reduction of up to 20% of | Locally agreed improvement trajectory based on comparison with HDFT performance last year. |
| **Quality** | **Infection control** | No. hospital acquired C.diff cases | Green if below trajectory YTD, Amber if above trajectory YTD, Red if above trajectory at end year or more than 10% above trajectory in year. | NHS England, NHS Improvement and contractual requirement |
| **Quality** | **Avoidable admissions** | The number of avoidable emergency admissions to HDFT as per the national definition. | tbc | tbc |
| **Quality** | **Mortality - HSMR** | Hospital Standardised Mortality Ratio (HSMR) | Blue = better than expected (95% confidence interval), Green = as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval). | Comparison with national average performance. |
| **Quality** | **Mortality - SHMI** | Summary Hospital Mortality Index (SHMI) | | |
| **Quality** | **Complaints** | No. complaints, split by criteria | Blue if no. complaints in latest month is below LCL, Green if below HDFT average for 2016/17, Amber if on or above HDFT average for 2016/17, 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 - complrehensive SIRIs and never events** | The number of comprehensive SIRIs and the number of never events reported in the year to date. The indicator includes hospital and community data. | Green if none reported in current month; Red if 1 or more never event or comprehensive reported in the current month. | |
| **Quality** | **Friends & Family Test (FFT) - Patients** | % recommend, % not recommend - combined score for all services currently doing patient FFT | Green if latest month >= latest published national average, Red if < latest published national average. | Comparison with national average performance. |
| **Quality** | **Safer staffing levels** | RN and CSW - day and night overall fill rates at trust level | Green if latest month overall staffing >=100%, amber if between 95% and 100%, red if below 95%. | The Trusts aims for 100% staffing overall. |
| **Quality** | **Staff appraisal rate** | Latest position on no. staff who had an appraisal within the last 12 months | Annual rolling total - 90% green. Amber between 70% and 90%, red<70%. | Locally agreed target level based on historic local and NHS performance |
| **Quality** | **Mandatory training rate** | Latest position on the % staff trained for each mandatory training requirement | Blue if latest month >=95%; Green if latest month 75%-95% overall, amber if between 50% and 75%, red if below 50%. | Locally agreed target level - no national comparative information available until February 2016 |
| **Quality** | **Staff sickness rate** | Staff sickness rate | Green if <3.9% , amber if between 3.9% and regional average, Red if > regional average. | HDFT Employment Policy requirement. Rates compared at a regional level also |
| **Quality** | **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 |
| **Finance and efficiency** | **Readmissions** | No. emergency readmissions (following elective or non-elective admission) within 30 days. | Blue if latest month rate < LCL, Green if latest month rate < HDFT average for 2016/17, Amber if latest month rate > HDFT average for 2016/17 but below UCL, red if latest month rate > UCL. | Locally agreed improvement trajectory based on comparison with HDFT performance last year. |
| **Finance and efficiency** | **Length of stay - elective** | Average LOS for elective patients | Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%. | Comparison with performance of other acute trusts. |
| **Finance and efficiency** | **Length of stay - non-elective** | Average LOS for non-elective patients | | |
| **Finance and efficiency** | **Theatre utilisation** | % of theatre time utilised for elective operating sessions | Green = >=85%, Amber = between 75% and 85%, Red = <75% | A utilisation rate of around 85% is often viewed as optimal. |
| **Finance and efficiency** | **Delayed transfers of care** | % acute beds occupied by patients whose transfer is delayed - snapshot on last Thursday of the month. | Red if latest month >3.5%, Green <=3.5% | Contractual requirement |

| Section | Indicator | Further detail | Traffic light criteria | Rationale/source of traffic light criteria |
|---|---|---|---|---|
| Finance and efficiency | Outpatient DNA rate | % first OP appointments DNA'd | | |
| Finance and efficiency | Outpatient new to follow up ratio | No. follow up appointments per new appointment. | Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%. | |
| Finance and efficiency | Day case rate | % elective admissions that are day case | | Comparison with performance of other acute trusts. |
| Finance and efficiency | Surplus / deficit and variance to plan | Monthly Surplus/Deficit (£'000s) | Green if on plan, amber <1% behind plan, red >1% behind plan | Locally agreed targets. |
| Finance and efficiency | NHS Improvement Financial Performance Assessment | An overall rating is calculated ranging from 4 (no concerns) to 1 (significant concerns). This indicator monitors our position against plan. | Green if rating =4 or 3 and in line with our planned rating, amber if rating = 3, 2 or 1 and not in line with our planned rating. | as defined by NHS Improvement |
| Finance and efficiency | 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 | Outpatient activity against plan (new and follow up) | Includes all outpatient attendances - new and follow-up, consultant and non-consultant led. | | Locally agreed targets. |
| Finance and efficiency | Elective activity against plan | Includes inpatient and day case activity | | Locally agreed targets. |
| Finance and efficiency | Non-elective activity against plan | | | Locally agreed targets. |
| Finance and efficiency | Emergency Department attendances against plan | Excludes planned followup attendances. | Green if on or above plan in month, amber if below plan by < 3%, red if below plan by > 3%. | Locally agreed targets. |
| Operational Performance | NHS Improvement governance rating | Trust performance on Monitor's risk assessment framework. | As per defined governance rating | as defined by NHS Improvement |
| Operational Performance | RTT Incomplete pathways performance | % incomplete pathways within 18 weeks | Green if latest month >=92%, Red if latest month <92%. | NHS England |
| Operational Performance | A&E 4 hour standard | % patients spending 4 hours or less in A&E. | Blue if latest month >=97%, Green if >=95% but <97%, red if latest month <95% | NHS England, NHS Improvement and contractual requirement of 95% and a locally agreed stretch target of 97%. |
| Operational Performance | Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals | % urgent GP referrals for suspected cancer seen within 14 days. | Green if latest month >=93%, Red if latest month <93%. | NHS England, NHS Improvement and contractual requirement |
| Operational Performance | Cancer - 14 days maximum wait from GP referral for symptomatic breast patients | % GP referrals for breast symptomatic patients seen within 14 days. | Green if latest month >=93%, Red if latest month <93%. | NHS England, NHS Improvement and contractual requirement |
| Operational Performance | Cancer - 31 days maximum wait from diagnosis to treatment for all cancers | % cancer patients starting first treatment within 31 days of diagnosis | Green if latest month >=96%, Red if latest month <96%. | NHS England, NHS Improvement and contractual requirement |
| Operational Performance | Cancer - 31 day wait for second or subsequent treatment: Surgery | % cancer patients starting subsequent surgical treatment within 31 days | Green if latest month >=94%, Red if latest month <94%. | NHS England, NHS Improvement and contractual requirement |
| Operational Performance | Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug | % cancer patients starting subsequent anti-cancer drug treatment within 31 days | Green if latest month >=96%, Red if latest month <96%. | NHS England, NHS Improvement and contractual requirement |
| Operational Performance | Cancer - 62 day wait for first treatment from urgent GP referral to treatment | % cancer patients starting first treatment within 62 days of urgent GP referral | Green if latest month >=85%, Red if latest month <85%. | NHS England, NHS Improvement and contractual requirement |
| Operational Performance | Cancer - 62 day wait for first treatment from consultant screening service referral | % cancer patients starting first treatment within 62 days of referral from a consultant screening service | Green if latest month >=90%, Red if latest month <90%. | NHS England, NHS Improvement and contractual requirement |
| Operational Performance | Cancer - 62 day wait for first treatment from consultant upgrade | % cancer patients starting first treatment within 62 days of consultant upgrade | Green if latest month >=85%, Red if latest month <85%. | NHS England, NHS Improvement and contractual requirement |
| Operational Performance | Children's Services - 10-14 day new birth visit | % new born visit within 14 days of birth | Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%. | Contractual requirement |
| Operational Performance | Children's Services - 2.5 year review | % children who had a 2 and a half year review | Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%. | Contractual requirement |

**Data quality assessment**

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

This page has been left blank

Harrogate and District
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Date of Meeting:** | 27th September 2017 | **Agenda item:** | 6.0 |
| **Report to:** | Board of Directors | | |
| **Title:** | Finance Report, including Financial Recovery Plan Monitoring and an update on CIP. | | |
| **Sponsoring Director:** | Jonathan Coulter, Finance Director | | |
| **Author(s):** | Jordan McKie, Deputy Finance Director | | |
| **Report Purpose:** | **Decision** ✓ **Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓ | | |
| **Executive Summary:** | • Financial deficit year to date of £5.2m<br>• Behind plan (excluding S&T funding) by £5.0m<br>• A range of recovery actions are being taken and are detailed in the report<br>• Cash remains a challenge despite an apparent healthy position at the end of August due to the timing of capital payments<br>• Use of resources rating of 3<br>• Formal request from NHSI to meet in October with Board members to discuss the financial position | | |

| **Related Trust Objectives** | | | | | |
|---|---|---|---|---|---|
| **To deliver high quality care** | | **To work with partners to deliver integrated care:** | | **To ensure clinical and financial sustainability:** | ✓ |

| **Key implications** | |
|---|---|
| **Risk Assessment:** | The current financial position is a high risk and is identified on the Corporate Risk Register as such |
| **Legal / regulatory:** | NHS Improvement Use of Resources rating is 3 |
| **Resource:** | None identified. |
| **Impact Assessment:** | Where appropriate QIAs have been completed for actions outlined in the financial recovery plan. |
| **Conflicts of Interest:** | None identified. |
| **Reference documents:** | None identified. |

| **Action Required by the Board of Directors:** |
|---|
| The Board is requested to note the financial position and the actions being taken to improve the current situation. |

This page has been left blank

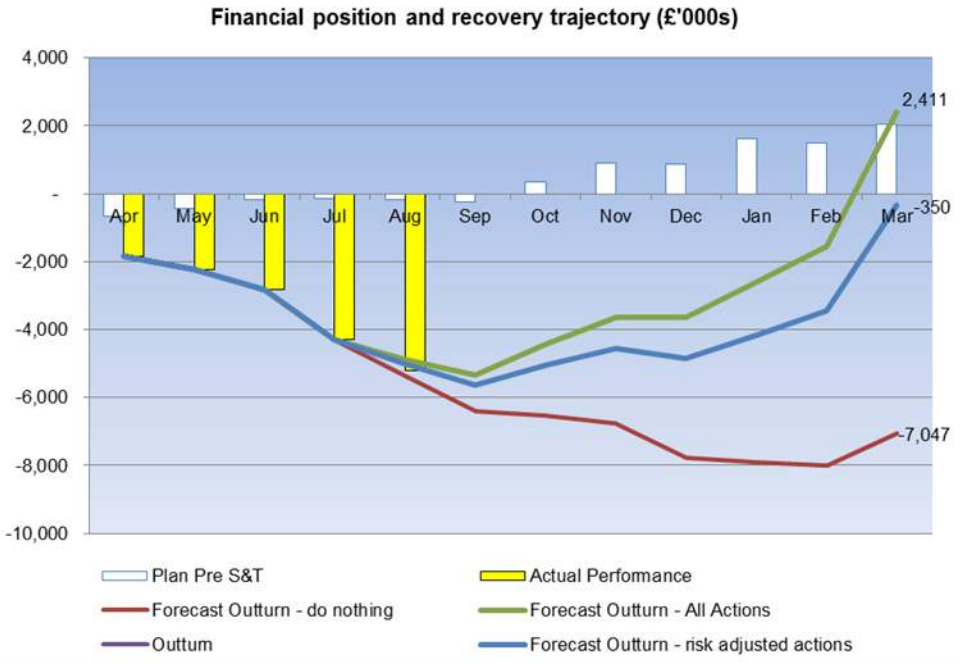
# August 2017 Financial Position

**Financial Performance**

- Financial performance continues to be a high risk to the Trust, with a deficit of £5.2m reported for the year to August. No Sustainability and Transformation Funding (STF) has been assumed in this position as a result of the adverse position. The Use of Resources rating remains as a 3. The position summarised in the table below -

| | Budget (£m) | Actual (£m) | Variance (£m) |
|---|---|---|---|
| Income | 88.908 | 86.350 | -2.558 |
| Expenditure | 89.075 | 91.563 | -2.488 |
| **Deficit before STF** | **-0.167** | **-5.213** | **-5.046** |
| | | | |
| **Surplus / deficit after STF** | **0.903** | **-5.213** | **-6.116** |

- The Trustwide recovery plan was outlined in detail at last months Board meeting. The graph below outlines performance against the anticipated trajectories.
- As demonstrated, the position has moved away from the previous run rate which is a positive start, and the actual expenditure in August was the lowest month's expenditure so far this year. However, the improvement expected in August was relatively modest and it is important that we start to see the benefit of our collective actions during the next few months.
- In September it is anticipated that greater benefits will be achieved as a result of improvements in activity levels, as well as reductions in ward expenditure, agency spend, non pay costs such as training, and improved performance against the cost improvement programme. Details of this can be found later in the document.
- Every single person in HDFT can make a difference and be part of recovering our financial position. It is vital that we get back on track and the work to date has been important in providing some momentum towards this.

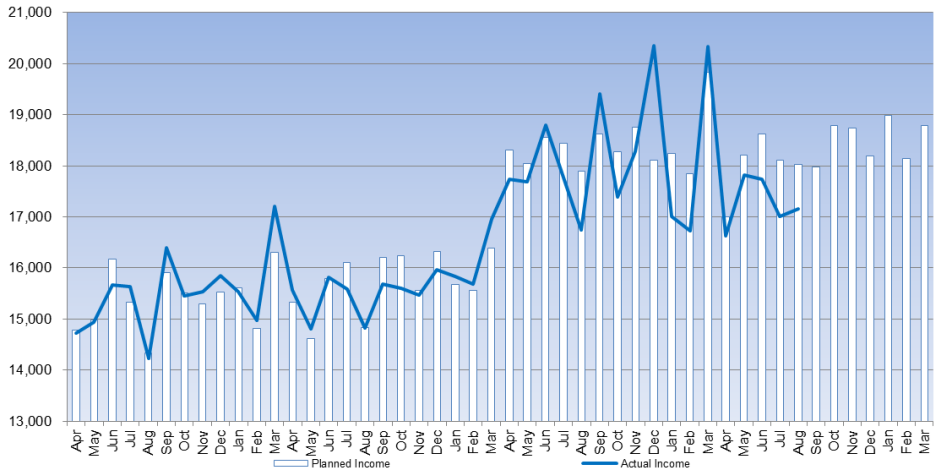


# Financial Position Continued

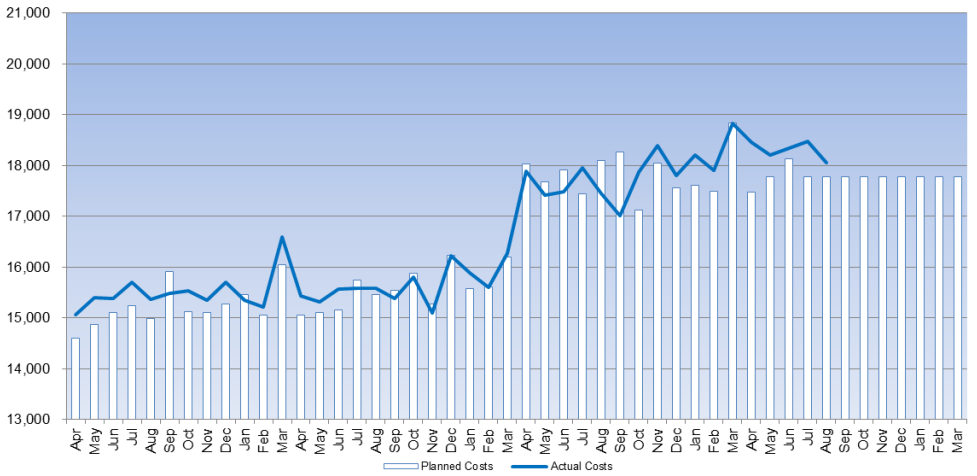
| | Budget | | Actual | Cumulative |
|---|---|---|---|---|
| | Annual Budget £000 | Proportion To Date £000 | To Date £000 | Variance £000 |
| **INCOME** | | | | |
| **NHS Clinical Income (Commissioners)** | | | | |
| NHS Clinical Income - Acute | 147,865 | 60,647 | 58,633 | (2,013) |
| NHS Clinical Income - Community | 52,413 | 21,821 | 21,430 | (391) |
| System Resilience & Better Care Funding | 913 | 381 | 381 | 0 |
| **Non NHS Clinical Income** | | | | |
| Private Patient & Amenity Bed Income | 1,472 | 614 | 583 | (31) |
| Other Non-Protected Clinical Income (RTA) | 523 | 218 | 199 | (18) |
| **Other Income** | | | | |
| Non Clinical Income | 11,800 | 5,214 | 5,111 | (104) |
| Hosted Services | 13 | 13 | 13 | 0 |
| **TOTAL INCOME** | **215,000** | **88,908** | **86,350** | **(2,558)** |
| **EXPENSES** | | | | |
| **Pay** | | | | |
| Pay Expenditure | (151,732) | (64,923) | (65,007) | (84) |
| **Non Pay** | | | | |
| Drugs | (7,585) | (6,011) | (5,889) | 122 |
| Clinical Services & Supplies | (15,237) | (6,759) | (6,769) | (10) |
| Other Costs | (17,729) | (8,876) | (9,925) | (1,049) |
| **Reserves :** Pay | (3,259) | (0) | 0 | 0 |
| Pay savings targets | 0 | 0 | 0 | 0 |
| Other Reserves | (4,006) | 1,093 | (45) | (1,138) |
| High Cost Drugs | (5,084) | 0 | 0 | 0 |
| Non Pay savings targets | 9 | 0 | 0 | 0 |
| **Other Finance Costs** | (18) | (7) | (6) | 1 |
| **Hosted Services** | (351) | (310) | (310) | (0) |
| **TOTAL COSTS** | (204,991) | (85,793) | (87,951) | (2,158) |
| **EBITDA** | **10,008** | **3,115** | **(1,601)** | **(4,716)** |
| Profit / (Loss) on disposal of assets | 0 | 0 | 0 | 0 |
| Depreciation | (5,081) | (2,117) | (2,243) | (126) |
| Interest Payable | (90) | (38) | (93) | (56) |
| Interest Receivable | 41 | 17 | 6 | (11) |
| Dividend Payable | (2,746) | (1,144) | (1,282) | (138) |
| **Net Surplus/(Deficit) before donations and impairmer** | **2,132** | **(167)** | **(5,213)** | **(5,046)** |
| Donated Asset Income | 0 | 0 | 0 | 0 |
| Impairments re Donated assets | 0 | 0 | 0 | 0 |
| Impairments re PCT assets | 0 | 0 | 0 | 0 |
| **Net Surplus/(Deficit)** | **2,132** | **(167)** | **(5,213)** | **(5,046)** |
| Consolidation of Charitable Fund Accounts | | | | |
| Sustainability and Transformation Fund | | | | |
| **Total and Consolidated Net Surplus/(Deficit)** | **2,132** | **(167)** | **(5,213)** | **(5,046)** |
| Technical Adjustments at Month 3 | | | | |
| Sustainability and Transformation Fund | 3,777 | 1,070 | 0 | (1,070) |
| **Operational Budgetary Position** | **5,909** | **903** | **(5,213)** | **(6,116)** |

# Financial Position Monthly Run Charts

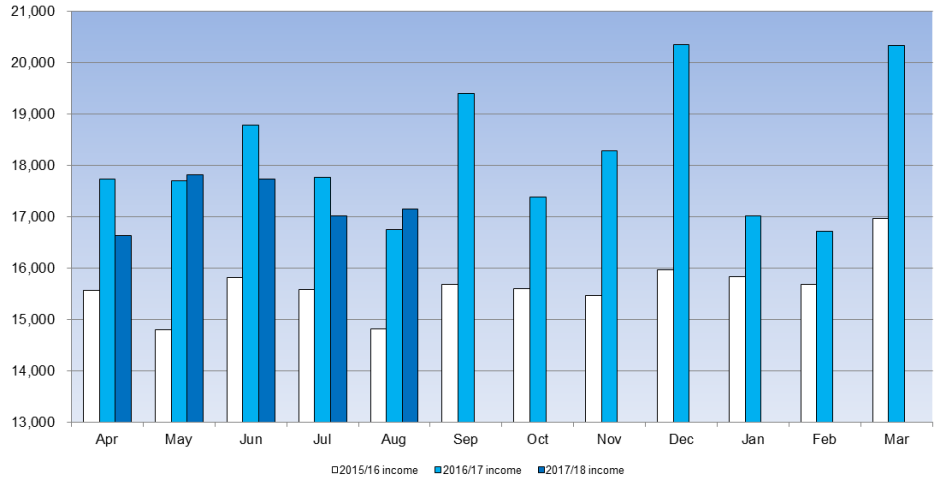
**Planned and Actual Income Apr 2014 - Mar 2018**



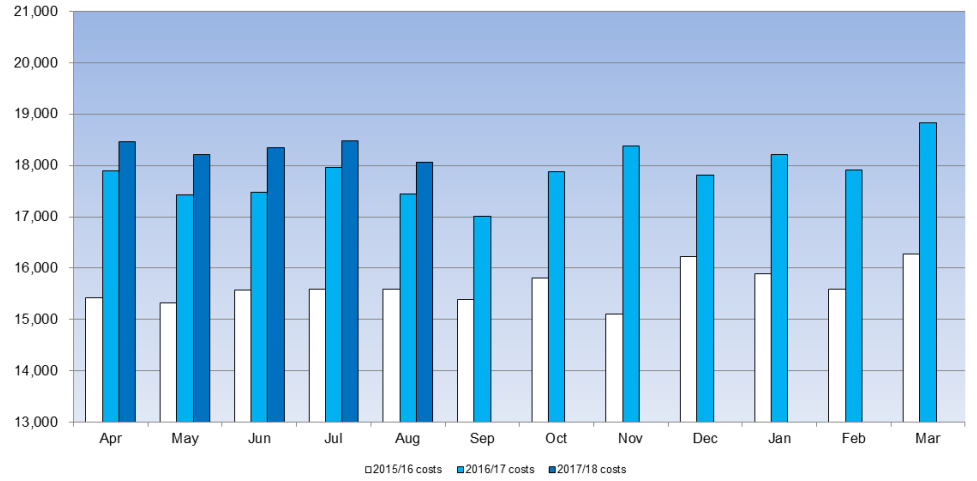

**Planned and Actual Costs Apr 2014 - Mar 2018**




**Actual Income 2015/16, 2016/17 & 2017/18**




**Actual costs 2015/16, 2016/17 & 2017/18**



# Financial Recovery Plan - Income

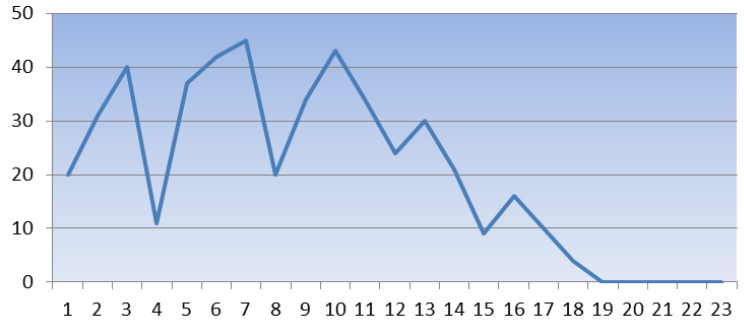
| | Planned Impact | | | | | | Planned improvements | | |
|---|---|---|---|---|---|---|---|---|---|
| | Aug | Total | RAG | Risk adjusted total | August Actual | Notes on progress to date | Sep | Oct | Nov |
| **Income** | | | | | | | | | |
| | | | | | | | | | |
| casemix | 145 | 390 | MEDIUM | 357 | 145 | Manual fix in place to recover comorbdity depth. Education and Awareness sessions undertaken. | 35 | 35 | 35 |
| locum T&O consultant | 0 | 510 | MEDIUM | 445 | 0 | Locum interviews undertaken, start date early November 2017. | 0 | 89 | 89 |
| GS / Gastro incl Wharfedale | 10 | 345 | HIGH | 168 | 0 | Discussions on going with GS consultants in order to progress changes, with commitment reached with three. Activity per list in WGH to increase from October, but still in process of organising extra lists | 48 | 48 | 48 |
| Ophthalmology | 0 | 231 | HIGH | 56 | 0 | Loss making lists stopped. Agreement for reduced payment for additional lists achieved as well as use of topical agent for cataracts. Impact from September. | 33 | 35 | 35 |
| professional leave | 0 | 375 | HIGH | 75 | 0 | Policy circulated for adoption | 0 | 65 | 65 |
| Activity recovery general | 0 | 1,211 | HIGH | 242 | 0 | Switch of Theatre lists for next 2 months agreed and being implemented. Outpatient clinic switch still under discussion on a specialty basis with some changes in place. | 173 | 181 | 181 |
| | | | | | | | | | |
| **sub-total** | 155 | 3,062 | HIGH | 1,343 | 145 | | 289 | 453 | 453 |

# Financial Recovery Plan Expenditure

| | Planned Impact | | | | | | Planned improvements | | |
|---|---|---|---|---|---|---|---|---|---|
| | Aug | Total | RAG | Risk adjusted total | August Actual | Notes on progress to date | Sep | Oct | Nov |
| **Spend** | | | | | | | | | |
| | | | | | | | | | |
| Ward Pay | 75 | 704 | HIGH | 496 | -58 | Above cap agency expenditure ceased mid month which has seen a postive impact, however, an increase in sickness and 1 to 1 care caused a pressure which is being addressed. | 75 | 104 | 85 |
| Theatre Pay | 0 | 162 | LOW | 157 | 0 | Theatre strategy signed off with new starters anticipated to have an impact in November. | -6 | -9 | 3 |
| Agency | 0 | 65 | LOW | 62 | 0 | Tenders for Direct Engagement currently under review. Implementation plan for Master Vendor model commenced. | 0 | 0 | 0 |
| Community | 0 | 139 | LOW | 132 | 23 | Ripon beds closed. | 0 | 23 | 23 |
| Additional Procurement Opportunities | 0 | 40 | LOW | 38 | 0 | Awaiting start date. | 0 | 0 | 0 |
| Additional CIP Requirement | 52 | 646 | HIGH | 416 | 52 | Additional plans under development. See CIP sheets for details. | 52 | 132 | 82 |
| | | | | | | | | | |
| **sub total** | 127 | 1,756 | HIGH | 1,300 | 17 | | 121 | 250 | 194 |

Despite the adverse variance in month relating to the ward position, this should improve with above cap agency nursing stopping following the introduction of these plans.

