Table of Contents

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Harrogate and District NHS
NHS Foundation Trust

The meeting of the Board of Directors held in public will take place on Wednesday 25 May 2016 in the Aire Room, The Pavilions, Great Yorkshire Showground, Harrogate, HG2 8NZ

Start: 9.40am Finish: 12.30pm

	AGENDA		
Item No.	**Item**	**Lead**	**Paper No.**
9.20am Patient Story – In private			
9.40am General Business			
1.0	**Welcome and Apologies for Absence** *To receive any apologies for absence*	Mrs Sandra Dodson, Chairman	
2.0	**Declarations of Interest and Board of Directors Register of Interests** *To declare any interests relevant to the agenda and to receive any changes to the register of interests*	Mrs Sandra Dodson, Chairman	2.0
3.0	**Minutes of the Board of Directors meeting held on 27 April 2016** *To review and approve the minutes*	Mrs Sandra Dodson, Chairman	3.0
4.0	**Review Action Log and Matters Arising** *To provide updates on progress of actions to the Board of Directors*	Mrs Sandra Dodson, Chairman	4.0
9.50am – 10.55am			
	Overview by the Chairman	Mrs Sandra Dodson, Chairman	
5.0	**Report by the Chief Executive** *To be considered and any Board directions defined*	Mr Jonathan Coulter, Acting Chief Executive	5.0
6.0	**Integrated Board Report** *To be considered for comment*	Mr Jonathan Coulter, Acting Chief Executive	6.0
7.0	**Report from the Chief Operating Officer** *To be considered for comment*	Mr Robert Harrison, Chief Operating Officer	7.0
8.0	**Report by the Director of Finance** *To be considered for comment*	Mr Jordan McKie, Acting Finance Director	8.0
10.55am – 11.05am - Break			
11.05am – 12.20pm			
9.0	**Report by the Director of Workforce and Organisational Development** *To be considered for comment*	Mr Phillip Marshall, Director of Workforce & Organisational Development	9.0

10.0	**Report from the Medical Director** *To be considered for comment*	Dr David Scullion, Medical Director	10.0
10.1	**National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Annual Report** *To receive the report for comment*	Mr David Lavalette, Consultant Trauma & Orthopaedic Surgeon	10.1
10.2	**Efficiency Programme Quality Impact Assessment Annual Report** *To receive the report for comment*	Dr David Scullion, Medical Director	10.2
11.0	**Report from the Chief Nurse** *To be considered for comment*	Mrs Jill Foster, Chief Nurse	11.0
11.1	**Patient Experience Q4 Report and Annual Report 2015/16** *To be considered for comment*	Mrs Jill Foster, Chief Nurse	11.1
11.2	**Care of Frail Older People Strategy** *To **approve** the strategy*	Dr Natalie Lyth, Clinical Director Integrated Care	11.2
12.0	**Oral Reports from Directorates** *12.1 Urgent, Community and Cancer Care* *12.2 Elective Care* *12.3 Integrated Care*	Mr Andrew Alldred, Clinical Director Dr Kat Johnson, Clinical Director Dr Natalie Lyth, Clinical Director	
13.0	**Committee Chair Reports** *13.1 To receive the report from the Quality Committee meeting held 4 May 2016* *13.2 To receive the report from the Audit Committee meetings held 5 and 19 May 2016*	Mrs Lesley Webster, Non-Executive Director/Chair of the Quality Committee Mr Chris Thompson, Non-Executive Director/ Chair of the Audit Committee	13.0 13.1
12.20pm – 12.30pm			
14.0	**Council of Governors minutes of the meeting held 6 February 2016** *To receive the minutes for comment*	Mrs Sandra Dodson, Chairman	14.0
15.0	**Matters relating to compliance with the Trust's Licence or other exceptional items to report, including issues reported to the Regulators** *To receive an update on any matters of compliance*	Mrs Sandra Dodson, Chairman	
16.0	**Any other relevant business not included on the agenda** *By permission of the Chairman*	Mrs Sandra Dodson, Chairman	
17.0	**Board Evaluation**	Mrs Sandra Dodson, Chairman	
	Confidential Motion – the Chairman to move: *That members of the public and representatives of the press be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicly on which would be prejudicial to the public interest.*		

Harrogate and District NHS
NHS Foundation Trust

BOARD OF DIRECTORS – REGISTERED DECLARED INTERESTS

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

The register is maintained by the Foundation Trust Office.

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

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

May 2016

Harrogate and District NHS
NHS Foundation Trust

Report Status: Open

BOARD OF DIRECTORS MEETING

Minutes of the Board of Directors meeting held in public on Wednesday 27 April 2016 at 8.45am in the Boardroom, Harrogate District Hospital, Lancaster Park Road, Harrogate.