**Inpatient Wards - Above cap agency shifts by week 2017/18**



# Financial Recovery Plan Cont

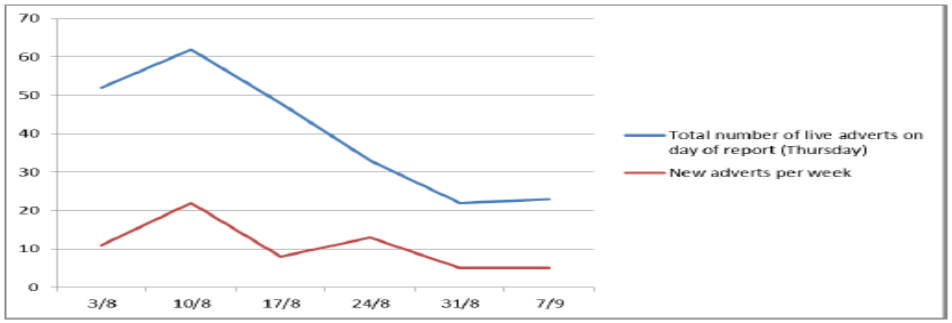
| | Planned Impact | | | | | | Planned improvements | | |
|---|---|---|---|---|---|---|---|---|---|
| | Aug | Total | RAG | Risk adjusted total | August Actual | Notes on progress to date | Sep | Oct | Nov |
| **Other** | | | | | | | | | |
| Board contingency | 83 | 667 | LOW | 633 | 83 | Board contingency phased into plan. | 83 | 83 | 83 |
| capitalisation | 22 | 178 | LOW | 169 | 22 | Continued assessment of ensuring expenditure is capitalised w here appropriate. | 22 | 22 | 22 |
| ASDM | 0 | 1,486 | MEDIUM | 1,232 | 0 | External support appointed and scoping underw ay for business case later this month. | 0 | 0 | 0 |
| Provisions | 0 | 300 | LOW | 285 | 0 | Work in relation to annual leave provision complete. | 0 | 0 | 0 |

# Financial Recovery Plan Cont

| | Planned Impact | | | | | | Planned improvements | | |
|---|---|---|---|---|---|---|---|---|---|
| | Aug | Total | RAG | Risk adjusted total | August Actual | Notes on progress to date | Sep | Oct | Nov |
| **Further Controls** | | | | | | | | | |
| Holding Vacancies | 0 | 945 | MEDIUM | 756.0 | 0 | Vacancy control process in place and reviewing all vacancies. Monitoring recruitment activity to assess benefit. | | 45 | 90 |
| Corporate Services Actions | 80 | 545 | LOW | 517.7 | 35 | Some schemes have progressed. QIA undertaken in some areas with some domestics schemes being removed as a result. | 42 | 70 | 70 |
| Non Pay Control | 0 | 210 | MEDIUM | 168.0 | 0 | A number of schemes underway as well as greater awareness. Weekly monitoring shows number of orders and value to have reduced. | | 35 | 35 |
| Reduce overtime/additional hours | 0 | 140 | LOW | 133.0 | 17 | Reduction since recovery plans put in place. Review occuring across directorates. | 20 | 20 | 20 |
| Training | 0 | 169 | LOW | 160.6 | 0 | Anticpated impact expected in September. | 39 | 39 | 39 |
| Other | | 0 | | | | | | | |
| **Total Benefit** | 80 | 2,009 | | 1,735 | 52 | | 101 | 209 | 254 |

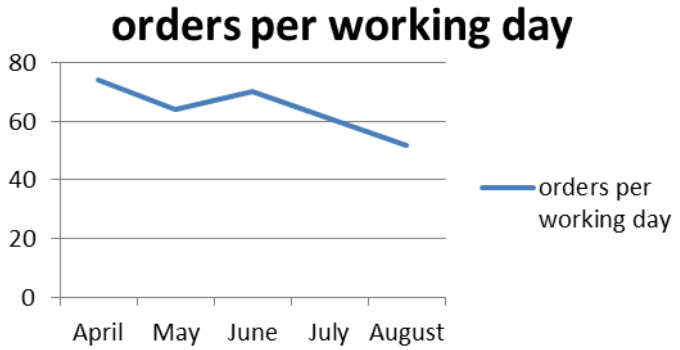
## Holding Vacancies

The graph outlines the change in recruitment activity since the scheme commenced



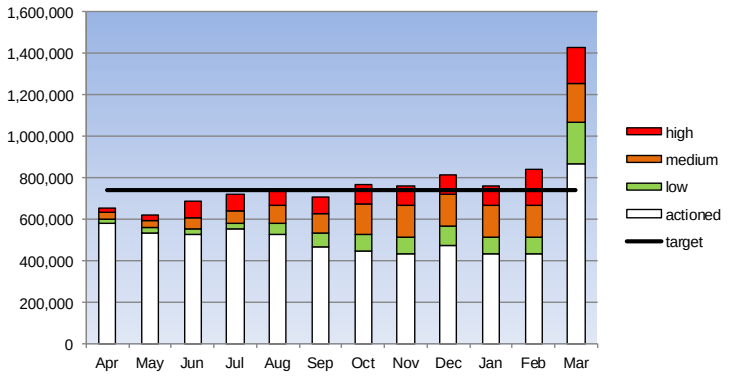

## Non-pay

The graph outlines the orders per working day since April:



# Efficiency Programme

## Trustwide Cost Improvement Programme 2017/18

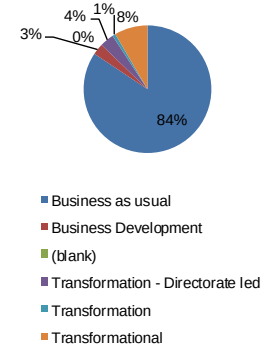



| Summary | Target | Actioned | Low | Medium | High | Total | Total %age | Risk Adjust | Risk Adj %age |
|---|---|---|---|---|---|---|---|---|---|
| Trustwide | 9,409,800 | 6,245,513 | 944,233 | 1,313,216 | 1,018,206 | 9,521,169 | 101% | 8,396,749 | 89% |
| | % age of target | | 10% | 14% | 11% | | | | |

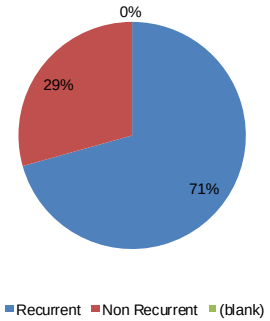
**Top 10 unactioned schemes** Top 10 as % of schemes - 19%

| No. | Scheme | Directorate | Value | Risk |
|---|---|---|---|---|
| 1 | Inpatient flow | Planned Care | 267,230 | high |
| 2 | Review of Inpatient Workstream | LTUC | 250,000 | medium |
| 3 | Review of Recruitment Process | LTUC | 240,000 | medium |
| 4 | Theatre Utilisation | Planned Care | 208,333 | high |
| 5 | Vacancy control | LTUC | 164,000 | low |
| 6 | Endoscopy scheme | Planned Care | 159,143 | high |
| 7 | Outpatient Productivity | LTUC | 150,000 | medium |
| 8 | Pharmacy savings | LTUC | 134,000 | medium |
| 9 | Pathology efficiency | LTUC | 121,100 | low |
| 10 | Business Development Programme | Planned Care | 120,000 | low |

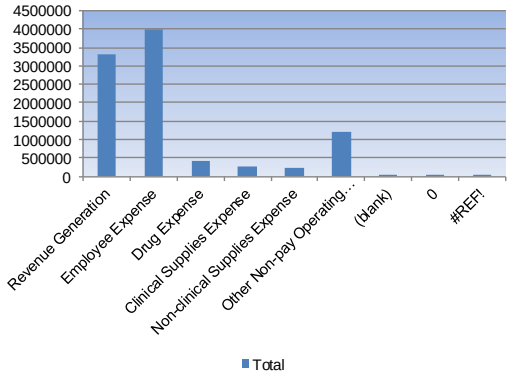
**CIP schemes by internal category**



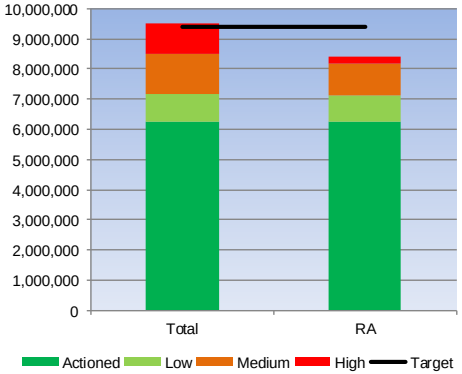

**Recurrent V Non Recurrent Plans**




**Efficiency Category**



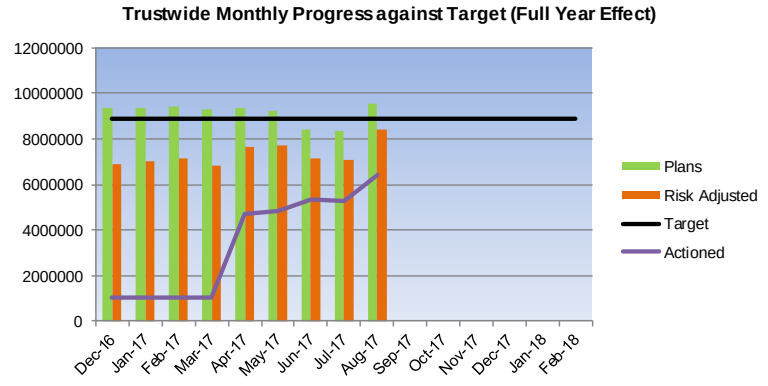

**Risk Profile**



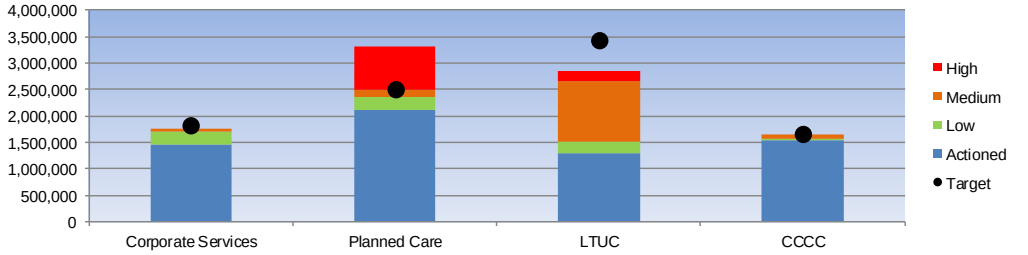
# Efficiency Programme Cont.

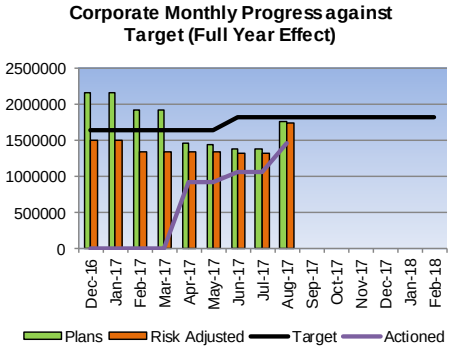
The CIP target was increased to £9.4m in June with new targets issued to each of the directorates. Current performance shows that plans are in place for 101% of this target, however the risk adjusted total outlines potential delivery of 89%

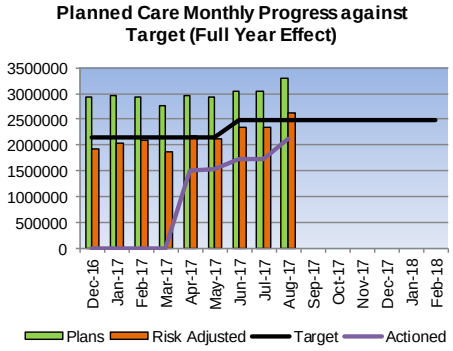
## Trustwide Cost Improvement Programme 2017/18

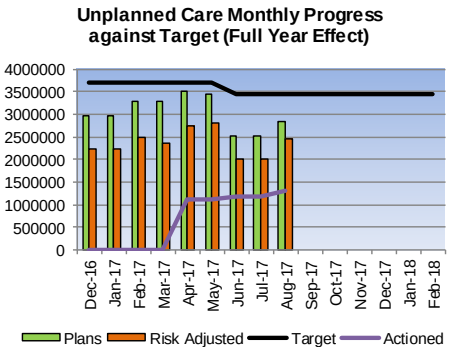


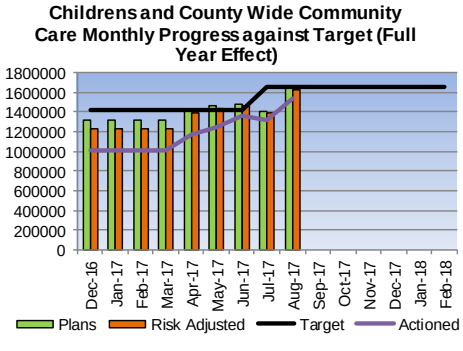

| Summary | Target | Actioned | Low | Medium | High | Total | Total %age | Risk Adjust | Risk Adj %age |
|---|---|---|---|---|---|---|---|---|---|
| Corporate Services | 1,818,900 | 1,452,350 | 248,800 | 49,300 | 0 | 1,750,450 | 96% | 1,728,150 | 95% |
| Planned Care | 2,497,000 | 2,120,763 | 227,833 | 151,127 | 804,506 | 3,304,230 | 132% | 2,619,008 | 105% |
| LTUC | 3,446,000 | 1,292,800 | 217,100 | 1,158,200 | 165,800 | 2,833,900 | 82% | 2,458,765 | 71% |
| CCCC | 1,647,900 | 1,541,100 | 35,000 | 71,800 | 0 | 1,647,900 | 100% | 1,631,790 | 99% |

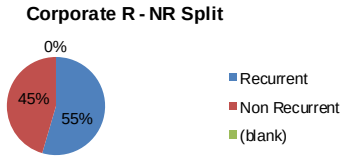


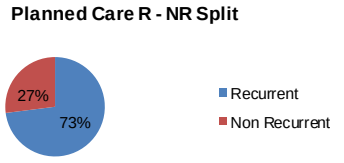



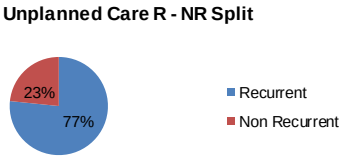



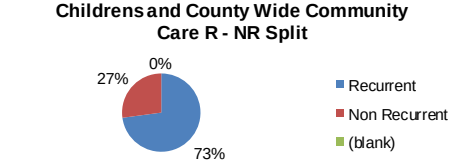



# Cashflow

As a result of the financial position and a number of historic issues the cash position for the Trust remains challenging.

The August position highlights an apparent improvement with a balance of £8.4m reported at the end of the month. The main driver for this is the timing of cash flows related to the capital programme. As the forecast position shows this will reduce significantly in the coming months.

The forecast position is based on the “Do Nothing” forecast outturn highlighted on page 1, as well as significant reductions to the capital programme. Any improvements to the financial position will obviously have a positive impact in this area.

As well as the pressure from the current position, a number of debts remain outstanding with other organisations. The top 5 organisations are outlined the table below, as well as the age profile of outstanding invoices.


| Outstanding Accounts Receivable Debts - AUGUST 2017 | 0 to 30 Days £000 | 31 to 60 Days £000 | 61 to 90 Days £000 | Over 91 Days £000 | Total £000 |
|---|---|---|---|---|---|
| NHS/WGA Debts | 462 | 40 | 2,858 | 6,048 | 9,408 |
| Insurance Companies | 47 | 35 | 12 | 16 | 110 |
| Other | 143 | 341 | 212 | 1,810 | 2,506 |
| **Totals** | 652 | 416 | 3,082 | 7,874 | 12,024 |

| August 2017 - Top 5 Receivables by organisation | £ |
|---|---|
| NHS HARROGATE AND RURAL DISTRICT CCG | 5,863,754.96 |
| NHS SCARBOROUGH AND RYEDALE CCG | 769,337.95 |
| NHS VALE OF YORK CCG | 746,390.65 |
| NORTH YORKSHIRE COUNTY COUNCIL | 713,368.77 |
| NHS HAMBLETON RICHMONDSHIRE AND WHITBY CCG | 577,308.74 |
| | **8,670,161.07** |

Harrogate and District
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Date of Meeting:** | 27th September 2017 | **Agenda item:** | 6.1 |
| **Report to:** | Board of Directors | | |
| **Title:** | Review of Treasury Management Policy | | |
| **Sponsoring Director:** | Jonathan Coulter, Finance Director & Deputy Chief Exec | | |
| **Author(s):** | Neil Outhwaite, Finance Analyst | | |
| **Report Purpose:** | **Decision** ✓ **Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓ | | |
| **Executive Summary:** | • The Trust's Treasury Management Policy has been reviewed by the Audit Committee (September 2017). The Audit Committee approved the policy and recommended onward approval by the Board. | | |

| **Related Trust Objectives** | | | | | |
|---|---|---|---|---|---|
| **To deliver high quality care** | | **To work with partners to deliver integrated care:** | | **To ensure clinical and financial sustainability:** | |

| **Key implications** | |
|---|---|
| **Risk Assessment:** | 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 / regulatory:** | NHS Improvement requirement. |
| **Resource:** | None identified. |
| **Impact Assessment:** | Not applicable. |
| **Conflicts of Interest:** | None identified. |
| **Reference documents:** | HDFT Treasury Management Policy V13 2017 |

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

This page has been left blank

Harrogate and District
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 |
| 12 | Sept 2016 | 12 month review of Policy | August 2017 |
| 13 | Aug 2017 | 12 month review of Policy | July 2018 |

| | | |
|---|---|---|
| **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 28 August 2017** |
| **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<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>Oct 2015<br>Sep 2016<br>Aug 2017 |

**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 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 NHS Improvement'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 NHS Improvement's safe harbour criteria.
- Revenue repurchase transactions where collateral is securities backed by the UK Government and the counterparty is a permitted institution under the NHS Improvement's definition.

## 5 APPROVED INVESTMENT INSTITUTIONS

The Department of Health changed the methodology for 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 0.25% 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 0.25%, 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 NHS Improvement. 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 |
| | |
| | |
| | |
| | |
| | |

NHS
Harrogate and District
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Date of Meeting:** | 27th September 2017 | **Agenda item:** | **7.0** |
| **Report to:** | Board of Directors | | |
| **Title:** | Chief Operating Officer's Report | | |
| **Sponsoring Director:** | Mr Robert Harrison, Chief Operating Officer | | |
| **Author(s):** | Ms Rachel McDonald, Head of Performance and Analysis<br>Mr Jonathan Green, Information Analyst Specialist | | |
| **Report Purpose:** | **Decision** [ ] **Discussion/ Consultation** [✓] **Assurance** [✓] **Information** [✓] | | |
| **Executive Summary:** | • Elective admissions remain below plan, with the impact from SSD and theatre refurbishment in July and August causing significant impact.<br>• Provisional data indicates that delivery of the 62 day standard for August and Quarter 2 will be achieved. | | |

| **Related Trust Objectives** | | | | | |
|---|---|---|---|---|---|
| **To deliver high quality care** | ✓ | **To work with partners to deliver integrated care:** | ✓ | **To ensure clinical and financial sustainability:** | ✓ |

| **Key implications** | |
|---|---|
| **Risk Assessment:** | Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF 4: risk of a lack of interoperable systems across New Care Models partners; BAF 9: risk of a failure to deliver the operational plan; BAF 10: risk of a breach of the terms of the NHS Provider licence; BAF 16: risk to delivery of integrated care models. |
| **Legal / regulatory:** | None identified. |
| **Resource:** | None identified. |
| **Impact Assessment:** | Not applicable. |
| **Conflicts of Interest:** | None identified. |
| **Reference documents:** | |

| **Action Required by the Board of Directors:** |
|---|
| It is recommended that the Board of Directors receive and note the content of the report. |

# CHIEF OPERATING OFFICER'S REPORT
# Board of Directors' meeting 27th September 2017

## 1.0 SERVICE ACTIVITY

The table below summarises the year to date position on activity for the main points of delivery.

| | Jul-17 | | | Aug-17 | | | Aug-17 YTD | | |
|---|---|---|---|---|---|---|---|---|---|
| **Activity type** | **Actual** | **Plan** | **Variance** | **Actual** | **Plan** | **Variance** | **Actual** | **Plan** | **Variance** |
| **New outpatients** | 7926 | 8167 | -2.9% | 8084 | 8556 | -5.5% | 39762 | 40445 | -1.7% |
| **Follow-up outpatients** | 15134 | 16379 | -7.6% | 15301 | 17159 | -10.8% | 77520 | 81116 | -4.4% |
| **Elective inpatients** | 247 | 307 | -19.5% | 244 | 305 | -20.0% | 1390 | 1573 | -11.7% |
| **Elective day cases** | 2343 | 2498 | -6.2% | 2364 | 2466 | -4.1% | 11648 | 12508 | -6.9% |
| **Non-electives** | 1853 | 1844 | 0.5% | 1777 | 1735 | 2.4% | 9157 | 8893 | 3.0% |
| **A&E attendances** | 4296 | 4120 | 4.3% | 3999 | 4120 | -2.9% | 20890 | 20333 | 2.7% |

For Leeds North CCG, new outpatient activity was 4.2% above plan and ED attendances were 7% above plan. For the period April-August, there has also been an increase in non-elective activity from Leeds North CCG, particularly in General Medicine. This has contributed to the overall increase in non-elective activity from all commissioners YTD of 4.5% (6% in August).

The Trust remains significantly behind plan for elective admissions – both inpatients and day cases. It should be noted that the majority of recovery plan actions will only begin to impact in September. July and August activity was impacted on by the planned temporary relocation of sterile services off site and alterations being made to lists to ensure that kit was available for the procedures booked. In addition to this, annual leave was encouraged to help manage this period and as a result of this, a high number of clinical staff had significant leave which also impacted on the volume of activity.

Activity has also been impacted by continued sickness of one Orthopaedic surgeon during recent months and in July, one General Surgeon.

Actions being undertaken to improve the activity position include:

- The alteration of clinic templates to increase the number of new patients seen per clinic;
- Replacing 10 other specialty theatre lists with T&O during September and October;
- The recruitment of a locum T&O consultant due to start November;
- Ongoing actions regarding ensuring clinics are filled at short notice when patient cancellations free up slots;
- Increasing the number of patients on each Wharfedale endoscopy list commencing in the last week in September;
- Increasing Saturday day surgery lists to additional specialties and utilising the skills of SAS doctors more and where possible, running lists without anaesthetists (local anaesthetic lists only) for appropriate cases, to therefore reduce costs and increase margin;
- Progression of the Ophthalmology anaesthetic drops list with agreement from one consultant to undertake these at the new remuneration level. This consultant is working with the management team in order that all the requirements are in place with the aim of running the first Saturday list from 7th October;
- Progression of the theatre staffing strategy with internal interviews undertaken in September for the leadership roles. The main theatre role was not recruited to and has now been advertised externally;

- Work continues with regards to theatre productivity with a focus currently on list start times. This work is being led through the transformation programme.

## 2.0 CHILDREN'S SERVICES

Many of the local authorities namely Middlesbrough, Darlington and North Yorkshire (where HDFT 0-19 services are commissioned) are either in the process of consulting upon or at the publishing stage of the new Children & Young People's plan. These strategic plans will outline the key priorities for children's services over a 3 year period which HDFT services will deliver to. This will incorporate the re-establishment of Children's Trusts to ensure there is a sharper focus on the needs of children and young people. A primary theme in all of these plans is emotional well-being.

HDFT Children's Services have been preparing for a CQC (Care Quality Commission) thematic review of mental health services for children and young people. This will incorporate nationally ten Health and Wellbeing Board areas, which will include North Yorkshire. This will take place in September and is being over seen by commissioners.

## 3.0 CANCER SERVICES

Performance

Trust performance for the 62 day standard was below 85% in July (83.2%), but projected performance for August and Quarter 2 is above the expected standard at 90.1% and 86.5% respectively.

Following the latest breach analysis meeting, several key issues and themes were identified as being contributory factors in the high 62 day breach count for July:

- Patients seen after day 7 for their first outpatient appointment;
- Radiology diagnostic capacity and reporting timescales;
- TRUS (prostate biopsy) pathway for prostate patients;
- Pathway and timeline for suspected non-melanoma skin cancers;
- Waits for EBUS (Endobronchial Ultrasound) at Leeds;
- Administration delays in typing and approving of letters.

These issues are being addressed in order to improve patient pathways and performance.

One patient breached the 31 day surgical subsequent treatment standard in August, meaning that provisional performance for the month fell below the expected 94% standard with 92.3% of 13 patients treated within 31 days. However, projected performance for Quarter 2 is at 96.6% for this standard.

Inter-Provider Transfer (IPT) performance

As stated above, projected performance for August with the current allocation rules is at 89.9%. A total of 19 patients were treated at tertiary centres in the month following a 2WW referral to Harrogate. Of these, 13 were transferred by day 38 (68.4%).

Shadow reporting of the 62 day standard shows that when the WYH draft policy interpretation of the national guidance re-allocation rules are applied, performance would be 0.2% lower for August but would still be above the expected standard at 89.9%. Please find below a comparator table illustrating HDFT's performance when re-allocation rules are applied.

| ACTUAL performance | Apr-17 | May-17 | Jun-17 | Q1 | Jul-17 | Aug-17 | Sep-17 | Q2 |
|---|---|---|---|---|---|---|---|---|
| Total | **50.0** | **57.5** | **58.0** | **165.5** | **47.5** | **60.5** | | **108.0** |
| Within 62 days | 44.0 | 48.0 | 50.5 | **142.5** | 39.5 | 54.5 | | **94.0** |
| Outside 62 days | 6.0 | 9.5 | 7.5 | **23.0** | 8.0 | 6.0 | | **14.0** |
| Performance | 88.0% | 83.5% | 87.1% | **86.1%** | 83.2% | 90.1% | | **87.0%** |

| Re-allocation (NATIONAL) | Apr-17 | May-17 | Jun-17 | Q1 | Jul-17 | Aug-17 | Sep-17 | Q2 |
|---|---|---|---|---|---|---|---|---|
| Total | **48.5** | **57.5** | **57.5** | **163.5** | **47.0** | **59.5** | | **106.5** |
| Within 62 days | 40.5 | 50.0 | 47.0 | **137.5** | 39.5 | 53.5 | | **93.0** |
| Outside 62 days | 8.0 | 7.5 | 10.5 | **26.0** | 7.5 | 6.0 | | **13.5** |
| Performance | 83.5% | 87.0% | 81.7% | **84.1%** | 84.0% | 89.9% | | **87.3%** |

| Difference (National/Actual) | Apr-17 | May-17 | Jun-17 | Q1 | Jul-17 | Aug-17 | Sep-17 | Q2 |
|---|---|---|---|---|---|---|---|---|
| Total | **-1.5** | **0.0** | **-0.5** | **-2.0** | **-0.5** | **-1.0** | | **-1.5** |
| Within 62 days | -3.5 | 2.0 | -3.5 | **-5.0** | 0.0 | -1.0 | | -1.0 |
| Outside 62 days | 2.0 | -2.0 | 3.0 | **3.0** | -0.5 | 0.0 | | -0.5 |
| % difference | -4.5% | 3.5% | -5.3% | **-2.0%** | 0.9% | -0.2% | | **0.3%** |

| Re-allocation (WYH policy) | Apr-17 | May-17 | Jun-17 | Q1 | Jul-17 | Aug-17 | Sep-17 | Q2 |
|---|---|---|---|---|---|---|---|---|
| Total | **46.5** | **59.5** | **54.5** | **160.5** | **47.5** | **59.5** | | **107.0** |
| Within 62 days | 38.5 | 52.0 | 44.0 | **134.5** | 40.0 | 53.5 | | **93.5** |
| Outside 62 days | 8.0 | 7.5 | 10.5 | **26.0** | 7.5 | 6.0 | | **13.5** |
| Performance | 82.8% | 87.4% | 80.7% | **83.8%** | 84.2% | 89.9% | | **87.4%** |

| Difference (WYH policy/Actual) | Apr-17 | May-17 | Jun-17 | Q1 | Jul-17 | Aug-17 | Sep-17 | Q2 |
|---|---|---|---|---|---|---|---|---|
| Total | **-3.5** | **2.0** | **-3.5** | **-5.0** | **0.0** | **-1.0** | | **-1.0** |
| Within 62 days | -5.5 | 4.0 | -6.5 | **-8.0** | 0.5 | -1.0 | | **-0.5** |
| Outside 62 days | 2.0 | -2.0 | 3.0 | **3.0** | -0.5 | 0.0 | | **-0.5** |
| % difference | -5.2% | 3.9% | -6.3% | **-2.3%** | 1.1% | -0.2% | | **0.3%** |

| IPTs (actual patients) SENT | Apr-17 | May-17 | Jun-17 | Q1 | Jul-17 | Aug-17 | Sep-17 | Q2 |
|---|---|---|---|---|---|---|---|---|
| Total | **10** | **22** | **18** | **50** | **15** | **19** | | **34** |
| Within 38 days | 3 | 14 | 7 | **24** | 8 | 13 | | **21** |
| Outside 38 days | 7 | 8 | 11 | **26** | 7 | 6 | | **13** |
| Performance | 30.0% | 63.6% | 38.9% | **48.0%** | 53.3% | 68.4% | | **61.8%** |

Oncology

The Trust continues to have pressures in relation to the provision of acute Oncology since the substantive consultant left the Trust. The Trust was not successful in recruiting a substantive replacement and it is felt this is due to the post being unattractive due to the amount of acute work the post-holder is expected to undertake.

An agency consultant is currently covering the post. A meeting has been arranged with Leeds and York to discuss a work plan that shares the acute oncology cover between the Harrogate funded agency post and the visiting consultants. If Leeds and York support this approach, the substantive consultant vacancy will be advertised again with a job plan that reflects this new way of working.

## 4.0 NATIONAL CANCER PATIENT EXPERIENCE SURVEY

The results of the National Cancer Patient Experience Survey 2016 were published in July 2017. Responses to the survey questionnaire were received from 298 HDFT patients which equates to a response rate of 73%, compared to the national average of 63%.

Quality health highlighted the following points for HDFT:

1. HDFT average rating of care was rated as 9 out of 10 which scored above the national average score of 8.7.

2. The section ‘Support for cancer’ was the highest performing section for HDFT with an average score of 91% whilst the national average score for this section was 75.2%

3. Question 25 regarding the information needed about operations, HDFT scored 99% which was 3% higher than the national average for all trusts.

4. 89% of patients felt they were told sensitively that they had cancer.

5. HDFTs lowest score was 46% on a question regarding if patients had received a care plan. However, the national average score for this question was 33%.

Compared to the previous year, HDFT dropped scores for the following questions:

- Q28. Groups of doctors or nurses did not talk in front of patients as if they were not there.
- Q36. Hospital staff definitely did everything to help control pain.
- Q37. Always treated with respect and dignity by staff.
- Q39. Staff told patient who to contact if worried post discharge.

The drops in scores for these questions weren’t significantly high; in comparison to 2015, there was an average 3% decrease in score.

*At this present time, the full national data set is not available so it is not possible to see how HDFT ranks in comparison to other Trusts.*

## 5.0 STROKE SERVICES

Regrettably the Trust has had to divert acute Stroke patients to York Teaching Hospital due to nurse staffing levels which have meant we have not been able to staff the Hyper Acute Stroke Unit with appropriately trained staff. The nurse staffing issues are due to a number of factors including vacancies, short term sickness and maternity leave. The significant reduction in the use of above cap agency has contributed to wider staffing challenges, however agency staff are not regularly utilised for to staff the HASU. This has been agreed with York for a two week period while we review our staffing position. The number of patients affected has been small with provisional information showing four patients have been transferred to York, of which one was admitted for Thrombolysis in the first 5 days.

## 6.0 CARBON AND ENERGY FUND

On 13th September 2017, the Quarter 2 monitoring and verification is scheduled to be held. At this present time, the submissions from Imtech and CEF have not been obtained. However Trust monitoring of the CHP operations illustrates that there has been a significant period of downtime which will affect the energy saving achieved.

This continues to be robustly implemented with respect to the maintenance contract and associated KPIs. This has led to 3 months where the Trust has not paid any maintenance charge. A saving of £104,553 including VAT has resulted from this.

The KPI penalties were applied to failure to deliver the defined chilled water and hot water temperatures. These variances however did not materially have an impact in the operation of the hospital.

## 7.0 FIRE RISK ASSESSMENTS

Work is ongoing with NHS Property Services (PS) and Trust staff in order to ensure all Fire Risk Assessments (FRA) are in place in the community properties. NHS PS have now agreed to undertake compartmentalisation surveys and are now progressing. The HDFT SALUS (Health and Safety) book has a fire risk assessment section which each manager undertakes for their respective area, and as part of this year's audit a specific request has been made to the auditor to check these in the community properties that are being included in the audit. This will help identify any areas that require additional support for the Trust Fire officer.

Harrogate and District NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Date of Meeting:** | 27 September 2017 | **Agenda item:** | 7.1 |
| **Report to:** | Board of Directors | | |
| **Title:** | Emergency Preparedness, Resilience and Response (EPRR) Core Standards Annual Assurance | | |
| **Sponsoring Director:** | Mr Robert Harrison, Chief Operating Officer (Accountable Emergency Officer) | | |
| **Author(s):** | Mrs Frances Bowden, Clinical Operations Manager<br>Mr Michael England, Emergency Planning Officer | | |
| **Report Purpose:** | **Decision** ✓ **Discussion/ Consultation** **Assurance** **Information** | | |
| **Executive Summary:** | • Self-assessment against NHS England Core Standards for EPRR<br>• Statement of Compliance: Substantial<br>• Improvement plan to address actions arising from self-assessment and assurance process | | |

| **Related Trust Objectives** | | | | | |
|---|---|---|---|---|---|
| **To deliver high quality care** | | **To work with partners to deliver integrated care:** | ✓ | **To ensure clinical and financial sustainability:** | ✓ |

| **Key implications** | |
|---|---|
| **Risk Assessment:** | Medium Risk associated with the limited compliance with Core Standards relating to CBRN/Hazmat training. Included on Operational Delivery Risk Register ref. EP2. |
| **Legal / regulatory:** | Providers of NHS funded services must comply with NHS England Core Standards for EPRR in accordance with the CCA 2004 and NHS Act 2006 (as amended) |
| **Resource:** | None |
| **Impact Assessment:** | Not applicable |
| **Conflicts of Interest:** | None |
| **Reference documents:** | NHS England EPRR Framework |

| **Action Required by the Board of Directors:** |
|---|
| The Board of Directors are asked to approve the EPRR Statement of Compliance and delegate responsibility for signing the statement to Mr R Harrison, Chief Operating Officer/Accountable Emergency Officer for the Trust<br><br>Board to determine whether a Non-executive Director is allocated to hold the EPRR portfolio for the organisation as identified in the EPRR deep dive topic into EPRR organisational governance. |

This page has been left blank

**Yorkshire and the Humber Local Health Resilience Partnership (LHRP)**
**Emergency Preparedness, Resilience and Response (EPRR) assurance 2017-2018**

## STATEMENT OF COMPLIANCE

Harrogate District NHS Foundation Trust has undertaken a self-assessment against required areas of the NHS England Core Standards for EPRR v5.0.

Following assessment, the organisation has been self-assessed as demonstrating the Substantial compliance level (from the four options in the table below) against the core standards.

| Compliance Level | Evaluation and Testing Conclusion |
|---|---|
| Full | Arrangements are in place and the organisation is fully compliant with all core standards that the organisation is expected to achieve. The Board has agreed with this position statement. |
| Substantial | Arrangements are in place however the organisation is not fully compliant with one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed. |
| Partial | Arrangements are in place however the organisation is not fully compliant with six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed. |
| Non-compliant | Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board or Governing Body and will be monitored on a quarterly basis in order to demonstrate future compliance. |

Where areas require further action, this is detailed in the attached core standards improvement plan and will be reviewed in line with the organisation's EPRR governance arrangements.

I confirm that the organisation has undertaken the following exercises on the dates shown below:

| | |
|---|---|
| A live exercise (required at least every three years) | 09/11/2016 |
| A desktop exercise (required at least annually) | 09/11/2016 |
| A communications exercise (required at least every six months) | 25/07/2017 |

I confirm that the relevant teams in my organisation have considered the debrief reports and actions required from the cyber incident at North Lincolnshire and Goole NHS FT and The Leeds Teaching Hospitals NHS Trust Pathology Incident. A plan for the identified actions arising is available.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

_____

Signed by the organisation's Accountable Emergency Officer

Click here to enter a date.
Date of Board / governing body meeting

Click here to enter a date.
Date signed

This page has been left blank

# Yorkshire and the Humber EPRR core standards improvement plan 2017-18

Organisation: Harrogate & District NHS Foundation Trust

## ACTIONS AND PROGRESS FROM 2016 / 2017

| Core standard reference | Core standard description | Improvement required to achieve compliance | Action to deliver improvement | Update on progress since last year |
|---|---|---|---|---|
| DD1 | Organisation has undertaken a Business Impact Assessment | Undertake Business Impact Assessment | Undertake risk based Business Impact Assessment of services, taking into account the resources required against staffing, premises, information and information systems, supplies and suppliers.<br>Ensure Risks identified are reflected as a appropriate on the relevant risk registers | BIA undertaken by directorates and services as part of their Business Continuity Planning process |
| DD2 | Organisation has explicitly identified its Critical Functions and set Minimum Tolerable Periods of disruption for these | Organisational BCP and BCP's for Critical Clinical Areas exist however detailed BCP's need developing for a number of other areas | Develop detailed BCP's for critical functions that remain outstanding. | Majority Complete. A small number of exceptions which will be done in the next 3 months |

*Add further rows as required*

## ACTIONS ARISING FROM 2017 / 2018 ASSURANCE PROCESS

| Core standard reference | Core standard description | Improvement required to achieve compliance | Action to deliver improvement | Deadline |
|---|---|---|---|---|
| 56 | Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7. | Improve CBRN/Hazmat Training compliance | CBRN training planned for 2017 at ED training days (See Y&H CBRN/Hazmat audit 2017). Training sessions are booked in. | Dec 2017 |
| 57 | Staff on-duty know who to contact to obtain specialist advice in relation to a HAZMAT/ CBRN incident and this specialist advice is available 24/7. | Raise awareness through training and ensure contact details for specialist advise is included in the CBRN/Hazmat policy | CBRN training planned for 2017 at ED training days (See Y&H CBRN/Hazmat audit 2017)<br>Clinical review of CBRN/Hazmat Policy | Dec 2017 |
| 65 | The organisation has sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme. | Improve CBRN/Hazmat Training compliance | Clinical Service Manager to follow up with YAS certification requirements to ensure we are able to provide appropriate training going forward. (See Y&H CBRN/Hazmat audit 2017) | Dec 2017 |

| | | | | |
|---|---|---|---|---|
| 66 | Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant. | Improve CBRN/Hazmat Training compliance | CBRN training planned for 2017 at ED training days (See Y&H CBRN/Hazmat audit 2017). Training sessions are booked in. | Dec 2017 |

*Add further rows as required*

**Please attach a copy of the responses to the governance deep dive standards**

| Core standard reference | Core standard description | Improvement required to achieve compliance | Action to deliver improvement | Deadline |
|---|---|---|---|---|
| DD2 | The organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report. | Include results of the 2017/18 NHS EPRR assurance process in 2017/18 annual report | Consider inclusion of results of EPRR assurance process in Trust Annual Report however this has not previously been included in the NHS Foundation Trust Annual Reporting Manual | May 2017 |
| DD3 | The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation. | Identify Non-executive Director who formally holds the EPRR portfolio for the organisation. | Board to determine whether a Non-executive Director is allocated to hold the EPRR portfolio for the organisation. | Oct 2017 |

Harrogate and District
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Date of Meeting:** | 27 September 2017 | **Agenda item:** | 8.0 |
| **Report to:** | Board of Directors | | |
| **Title:** | Report by the Director of Workforce and Organisational Development | | |
| **Sponsoring Director:** | Mr Phillip Marshall, Director of Workforce and Organisational Development | | |
| **Author(s):** | Mr Phillip Marshall, Director of Workforce and Organisational Development | | |
| **Report Purpose:** | **Decision** √ **Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓ | | |
| **Executive Summary:** | • Significant reduction in advertisements placed as part of recruitment controls<br>• Candidate for Chair to be proposed at Council of Governors' meeting on 25 September 2017<br>• Position and progress on HEE(Y&H) conditions<br>• Trust to sign Time to Change Employer Pledge | | |

| **Related Trust Objectives** | | | | | |
|---|---|---|---|---|---|
| **To deliver high quality care** | ✓ | **To work with partners to deliver integrated care:** | ✓ | **To ensure clinical and financial sustainability:** | ✓ |

| **Key implications** | |
|---|---|
| **Risk Assessment:** | Any identified risks are included in the Directorate and Corporate Risk Registers and the Board Assurance Framework. |
| **Legal / regulatory:** | 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 |
| **Resource:** | None identified. |
| **Impact Assessment:** | Not applicable. |
| **Conflicts of Interest:** | None identified. |
| **Reference documents:** | Nil |

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

It is recommended that the Board:

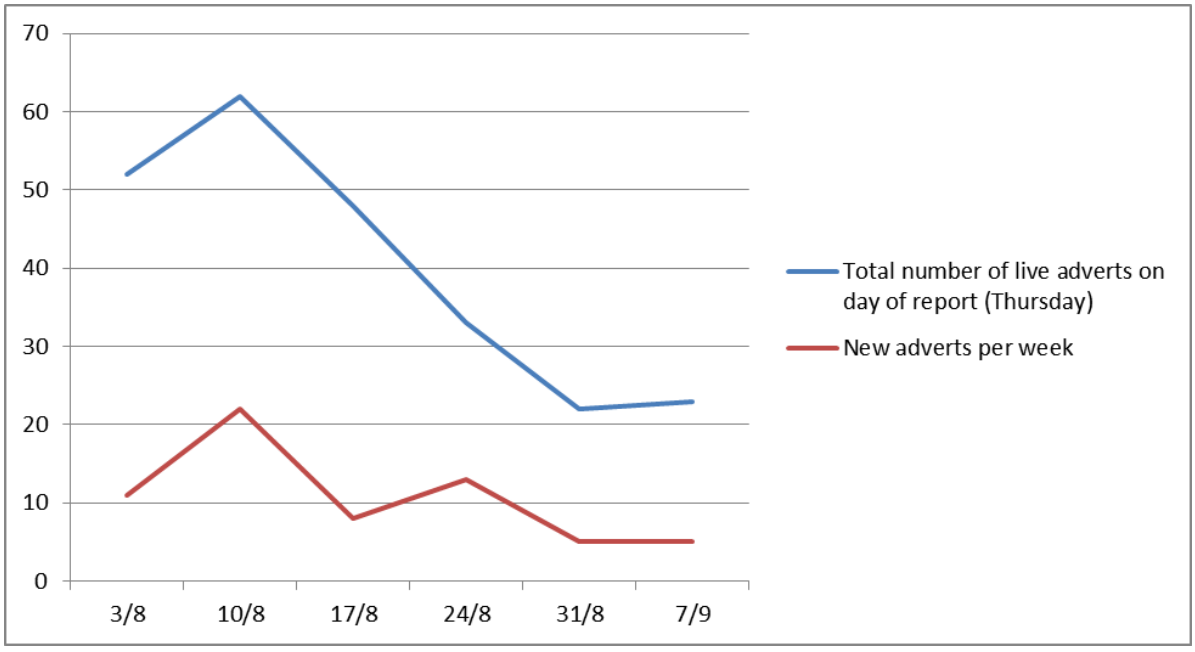
- Notes items included within the report
- Endorses the recommendation of the Senior Management Team to sign the Time to Change Employer Pledge

### a) Financial Constraints

The Workforce and Organisational Development team is implementing a number of measures which have been put in place to improve the financial position of the Trust. These include cessation of above-cap agency recruitment to inpatient wards to cover staff shortages, reviewing professional leave for Consultants, and a temporary control on training expenditure (including expenditure on backfill costs resulting from staff unavailability) unless the training activity is mandatory and/or essential to professional regulation and delay would place the individual in breach. Note that this applies to all staff including doctors.

The Business Case for Direct Engagement of temporary medical staff, from October 2017, and the establishment of an internal bank (from January 2018), already looks likely to generate potential savings in excess of those included in the financial recovery plan.

Enhanced recruitment controls have been put in place and vacancies which are deemed essential are reviewed weekly at the Vacancy Control group meeting. Recruitment activity has been stopped for advertised vacancies which have not reached the point of issuing invitations to interview. The headcount including bank staff at 10 August was 4,511 (excluding bank staff 4,209) and at 7 September was 4,481 (excluding bank staff 4,189). The graph below shows the change in recruitment activity since the most recent recruitment controls were put in place:



### b) Sickness Absence

Absence figures across the organisation decreased in July 2017, moving from 4.08% to 3.92% and sickness absence percentages for the year to date (April – July) remain below the threshold and sit at 3.89%. In comparison, in July 2016, the sickness absence rates for the Trust overall were at 4.48%.

There has been a decrease in sickness rates across three of the Directorates in July. Rates in Corporate services have reduced to 2.56% from 2.84%, in Children's and County wide Community Care from 4.46% to 3.86% and in Long term and Unscheduled Care rates have reduced from 4.50% to 3.98%. Planned and surgical care (4.02%) has, however, seen an increase to 4.85%.

Hot spot areas are continuing to be targeted and we are looking at rotating to another hot spot area within Planned and Surgical Care, as Farndale have managed to conclude the majority of their long term sickness cases. Targeted work on Woodlands ward is continuing, and a review has taken place in adult and community services where a number of the long-term sickness cases in this area are back at work. The Workforce and Organisational Development team is working on a further review with Long Term and Unscheduled Care to provide specific management support with sickness overall in this Directorate, and there is some pilot work taking place in Planned and Surgical Care to look at a new way of reporting and managing absence.

### c) Appointment of new Chair

It is a requirement of the Constitution of the Trust that it should have an appointed Chair and, if possible, the aim is to have the new Chair in place by 31 October, when Mrs Dodson's extension in post expires. At the shortlisting meeting on 25 August the Interview Panel of the Nominations Committee selected three candidates to attend the final interviews on 13 September. The three-part interview process included a significant number of Board members, Governors, staff and stakeholders. The feedback from the candidates was that the recruitment process, and in particular the arrangements for the interviews, were thorough and efficient.

A preferred candidate was selected and, subject to satisfactory completion of pre-employment checks, their name will be proposed to an Extraordinary meeting of the Council of Governors on 25 September for approval. An induction programme for the new Chair is under development.

### d) Health Education England (Yorkshire and Humber) Conditions

The Trust has been subject to a number of conditions and these were reviewed at the August meeting of the Workforce and Organisational Development Steering Group. The list of those currently open includes both items from 2017 and some from assurance visits in previous years. Progress against the conditions is being taken forward in the respective Directorates. It was emphasised at the meeting that Doctors in Training are critical to the provision of patient care at the Trust and we need to ensure they have a positive experience to deliver a future workforce pipeline.

The Directorates have been tasked with ensuring that significant progress is made with addressing these conditions in preparation for the next visit of the HEE (Y&H) team which is due in late September.

### e) Job Planning

The latest Job Planning figures, for the end of August, show a reduction in completed Job Plans overall. The reduction was discussed in detail at the Senior Management Team meeting in September and the Directorates were tasked with improving the position by delivering the action plans to which they committed earlier in the year.

The outcome of audits against the requirements of Schedule 15 of their contract has been that a small number of doctors (shown not to have completed one or more of an appraisal, a Job Plan and their Mandatory and Essential training at their incremental date) are in the process of having their pay progression reviewed.

| SEPTEMBER 2017 JOB PLANNING CENTRAL REPORT - CONSULTANTS | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Directorate** | **Number of Consultants** | **Job Plans within 12 months** | **%** | **Job Plans older than 12 months** | **%** | **Number of Consultant with no Job Plans recorded** | **%** | **In progress** | **Notes** | **RAG** |
| C & CWCC | 13 | 12 | 92.31% | 1 | 7.69% | 0 | 0.00% | 0 | Slightly worse | |
| LT & UC | 56 | 38 | 67.86% | 17 | 30.36% | 1 | 1.79% | 0 | Slightly worse | |
| P & SC | 64 | 51 | 79.69% | 12 | 18.75% | 1 | 1.56% | 0 | Slightly worse | |
| **Total** | **133** | **101** | **75.94%** | **30** | **22.55%** | **2** | **3.12%** | 0 | | |

| SEPTEMBER 2017 JOB PLANNING CENTRAL REPORT - SAS GRADES | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Directorate** | **Number of SAS Doctors** | **Job Plans within 12 months** | **%** | **Job Plans older than 12 months** | **%** | **Number of SAS Doctors with no Job Plans recorded** | **%** | **In progress** | **Notes** | **RAG** |
| C & CWCC | 7 | 7 | 100.00% | 0 | 0.00% | 0 | 0.00% | 0 | No change | |
| LT & UC | 11 | 10 | 90.91% | 1 | 9.09% | 0 | 0.00% | 0 | No change | |
| P & SC | 40 | 11 | 27.50% | 7 | 17.50% | 22 | 55.00% | 0 | Worse | |
| **Total** | **58** | **28** | **48.28%** | **8** | **13.79%** | **22** | **37.93%** | 0 | | |
| **Change from previous month (in-date JPs)** | | **Improved** | | **No change** | | **Worse** | | | | |

### f) HR Directorate Priorities

The HR Directorate Priorities have been reviewed and agreed at the recent meeting of the Workforce and Organisational Development Steering Group. Directorates have been invited to link into the priorities through their HR Business Partners if there was anything specific where they could move them forward, for example in identifying workforce 'hotspots' to be tackled. In discussion it was agreed that what was needed was system- and Health Care Partnership-wide resilience; more efficient use of corporate functions needed to be seen as an opportunity rather than a threat so that the communication around the context of initiatives was very important and that the paper majored on the voice of the staff being built into strategic plans for the Trust. A view was expressed (from a non-HR attendee at the meeting), and strongly supported, that the term 'back office function' was demeaning and did not reflect that everyone employed within the Trust contributed to high quality patient care. Staff at all levels worked as a team and it was important that the language used was changed to reflect this.

### g) Celebrating Success Tea Party

The Trust held a Celebrating Success Tea Party on the 24 July, at which we celebrated the staff who received long service awards for 25, 30 and 40 years' service. There were also presentations for the Celebrating Success Awards. The winners had presented at a 'Dragons Den-style' pitch and representatives of all shortlisted entries were invited to attend. The event was held in Herriots which was transformed into a vintage-style tearoom, with vintage crockery, cake stands, bunting and colourful decorations, and the Catering team supplying finger sandwiches fit for Royalty! The event was self-funding through sponsorship and it was a fantastic, fun-filled afternoon.

It is proposed that the Long Service Awards continue to be recognised at an annual tea party in both community and acute Trust sites. The Celebrating Success Awards would be embedded into the Making a Difference/Quality Champions process.

### h) General Nurse Recruitment

On 20 September the Trust hosted another Student and Registered Nurse Recruitment Evening. Advertisements and messages via all local universities were distributed to maximise the reach and potential audience of likely attendees. Colleagues from across the Trust were available to discuss nursing careers at HDFT, facilitate tours and interview prospective employees.

Over the past 12-18 months the Trust has offered a number of positions to student nurses, most of whom are due to qualify in the coming weeks. During the student's study, all were offered the chance to begin working on their ward prior to qualification as a care support worker. Eighteen students are scheduled to join during September and October and an additional eight have started work as Care Support Workers.

### i) Global Health Exchange

During August the Trust processed four certificates of sponsorship and made one further initial visa request to support the fifth nurse. The five individuals are working through their application forms and a decision regarding their arrival date will be made once they receive their visa from UK Visa and Immigration. It is anticipated that four nurses from India will start working in the Trust towards the end of October.

The remaining nurses continue to complete their IELTS test (eight), NMC computer-based test (five) and one is progressing their NMC application.

### j) Appraisal rates

The Appraisal Period commenced on 1 April 2017 and is now in its last month; the current percentage completion rate is 65.52%. The overall appraisal figure (looking back over the previous 12 months) is 78.5% against the 90% target.

A concentrated effort is now required in order to meet the target and to complete all appraisals before entering the winter pressures period. By completing the appraisals it will allow staff to focus on their objectives and continue to concentrate on providing high quality care to all Trust patients during the busiest time of year.

Some staff have previously expressed concern about the length of the appraisal report and the Workforce and Organisational Development team therefore developed an 'Appraisal-on-a-page' and trialled it with a number of senior and middle managers. As a result of positive feedback this has been introduced as an alternative to the longer version – the idea being to make the appraisal documentation simpler; whilst there is one standard of appraisal there are now two ways of reporting it. The new form is available on the Trust intranet. Directorate colleagues have been invited to comment on the progress they have made in executing their action plans to achieve the target figure.

**k) National Staff Survey**

The 2017 NHS Staff Survey will go live on Monday 9 October and close on 1 December. The survey is being administered by Capita as mixed mode (paper and email) and will be sent to 1,250 staff, selected at random by Capita. A communication plan is in place to promote the survey, which will include infographics linked to the Trust values.

There will be no changes to the survey questions from 2016; however, the Survey Co-ordination Centre is requesting two additional items of data on the staff list this year; namely, disability and pay band.

To encourage responses Capita will send out six email reminders for the on-line survey scheduled at weekly intervals and two reminder letters for paper-based surveys. The Trust will follow up with generic emails to all staff using infographics. Managers will also receive an update on response rates on a regular basis (likely to be weekly) and will be asked to encourage their staff to complete the survey.

**l) Staff Friends and Family Test, Quarter 2**

The Staff Friends and Family Test went live on Monday 11 September and remained open for a two week period, until Friday 22 September. All staff were invited to participate in the Staff Friends and Family Test to answer whether they would recommend the Trust to their friends and family as a place to work and receive treatment/care. A survey link was sent to all staff who have an email account, paper copies have been distributed to some wards and for this Quarter an open URL has been created to increase the number of responses: consequently the HR team were also be available at Herriots Restaurant between 11.30am to 2.00pm (Monday to Friday) to allow individuals the opportunity to complete the survey online during their lunch break.

**m) New medical education posts**

Due to the expansion of the medical student numbers and introduction of the Physician Associate programme from the University of Leeds, interviews were held on 11 September for the role of Ward-Based Teacher to support the learning objectives of Physician Associates and medical students in the clinical areas.

In addition, there is also a new post of Deputy Director of Undergraduate Medical Education to support Dr Gareth Davies (Director of Undergraduate Medical Education) with ensuring that the quality of third year medical placements and the success of the Physician Associate Programme placements.

### n) Time to Change

'Time to Change' is a campaign to end the stigma and discrimination that people with mental health problems face in England. It is run by the charities Mind and Rethink Mental Illness, with funding from the Department of Health, Comic Relief and the Big Lottery Fund. The Time to Change employer Pledge signals the commitment of organisations to change the way they think and act about mental health in the workplace and make sure that employees who are facing these problems feel supported.

A survey of employers already signed up to the Pledge revealed that:

- 95% said it had a positive impact on their organisation
- 80% of organisations agreed that it had helped to raise awareness of mental health amongst staff
- 50% reported a rise in staff disclosure of mental health problems, which helps to intervene early and prevent long term sickness

Signing the Time to Change Employer Pledge is free and we will receive dedicated support throughout the process as well as a year of support after signing. This includes coaching on our action plan, connections to other employers and free masterclasses where the Trust can learn from leading employers on how they have achieved success. It is intended to sign up the Trust to the Time to Change Pledge.

The Board is requested to **endorse** the recommendation of the Senior Management Team that the Trust sign the Time to Change Employer Pledge.

### o) Christmas Lunch

Following discussions at the Partnership Forum meeting on 31 August, the Trade Unions were unanimously in favour of retaining the staff Christmas/festive meal at Harrogate District Hospital, despite the financial challenges faced and actions taken by the Trust to address them. Community-based Trade Union representatives were also supportive of the steps taken last year to offer them something broadly similar and would like to repeat that. Everyone at the meeting considered that making this offer was an excellent opportunity to bring individuals and teams together and was a real unique selling point for the Trust as a whole. Staff Governors also expressed a view that, if possible, the Christmas lunch/festive meal should continue as in previous years.

Those at the meeting were also content for voluntary donation collection boxes to be available should members of staff wish to contribute towards the cost of their meal.

**Phillip Marshall**
**Director of Workforce and Organisational Development**

September 2017

This page has been left blank

NHS
Harrogate and District
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Date of Meeting:** | 27th September 2017 | **Agenda item:** | 9.0 |
| **Report to:** | Trust Board | | |
| **Title:** | Chief Nurse Report | | |
| **Sponsoring Director:** | Jill Foster | | |
| **Author(s):** | Jill Foster | | |
| **Report Purpose:** | **Decision** | | **Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓ |
| **Executive Summary:** | • Monitoring of nurse recruitment and retention continues to show a challenging but improving position<br>• There has been three Patient Safety Visits but no Director Inspections in July and August.<br>• The number of unavoidable, as opposed to avoidable, category 3 pressure ulcers is increasing as per Trust target<br>• Complaints in August are the highest in month year to date<br>• Update on the work being undertaken to gain accreditation for being Baby Friendly | | |

**Related Trust Objectives**

| | | | | | |
|---|---|---|---|---|---|
| **To deliver high quality care** | ✓ | **To work with partners to deliver integrated care:** | ✓ | **To ensure clinical and financial sustainability:** | ✓ |

**Key implications**

| | |
|---|---|
| **Risk Assessment:** | Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF 1: risk of a lack of medical, nursing and clinical staff; BAF 3: risk of failure to learn from feedback and incidents and BAF 13: risk of insufficient focus on quality in the Trust. |
| **Legal / regulatory:** | None identified. |
| **Resource:** | None identified. |
| **Impact Assessment:** | Not applicable. |
| **Conflicts of Interest:** | None identified. |

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

- Be **assured** by the monitoring of nurse recruitment and retention and the governance process for assuring safe staffing levels
- **Note** the reporting of Director Inspections and Patient Safety Visits
- Be **assured** of progress toward the Trust pressure ulcer target
- **Note** the increase in numbers of complaints received by the Trust in August.
- **Acknowledge** the work to improve standards for mothers and babies
- **Note** the Review of Whistle Blowing arrangements

The Chief Nurse report provides an overview of care quality, activities underpinning care and assurances on staffing arrangements. More details on key performance metrics are provided in the Integrated Board Report.

## 1. Nurse Recruitment

1.1 The Trust's recruitment and retention working group continue to work toward zero vacancies. A recruitment event was held on the evening of 20 September 2017 - seven people attended and six were interviewed. Offers were made to two Registered Nurses and four Student Nurses qualifying in September 2018.

1.2 The next event is planned for October 2017.

1.3 The Trust is expecting 20 newly qualified nurses to start in September and October with a further 12 starting in January and March 2018.

1.4 Following the decision at June 2017 Trust Board to invest in the nurse establishment in Long Term and Unscheduled Care (LTUC) directorate, the directorate has accelerated the recruitment of Care Support Workers (CSW). 27 additional CSWs were required to support the new rosters. These roles have now been either appointed to or offers made.

1.5 In Main Theatres there are 15.19 WTE Band 5 vacancies (9.27 RN's and 5.9 ODP's). By September this will have reduced to 10WTE.

1.6 As I reported last month the current number of vacancies means there are significant gaps in the planned rosters for the wards. We continue to take action to mitigate the risk due to staffing gaps by

- Maximising effective rostering
- All shifts out to NHSP and agencies within cap
- All shift gaps published at ward level
- Incentive scheme offered
- Staffing gaps reviewed daily and staff moved to minimise risk
- Bed closures where feasible

1.7 All rosters are now published eight weeks in advance of the start date.

1.8 The number of 'hours owed' to the Trust is decreasing.

1.9 The result of these actions are reported in the actual versus planned staffing levels in Appendix One

## 2 Outstanding Trust Board Actions – Recommendation Paper on the Trust Substantive Nursing Workforce Requirements

2.1 The Board will recall in November 2016 there was an action for a recommendation paper on the Trust substantive nursing workforce requirements. This was in relation to the information received about the actual v planned staffing and the information for the ward nursing acuity and dependency audit as there was a discrepancy between the two reports.

2.2 The discrepancy concern was between the actual versus planned staffing table which highlighted the monthly ward hotspots where it had been more challenging to maintain staffing at the planned level and the acuity and dependency audit which indicated different ward areas potentially required additional staff over and above their current substantive workforce.

2.3 The Board will be aware all in-patient area substantive nursing workforce and budgets were reviewed and in June 2017 the Board approved substantial investment into the ward budgets of the Long Term and Unscheduled Care Directorate resulting in new Care Support Worker roles. Therefore I believe the original action is complete.

## Patient Safety

### 3 Unannounced Directors' Inspections 2017-2018

3.1 The rolling programme of unannounced Directors Inspections is designed to provide assurance on care standards with particular regard to infection prevention and control.

3.2 The following services have been inspected and rated as 'green' during 2017/18:

| Date of inspection | Ward/Dept. visited | Risk Rating |
|---|---|---|
| 21/04/17 | Trinity | Green |
| 12/05/17 | Granby | Green |
| 18/05/17 | Wensleydale | Green |
| 01/06/17 | Selby MIU | Green |
| 16/06/17 | ITU | Green |
| 16/06/17 | Littondale | Green |

3.3 There have been no Director Inspection Visits in July and August 2017. A full programme of inspection is being arranged for the rest of the year.

### 4 Patient Safety Visits

4.1 Patient Safety visits are scheduled visits designed to provide assurance regarding patient safety. They have a unique purpose and value in encouraging a positive safety culture. Visits are designed to encourage staff to raise any concerns in a forum which is supportive, building good communication and establishing local solutions to minimise risk whenever possible. Key findings are followed up by the directorate teams, any high priority actions are considered through the appropriate corporate group such as the 'Improving Patient Safety Group'.

| Date | Area | Key Findings |
|---|---|---|
| 25/04/17 | Littondale | • Pressure of work due to staffing levels for both medical and nursing staff, good feedback regarding the contribution of the ACP<br>• Showers leaking and concern about increased falls risk – estates aware<br>• Ward is paperless for rostering<br>• Still some delays for ward attenders |
| 23/03/17 | Granby | • Nurse staffing levels concern as staff often work through break and stay late<br>• There is limited space on ward but potential to convert unused rooms<br>• Alternative methodology for cannula care audit was discussed |

| | | |
|---|---|---|
| | | • Staff believe patients would benefit from therapy provision at weekends<br>• Staff could use OT room when not in patient use for breaks<br>• Staff would like to push forward 'End of PJ Paralysis' campaign |
| 06/06/17 | Byland | • Nurse Staffing -The ward felt that Nurse staffing gaps were the greatest risk to patient safety in the department but recognised that this was reflected on the departmental, directorate and corporate risk registers.<br>• Medical Staffing - Whilst the ward has daily consultant ward rounds, there is limited cover from 2 junior doctors and no middle grade support.<br>• Falls - The ward is a high risk fall area. The ward tries to cohort patients at high risk of falling however this often requires an additional CSW to special.<br>• Pressure Ulcers - The ward area hasn't had any hospital acquired pressure ulcers for a while.<br>• MDT meetings - The visiting team were informed that MDT meetings are held daily where the ward team run through each patient's needs. The ward is using the Expected Discharge Dates in order to manage the clinical team's expectations and priorities.<br>• Therapy Service provision - No therapy service input over the weekend. Reduced SALT provision. |
| 21/06/17 | Pharmacy | • Carter Review - Recommended that 80% of pharmacist resources are utilised for direct medicines optimisation – current performance is 84% and know we can improve on this in the next few months<br>• We have improved the % of medicines reconciliation done within 24 hours – Feb 2016 at 80%, currently at 87% aiming for 90% by April 2018. We are the best in the region.<br>• We have increased the number of pharmacists actively prescribing. Feb 2016 – 10%, currently 17% and once all those who have completed the course are ratified – 30%. If all pharmacists are accepted on the courses they have applied for by next year – 58%<br>• Summary Care Record – aiming for new junior doctors to be trained and then rolled out to all relevant medical staff<br>• Still need to improve the % of non-pharmacist ward based activity – should improve post September when two student technicians qualify and the new support workers that we have recruited recently will be fully up and running - so this should make the ward based team service sustainable. We are training more student technicians with (hopefully) 5 qualifying next year. ePMA<br>• Reports now available for: Antibiotics prescribed, allergy not recorded, patients' Medicines On Admission / prescribed warfarin and when patients are discharged we ensure that info on Dawn (warfarin software) is updated / fax TTOs to relevant AC Service. |
| 27/06/17 | Main Out-Patients Dept | • A&E patients continue to be sent to clinic to be seen by specialists inappropriately.<br>• Outpatient Administrative Support looks ahead at coming clinics to manage appointments of patients requiring Patient Transport Service<br>• A number of the clerical support staff have worked in the department for an extended period of time however the department was in the process of recruiting to a 19hour clerk post for Ophthalmology and ENT clinic.<br>• Taxis that are used to transfer staff to/from outreach clinics continue to be an issue. There was an incident recently where a driver started to fall asleep at the wheel putting staff at risk. Patient Waiting Times<br>• Long waiting times for patients in clinic is a recurrent FFT theme. The most common cause for this is understood to be as a result of clinicians not arriving to clinic on time and overbooked clinics due to urgent appointments. Limited Space<br>• The department suffers from limited space form storage and waiting areas. There was some discussion around developing the courtyard space between East and West Waiting. Disabled Toilet<br>• Following the adjustment to the seat pan, the disabled toilet continues to be out of order.<br>• There had also been some issues raised relating to the door which can be opened outwards into the corridor in order to allow wheelchair uses to easily get through the door. The department have put signage on the doors to warn visitors.<br>• There was a discussion about changing places facilities and the support that is available to patients who require these. LD patients<br>• Lynn made the visiting team aware of an incident where by a patient had been sent multiple follow up appointment letters following an urgent attendance but had DNA'd. It transpires tha the patient had Learning Disabilities but had not been flagged. There were concerns around the safety netting of vulnerable patients requiring 2 week wait appointments. FFT feedback<br>• • Poor car parking facilitites<br>• • Long appointment waiting times |

| | | |
|---|---|---|
| | | • Lack of Patient WiFi. Outpatient Department Project<br>• Screens used in waiting areas to present relevant patient information regarding the department, appointment and facilities.<br>• New signage to be put up and waiting areas renamed to reduce confusion and to be compatible with Web-V checkin stands.<br>• Since the directorate restructure all outpatient services had been moved under one directorate. There was now good communication between surgical, medical and outreach outpatient departments.<br>• The department has noticed that whilst there appears to have been a lot of progress in discussions around the project, it appears to have quietened down. It was though this might be linked to operational pressures and capacity within the directorate management teams as project managers are pulled back into directorate rolls. There was also a Gap without a Matron currently responsible for the department.<br>• However it was understood that a number of changes were due to come into place in the near future. Admissions Office<br>• Treatment booking forms were not being completed properly with very limited information. An example of an incomplete booking form was shared with the group. It was suggested that this would be raised at the Improving Patient Safety Steering Group and that there was potential for auditing the quality of these forms. |
| 06/07/17 | Endoscopy | • No written report. Chairman and Director of Workforce and Organisational Development following up issues raised. |
| 28/07/17 | General Office | • The report has been circulated to the area team for comment and action and is due to be discussed at October SMT |
| 10/08/17 | Main Theatres | • The report has been circulated to the area team for comment and action and is due to be discussed at October SMT |
| 22/08/17 | Oakdale | • The report has been circulated to the area team for comment and action and is due to be discussed at October SMT |

## Patient Outcomes

### 5 Pressure Ulcer Target 2017/18

5.1 As I discussed in July the pressure ulcer reduction target this year, in both the hospital and the community, is to reduce the number of avoidable Category 3 and 4 pressure ulcers. This target has been identified from the root cause analysis of Category 3 and 4 pressure ulcers in 2016/17 which determined, in both the hospital and community, 66% of Category 3 and 4 pressure ulcers analysed were deemed avoidable. The table below provides further detail of results to date.

**April-August 2016 and April - August 2017 Comparison**

| Community Datix | 2016 | 2017 | Comparison |
|---|---|---|---|
| Category 2 | 69 | 82 | 18.8% ↑ |
| Unstageable / Cat 3 | 35 | 27 | 22.9% ↓ |
| Category 4 | 2 | 0 | 100% ↓ |

| Community RCA | 2016 | 2017 | Comparison |
|---|---|---|---|
| Avoidable | 22 | 9 | 59% ↓ |
| Unavoidable | 14 | 17 | 21.4% ↑ |
| Total | 36* | 26** | |

*Note two incidents investigated under one SIRI **Note 1 x Community RCAs pending

| Hospital Datix | 2016 | 2017 | Comparison |
|---|---|---|---|
| Category 2 | 59 | 70 | 18.6 % ↑ |
| Unstageable / Cat 3 | 17 | 17 | 0.00% ⟷ |
| Category 4 | 0 | 0 | N/A |

| Hospital RCA | 2016 | 2017 | Comparison |
|---|---|---|---|
| Avoidable | 9 | 7 | 22.2% ↓ |
| Unavoidable | 6 | 7 | 16.6% ↑ |
| Total | 15 | 14* | |

*Note 3 x Hospital RCAs pending

### 6 Children's and Adult Safeguarding

6.1 There is a Care Quality Committee thematic review of mental health services for children and young people currently underway in North Yorkshire involving some services provided by HDFT.

6.2 'Safeguarding Week' is taking place across North Yorkshire from 9 – 13 October 2017. The theme is 'Domestic Abuse' and is raising awareness of safeguarding issues in relation to domestic abuse for both adults and children.

## Patient Experience

### 7 Complaints

7.1 In July the Trust received 11 complaints.
In August the Trust received 22 complaints.

Of the 16 complaints received in July, 9 have been graded Yellow, 6 green and 1Amber.
Of the 22 complaints received in August, 20 have been graded Yellow and 2 Green.

7.2 The number of complaints received by month, year to date (YTD) compared with 2016/17 and 2015/16 is shown below.

| **Total number of complaints by month for 2017/18 compared to 2016/17 and 2015/16** | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **April** | **May** | **June** | **July** | **Aug** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** | **Total** |
| **2017/18** | 16 | 20 | 16 | 11 | 22 | | | | | | | | |
| **2016/17** | 18 | 16 | 24 | 21 | 25 | 19 | 19 | 18 | 9 | 14 | 26 | 25 | **234** |
| **2015/16** | 26 | 18 | 30 | 15 | 17 | 26 | 11 | 9 | 12 | 12 | 21 | 16 | **213** |

7.3 The number of complaints received in August is the highest in month received so far this year; however it is not an unusually high monthly figure for the Trust. As the Trust has been under significant pressure in the last two months for activity and nursing workforce gaps I have looked at from when and where this month's complaints have been generated.

Of the 22 complaints received in August, 12 relate to care received in July and August, eight relate to care received from February to June 2017 and the remaining two are from 2016 and 2006. Out of the 22 complaint only nine relate to in-patient areas and the Emergency Department.

The total number of complaints YTD is **85.** The total number of complaints for the same period of time in 2016/17 was **105**.

**8 Baby Friendly Initiative**

8.1 In July I reported about the UNICEF Baby Friendly global initiative. This accreditation programme is recognised and recommended in numerous government and policy documents across all four UK nations, including NICE. Baby Friendly accreditation is a nationally recognised mark of quality care for babies and mothers.
8.2 Harrogate maternity unit has been accredited as Baby Friendly since 2002, and has undergone numerous external assessments to maintain this accreditation. Harrogate Maternity Unit underwent a full assessment to maintain accreditation in August and I am happy to confirm they have maintained accreditation.

8.3 Neonatal Standards –since 2013 bespoke Baby Friendly standards for neonatal units have been developed. These standards are around supporting close and loving relationships, breast milk and breastfeeding and valuing parents as partners in care. In August we were assessed to these standards for the first time. The assessors were very impressed. The final decision is going the Determination Panel in October.

8.4 Maternity - what happens next?

Following the assessment the Maternity Unit was invited to work towards a gold award. This is a new award and involves a further assessment around the leadership, culture, monitoring and progression in the unit. We are submitting a further application. I am expecting this work to be completed and a decision regarding the unit in November.

**9.0 Review of Whistle Blowing Arrangements**

In September 2017 the Audit Committee considered a review of whistle blowing arrangements undertaken by the Freedom to Speak Up Guardian, Dr Sylvia Wood. A copy of the report is included at agenda item 9.2.

Members of the Board are asked to note the report. It is proposed further updates are provided to the Board on a quarterly basis.

**Jill Foster**
**Chief Nurse**
**September 2017**

## Appendix One

### Actual versus planned nurse staffing - Inpatient areas

### August 2017

The table below summarises the average fill rate on each ward during **August 2017.** The fill rate is calculated by comparing planned staffing hours and actual staffing achieved.

In addition we are required to submit information on the total number of patients that were on each ward throughout the month – this is then used to calculate the "Care Hours per Patient Day" (CHPPD) metric. Our overall CHPPD for August was **8.10** care hours per patient per day.

| | **Aug-2017** | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Day** | | **Night** | | **Care hours per patient day (CHPPD)** | | |
| **Ward name** | **Average fill rate - registered nurses/ midwives** | **Average fill rate - care staff** | **Average fill rate - registered nurses/ midwives** | **Average fill rate - care staff** | **Registered nurses/ midwives** | **Care Support Workers** | **Overall** |
| AMU | 96.0% | 92.2% | 96.0% | 124.7% | 4.10 | 2.60 | 6.80 |
| Byland | 94.5% | 79.6% | 64.5% | 98.4% | 2.90 | 3.90 | 6.80 |
| CATT | 86.5% | 108.1% | 89.5% | 87.7% | 4.60 | 3.20 | 7.80 |
| Farndale | 136.3% | 183.9% | 106.5% | 143.5% | 3.40 | 4.20 | 7.60 |
| Granby | 97.2% | 150.0% | 100.0% | 137.1% | 2.90 | 3.60 | 6.50 |
| Harlow | | | | | | | |
| ITU/HDU | 85.4% | - | 82.6% | - | 26.30 | 1.30 | 27.70 |
| Jervaulx | 94.0% | 96.4% | 67.7% | 110.2% | 3.00 | 4.60 | 7.60 |
| Lascelles | 95.8% | 98.7% | 100.0% | 100.0% | 4.50 | 4.20 | 8.60 |
| Littondale | 90.4% | 134.2% | 94.6% | 180.6% | 3.10 | 2.50 | 5.60 |
| Maternity Wards | 96.6% | 93.5% | 98.5% | 98.4% | 11.60 | 3.40 | 15.00 |
| Nidderdale | 95.4% | 94.0% | 100.0% | 95.2% | 3.40 | 3.50 | 6.90 |
| Oakdale | 82.1% | 123.7% | 87.9% | 146.8% | 4.10 | 3.50 | 7.60 |
| Special Care Baby Unit | 90.3% | 57.7% | 93.5% | - | 14.40 | 2.00 | 16.40 |
| Trinity | 106.4% | 92.7% | 100.0% | 93.5% | 4.50 | 3.90 | 8.30 |
| Wensleydale | 84.6% | 168.5% | 100.0% | 145.2% | 3.40 | 3.70 | 7.10 |
| Woodlands | 65.0% | 90.3% | 80.6% | 71.0% | 9.70 | 3.20 | 12.90 |
| **Trust total** | **91.4%** | **110.0%** | **90.2%** | **115.1%** | **4.60** | **3.50** | **8.10** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ED | **83.5%** | **232.3%** | **87.1%** | **112.9%** | | | |

### Further information to support the August data

On the medical wards Jervaulx, Byland, CATT, AMU and Oakdale, where the Registered Nurse (RN) fill rate was less than 100% against planned; this reflects current band 5 Registered Nurse vacancies and is reflective of the local and national position in particular

regarding the difficulties in recruiting Registered Nurses. The Trust is engaged in an extensive recruitment plan in response to this.

In July 2017 we revised our ward establishment skill mix on Jervaulx and Byland wards. The ward occupancy levels fluctuated in these two wards during August and the staffing requirements were monitored on a shift by shift basis.

The Harlow Suite was closed during August and the Harlow staff were deployed to Farndale ward, however, these staff are not reflected in the Farndale numbers. In addition Harlow staff supported other ward areas throughout the month.

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

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

On Nidderdale ward although the day time RN and care staff hours were less than planned, 8 beds were closed for the majority of the month which enabled staff to assist in other areas.

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

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

On Wensleydale ward the daytime RN hours were less than planned due to RN sickness and vacancies.

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

**July 2017**

The table below summarises the average fill rate on each ward during **July 2017.** The fill rate is calculated by comparing planned staffing hours and actual staffing achieved.

In addition we are required to submit information on the total number of patients that were on each ward throughout the month – this is then used to calculate the "Care Hours per Patient

Day" (CHPPD) metric. Our overall CHPPD for July was **8.50** care hours per patient per day metric.

| | Jul-2017 | | | | | | |
|---|---|---|---|---|---|---|---|
| | Day | | Night | | Care hours per patient day (CHPPD) | | |
| **Ward name** | **Average fill rate - registered nurses/ midwives** | **Average fill rate - care staff** | **Average fill rate - registered nurses/ midwives** | **Average fill rate - care staff** | **Registered nurses/ midwives** | **Care Support Workers** | **Overall** |
| AMU | 97.5% | 91.2% | 96.0% | 137.6% | 4.30 | 2.80 | 7.00 |
| Byland | 90.4% | 83.5% | 66.7% | 114.0% | 2.80 | 4.20 | 7.00 |
| CATT | 94.5% | 96.8% | 89.9% | 94.8% | 5.00 | 3.10 | 8.20 |
| Farndale | 93.0% | 147.6% | 100.0% | 135.5% | 3.50 | 4.90 | 8.30 |
| Granby | 101.8% | 136.3% | 100.0% | 138.7% | 3.00 | 3.60 | 6.60 |
| Harlow | 101.6% | 95.2% | 93.5% | - | 6.90 | 2.10 | 9.00 |
| ITU/HDU | 102.9% | - | 102.6% | - | 24.90 | 1.50 | 26.40 |
| Jervaulx | 98.8% | 88.2% | 69.4% | 106.5% | 3.10 | 4.30 | 7.40 |
| Lascelles | 98.3% | 93.5% | 100.0% | 100.0% | 4.20 | 3.70 | 7.90 |
| Littondale | 96.7% | 128.4% | 97.8% | 200.0% | 3.50 | 2.70 | 6.20 |
| Maternity Wards | 104.5% | 88.7% | 100.3% | 95.2% | 13.20 | 3.70 | 16.90 |
| Nidderdale | 81.4% | 102.8% | 73.1% | 206.5% | 3.80 | 3.90 | 7.70 |
| Oakdale | 91.0% | 123.1% | 95.2% | 156.5% | 4.20 | 3.40 | 7.60 |
| Special Care Baby Unit | 93.3% | 50.0% | 100.0% | - | 13.60 | 1.10 | 14.70 |
| Trinity | 117.8% | 86.8% | 104.8% | 96.8% | 4.30 | 3.90 | 8.20 |
| Wensleydale | 85.6% | 164.5% | 100.0% | 154.8% | 3.40 | 3.70 | 7.10 |
| Woodlands | 78.0% | 71.0% | 83.9% | 90.3% | 11.50 | 3.30 | 14.90 |
| **Trust total** | **95.2%** | **104.8%** | **92.5%** | **125.7%** | **5.00** | **3.50** | **8.50** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ED | 82% | 230% | 87% | 113% | | | |

**Further information to support the June data**

On the medical wards Jervaulx, Byland, CATT and AMU, where the Registered Nurse (RN) fill rate was less than 100% against planned; this reflects current band 5 Registered Nurse vacancies and is reflective of the local and national position in particular regarding the difficulties in recruiting Registered Nurses. The Trust is engaged in an extensive recruitment plan in response to this.

In July 2017 we redefined our ward establishment skill mix on Jervaulx and Byland wards to have additional care staff on duty to support RN vacancies. In addition, the ward occupancy levels fluctuated in these two wards during July and the staffing requirements were monitored on a shift by shift basis.

The planned staffing levels on the Delivery Suite and Pannal ward (maternity wards) have been combined to reflect the close working relationship of these two areas and the

movement of staff between the wards in response to fluctuating occupancy and activity levels. Some of the care staff gaps were due to sickness; however a professional assessment was made on a shift by shift basis to ensure that nurse staffing numbers matched the activity.

On Nidderdale ward although the day and night time RN hours were less than planned the occupancy levels varied in this area throughout the month which enabled staff to assist in other areas.

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

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

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

This page has been left blank

Harrogate and District
NHS Foundation Trust

**Title: Review of Whistle Blowing Arrangements**

**Report to: Audit Committee**

**Report from: Dr Sylvia Wood, Deputy Director of Governance**

**Date: September 2017**

The Trust has had a policy and processes in place for whistleblowing since 2003. The new policy is based on the 'standard integrated policy' published by NHS Improvement and NHS England in April 2016. This was one of a number of recommendations of the Freedom to Speak Up review by Sir Robert Francis published in February 2015, and it was expected that this policy would be adopted by all NHS organisations in England as a minimum standard to help to normalise the raising of concerns for the benefit of all patients. The HDFT policy is now called the "Speaking Up Policy" (formally known as the Whistleblowing Policy) to promote the culture of speaking up. A key addition to the new policy was to introduce the role of the Freedom to Speak Up Guardian.

It was reviewed by the Audit Committee and approved by the Policy Advisory Group prior to ratification by Partnership Forum in March 2017.

It is important to note that whistleblowing contacts may be made via a number of routes including reporting an incident using Datix, or contacting and talking to:

- The Risk Management team;
- The HR team;
- The Freedom to Speak Up Guardian;
- Executive Directors;
- The Non-executive Director with responsibility for whistleblowing;
- The Local Counter Fraud Specialist;
- Staff governors;
- Trade Unions and Professional Organisations.

Some contacts might not be recorded as a whistleblowing concern e.g. reporting a patient safety concern via Datix, and a member of staff might use more than one route e.g. HR and the Freedom to Speak Up Guardian, and the contact might be recorded on both logs. The data that we have about numbers of contacts needs to be considered in this context.

## Review of Freedom to Speak Up Guardian role

In October 2016 Dr Henrietta Hughes was appointed as the National Guardian for the NHS and I was appointed to the local Freedom to Speak Up (FTSU) Guardian role. Local FTSU guardians have a key role in helping to raise the profile of raising concerns in their organisation and in providing confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concern has been handled. They are expected to work with trust leadership teams to create a culture where staff are able to speak up in order to protect patient safety and empower workers.

Key progress:

1. Training, national and regional meetings

The National Freedom to Speak Up Guardians Office provide a one day training course for local guardians and I attended this on 16 February 2017, and then the National FTSU Guardians Conference on 8 March 2017. There is an expectation that local guardians also attend regional meetings. There have been some regional meetings in Yorkshire and Number for acute trusts and I hope to attend some future meetings.

2. Development of resources

Resources and information for staff have been sourced and made available from a dedicated intranet page at http://nww.hdft.nhs.uk/trust-wide/freedom-to-speak-up/. There is clear information about the various ways staff can raise a concern including the dedicated email address for the FTSU guardian FreedomToSpeakUp@hdft.nhs.uk. It is important that contact arrangements are confidential. Only the FTSU Guardian has access to this email address. During periods of annual leave, an “out of office” message is provided which highlights the other options and routes for raising a concern during that period of absence.

The NHS Employers manager's guide for raising (whistleblowing) concerns provides clarity on the role of a manager when a concern is raised, tips for handling concerns positively, the benefits of effective staff engagement and signposts where to go for further support. This has been highlighted to staff and is available from the intranet page.

There are links to information provided by NHS Employers, the National FTSU Guardian’s Office and the Whistleblowing helpline. E-learning resources developed by Health Education England’s e-Learning for Healthcare team to equip healthcare staff with the knowledge and confidence to raise concerns are highlighted, and are available from the intranet and personal training accounts.

In addition a link is provided to three education and training films that have been developed by e-learning for Healthcare – “Raising Concerns, “Responding to Concerns” and "Making Speaking Up Business as Usual" at www.e-lfh.org.uk/programmes/freedom-to-speak-up/additional-resources. These complement the e-learning, and support healthcare professionals to feel empowered to raise and respond to concerns.

3. Communication with staff

I attended Team Brief in November 2016 to introduce the role of the FTSU Guardian. During the preparation of the new policy I attended a meeting of the staff governors in March 2017 to gain the support of staff governors in acting as champions of the FTSU role.

The new role, policy and processes were launched during May 2017, with a presentation at Team Brief on 12 May, and at Partnership Forum on 18 May. The latter was to ensure staff side colleagues were fully informed and able to support the role.

Various communications have been included in the weekly staff bulletin during May, June and August. The communications have had a slightly different focus, but all have highlighted the important of having a culture of speaking up about concerns, and signpost staff to the policy and other resources on the intranet. An example of one of the communications is given as appendix 1. This has also been specifically shared with switchboard staff in order that they can efficiently direct contacts made to them.

In addition a poster has been developed and circulated to staff about actions taken following the 2016 Staff Survey results and the appointment and role of the FTSU Guardian was included in that.

4. Self-assessment against the NHS Employers “Draw the line” campaign

NHS Employers 'Draw the line' self-assessment tool contains a set of questions for assessing the effectiveness of local raising concerns policies and procedures. The tool has been used to check where the organisation is in relation to raising concerns, to evidence strengths and areas that need improvement along with any actions needed. The current version is provided in appendix 2 and is being used as an action plan to progress areas that need strengthening.

5. Contacts and outcomes

| | Q3 2016/17 | Q4 2016/17 | Q1 2017/18 | Q2 2017/18 |
|---|---|---|---|---|
| Numbers of FTSU contacts | 1 | 0 | 4 | 2 |
| Contacts that remain open | 0 | 0 | 2 | 2 |

Contacts have been received from Planned and Surgical Care, Long Term and Unscheduled Care and Corporate directorates and the details and progress are captured in a password protected log.

Themes:

- Attitudes and behaviours x4
- Service changes x1
- Staffing levels x1
- Other x1

Summary of issues raised:

- Bullying behaviours by managers raised in 3 cases;
- Band 2 members of staff feeling undermined, unsupported and unable to further their career progression in 2 cases;
- One team feeling unsupported, under staffed, and criticised for raising patient safety concerns, with 3 contacts from that one team;
- Poor management of capability issues for one member of staff with a disability who was subsequently referred to Access to Work, a publicly funded employment support programme that aims to help more disabled people start or stay in work;
- Potential fraudulent activity in one case;
- The majority described a reluctance to raise concerns and were anxious about the potential negative impact of speaking up.

Actions taken:

- Given reassurance and thanks for raising their concern, emphasising that we are aiming to create a culture where it is normal to raise concerns without fear;
- Discussed several cases with Ros Tolcher;
- Raised an issue in confidence with the relevant Clinical Director when a contact was not willing to have the concern raised with other managers and HR for fear of a detrimental effect on their job;
- Maintained contact to monitor progress by a line manager and HR and to offer support if not resolved;
- Monitoring progress of actions and support for one team;
- Monitoring the effect of a separate piece of work by HR around values and behaviours within another team.

Follow up:
I have continued to maintain some contact until I have confirmed that the member of staff is satisfied that progress has been made with the actions undertaken. Awaiting confirmation that progress has been made with 3 of the outstanding cases and one is actively being addressed.

I am developing a feedback and evaluation questionnaire to send to contacts in order to gather information about how effective they found the role of the FTSU guardian, whether there was anything else they would have found helpful and crucially whether they would feel confident about raising concerns in the future and recommend speaking up to colleagues. Examples of comments received so far include:

> "Thank you for your support, I hope something will be sorted as a result and other people will be able to express their concerns - after all we are all here for the same purpose".
>
> "Thank you for asking how things are going - I really appreciate this"

6. Planned actions to take

The actions identified on the "draw the line" action list will be progressed. Key amongst these are to:

- Strengthen the information provided at induction and in the "Pathway to Management" course for managers;
- Start to include local examples and feedback from contacts in communications with staff;
- Undertake a staff survey to assess staff confidence in speaking up with concerns and knowledge about the ways to do this, and using the results to plan further communications.

**Human Resources data and report**

HR maintains a whistleblowing log and the data shows:

| | Q3 2016/17 | Q4 2016/17 | Q1 2017/18 | Q2 2017/18 |
|---|---|---|---|---|
| Numbers of whistleblowing contacts | 1 | 0 | 3 | 0 |

All 4 cases reported "endangering the health and safety of an individual" as the reason for the concerns raised. The other options for the reason for a concern are: suspected criminal offence; failing to meet legal obligations; miscarriage of justice; environmental damage; concealing information relating to any of these. Further enquiry shows that the detail behind the contacts is similar to those raised to the FTSU guardian:

- Patient safety and dignity, together with a staff bullying culture;
- Bullying behaviours shown following the raising of a patient safety concern;
- Poor team morale as a result of workload capacity.

It is recognised that a number of concerns raised relate to potential bullying behaviours and integral to this is the Trust's commitment to responding to the "Tackling bullying in the NHS Call to Action." The HR team are leading on this piece of work by raising awareness of this NHS wide problem in partnership with Trade Union colleagues. The responses to the Call to Action are:

- Liz Pugh, HR Business Partner, has been nominated as the 'Call to Action' lead
- Sarah Whitton, HR Advisor, has been nominated as the HR liaison overseeing the Bullying and Harassment Advisory Service and having direct links with the Yorkshire and Humber national Social Partnership Forum 'Call to Action' Task and Finish Group.
- A Call to Action presentation was delivered at July's Partnership Forum, based on the findings of the national staff survey 2016, which received wide support from attendees.
- Plans are being put in place to look at more collaborative working with all available resources with early intervention being a key focus.
- Drama Triangle training has been delivered recently by the Health and Wellbeing Manager to the Bullying and Harassment Advisors, and members of the operational HR Team, to understand the dynamics of working relationships with tools to empower individuals to turn negative behaviours into positive ones.
- Anti-bullying week is 13th to 17th November 2017 and work is in progress to look at launching a staff support campaign that week. The aim being to give staff the opportunity to put forward ideas for improving the working culture and sharing success stories i.e. following mediation.
- The Trust's Bullying and Harassment Policy and toolkit is under review. The focus will be to ensure staff feel fully supported to raise concerns where working relationships are having a detrimental impact on themselves or colleagues.
- A baseline assessment will be undertaken to understand the nature and extent of bullying, with a goal for improvement and corresponding action plan to address the problem; with a measurable improvement by 2020.

**Summary**

A considerable amount of work has been undertaken during the last 12 months to establish and publicise the role of the FTSU guardian. The number of contacts to date has been small but the feedback so far suggests that these staff have valued having a confidential method of raising and talking about their concerns. Actions have been progressed although the effectiveness of some of the actions is limited when the member of staff is determined to remain anonymous.

Several describe bullying behaviours and the majority described a reluctance to raise concerns and were anxious about the potential negative impact of speaking up. It is really important that we support these staff, respect their confidentiality and take what actions we can to ensure there is a positive benefit of speaking up. In order to improve the culture around Freedom to Speak Up, we should follow a few basic principles:

1. Maintain trust – observing principles of confidentiality, recognising that anonymity has a place in enabling some conversations to happen
2. Create and maintain awareness – a regular drip-feed of information and publicity
3. Establish connections – building a relationship with the person raising the concern, and understanding their fears about their job and relationships with colleagues
4. Take action – ensuring appropriate steps are taken to address the concerns and issues raised within the constraints of confidentiality, sharing and celebrating the benefits brought about by raising concerns, and therefore encouraging others to feel motivated to speak up.

The plans developed by the HR team to respond to "Tackling bullying in the NHS Call to Action" will be very helpful and joint work to support this is being planned. At the moment the capacity to deliver the FTSU role in its current form is manageable, with good support from HR, executive directors and senior managers when needed.

**Appendix 1: Item in Staff Bulletin 16 August 2017**

## Freedom to speak up

Speaking up is an effective way to achieve service improvement, leading to better patient care and a better working environment for staff. The freedom to raise concerns without fear means staff have the confidence to go ahead and "do the right thing".

The Trust wants to ensure all staff feel able to raise a concern and are aware of the different ways of doing this. In many circumstances the easiest way will be for staff to raise it formally or informally with their line manager (or lead clinician or tutor). But where this doesn't feel appropriate any of the options set out in the Speaking Up Policy (also known as the Whistleblowing Policy) can be used. This policy and other useful information and links are on the intranet at Freedom To Speak Up. Click here for a poster to download and print, with top tips for effectively raising concerns, and a managers guide to raising concerns.

Freedom to Speak Up Guardians have a key role in helping to raise the profile of raising concerns in their organisation and provide confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concern has been handled. The HDFT Freedom to Speak Up Guardian is Dr Sylvia Wood, Deputy Director of Governance, Freedomtospeakup@hdft.nhs.uk and telephone 01423 553541.

Guardians don't get involved in investigations or complaints, but help to facilitate the raising concerns process where needed, ensuring organisational policies are followed correctly.

Please support your colleagues to raise their concerns.

## Appendix 2: Self-assessment against the NHS Employers "Draw the line" campaign

| DRAW THE LINE - Raising Concerns<br><br>HDFT Self assessment: August 2017 | Yes | More work required | Unsure | No | Evidence | Notes | Actions |
|---|---|---|---|---|---|---|---|
| ORGANISATIONAL COMMITMENT: Ability to show the board, or other appropriate governance structure, commitment to the principles of your raising (whistleblowing) concerns arrangements gives a strong message to staff about the type of culture and behaviours that are acceptable within your organisation. Having buy-in and leadership from management and staff side will be important to achieve this. | | | | | | | |
| The board is committed to promoting the importance of raising (whistleblowing) concerns and considers the effectiveness of local procedures on a regular basis. | | ✓ | | | Whistleblowing log has been reviewed by Board during 2016<br>Commitment to learning from incidents, complaints<br>Learning events and listening events<br>Promotion of values and behaviours<br>Fit and proper person test | | SW - FTSU report going to Audit Committee September - highlight to Board after that<br>SW - include in Quality Account |
| We have appointed a Freedom to Speak Up (FTSU) guardian, as required in the NHS Standard Contract. This person has lead responsibility for ensuring all staff understand their roles and responsibilities when raising and handling concerns and are signposted to where they can seek further advice and support. | ✓ | | | | | | SW - to add to job description at next appraisal |
| We have adopted the national raising (whistleblowing) concerns policy for the NHS, making it explicitly clear that our organisation will not tolerate bullying or any other types of victimisation, against any member of staff who has raised a concern. | ✓ | | | | Speaking Up Policy | | |
| Our policy makes it clear that all concerns will be taken seriously regardless of their nature or level of seriousness, and that staff will not be penalised, even if their concerns are subsequently found to be misdirected. | ✓ | | | | Speaking Up Policy | | |
| Our policy makes clear our stance and formal actions to be taken where staff are found to have maliciously provided false information with the intent of harming individuals or the organisation. | | | | ✓ | | There isn't anything specific about this in the Speaking Up Policy<br>Check reference to Disciplinary Policy | JH to d/w Sarah Wilson |
| SUPPORT FOR MANAGERS AND STAFF: Having formal policies and arrangements in place are an important starting point. It is equally important to make sure that staff fully understand their roles and responsibilities, and know how to proceed and respond appropriately. Offering support such as training, mediation, counselling, and stress management will be key to ensure issues can be effectively resolved at the earliest opportunity. | | | | | | | |
| Our organisation has separate policies which clearly differentiate between a grievance and raising a (whistleblowing) concern. This ensures staff are clear about which process they need to follow. | ✓ | | | | Grievance Policy and Speaking Up Policy | | |
| Our organisation offers a range of support to staff who raise or have concerns raised about them. This includes, mediation, counselling, stress management and signposting to where they can seek additional independent advice and support. | ✓ | | | | Speaking Up Policy talks about support<br>Resources on the intranet at:<br>http://nww.hdft.nhs.uk/corporate/human-resources/healthwellbeing/<br>Mediation service<br>Staff counselling etc | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Our organisation offers a number of informal and formal platforms which enable staff to raise concerns openly, confidentially and anonymously (e.g. discussions at team meetings/one to ones/appraisal, helpline or dedicated email box). | ✓ | | | | Speaking Up Policy outlines ways to raise concerns<br>Risk Management policies<br>Bullying and Harrassment Policy<br>Appraisals<br>Open door policy<br>Ask the directors<br>Director walk abouts<br>Patient safety visits<br>Team Brief | | |
| Our organisation delivers effective awareness training for all staff so they are clear about what concerns they can raise and how to raise them. Managers are clear about their roles and responsibilities when handling concerns and are supported to do so effectively. | | | ✓ | | Leadership development - to equip managers to address difficult conversations<br>Values and behaviours - emphasis on teamwork and solutions<br>Risk Management training<br>HR training | | JH - to add to local induction checklist and induction handbook. Review for all staff - maybe one off induction training<br>JH - add to Pathway to Management. SW to develop a few slides - include E-learning<br>SW - Review wahts in Dynamic |
| We provide all staff with information which clearly outlines how to raise concerns internally within the organisation and how they can escalate concerns through appropriate external routes | ✓ | | | | Speaking Up Policy, FTSU communications | | |
| COMMUNICATIONS AND STAFF ENGAGEMENT: Raising awareness about your raising (whistleblowing) concerns arrangements among staff is important to ensure they know what to do. Clear statements from senior management about the organisation's support for the reporting of wrongdoing through appropriate channels, and open reporting the type and level of concerns raised and resultant actions, will help to build staff confidence to speak up. | | | | | | | |
| Our organisation provides regular communications to all staff (including those permanently employed on a full-time/part-time basis, temporary/contracted workers and volunteers) to raise the profile and understanding of our raising (whistleblowing) concerns arrangements. | | ✓ | | | Communications in staff bulletin<br>Team Brief<br>Partnership Forum<br>Staff Governors meeting | How to reach temporary / contracted workers and volunteers? | JH - Add to local induction checklist for bank and agency staff<br>SW - D/w FT about adding to induction for volunteers |
| We communicate key findings to staff about the level and type of concerns raised and any resultant actions taken, as is appropriate under the scope of confidentiality. | | | | ✓ | | Not done yet | SW - To feedback to staff 6 monthly… after report to Audit Committee?<br>SW - Add link to front page intranet? |
| Staff are consulted and encouraged to feed into any review of local arrangements to ensure they are fit for purpose and fully support staff to raise and handle concerns professionally and appropriately. | ✓ | | | | Organisational change policy<br>Grievance policy | | |
| Our organisation regularly shares good practice and learning from concerns raised through a variety of forum with the key aim of fostering openness and transparency, such as staff briefings, team meetings and the intranet. | | ✓ | | | Staff survey - you said, we did<br>Team brief<br>Quality governance framework to cascade and escalate information | Link to QIP learning | SW - Feedback via team brief - ?October<br>SW - Include in learning communications |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| CONTINUAL EVALUATION AND ASSURANCE: A well-run organisation will periodically review its whistleblowing arrangements to ensure all staff are aware of them, confidently use them, are kept up to date with current employment law and follow best practice. Monitoring and evaluating these arrangements will help the board or other appropriate governance structure to demonstrate to regulators that their arrangements are working effectively. | | | | | | | |
| Our organisation has systems in place to ensure that all concerns raised are appropriately logged, detailing how each concern has been progressed, and any actions taken as a result of the issue being raised. | ✓ | | | | Raising concerns log - J:Governance / FTSU WB log | | |
| The FTSU guardian regularly engages with management teams to ensure board and governance reports reflect any trust-wide issues, and these issues are addressed at board meetings. | | ✓ | | | | To discuss - what would be appropriate? | SW - Report to SMT October? |
| We actively seek the opinion of staff to assess that they are aware of and, are confident in using local processes. We use this feedback to ensure our arrangements are developed based on staff experiences and learning. | | ✓ | | | National Staff Survey<br>2016 National Staff Survey and FFT action plan - focus on violence and agression update to staff August 2017. Poster on key initiatives including FTSU Guardian | | SW - Local staff survey - when ? With IA of whistleblowing processes |
| Data is correlated with information available from other risk management systems such as: key findings from reviews or surveys, exit interviews, adverse incidents, near misses to identify trends and areas for improvement. | | ✓ | | | | How to do this systematically? Consider exit interviews, staff FFT | SW - Include in QIP and learning from incidents, complaints etc |

This page has been left blank

Harrogate and District NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Date of Meeting:** | 27 September 2017 | **Agenda item:** | 10.0 |
| **Report to:** | Board of Directors | | |
| **Title:** | Report from the Medical Director | | |
| **Sponsoring Director:** | Dr David Scullion, Medical Director | | |
| **Author(s):** | Dr David Scullion, Medical Director | | |

**Report Purpose:**

| Decision | | Discussion/ Consultation | | Assurance | ✓ | Information | ✓ |
|---|---|---|---|---|---|---|---|

**Executive Summary:**

- The Trust has completed the annual medical revalidation statement of compliance with regulatory procedures.
- The National Mortality Case Note Review programme aims to roll out a standardised review method across the NHS, it is a learning process and not one to benchmark or "name and shame" individual Trusts.
- The Learning from Deaths policy is presented to the Board, it has been reviewed by the Quality Committee. The policy is in line with the new requirements for reporting of deaths.
- There are no mortality alerts (HSMR/SHMI/CUSUM) for the cumulative period May 2016-May 2017.
- Dr Alison Layton will step down from her joint role as Clinical Director for the Yorkshire and Humber Clinical Research Network (CRN) in December 2017 pending a new appointment.
- The proposal to develop joint academic posts with the University of Leeds and Leeds Teaching Hospitals NHS Trust is being considered further.
- There have been three consultant appointments.
- Following the National Cataract Audit the Trust has the lowest incidence (0.43% adjusted rate) of posterior capsular rupture of all the units who provided data for analysis (47% of eligible NHS Trusts).
- The Trust is reviewing new guidance from the Joint Advisory Group for endoscopy which is intended to address increasing demand for endoscopy services.

**Related Trust Objectives**

| To deliver high quality care | ✓ | To work with partners to deliver integrated care: | | To ensure clinical and financial sustainability: | ✓ |
|---|---|---|---|---|---|

| Key implications | |
|---|---|
| **Risk Assessment:** | None identified. |
| **Legal / regulatory:** | None identified. |
| **Resource:** | None identified. |
| **Impact Assessment:** | Not applicable. |
| **Conflicts of Interest:** | None identified. |
| **Reference documents:** | Appendix 10.1 – Medical revalidation, statement of compliance with regulatory procedures<br><br>Appendix 10.2 – Learning from Deaths Policy |

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

It is recommended that the Board:

- Note compliance for the year 2016/17 with the medical revalidation annual Statement of Compliance with regulatory procedures.
- Receive and note the Learning from Deaths policy.
- Note joint academic posts with the University of Leeds and Leeds Teaching Hospitals NHS Trust are being considered further.

## 1. Revalidation Update

The Trust is required by NHS England to complete an annual Statement of Compliance with regulatory procedures. I can inform the Board that the Trust remains fully compliant with all the requirements of a Designated Body. The Board is asked to note compliance for the year 2016/17. See item 10.1 for further detail.

## 2. Mortality update

The contract for the National Mortality Case Note Review programme has been awarded to the Royal College of Physicians. The aim is to roll out the standardised review method across the NHS in England and Scotland. It has once again been emphasised that this is a learning process and not one to benchmark or "name and shame" individual Trusts. Further training sessions are being rolled out between August 2017 and January 2018 to train "Tier 1" trainers to act as a regional resource to support Trusts. I have canvassed colleagues to attend.

The Board is asked to receive and note the Learning from Deaths policy (see item 10.2). This has previously been through the Quality Committee. Comments received have been incorporated. The policy is in line with the new requirements for reporting of deaths. It is anticipated that future changes to the policy may be required as it is rolled out and learning from deaths received, not only internally but from external sources. The Quality Committee and Board will be kept updated of any future material changes to the policy. The production of the policy has been a combined effort. I am particularly indebted to Dr Sylvia Wood, Mrs Lesley Webster, Mr Neil McLean and colleagues in Maternity, Paediatrics and the ED for their valuable insights, comments and assistance.

The crude mortality rate increased to 1.09%. This remains below the historical average. The rolling 12 month crude death rate is now at 1.19%.

There are no mortality alerts (HSMR/SHMI/CUSUM) for the cumulative period May 2016-May 2017.

The HSMR increased to 107.6 (105.2) for the rolling period ending June 2017. The estimate remains within expected limits for the Trust. The SHMI fell to 89.9 (91.5) for the rolling 12 month period to end of May 2017. This estimate remains below the expected level for the Trust.

## 3. Research update

The 2016/17 year was a successful one in terms of regional research performance. Currently we are the top recruiting region across the UK research networks. The vacant COO post has been appointed following a competitive exercise.

Dr Alison Layton is to step down from her joint role as Clinical Director for the Yorkshire and Humber Clinical Research Network (CRN). This is a mutually agreed decision, Alison in particular feeling the time is right for new blood in the role. She has agreed to stay on until 31 December pending a new appointment. Alison has worked tirelessly both locally, regionally and nationally to champion medical research. For many years she has been the major driving force in working with our local research teams to cement the reputation of HDFT in the Yorkshire and Humber CRN. I would like to extend her my personal thanks for her expert leadership and guidance over the years and hope the Trust Board will do the same.

Following a recent meeting between myself, Dr Tolcher and Professor Paul Stewart, Dean of Medicine in Leeds, the subject of joint academic posts with the University of Leeds and Leeds Teaching Hospitals NHS Trust was again raised. Previous attempts to develop these roles were not successful for a variety of reasons. There is a strong appetite to reinvigorate this process and I am liaising with the relevant clinical specialties to offer my assistance. I wish the Board to note this development and will provide an update as appropriate.

**4. New Consultant appointments:**

| | |
|---|---|
| Neurology | Dr Bindu Yoga |
| Elderly Medicine | Dr Ipshita Scarrott (Locum in place from June 2016) |
| Trauma & Orthopaedics | Mr Vijai Ranawat (Locum post pending substantive) |

**5. National Cataract Audit**

The results of a national audit were recently made public. HDFT currently has the lowest incidence (0.43% adjusted rate) of posterior capsular rupture of all the units who provided data for analysis (47% of eligible NHS Trusts). This is the commonest complication of cataract surgery and can, in extreme cases, permanently threaten sight. I would like to extend my congratulations to my ophthalmology colleagues. In the light of planned changes to the service delivery model for cataract surgery, it is vital that quality standards are carefully monitored and maintained.

**6. Increasing demand for endoscopy services**

There has been a sustained increase in demand which presents significant operational challenges across the NHS. The Joint Advisory Group for endoscopy recognises these pressures and has reviewed current guidelines in line with best available evidence. Suggested areas of practice review have emerged to ensure quality and safety, but relieve some of the pressures on already stretched services.

- Changes to surveillance intervals tolerances based on risk stratification;
- Waiting time tolerance allowances;
- Waiting list validation to ensure efficient use of resource;
- Review of referral criteria for 2 week wait patients; and
- Adoption of best practice operating procedures.

The implications for the Trust are currently being explored.

# A Framework of Quality Assurance for Responsible Officers and Revalidation

## Annex E - Statement of Compliance

# Statement of Compliance

Version number: 2.0

First published: 4 April 2014

Updated: 22 June 2015

Prepared by: Gary Cooper, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Publications Gateway Reference: 03432

**NB:** The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes.

# Designated Body Statement of Compliance

The board / executive management team – HARROGATE AND DISTRICT NHS FOUNDATION TRUST can confirm that

- an AOA has been submitted,
- the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
- and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   YES

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   YES

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   YES

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent);

   YES

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   YES

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1] (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for doctors to include at their appraisal;

   YES

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

| YES |
|---|

8. There is a process for obtaining and sharing information of note about any licensed medical practitioner's fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works;[3]

| YES |
|---|

9. The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners[4] have qualifications and experience appropriate to the work performed;

| YES |
|---|

10. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

| YES |
|---|

Signed on behalf of the designated body

Official name of designated body: Harrogate and District NHS Foundation Trust

Name: Sandra Dodson Signed: ……

Role: Chairman of the Board

Name: Dr Ros Tolcher Signed: ……

Role: Chief Executive

Date: 27 September 2017

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

**Medical Appraisal – Annual Statement of Compliance**

1. The Responsible Officer Regulations came into force on 1 January 2011. They have subsequently been amended, by Statutory Instrument, to widen the responsibilities of the Responsible Officer to include, amongst other things, a duty to be assured that doctors have sufficient knowledge of the English language necessary for the work to be performed in a safe and competent manner.

2. In April 2014 NHS England launched the Framework for Quality Assurance, developed as a checklist against each of the requirements of the Responsible Officer Regulations. There are two specific annual reports which are to be rendered to NHS England. The Annual Organisational Audit of Appraisal and Revalidation was submitted to NHS England, in accordance with the Framework of Quality Assurance (FQA) process earlier in the year. This audit is part of a process which all Designated Bodies must undertake in order to provide assurance to NHS England that our appraisal and revalidation process operates effectively. There were no matters raised by NHS England against the Annual Organisational Audit for the Trust.

3. The second report NHS England requires is for Designated Bodies to send an annual Statement of Compliance with the medical appraisal and revalidation process by 30 September each year. This requires the Board of Directors of the Trust to confirm that an Annual Audit of Appraisal has been submitted and to answer series of 10 questions about the process which the Trust has in place to comply with the Regulations.

4. The draft Designated Body Statement of Compliance is shown below. Board colleagues will note that the Trust complies with all the requirements laid out in the Statement. NHS England (North) will be undertaking a routine Higher Level Responsible Officer Quality Review desktop exercise on 18 October 2017.

5. The Board of Directors is **recommended** to **approve** the Designated Body Annual Statement of Compliance for signature by the Chairman and Chief Executive.

This page has been left blank

# LEARNING FROM DEATHS POLICY

| Version | Date | Purpose of Issue/Description of Change | Review Date |
|---|---|---|---|
| 1 | September 2017 | Initial issue | September 2019 |

| | | |
|---|---|---|
| **Status** | Open | |
| **Publication Scheme** | Our policies and procedures | |
| **FOI Classification** | Release without reference to author | |
| **Function/Activity** | Learning from deaths | |
| **Record Type** | Policy | |
| **Project Name** | | |
| **Key Words** | | |
| **Author** | Dr Sylvia Wood, Deputy Director of Governance | **Date/s** |
| **Approval and/or Ratification Body** | Improving Patient Safety Steering Group<br>Quality Committee | August 2017<br>September 2017 |

**CONTENTS**

# 1. INTRODUCTION

## 1.1. Purpose

For many people death under the care of the NHS is an expected outcome. The vast majority experience excellent care in the months or years leading up to their death. A small minority of patients who die, experience poor quality care provision resulting from multiple contributory factors which may include system-wide failures. The purpose of mortality reviews is not only to identify areas of good practice, but also lapses in care that can be shared both internally and more widely across the NHS for system learning.

The National Quality Board published National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigation and Learning from Deaths in Care (March 2017). The aim of the framework is to standardise an approach to learning from deaths, and the case is made for ensuring that learning from a review of the care provided to patients who die is integral to a provider's governance and quality improvement work. This policy outlines how that will be done within HDFT.

## 1.2. Scope

This policy and the processes described currently apply to patients who have died whilst an inpatient in HDFT. There are no specific exclusions and other deaths may be identified for detailed review e.g. if concerns are raised about the death of a patient:

- Within (but not necessarily limited to) 30 days of discharge;
- Whilst under the care of community services;
- Within a particular service specialty;
- In the Emergency Department;
- By another organisation in relation to care provided by the Trust in the past.

This policy and the processes described will link to existing processes for reviewing, investigating and learning from deaths.

## 1.3. Definitions

Case note review: A structured scrutiny of case notes alone to determine whether there were any lapses in the care provided to the patient who died in order to learn from what happened. It is anticipated a judgement of avoidability of death will form part of the review. Examples of good care should be highlighted. The Structured Judgement Review (SJR) method delivered by the Royal College of Physicians will be adopted locally.

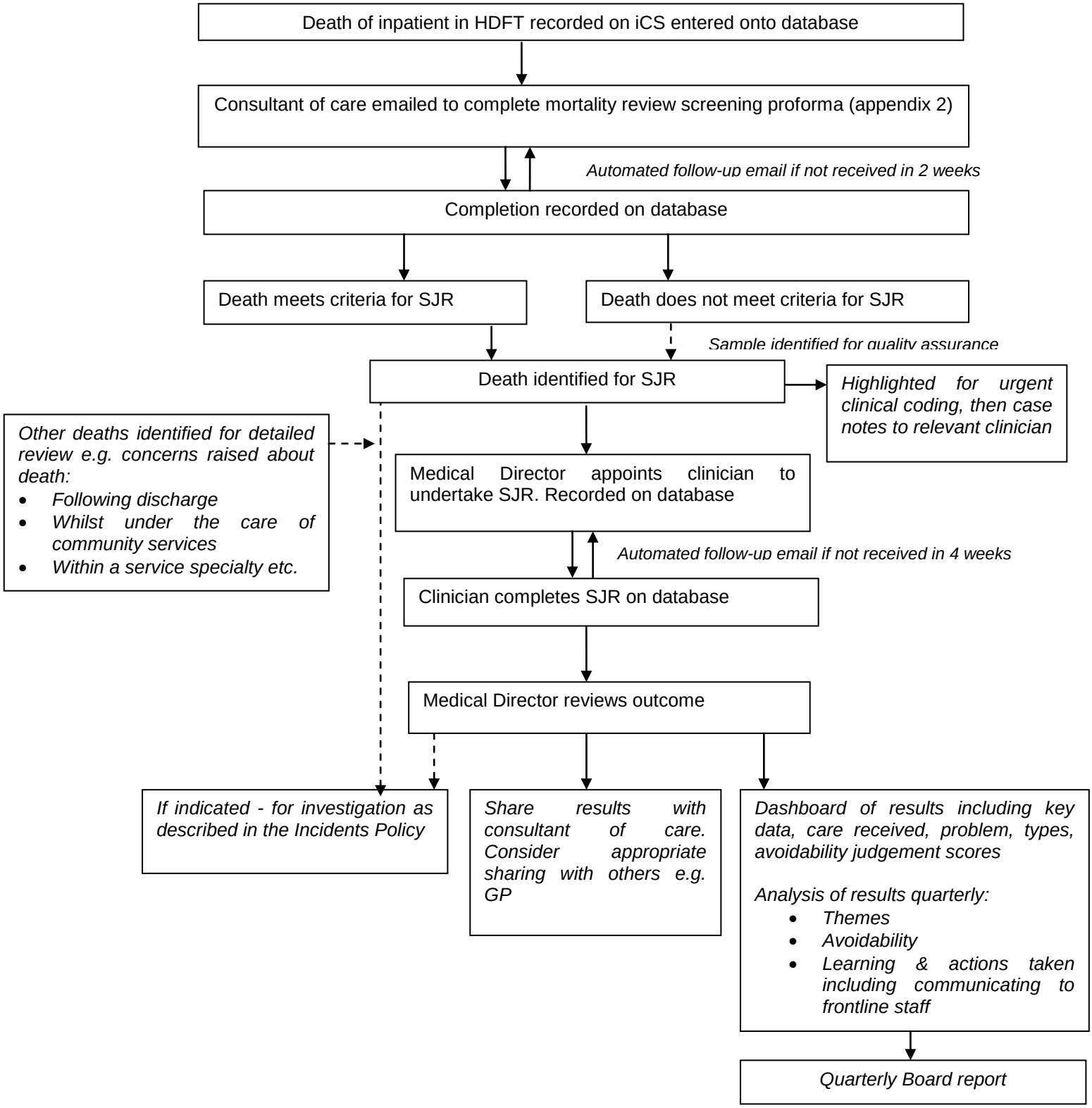
Investigation: The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events.

Death due to a problem in care: A death that has been clinically assessed using a recognised methodology of case note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.

## 2. LEARNING FROM DEATHS POLICY

The policy details a process for identifying, reviewing and learning from deaths and this is summarised below.

### 2.1. Learning from deaths process



The patient administration system (iCS) is used to identify the death of a patient whilst an inpatient in HDFT for the learning from deaths process. Coded data regarding diagnoses during the preceding episode of care and flagged data e.g. patient flagged as having learning disabilities, is used to identify patient deaths that meet any of the categories identified in 2.2. A screening process is being implemented to capture early feedback from the consultant of care about whether any of these categories are relevant.

Deaths that fulfil any of the above categories will trigger a case note review. HDFT has adopted the methodology for this developed by the National Mortality Case Record Review (NMCRR) programme and clinicians have been trained to use the Structured Judgement Review method (SJR).

The Medical Director will appoint a clinician with appropriate expertise to undertake a SJR. Whenever possible, the clinician will not have been involved in the care of the patient who died. The outcome of the SJR will highlight good practice, as well as identify any lapses in care and system failings. The aim is to identify and share learning, and to implement effective and sustainable changes to practice to improve quality of care.

There is clear reference to existing processes within the governance arrangements for investigation, and engagement with families and carers when this is appropriate, and quality improvement.

## 2.2. Categories and selection of deaths in scope for case note review

The processes described aim to identify deaths that meet any of the criteria below:

- Deaths where bereaved families and carers, or staff have raised a significant concern about the quality of care provision;
- Inpatient deaths of those with learning disabilities (LD) and severe mental illness. Note: there is a requirement to investigate any death in a person detained under the MHA;
- Deaths in a service specialty, diagnosis or treatment group where an alarm has been raised e.g. SHMI, audit, concerns from CQC or other regulator;
- Deaths in areas where people are not expected to die e.g. relevant elective procedures;
- An infant or child death, and a stillbirth or maternal death;
- Deaths where learning will inform existing or planned improvement work e.g. sepsis.

A mortality review screening proforma (appendix 2) has been developed to collect feedback from the consultant of care in order to identify cases that meet these criteria as quickly as possible. Some deaths that meet the criteria may be identified through other processes such as:

1. Self-reported by clinicians;
2. Flagging of vulnerable patients through iCS;
3. Concerns raised by staff / family through the Patient Experience Team;
4. Feedback to HDFT from Coroner's Officer;
5. Monitoring of standardised mortality rates using the Healthcare Evaluation Data (HED) tool;
6. Communication from Care Quality Commission.

Deaths identified as meeting any of the criteria will trigger a case note review as described below.

## 2.3. Case note review

A case note review is to determine not only examples of good practice, but also whether there were any problems in the care provided to the patient who died in order to learn from what happened. For those patient deaths meeting the criteria for a detailed review of case notes, the NMCRR data collection sheet is used. This is available from National Mortality Case Record Review (NMCRR) programme resources | RCP London.

This SJR methodology has been validated and used in practice within a large NHS region and is in the process of being rolled out in England and Scotland. It is based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible.

In order to ensure deaths are investigated to a high standard, staff using the SJR methodology are expected to have received training, and to have the skills to undertake the structured judgement review appropriately. A cohort of clinicians at HDFT have been trained by the NMCRR programme. Regional tier one trainers are a resource for trusts to access to train in-hospital reviewers.

The Medical Director will appoint a clinician with appropriate expertise to undertake a SJR. Whenever possible, the clinician will not have been involved in the care of the patient who died. In some circumstances, the appropriate mental health provider will be invited to participate in the SJR of deaths of patients with known severe mental health needs. The case note review may take the form of a multidisciplinary review in selected cases.

A sample of deaths identified by the screening process as *not* requiring detailed review will be included for case note review. This will provide some quality assurance of the screening process as well as ensuring that a proportion of expected deaths are also reviewed. This will include some patients receiving end of life care. There is no recommended process for identifying such cases. A number of methods are available. The results of the case note review will be shared with the consultant of care. If it is considered to be relevant, the result may also be shared with other organisations that have been involved in the patient's care, including the patient's GP. It is anticipated that wider system learning will be available using online data analysis methodology.

## 2.4. Investigation

If through the course of screening or case note review, concerns are identified regarding the provision of care, consideration will be given to whether the case should be reported as a patient safety incident, meaning, any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS funded care in accordance with the Incidents Policy. This policy sets out the framework for reporting and investigation of Patient Safety Incidents including identification and investigation of Serious Incidents (SIs). In a small number of cases it is possible that the Statutory Duty of Candour process will be triggered.

Investigation is more in-depth than case note review as it gathers information from additional sources. The investigation process provides a structure for considering how and why problems in care occurred so that actions can be developed that target the causes and prevent similar incidents from happening again.

HM Coroner may request reports for any matters referred whereby an investigation is required and the liaison point for any request will be via the head of Risk Management. It is expected that the Trust will cooperate fully with parallel Coronial processes.

## 2.5. Engagement with bereaved families and carers

The Care of the Dying Adult and Bereavement Policy provides guidance to staff regarding the management of death and the relevant information that must be provided to patients, relatives and carers. If concerns are raised by the bereaved family or carers about patient dignity and choice, or detrimental care provision, the policy specifically encourages reporting of this as an incident in order to enable learning and improvement.

If concerns are raised about the death of a patient by relatives, carers, or staff, that death will be subject to a case note review. If as a result of case note review lapses in care are identified, an appropriate investigation will be undertaken in accordance with the Incidents Policy. In such circumstances, the family and carers will have an opportunity to ask questions and raise any concerns, and will be supported through the investigation as described in the Incidents Policy, Investigating, Learning and Supporting Guide, HDFT Being Open and Duty of Candour Policy and Making Experiences Count Policy.

## 2.6. Reviewing and investigating infant or child deaths

The processes for investigating deaths in childhood are defined in the HDFT Expected and Sudden Unexpected Death in Childhood Policy. It relates to infants and children from birth to 18 years. All deaths in childhood should be notified to the Child Death Review Team whether expected or not. There is a statutory requirement for all Safeguarding Children's Boards to have in place systems for reviewing all child deaths from April 2008. Notification should be made to the Local Safeguarding board:
http://www.safeguardingchildren.co.uk/notification-cdop.html

A serious case review (SCR) takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved. It looks at lessons that can help prevent similar incidents from happening in the future. A SCR should take place if abuse or neglect is known, or suspected, to have been involved and:

- a child has died (including deaths by suspected suicide); or
- a child has been seriously harmed and there is cause for concern about how organisations or professionals worked together to safeguard the child; or
- the child dies in custody.

Local Safeguarding Children Boards (LSCB) follow statutory guidance for conducting a serious case review. The decision to conduct an SCR should be made within one month of the notification of the incident. The LSCB must then notify the National Panel of Independent Experts and Ofsted of this decision.

The LSCB should appoint one or more reviewers to lead the SCR. The lead reviewer must be independent of the LSCB and any organisations who are involved with the case. The LSCB should submit the names of these reviewers to the National Panel of Independent Experts.

For the review process, the LSCB should make sure there is appropriate representation of the different professionals and organisations who were involved with the child and the family. The LSCB may decide to ask them to give written information about their involvement with the child. The LSCB should aim to complete an SCR within 6 months and agree how the learning will be disseminated.

In selected cases, it may be appropriate for an internal SJR to take place in parallel with the above processes. This would be at the discretion of the Chief Nurse, Medical Director and Risk Management lead.

## 2.7. Reviewing and investigating stillbirths

Stillbirths are investigated using the stillbirth investigation toolkit, in order to systematically review the case and identify any lapses in care.

## 2.8. Reviewing and investigating maternal deaths

Maternal deaths are investigated as defined in the Maternal Death Guideline. The Trust reports to MBRRACE-UK for the National Confidential Enquiry into Maternal Deaths and national surveillance of late fetal losses, stillbirths and infant deaths. See www.mbrrace.ox.ac.uk

The existence of these policies, guidelines and processes for infant or child deaths, stillbirths and maternal deaths does not exclude a structured case note review in selected cases where concerns are raised. This will usually be at the discretion of the Chief Nurse and/or Medical Director.

## 2.9. Deaths of people with learning disabilities

The death of any inpatient in HDFT known to have learning disabilities and flagged as such on the patient administration system (iCS), will trigger a detailed review of case notes using the structured judgement review.

In addition the Acute Liaison Nurse - Learning Disabilities will automatically refer the death to the Learning Disabilities Mortality Review (LeDeR) Programme About the programme | School for Policy Studies | University of Bristol which aims to make improvements to the lives of people with learning disabilities. It clarifies any potentially modifiable factors associated with a person's death, and works to ensure that these are not repeated elsewhere. LeDeR has produced guidance for conducting local reviews. Reviews of deaths | School for Policy Studies | University of Bristol. See also the LeDeR process flowchart in appendix 3.

## 2.10. Deaths in the Emergency Department

The Emergency Department regularly review patients who attended the Emergency Department, were admitted and died within 48 hours of admission. Case notes are reviewed and care analysed for timeliness, measurement and escalation of early warning score, diagnosis, omissions or learning points, demonstration of good care, consideration of palliative care, recent admission (within 14 days) and whether patient came from their own home or a care facility. Good practice, lessons to learn and actions are shared with the department staff and with the Medical Director.

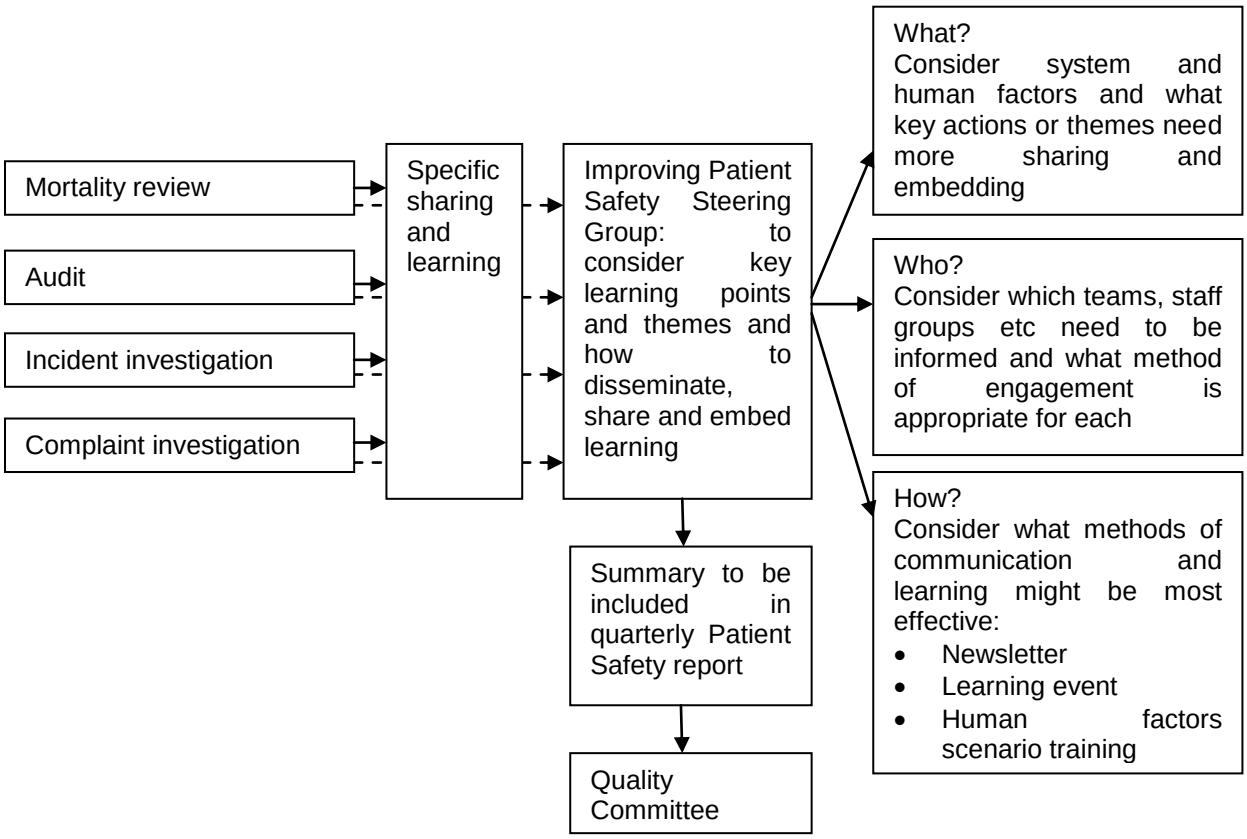
## 2.11. Sharing and implementing learning from deaths

Any specific areas for learning that are identified by a SJR will be shared with the patient's consultant of care and any other relevant staff involved in the patient's care.

However, regarding lapses in care, the Trust acknowledges the primary role of system factors within or beyond the organisation rather than individual errors. The aim of the review and learning process is to prioritise effective and sustainable changes to practice,

underpinned by human factors approaches, systems thinking and quality improvement methodologies.

The themes and learning points identified from the responding to deaths process will also be shared at a quarterly meeting of the Improving Patient Safety Steering Group. This group has multi-disciplinary and multi-professional input. The group will be engaged in reviewing learning from deaths alongside learning from incidents, complaints and good practice. They will identify key themes and actions for sharing, focusing on system and human factors. The group will be responsible for identifying and reviewing methods of disseminating learning, and ensuring these feed into the directorate and Trust governance structures. Processes and tools for communicating the output of investigations, themes, good practice and learning to frontline clinical staff will be established.




Specific learning may be shared with other organisations if appropriate. It is anticipated that the development of the national mortality review programme will facilitate future learning regionally and nationally.

## 2.12. Reporting

Sharing the data and information from this process supports an open and honest organisational culture.

The Medical Director will report data and learning points to the public Board every quarter. The information is to include:

- Total no of inpatient deaths (including ED deaths);
- Number of deaths subject to case note review;

- Number of deaths investigated under the SI framework;
- Number of deaths that were reviewed / investigated;
- Themes and issues identified from review and investigation, including examples of good practice;
- Actions taken in response, actions planned and an assessment of the impact of actions taken.

In these ways the results and the learning will be highlighted and reported to the Quality Committee and the Board of Directors, to be considered alongside other information and data. This will enable learning to be incorporated into the Trust's long term strategic plans and quality priorities.

A dashboard of data will be prepared based on the NHS England national guidance on learning from deaths dashboard. NHS England » National Guidance on Learning from Deaths. The quarterly dashboard and report will be shared with commissioners.

# 3. ROLES AND RESPONSIBILITIES

## 3.1. Trust Board

The Board is responsible for the quality of the healthcare the Trust provides. The Board has specific responsibilities for:

1. Ensuring the Trust has robust systems for recognising, reporting and reviewing or investigating deaths where appropriate:
2. Ensuring the Trust learns from problems identified by reviews or investigations as part of a wider process that links different sources of information to provide a comprehensive picture of their care. In this context 'learning' means taking effective, sustainable action (via appropriately resourced quality improvement work) to address key issues associated with problems in care;
3. Providing visible and effective leadership to support their staff to improve what they do;
4. Ensuring the needs and views of patients and the public are central to how the Trust operates.

## 3.2. Executive Directors with responsibility for learning from deaths

Dr David Scullion (Medical Director) is the Trust Executive Director with responsibility for learning from deaths, and Mrs Lesley Webster is the Non-Executive Director Lead.

## 3.3. Medical Director

The Medical Director is the Trust Executive lead for mortality and is responsible for ensuring the Trust has a policy and processes in place to ensure a standardised approach is in place in the Trust to learn from deaths. This must meet the content of national guidance and must be integrated with the Trust's governance and quality improvement work.

They are responsible for ensuring sufficient clinicians at HDFT have been trained by the NMCRR programme.

The Medical Director will oversee the structured judgement reviews, discussing outcomes with relevant clinicians and ensuring the application of other policies such as the Incidents Policy and the HDFT Being Open and Duty of Candour Policy.

### 3.4. Improving Patient Safety Steering Group

The Improving Patient Safety Steering Group will approve this policy. The group will also be responsible for considering the learning points and actions identified by this process alongside other evidence, ensuring themes, system and human factors are identified and appropriate dissemination and quality improvement methodologies are adopted.

### 3.5. Head of Performance & Analysis, Information Services

The Head of Performance and Analysis is responsible for ensuring the completion of a quarterly dashboard to aid the systematic recording and reporting of deaths and learning from the care provided.

### 3.6. Acute Liaison Nurse - Learning Disabilities

The Acute Liaison Nurse - Learning Disabilities will notify the LeDeR programme of deaths of inpatients known to have learning disabilities.

## 4. POLICY DEVELOPMENT AND EQUALITY

This policy was developed using the references listed below and with input and advice from the staff listed in appendix 1. An equality impact assessment stage 1 has been completed. The need for a stage 2 impact assessment is being considered.

## 5. CONSULTATION, APPROVAL AND RATIFICATION PROCESS

The initial consultation was undertaken as part of the policy development as above. The draft policy will be taken to Improving Patient Safety Steering Group for approval. The first version of this policy will then be presented to the Quality Committee for ratification and the Board of Directors for information.

## 6. DOCUMENT CONTROL

The current version of this policy will always be available from the intranet. Previous versions will be archived within the intranet as evidence of previous Trust policy. Paper copies may not be the most up to date version.

## 7. DISSEMINATION AND IMPLEMENTATION

This policy will be highlighted to key staff during the development of the policy and processes. The final version will be uploaded to the intranet and key staff will be notified of the location by email.

## 8. MONITORING COMPLIANCE AND EFFECTIVENESS

The processes within this policy will be monitored regularly and the results included in a quarterly report to Quality Committee, the Board of Directors and relevant commissioners. Any concerns about compliance with the policy and processes will be addressed with relevant staff.

## 9. REFERENCE DOCUMENTS

National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigation and Learning from Deaths in Care (March 2017). NHS England » National Guidance on Learning from Deaths

Implementing the Learning from Deaths framework: key requirements for trust boards. NHS Improvement (July 2017)

National Guidance on Learning from Deaths dashboard. NHS England » National Guidance on Learning from Deaths

Mortality Review Programme: Yorkshire and Humber AHSN Improvement Academy. Improvement Academy - Mortality Review Programme

National Mortality Case Record Review Programme: Royal College of Physicians. National Mortality Case Record Review Programme | RCP London

National Mortality Case Record Review (NMCRR) programme resources: Royal College of Physicians. National Mortality Case Record Review (NMCRR) programme resources | RCP London

## 10. ASSOCIATED DOCUMENTATION

HDFT Incidents Policy

HDFT Being Open and Duty of Candour Policy

HDFT Expected and Sudden Unexpected Death in Childhood Policy

Care of the Dying Adult and Bereavement Policy

Investigating, Learning and Supporting Guide

Making Experiences Count Policy

NMCRR data collection sheet from National Mortality Case Record Review (NMCRR) programme resources | RCP London.

## 11. APPENDICES

Appendix 1: Consultation Summary
Appendix 2: Mortality Review Screening Proforma
Appendix 3: LeDeR process flowchart

## 11.1. Appendix 1: Consultation Summary

| | List Groups and/or Individuals Consulted |
|---|---|
| **Those listed opposite have been consulted and any comments/actions incorporated as appropriate.**<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. | Dr David Scullion, Medical Director |
| | Dr Sylvia Wood, Deputy Director of Governance |
| | Rachel McDonald, Head of Performance & Analysis |
| | Paul Nicholas, Deputy Director of Performance and Informatics |
| | Jolyon Ingle, Head of Information Systems Development |
| | Lesley Webster, Non-executive Director with responsibility for overseeing progress with learning from deaths |
| | Ben Haywood, Acute Liaison Nurse - Learning Disabilities |
| | Janet Farnhill, Senior Nurse-Adult Safeguarding |
| | Ian Cannings, Clinical Lead Paediatrics |
| | Kat Johnson, Clinical Director Planned and Surgical Care and Consultant Obstetrician |
| | HDFT / TEWV Engagement meeting |
| | Noreen Hawkshaw, Macmillan Lead Nurse for Cancer and End of Life Care (and End of Life Steering Group) |
| | Alison Pedlingham, Head of Midwifery |
| | Sue Oxendale, Bereavement Midwife |
| | Improving Patient Safety Steering Group |
| | Neil McLean, Non-executive Director with responsibility for children |
| | Jill Foster, Chief Nurse |
| | Andrea Leng, Head of Risk Management |
| | Mel Jackson, Patient Safety Manager |
| | Rebecca Wixey, Clinical Effectiveness & NICE Manager |
| | Dave Earl, Deputy Medical Director |

## 11.2. Appendix 2: Mortality Review Screening Proforma

The aim of this review is to contribute to identifying learning from deaths of patients to improve future patient care.

Patient demographics

| | | |
|---|---|---|
| Date of admission: | Time of admission: | Date of death: |
| Type of admission: | Acute / elective<br>If acute: from GP / ED / other | |
| Did the patient have:<br><br>Learning disabilities?<br>Significant mental health illness?<br>An elective procedure during this admission?<br>Sepsis?<br><br>Was this a maternal, neonatal or paediatric death?<br>Are you aware of concerns about the care provision from staff, family, carers or advocates?<br><br>*If yes to any of the above – this case will require a structured judgement review. You can stop and SUBMIT, or complete the remainder of the review if you wish to provide more information.*<br>*If no to all of the above – please complete the remainder of this review.* | | <br><br>Y ☐ N ☐<br>Y ☐ N ☐<br>Y ☐ N ☐<br>Y ☐ N ☐<br><br>Y ☐ N ☐<br>Y ☐ N ☐ |
| Did the patient have appropriate reviews? Y ☐ N ☐ | How many ward moves during episode of care? | |
| Was the patient under the care of the appropriate clinical speciality? | | Y ☐ N ☐ |
| What was the admitting diagnosis? | | |
| What was the main condition being treated if different from admitting diagnosis? | | |
| Was key treatment initiated promptly and according to protocols / pathways where appropriate (e.g. antibiotics / fluids / chest drain)? | | Y ☐ N ☐ N/A ☐ |
| Is there evidence of appropriate clinical decision making and communication? | | Y ☐ N ☐ N/A ☐ |
| Were agreed pathways followed where appropriate? (e.g. Trust Guidelines / Care Bundles for Stroke / Sepsis / Pneumonia etc.) | | Y ☐ N ☐ N/A ☐ |
| Was there any failure to recognise deterioration? Y ☐ N ☐ | Was there any failure to escalate? | Y ☐ N ☐ |
| Was a DNACPR in place? Y ☐ N ☐ | Was a ceiling of care defined? | Y ☐ N ☐ |
| Surgical procedure? If yes: Y ☐ N ☐<br><br>Date …… | If yes:<br>Elective<br>Non-elective | Y ☐ N ☐<br>Y ☐ N ☐ |

| | |
|---|---|
| Procedure …… | |
| Procedure carried out by: | Name of surgeon Grade |
| Anaesthetic carried out by: | Name of anaesthetist Grade |
| What was the certified cause of death? | |
| Do you agree with the certified cause of death? | Y ☐ N ☐ |
| If not, please indicate the cause of death in your opinion: | |
| Was the death referred to the coroner? Y ☐ N ☐ | If no, would this have been appropriate? Y ☐ N ☐ |
| Was a post mortem examination undertaken? | Y ☐ N ☐ |

**Overall care judgement - please score overall care using the scale below:**

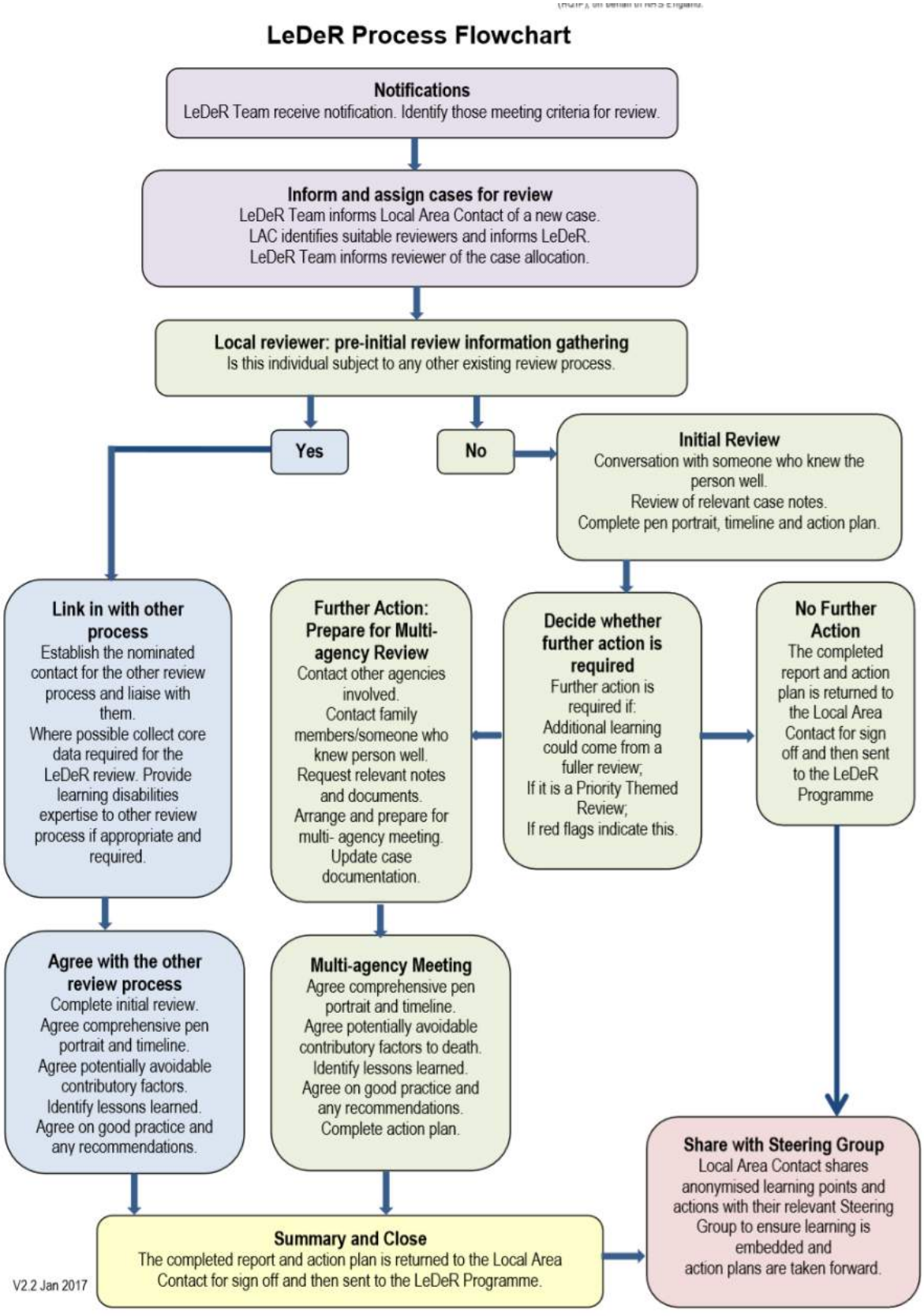
| | | |
|---|---|---|
| **1** ☐<br>Poor care – may have led to harm(s) and / or patient / family distress. Indicate reasons below | **2** ☐<br>Adequate care | **3** ☐<br>Good care |

| | |
|---|---|
| Things that could be improved: | Things that went well: |
| Do you think this case would benefit from a structured judgement review by an independent clinician to highlight any learning? | Y ☐ N ☐ |
| Any additional comments | |

| | |
|---|---|
| Name of person completing form: | |
| Signature: | Date review completed: |

SUBMIT

## 11.3. Appendix 3: LeDeR process flowchart



Harrogate and District NHS Foundation Trust

# Board Committee report to the Board of Directors

| | |
|---|---|
| **Committee Name:** | Finance Committee |
| **Committee Chair:** | Maureen Taylor, Non Executive Director |
| **Date of last meeting:** | 5th September 2017 |
| **Date of Board meeting for which this report is prepared** | 27th September 2017 |

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

1. Month 4 figures were reported which show the Trust is £4.9m behind plan due to a combination of expenditure and income variances. The letter to NHS Improvement dated 15th August 2017 was discussed.
2. The Trust will not secure S & T funding until the current deficit is brought back on track.
3. The recovery plan previously presented at the Board meeting in August was discussed and a robust debate took place about ownership and timing of recovery actions.
4. In terms of monitoring and scrutiny of the recovery plan, it was agreed that this would be better done at the full Board where all NEDs and Clinical Directors were present and could contribute to the debate.
5. Cash was slightly behind plan at the end of July. The agreement with HaRD CCG to pay in 10 instalments has been deemed as payment in advance by NHSE and subsequently our cash flow will be impacted. The top 5 debtors account for £8.9m in outstanding payments. Within WYAAT we are an outlier in terms of receiving payment for 2016/17.
6. The Committee received a verbal update in relation to progress on the Carter recommendations, Model Hospital and Service Line Reporting. There is a lot of data within these work-streams so there is a need to prioritise the actions we take.
7. The committee received a paper on the Budget Planning process about to commence including the links to WYAAT and STP work.
8. The Committee received an update on business development including activity at Wharfedale Hospital and contracts that the Trust will be bidding to secure in the coming months.

| **Are there any significant risks for noting by Board? (list if appropriate)** |
| --- |
| • Receipt of S & T money is dependent on getting back on track financially and achieving our budgeted surplus. Failure to do this will impact on our capital programme.<br><br>• Outstanding debts from 2016/17 continue to impact the cash position as does the change in payment profile by HaRD CCG. |
| **Matters for decision** |
| None |

| **Action Required by Board of Directors:** None |
| --- |

Harrogate and District NHS Foundation Trust

# Board Committee report to the Board of Directors

| | |
|---|---|
| **Committee Name:** | Audit Committee |
| **Committee Chair:** | Chris Thompson, Non Executive Director |
| **Date of last meeting:** | Thursday 7th September 2017 |
| **Date of Board meeting for which this report is prepared** | Wednesday 27th September 2017 |

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

1. This was the first meeting of the Committee since May, so there was a degree of "catching up" by considering minutes from the four most recent meetings of both the Corporate Risk Review Group and the Quality Committee. We discussed whether there was a need for any additional focus on the risks associated with the delivery of the Trust's financial recovery plan, and it was agreed that the individual directorate risk registers should provide the necessary focus together with regular review at Board meetings.

2. The Committee reviewed the latest versions of the Corporate Risk Register and the Business Assurance Framework and was satisfied that both were sufficiently up to date and accurate.

3. The first formal update from the Freedom To Speak Up Guardian was considered and it was agreed that a version of the report should be presented to the Board on a six monthly basis in order to ensure that any emerging issues are recognised and are being effectively dealt with.

4. The annual Procurement Savings Report was considered and noted. The Procurement team have achieved all of the prescribed KPI's and are now working to capitalise on further opportunities that are presented through the various WYAAT procurement initiatives. It was agreed that the quarterly procurement reports would be presented to the Audit Committee for detailed consideration, but that summaries would still need to be presented to the Trust Board.

5. The Committee welcomed the introduction of formal notes on the outcomes of the Limited Assurance Review Meetings that are taking place – these provide an excellent analysis for critical improvements that should be in evidence at the time of the subsequent Follow Up audits and also of the degree of importance that is being given to these areas by the Senior Management Team.

6. There was very positive discussion around the 100% KPIs in evidence around the timely submission of draft and final reports by Internal Audit and the receipt of responses from the auditees.

7. The topic of the effective control policies published on the intranet had been the subject of a recent “limited assurance” Internal Audit report and a possible approach of introducing categories for policies that would provide an indication as to the importance attaching to the regular updating of the policy was considered. The Committee recognised that this area is still one that is “work in progress” and will consider it further following the Internal Audit work later this year.

8. Following discussion at recent meetings the Committee was disappointed that there is little evidence of Post Project Evaluations (PPEs) being submitted to the PPE Committee on time. This is creating a great deal of frustration and wasted time for those involved. It was agreed that the Committee’s concerns would be brought to the attention of those individuals who are asked to prepare PPEs.

9. The Committee also considered and approved the following documents:
    a. Whistleblowing Policy (see attached)
    b. Internal Audit Charter
    c. Fraud and Corruption Policy
    d. Internal and external audit working together policy
    e. Treasury Management Policy and Annual Report on Treasury Activity (see item 6.4 on Board agenda)

## Are there any significant risks for noting by Board? (list if appropriate)

There were no new risks identified and discussed by the Committee which are to be brought to the attention of the Board.

## Matters for decision

There are no matters that require a decision to be taken by the Board

## Action Required by Board of Directors:

The Board is asked to note the considerations that took place at the meeting of the Audit Committee on 7th September 2017.

Harrogate and District
NHS Foundation Trust

# Council of Governors' Meeting

Minutes of the public Council of Governors' meeting held on 3 May 2017 at 17:45 hrs at The Pavilions of Harrogate, Great Yorkshire Showground, Harrogate, HG2 8NZ



**Present:**

Mrs Sandra Dodson, Chairman
Ms Pamela Allen, Public Governor/Deputy Chair of Council of Governors
Cllr. Bernard Bateman, Stakeholder Governor
Dr Sally Blackburn, Public Governor
Mrs Angie Colvin, Corporate Affairs and Membership Manager
Mr Jonathan Coulter, Finance Director/Deputy Chief Executive
Ms Clare Cressey, Staff Governor
Mrs Liz Dean, Public Governor
Mr Tony Doveston, Public Governor
Miss Sue Eddleston, Public Governor
Mrs Jill Foster, Chief Nurse
Mrs Joanne Harrison, Deputy Director of Workforce and Organisational Development
Mr Rob Harrison, Chief Operating Officer
Mrs Jane Hedley, Public Governor
Mrs Ann Hill, Public Governor
Cllr. Phil Ireland, Stakeholder Governor
Mrs Pat Jones, Public Governor
Mr Neil McLean, Non-Executive Director
Mrs Sally Margerison, Staff Governor
Mrs Zoe Metcalfe, Public Governor
Mr Peter Pearson, Public Governor
Dr Daniel Scott, Staff Governor
Dr David Scullion, Medical Director
Mrs Maureen Taylor, Non-Executive Director
Mr Chris Thompson, Non-Executive Director
Dr Ros Tolcher, Chief Executive
Mr Steve Treece, Public Governor
Mrs Lesley Webster, Non-Executive Director
Dr Jim Woods, Stakeholder Governor

**In attendance:**

20 members of the public
Mrs Shirley Silvester, Head of Learning and Organisational Development
Mrs Sharon Wilkes, Clinical Workforce Transformation Lead

## 1. Welcome and apologies for absence

Apologies were received from Mrs Yvonne Campbell, Staff Governor, Mrs Cath Clelland, Public Governor, Dr Sarah Crawshaw, Stakeholder Governor, Mrs Emma Edgar, Staff Governor, Mrs Beth Finch, Stakeholder Governor, Mr Phillip Marshall, Director of Workforce and Organisational Development, and Mr Ian Ward, Non-Executive Director

Mrs Dodson was delighted to see so many members of the public at the meeting and offered them a warm welcome. She hoped they would find the meeting interesting and informative and welcomed questions for Governors or any member of the Board in attendance. She asked that any questions for item 11 on the agenda to be submitted during the break.

Mrs Dodson was also delighted to introduce Mrs Silvester and Mrs Wilkes, who would be talking about apprenticeships at item 9 on the agenda and she welcomed Mrs Katherine Roberts, newly appointed Company Secretary who would be joining the Trust on 30 May.

## 2. Minutes of the last meeting, 18 February 2017

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

## 3. Matters arising and review of action schedule

Mrs Harrison provided a further update regarding the Global Health Exchange Programme; item 1 on the outstanding action schedule.

In collaboration with Health Education England, the Trust was supporting the development of a Global Health Exchange programme. Based on the three fundamental principles of learn, work and return, the programme would offer up to three years' work-based educational experience in the UK for registered nurses.

Mrs Harrison was pleased to report that that first candidate on the Global Health Exchange programme had now passed their English language test and had started competency assessments with a further three nurses in the process of a re-examination and awaiting results. She also confirmed that a second cohort of registered nurses was being identified and twenty applications of interest had been submitted.

Governors would be kept up to date with further progress.

There were no questions for Mrs Harrison.

Item 2 on the outstanding action schedule – Mr Harrison confirmed that seating had been made available by the maternity entrance and was already available in certain areas including the main entrance, opposite Cardiology on the ground floor and outside the Clinical Assessment Team on the first floor. Discussions were taking place with the Fire Officer regarding further seating, particularly around Wensleydale Ward and Nidderdale Ward on the first floor.

Item 3 on the outstanding action schedule would be covered under item 7 on the agenda.

There were no other matters arising.

**ACTION:**

- **Further update on the Global Health Exchange programme at the next meeting on 2 August.**
- **Further update on seating at the next meeting on 2 August.**

## 4. Declaration of interests

There were no additional declarations of interests from Governors than those listed on Paper 4.0.

Mrs Dodson reminded Governors that they would be asked to sign a Declaration of Interest form on an annual basis and that the overall summary would be brought to each quarterly Council of Governor meeting as a standard item on the agenda. Governors were reminded that it was the obligation of each individual Governor to inform the Trust in writing within seven days of becoming aware of the existence of a relevant or material interest.

## 5. Chairman's verbal update on key issues

### 5.1 Update on Governors' terms of office

Following a review of Governors' terms of office, and those with tenures expiring mid-year, Mrs Dodson and Ms Allen had met with Dr Blackburn, Mrs Hedley and Mr Pearson individually to discuss extending their term of office until 31 December 2017. This would create both cost and resource efficiencies and bring the election process back in line with annual Council of Governor elections rather than the need to hold two elections this year.

Each of these Governors agreed to this proposal and therefore Mrs Dodson now required the approval of the Council of Governors to extend the terms of office for:

Dr Sally Blackburn, Public Governor for Harrogate and surrounding villages, second term of office 1 August 2014 to 31 December 2017.

Mrs Jane Hedley, Public Governor for Wetherby and Harewood including Otley and Yeadon, Adel and Wharfedale and Alwoodley wards, second term of office 1 July 2014 to 31 December 2017.

Mr Peter Pearson, Public Governor for Ripon and west district, first term of office 1 August 2014 to 31 December 2017.

Mrs Jones asked what would have been the outcome if any of the Governors had disagreed with the proposal, to which Mrs Dodson confirmed their existing term of office would have remained.

There were no further questions and all Governors present were in agreement with the extensions to the terms of office until the end of 2017. The annual election process would therefore commence in the autumn.

Finally, Mrs Dodson wished to announce that Dr Sarah Crawshaw, Stakeholder Governor representing Leeds University had stood down from the Council with immediate effect. Dr Crawshaw had demonstrated a real interest in all aspects of the Trust and had contributed to the research strategy. On behalf of the Council of Governors, Mrs Dodson wished to thank Dr Crawshaw for her commitment and contribution.

Mrs Dodson would now discuss the opportunity of representation from a different provider of education with Dr Tolcher in order to secure a replacement Stakeholder on the Council.

**ACTION:**

- **Mrs Dodson to discuss a replacement Stakeholder Governor with Dr Tolcher.**

## 6. Governor Sub-Committee Reports

Mrs Dodson moved on to clarify the role of the two formal sub committees and the Patient and Public Involvement, Learning from Patient Experience Group. She said how important it was for the general public to hear about the work of these sub-committees and thanked Governors for their commitment and involvement.

### 6.1 Volunteering and Education

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

Mrs Hedley highlighted the large number of students who had applied to shadow a doctor and the large number of consultants who had offered work experience ensuring the success of the programme.

Mrs Hedley thanked the Corporate Support Team who were working hard to process the number of students applying for a Work Experience placement including 55 students who had applied to shadow a doctor. She also thanked the 15 consultants who had agreed to support the programme.

There were no questions for Mrs Hedley.

### 6.2 Membership Development and Communications

The report from the Membership Development and Communications Governor Working Group, chaired by Ms Allen, had been circulated prior to the meeting and was taken as read.

Ms Allen highlighted the next Medicine for Members' presentations taking place on Thursday 18 May and again on Thursday 25 May in the Lecture Theatre, Strayside Education Centre, 3rd Floor, Harrogate District Hospital.

The Diabetes Nurses would be talking about recent work undertaken to sustain and promote safe insulin management. They would also be sharing information about the transition service; a service to help young people aged 16-25 and their families to live with diabetes as well as how the Trust supported older people with diabetes and the work with GPs and Practice Nurses to help with their knowledge and understanding of diabetes.

There were no questions for Ms Allen.

**6.3 Patient and Public Involvement – Learning from Patient Experience**

The report from Mrs Dean, on the last meeting of the Learning from Patient Experience Group, had been circulated prior to the meeting and was taken as read.

Mrs Dean highlighted three areas from her report: unannounced Directors' Inspections, complaints and nurse recruitment.

Mrs Dean reported that the Learning from Patient Experience Group had discussed the increase in complaints and they were aware that a lot of work had been undertaken to encourage feedback, both positive and negative. The Group received assurance that the Directorates were dealing with these and would continue to monitor and receive further updates at each meeting.

Finally, Mrs Dean confirmed that nurse recruitment was discussed at each meeting. She was pleased to report that the Nursing Team and HR were working extremely hard and thinking outside the box with innovative ways to engage with people interested in a career in healthcare.

There were no questions for Mrs Dean.

Mrs Dodson thanked each Governor for their update and confirmed how the sub-committees helped them to deliver their constitutional responsibilities and gain assurance on the quality of patient care. She described other ways in which Governors could triangulate information including, Board meetings, Patient Safety Visits and engaging in Quality of Care Teams, to name a few.

**7. Update on Quality of Care Teams**

Mrs Foster's report was circulated prior to the meeting and taken as read. The report provided Governors with information and assurance on the regularity and effectiveness of Quality of Care Teams across the Trust.

Due to the level of complexity in undertaking Quality of Care Team meetings across the Trust, it was agreed not be prescriptive but allow Directorates to determine the formatting and frequency of meetings. Mrs Foster referred to the tables in her report listing the number and effectiveness of each Quality of Care Team meeting against set criteria in each Directorate and the standards expected of each local arrangement.

It was concluded that not all areas were complying with meetings or the required standards and Directorates were being asked to provide a further update to the Learning from Patient Experience Group on 10 May.

Mrs Dean asked for clarification regarding the Governor link criteria in the report tables. Mrs Foster confirmed this was to identify which teams had a Governor assigned to them but it was not a requirement for all teams as there were not enough Governors to attend each one.

There were no further questions for Mrs Foster.

Mrs Dodson stated that Mrs Colvin would progress to work with Directorates and reassign Governors to their preferred Quality of Care Teams.

**ACTION:**
- **Mrs Colvin to review Governors assigned to Quality of Care Teams.**

**7.1 Quality Priorities for 2017/18**

Mrs Foster outlined the purpose of the Quality Account, an integral part of the Annual Report and Account, which reflected both on the highest priorities of the Trust for the forthcoming year and reported on progress made in the past year.

Mrs Foster highlighted the importance of stakeholder engagement in producing the Quality Account and the priorities for improvement in 2017/18 would be:

- Improve learning from incidents, complaints and good practice.
- Improve the patient experience of discharge processes.
- Reduce the morbidity and mortality related to sepsis.
- Provide high quality stroke care demonstrated by improvement in national indicators.
- Strengthen the voice of children, young people and families by seeking patient reported experience and using this in the development of a number of services.

Ms Allen commented that Governor and stakeholder involvement in the Quality Priorities process had been very interesting. She confirmed that Governors had met with the Chief Nurse, Deputy Director of Governance and the External Auditor for a robust discussion and staff had worked extremely hard to pull the document together. On behalf of the Council of Governors, Ms Allen fully endorsed the Quality Priorities for 2017/18 and the Quality Account.

Mrs Dodson added that the Quality Account would continue to be monitored through the Quality Committee.

There were no questions.

## 8. Report from the Nominations Committee

Mrs Dodson's report regarding the recruitment of a new Non-Executive Director and appointment of a new Vice Chair was circulated prior to the meeting and taken as read.

She referred to the minutes of the Nominations Committee held on 12 April and confirmed that Governors were unanimous with the view to seek a Non-Executive Director with a clinical background to replace Professor Proctor. In addition, she commented on the recommendation from the Care Quality Commission and NHS Improvement's Well-Led Framework to have a Non-Executive Director with a clinical background.

Dr Scott asked if no-one had applied with a clinical background, would the Trust have re-advertised? Mrs Dodson thanked Dr Scott for his question and confirmed this was a Governors' appointment however, if no-one had applied with the required skill set, another Nominations Committee would have reviewed the recruitment process and current market. She reminded Governors that a similar situation happened four years ago when looking for a Non-Executive Director with accountancy expertise; it took two recruitment processes to appoint a suitable Non-Executive Director.

Mrs Dodson asked Mr Thompson to leave the room at this stage in the meeting.

She then went on to explain that when Professor Proctor left the Trust, this left a vacancy for Vice Chair as well as the vacancy for a new Non-Executive Director. Again, referring to the minutes of the Nominations Committee held on 12 April, she highlighted that the appointment of the Vice Chair was the constitutional responsibility of the Council of Governors. The Nominations Committee agreed to recommend the nomination of Mr Thompson as Vice Chair of the Board of Directors and Mrs Dodson asked if there were any further questions.

There were no further questions and the Council of Governors approved the minutes of the Nominations Committee held on 12 April and unanimously approved the recommendation of the Nominations Committee to appoint Mr Thompson as Vice Chair of the Board of Directors for the remainder of his second term of office until 29 February 2020.

Mr Thompson returned to the room at this stage in the meeting and Mrs Dodson congratulated him on the appointment of Vice Chair.

Mr Thompson thanked the Council of Governors and expressed his appreciation in their confidence. He looked forward to supporting the Board of Directors, the Council of Governors and the new Chair, as well as supporting Mrs Dodson in her remaining term of office.

### 8.1 Update from the Nominations Committee on the Chairman's recruitment process

Ms Allen provided an update from the Nominations Committee on the recruitment process for a new Chair as Mrs Dodson's final term of office came to an end on 31 September. With the support of Mr Ward, Senior Independent Director, Ms Allen had been co-chairing the process for the appointment which was a constitutional responsibility of the Council of Governors.

She confirmed the advertisement was published on 3 March and listed on Gatenby Sanderson's website; the recruitment specialists appointed by the Governors to facilitate the recruitment process. There had been over 80 expressions of interest lodged through Gatenby Sanderson's microsite and seven applications submitted by the closing date of 3 April.

Gatenby Sanderson held initial informal discussions with each applicant and comments and recommendations were forwarded to the Interview Panel.

The Interview Panel then met on 12 April to longlist six candidates; Ms Allen commented that all six were male. One candidate withdrew from the process after longlisting but before shortlisting.

Gatenby Sanderson then undertook detailed interviews with each candidate and the Interview Panel met on 2 May to consider their reports. Three candidates were shortlisted for the interview process on 22 May.

Gatenby Sanderson would be undertaking psychometric testing on the candidates prior to interview and the candidates would be offered the opportunity to meet with key Board members during the week 15 May.

The interview process would involve a presentation to an audience of around 90 people (including Governors, Non-Executive Directors, representatives of acute and community staff, stakeholders, trade unions, Patient Voice Group and the Youth Forum), in the Lecture Theatre at Harrogate Hospital followed by two discussion groups and then a formal interview. Governors would be involved in each part of the process. An extra-ordinary Council of Governors' meeting had been arranged on 16 June to ratify the appointment of the new Chair and Mrs Colvin would circulate these details to all Governors.

There were no questions for Ms Allen.

**9. Presentation – Apprenticeships**

Mrs Dodson welcomed Mrs Silvester and Mrs Wilkes to present about the new apprenticeship scheme.

Mrs Silvester thanked Mrs Dodson for the opportunity to present the launch of the apprenticeship scheme at the meeting; 'Get in, Get on, Go further' – a national drive to recruit apprentices.

She explained what an apprenticeship was; a real job with real training meaning people could earn while they learn and gain a nationally recognised qualification. 80% of the time would be spent in the workplace and 20% of the time would be spent off-the job training. There would usually be an exam at the end of the training to ensure the standard had been reached.

Mrs Silvester talked about the Government drive to increase apprenticeships across all industries to address skill shortages nationally, not just in the NHS. There would be an Apprenticeship Levy to raise £3 billion by 2020 to support the development of

staff through the apprenticeship framework. Target apprenticeship numbers had been set at 2.3% for the public sector.

Mrs Silvester showed a short film at this stage in the presentation produced by Health Education England titled *NHS - The Apprenticeship Journey. The film showed apprentices giving their thoughts on a wide range of apprentice opportunities in the NHS including Pharmacy Technician, Theatre Assistants, Business Administration and Healthcare Assistants. Mrs Silvester described a career for life in the NHS using a flowchart; a journey starting out as an Apprenticeship Care Support Worker at entry level working up the ranks including positions such as Senior Care Support Worker, Registered Nurse, Matron, with the possibility to reach as high as a Chief Nurse.

Mrs Wilkes highlighted the benefits to the apprentice including:

- Opportunity to earn and learn at the same time.
- A genuine job – paid employment.
- All training and assessment costs paid for through Apprenticeship Levy.
- Alternative route into training and employment for people of all backgrounds and ages.
- Supported by high quality education providers.
- Guarantee of a job once apprenticeship successfully completed.
- Excellent career prospects thereafter.

She also talked about the benefits to the Trust which could:

- Increase the number of young people working in the NHS.
- Allow the Trust to 'grown our own'.
- Develop skilled, motivated and qualified workers – linked to excellent patient care and patient experience.
- Provide opportunities for an older workforce.
- Make the NHS a really attractive place to work and stay.

Finally, Mrs Wilkes provided an update on next steps. She confirmed the target for the Trust was 100 apprentices per year with the aim to have 40 Care Support Worker Apprentices during year one commencing in July.

The Trust would be working in partnership with Harrogate College as the educational provider and a new West Yorkshire Excellence Centre led by Bradford District Care NHS Foundation Trust and Leeds Teaching Hospitals NHS Trust to improve the quality and accessibility of training for the region's healthcare support workforce.

Finally, Mrs Silvester asked everyone to 'spread the word'. The scheme would be promoted with schools, at careers fairs, on social media and further information was available in the information sheets and on the website.**

Mrs Dodson opened up questions from the floor.

Mrs Jones asked for clarification on the starting age. Mrs Silvester confirmed this was 18 for a Care Support Worker but 16 for other schemes. Mrs Jones went on to ask what would be the outcome if the apprentice did not receive the required standard. Mrs Silvester confirmed the apprentice would have undergone an

assessment as part of the application process which could include their ability to achieve GCSE in English and Maths as part of the scheme.

Mrs Margerison asked if the plan was to roll out apprenticeships across the whole Trust, including the community. Mrs Wilkes confirmed this was the plan and in addition to Care Support Workers opportunities would be available in Estates, Catering and Domestic Services to name a few.

Mrs Hill asked for clarification regarding the guarantee of a job and Mrs Silvester confirmed this was the criteria for the scheme.

Mrs Dean asked for further detail on the length of the apprenticeships. Mrs Silvester explained that depending upon the role/level, the scheme could be from 12 months to four years. She confirmed that the Trust was currently discussing workforce planning and taking this into account.

Dr Blackburn commented on staff capacity to teach apprentices. Mrs Wilkes confirmed the apprentice would attend college one day a week, undertake theory and practical courses and there would be Clinical Skills Trainers employed to support apprentices in the Trust. They would also be given support from ward staff in the same way as any other member of staff.

Mrs Hedley asked, if someone joined the scheme as an apprentice and did not progress, could they still be employed. Mrs Silvester responded that individual circumstances, skills and ability would be considered.

In response to Ms Cressey's question asking if existing staff could use the scheme, Mrs Wilkes confirmed they could as long as they were using different skills, looking to expand and develop their career.

There were no further questions for Mrs Silvester and Mrs Wilkes and Mrs Dodson thanked them for such an informative presentation.

**10. Chief Executive's Strategic and Operational Update, including Integrated Board Report and Operational Plan 2017/18**

Dr Tolcher presented the following headlines:

<u>Overview of 2016/17</u>

Dr Tolcher highlighted four key areas:

- A strong sustained operational performance – despite many challenges the Trust sustained safe and effective services and excellent feedback from patients and service users.
- The busiest year ever and, in fact, in early January the busiest day ever in the history of the organisation!
- Sustainability and transformation – plans locally and across the West Yorkshire and Harrogate Sustainability and Transformation Partnership (STP); the third largest STP in the country.
- A celebration of the team effort from all staff who demonstrate a passion for high quality care.

Dr Tolcher gave an overview of some of the achievements. All NHS Constitution standards were achieved including waiting times and cancer pathways and, over the 12 months, more than 95% of people attending Emergency Department were seen and treated, admitted or discharged within four hours. The Trust had received a 'Good' Care Quality Commission rating and achieved a 'Bronze' level in Investors in People; a critical success factor in recruiting and retaining high quality staff. She highlighted the reduction in serious incidents, falls and hospital acquired pressure ulcers, and cases of C.Difficile infection and confirmed a 15% growth in revenue due to new business won and defended.

She went on to talk about the financial position and confirmed that, despite a huge collective effort, the Trust did not achieve the target required to receive the last quarterly payment of national 'sustainability and transformation' (S&T) funding. This meant the final position at the end of the year was a surplus of £3.7m, including the first three quarterly payments of S&T funding, £3.1m below plan. The Trust had planned for a £6.8m surplus, crucial to re-invest in patient care, infrastructure and equipment, therefore this position created significant challenges moving into 2017/18.

Dr Tolcher went on to summarise activity trends over the last four years; looking at elective (planned) inpatient and day case activity, non-elective (emergency admissions) activity, and Emergency Department attendances and this showed that each year more patients were treated than the year before so the activity continued to grow year on year.

Looking at quality trends over the last four years, serious incidents had reduced. There had been two high category incidents in comparison to 11 last year; still two too many, but a positive reduction. Complaints had been consistent over the last four years, inpatient falls had gone down and the Trust continued to work hard to drive further improvements in this area. Dr Tolcher reported positive patient Friends and Family Test results and confirmed that the Trust continued to monitor appraisal rates. With two year's data to compare, pressure ulcers, hospital acquired avoidable grade three or four had reduced. Pressure ulcers community acquired avoidable grade three or four had gone up however, Dr Tolcher confirmed these were difficult to interpret and there had been a considerable amount of work in the nursing teams to improve and encourage the reporting of pressure ulcers.

Dr Tolcher then presented some statistics which showed a downward trend since 2013/14 including Emergency Department attendances, referral to treatment percentage incomplete pathways within 18 weeks, A&E 4 hour performance and cancer 62 day performance; standards which continued to be a challenge to meet consistently.

Dr Tolcher provided further information on the top scoring risks:

The top scoring strategic risks for the Trust related to:

- Lack of medical, nursing and clinical staff. This was the single biggest challenge to the organisation and created financial pressures. The Trust was looking at a variety of innovative ways to improve this ongoing challenge.

- Ability to deliver integrated models of care; working with partners to make changes in how healthcare is delivered.
- System level financial risks.
- Lack of integrated IT structure.
- Risk that critical infrastructure is not fit for purpose.

The top scoring operational risks in the organisation at the current time was:

- Risks to service delivery due to lack of experienced registered nurses for recruitment to vacancies.

The year ahead

Finally, Dr Tolcher highlighted three key areas for the year ahead; maintaining services safe and sound, clinical transformation – finding new ways of delivering care, and business development and strategy.

These key areas would shape the work for the Executive Team and Directorates going forward.

Dr Tolcher ended her presentation by thanking the Council of Governors for their engagement over the last 12 months.

Mrs Dodson thanked Dr Tolcher for her update and opened up questions from the floor.

Mrs Dean referred to Dr Tolcher's comment regarding workforce gaps and expressed concerned that the apprenticeship scheme could add to the significant pressure on the workforce as inexperienced apprentices would require more support. She referred to conversations from the Learning from Patient Experience Group regarding challenges around nursing staff.

Mrs Silvester responded that the Trust would be looking at having 40 Care Support Workers throughout the hospital. Ward managers would continue to review the balance of staff and take into account the one or two apprentices. There would also be Clinical Skills Trainers employed and funded through the Apprenticeship Levy to help take pressure off ward staff.

Mrs Harrison added that a workshop with all the Directorates had been held in May and the apprenticeship scheme formed part of the Clinical Workforce Strategy. She reassured Governors that this would continue to be monitored.

**11. Question and Answer session for members of the public and Governors**

Mrs Dodson moved to the tabled questions submitted prior to the meeting and during the break.

**Mrs Margerison, Staff Governor, had submitted the following question:**

**'Given that the community contract had been reduced in value further by the Clinical Commissioning Group and that community services were about to go through another rapid period of change due in part to Vanguard not achieving**

**the expected outcomes, could the Non-Executive Directors assure Governors that patient safety and staff welfare were at the top of the Trust's agenda? Also, how would the Board and Community Leaders going to keep staff engaged and informed during this difficult time?'**

Mr McLean responded stating that the Vanguard was a trial to try to do things in a different way and he pointed out the complexity and time spent on this. He commented that Non-Executive Directors regularly challenged the Executive Directors about the process, achievements and outcomes and it had become apparent that some new ways of working were not going as well as expected so there was a need to take stock and review. He acknowledged this would have an impact on staff and highlighted the need to reflect as part of the review and consider how the Trust would react to what it was being commissioned and paid to deliver. He confirmed there had been lengthy discussions at Board meetings which included the impact on staff and further quality impact assessments would have to be signed off by the Chief Nurse and Medical Director. He recognised that staff were a valuable asset and understood how this period of further change would unsettle teams. He stated that there would be absolute transparency and focus at Board and the Non-Executive Directors would continue to have the best interest of the Trust and its staff in mind.

Dr Tolcher emphasised the focus on the quality of care to patients and she expressed the importance of keeping engaged with the workforce. There had been a listening event for staff with further events planned. Work was underway on the current level of risk to patients and how staff were dealing with this. She explained that historically the nursing teams had provided care for patients that the Trust was not being paid for. The review would look at using staff time effectively and promote the use of quality frameworks to report quality of care issues.

Mrs Lennon, Chair of The Patient Voice Group, commented that patient feedback confirmed how much staff were valued in the community and she expressed the importance of a positive and honest message to confirm patient expectations and assure them that safety would not be compromised. She highlighted the voluntary sector and stated the positivity of change rather than a focus on cut backs.

**Mr Treece, Public Governor, had submitted two questions, but felt one had been answered already under item 6:**

**'What steps are being taken to improve incident reporting, especially no harm or near miss incidents?'**

Dr Tolcher thanked Mr Treece for his question and confirmed that that Trust had done lots of work to raise awareness on the reporting of incidents and the value of learning from this. She acknowledged there were issues with the current system for reporting incidents and a review was underway to look at enhancements in IT.

**Dr Scott, Staff Governor, commented on the increase in Emergency Department attendances.**

Dr Tolcher commented on the general context driving the increased attendances including the growing frail population, lack of alternatives, Local Authority cuts, increasing trend for people requiring mental health support, and reduction in social infrastructure.

**A member of the public commented on delayed transfers of care and asked what the Trust was doing about this.**

Dr Tolcher agreed that delayed transfers of care created a huge 'ripple effect' in the system. She explained the meaning of 'delayed transfers of care' – the patient was medically fit for discharge and did not require a bed, but for another reason, there was a delay in discharge. The term 'bed blocking' was often used and Dr Tolcher confirmed figures had gone up and were high in this area. Some of the reasons were patients waiting for social care, waiting for their choice of ongoing nursing care, ability to discharge safely to community services, and homeless people with complex needs.

Mr Harrison highlighted the recent 'Every Hour Matters' week held at the beginning of March to try to work through some of the discharge issues and recognise access to packages of care in the community. He acknowledged the team effort put in by staff and external stakeholders including North Yorkshire County Council, Tees, Esk and Wear Valley NHS Foundation Trust, Yorkshire Ambulance Service, the Red Cross and Commissioners. He was pleased to report that following the week, delayed transfers went down, however there was further work to do.

**Mrs Roberts, Patient Voice Group member, submitted the following question:**

**'I wanted to raise an issue particularly in relation to 'Blue Badge' parking spaces Sometimes with the lack of available spaces for patients specifically attending for outpatient appointments, we understand that some patients turn up very early to park in order to secure a place in time for their appointment. They then go for a coffee whilst waiting and, although his means that they make their appointment on time, the consequence can be that spaces are blocked making the parking solution even harder. Is there any way that the Trust could ease this situation to ensure as much appropriate availability of all the parking spaces and ease the constant stress of parking for 'Blue Badge' holders.'**

In response, Mr Harrison highlighted that the Trust continued not to charge a parking fee for 'Blue Badge' holders. He confirmed that any space in the car park could be accessed free of charge by a person carrying a disabled 'Blue Badge' as not all disabled people required a wider parking space. He agreed to discuss this further with the Estates Team to communicate this better to patients and service users.

He also confirmed that the Trust followed national guidelines and had more than the recommended number of disabled parking spaces in relation to the overall number of parking spaces.

**ACTION:**
- **Mr Harrison to discuss the use of parking spaces for 'Blue Badge' holders to the Estates Team.**

**Mr Andrews, a member of the public, asked the following question:**

**'There is intense pressure on Trusts to abolish hospital Chaplains. Is this likely to happen?'**

Dr Scullion commented that he had not heard of this action. He expressed that he would not support this and was not sure such an instruction could be imposed. Mrs Dodson also confirmed that such an action could not be imposed.

**Miss Sue Eddleston, Public Governor, submitted the following questions:**

**'New Meet & Greet System at Ripon Hospital - Do we have any news as to when the new system is going to be starting and what help will be available for patients having difficulty understanding the new technology that is being installed.'**

Mr Harrison confirmed that the Trust would be introducing check-in kiosks for patients attending Harrogate Hospital and Ripon Community Hospital. The kiosks would be similar to the ones used in GP surgeries and now most hospitals had them. Volunteers would be available to help patients who required assistance and the reception desk at Harrogate Hospital would also remain for those patients wishing not to use the kiosks. The timeline for the kiosks to be in use would be around July.

**'I would like an update on stroke care for patients in the Harrogate area and what they can expect from Harrogate District as to their care. Some patients have expressed concern that Harrogate will no longer be caring for stroke patients and they believe they will be sent to York and Leeds. They wonder why this should happen. Plus allaying patients worries that their long-term outcome would not be compromised by having to travel further distances. Plus they express worries of added difficulties in visiting their loved ones so far away. Also one lady, living in Boroughbridge, has a husband who has had three strokes, is at home now, but the patients has not had any after care or help whilst at home and is struggling. What is available for this gentleman in that area regards aftercare and rehabilitation. His wife is herself struggling from ongoing cancer treatment so she is finding it difficult to help herself and her husband.'**

Mr Harrison confirmed that stroke care was a key priority for the West Yorkshire and Harrogate Sustainability Transformation Partnership. Working with Healthwatch, an independent organisation of the NHS, they were seeking views from the general public, people who had had a stroke and their carers, and were asking themto provide comments regarding about the service they had received and how best this could be further improved in the future.

Overwhelmingly patients and the public wanted to know that they would receive the best possible care with the best possible outcome as near to home as possible. Mr Harrison commented that most people suffering a heart attack would know they would go to Leeds if they required immediate intervention and then return to Harrogate as soon as possible. The same could be said for stroke patients, but nothing had been decided as yet. Realistically, Harrogate would never be able to provide the skillset available in a regional specialist centre, but the Trust could support ongoing care, similarly for heart attacks, major trauma and neurology where initial treatment in a specialist centre had improved outcomes in these areas.

Dr Scullion echoed Mr Harrison's comments and stated that every hospital could not provide every service for every patient. He expressed the importance of getting the best outcome for the patient. He confirmed there was lots of work ongoing at a regional level and decisions were still to be made. The Trust was still accepting

patients with acute stroke until system changes were confirmed. This would be a service improvement and not a service cut.

**Mr Pearson, Public Governor, submitted the following questions:**

**'Anyone wishing to have an X-ray at Ripon needs an appointment which involved phoning a Harrogate number (for transfer). Callers have had difficulties getting a response when calling. This contrasts with Harrogate which provides a drop in service.'**

Mr Harrison confirmed that it was not cost effective to provide the same service in Ripon as it was in Harrogate due to the size of hospital and the number of patients requiring this service. Ripon Community Hospital managed a drop in service for Minor Injuries Unit, inpatients and Ripon outpatient clinics and bookable appointments for patients wishing to choose to have their scan in Ripon.

With reference tothe telephone number, there had been some issues, but this had improved and a Harrogate number had been set up on the digital system to go straight through to Ripon Hospital.

Mr Harrison was pleased to report positive feedback received from a recent Radiology Customer Service Satisfaction Survey and patients were often contacted and seen before their appointment time. Patients did also have the option of using the Harrogate drop in service.

**'The surface of the car park at Ripon is in a terrible state. I have mentioned this previously. I have since inspected it and can confirm that the surface is poor. It would appear to be a serious health and safety risk, especially as many of the legitimate users are elderly or otherwise infirm.'**

Mr Harrison confirmed the car park and Ripon Community Hospital was the property of NHS Property Services and the Trust was reliant on them for the upkeep of the hospital and grounds. The car park was reported to NHS Property Services last year and this feedback would be re-referred to them.

**ACTION:**
- **Mr Harrison to re-refer the state of Ripon Hospital car park to NHS Property Services.**

**'Is Ripon Hospital, including the services provided, under review?'**

Dr Tolcher reaffirmed that the Trust was committed in providing services in Ripon where it was appropriate to do so. Ripon Community Hospital as a building was no longer fit for purpose and discussions had been underway for some time about how to re-provide services in Ripon. Dr Tolcher confirmed it would be more expensive to refurbish the hospital and work was being led by commissioners in dialogue with NHS England and NHS Property Services. Dr Tolcher updated Governors that, to the best of her knowledge, commissioners were not asking the Trust to stop providing any services already provided, but that bed based care was being reviewed as part of the new models of care project.

**12. Assurance on challenges for 2017/18 and reflection on performance 2016/17**

On behalf of the Non-Executive Directors, Mrs Dodson endorsed Dr Tolcher's update and referred to Mr McLean's response to Mrs Margerison's question regarding community contracts and staff welfare. Due to time in this meeting, Mrs Dodson suggested Governors could discuss further with Non-Executive Directors when there was more time.

**13 Any other business**

Mrs Hedley wished to thank and congratulate Dr Tolcher on her letter sent to staff which Governors had sight of regarding the topics covered in her update.

A member of the public wished to remark that the Trust was well-led.

There were no further items of business and therefore Mrs Dodson closed the meeting. She thanked everyone for attending and confirmed the next meeting would take place on Wednesday, 2 August 2017 at 5.45pm at St. Aidan's Church of England High School, Oatlands Drive, Harrogate, HG2 8JR.



* https://www.youtube.com/watch?v=a3yWXipMOk4

** https://www.stepintothenhs.nhs.uk/
https://www.gov.uk/apply-apprenticeship
Email: Learning&development@hdft.nhs.uk

This page has been left blank