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

In attendance:
Mr A Alldred, Clinical Director for Acute and Cancer Care
Dr K Johnson, Clinical Director for Elective Care
Dr Natalie Lyth, Clinical Director for Integrated Care
Ms D Henderson, Company Secretary
Mr D Plews, Deputy Director of Partnerships and Innovation **(RPIW only)**
Ms M Ingham, Business Manager for Integrated Care **(RPIW only)**
Mrs B Neville, Rheumatology Specialist Nurse **(Patient Story only)**
SM, Patient Story **(Patient Story only)**

Patient Story

Mrs Dodson introduced Mrs Beverley Neville and patient SM. Mrs Dodson thanked SM for taking the time to share his story with the Board. SM talked about the challenges faced by him over the course of his life, following a diagnosis of Psoriatic Arthritis.

Mrs Dodson highlighted the importance of hearing patient stories which focused on the longer term, as opposed to immediate issues. This reiterated that the focus should not only be on the acute health service, but should be on the patients who live with chronic pain every day, and the impact of public health prevention.

Dr Tolcher thanked SM for sharing his story, particularly the emotional impact of the treatment given in improving his quality of life. Dr Tolcher asked if there had been a point at which he had concerns regarding the availability of resources. MS stated that he had never overtly been given the message that due to the expense of the treatment it may be unavailable, but noted that the privilege of receiving it had been reinforced by the staff, particularly Mrs Neville. He stated that the staff did not shy away from pushing him to take responsibility for his own treatment.

Mr Alldred noted that as a Pharmacist, it was pleasing to see the results of medications from clinical research coming into practice and the impact it had on patients.

Rapid Process Improvement Workshop Update

Mr David Plews and Ms M Ingham reported that planning had continued for the delivery of two forthcoming Rapid Process Improvement Workshops to enhance the surgical pathway and improvements to the urology cancer pathway.

The work to enhance the surgical pathway involved planned observations following patient pathways through theatres. Further data collection and triangulation had also been undertaken. A value stream map had been developed which demonstrated patient flow through a pathway from pre-assessment through theatres and back to the ward. As a result, potential areas of improvement were being explored and clear targets for the workshop had been set which included: reduction of the number of patients arriving the day before surgery; reduction in the delay between patients being sent for and arriving at theatres; and reduction in the number of cancellations on the day by 25%.

With regard to the workshop on urology cancer pathway improvement, the workshop would focus on improving the prostate cancer pathway, with a view to applying learning to other cancer pathways as appropriate. Observations of clinics and collection of data on performance had taken place, with further work required relating to triangulation and target-setting. Work to date had uncovered a need for future improvement work on theatre scheduling and this would be considered as a focus for an additional workshop.

Board members were invited to attend public briefings detailing the summary of the improvements made on 13 May and 10 June.

1. Welcome and Apologies for Absence

No apologies for absence had been received. Mrs Dodson welcomed two Governors to the meeting and extended a welcome to Rosemary Peacock, Senior Research Fellow from Bradford Teaching Hospitals NHS Foundation Trust, who attended the Board for the second meeting in a row as an observer, as part of a research project into the use of patient data to inform quality.

2. Declarations of Interest

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

3. Minutes of the meetings of the Board of Directors on 30 March 2016 and 8 April 2016

The draft minutes of the meetings held 30 March 2016 and 8 April 2016 were accepted as a true record.

4. Review of Actions Schedule and Matters Arising

With regard to action 1, Mrs Foster confirmed that a paper would be presented to the Board meeting detailing a process for improving patient feedback on quality of care. Mrs Foster would confirm a date for completion with Ms Henderson out-with the meeting.

With regard to action 2, discussions remained ongoing to review the thresholds for determining Serious Incidents Requiring Investigation (SIRI) performance, based on a meaningful metric which would add value to Board assurance.

There were no other matters arising.

5. Board of Directors Terms of Reference

5.1 Mrs Dodson referred to the Board Terms of Reference which had been circulated alongside a marked-up version of the current Terms of Reference to clearly detail the proposed changes.

5.2 Mr Thompson referred to the location of Board meetings, and suggested that in the context of the recent changes to the structure and shape of the Trust, consideration be given to alternating the venue of meetings to better represent the growing catchment area. Dr Tolcher agreed that options should be explored further but asked that consideration be given to the value in terms of ensuring the Board of Directors can fulfil their statutory duties first and foremost.

5.3 Mr Ward suggested that other meetings, for example, Council of Governors, would be better placed to be held in other areas. Mrs Dodson suggested that the use of meetings to enhance relationships with service users be included in the development of the wider Patient and Public Involvement Strategy currently under development.

5.4 Mrs Foster asked that a specific clause be included in the Terms of Reference with regard to the Board's duties relating to Equality and Diversity Standards.

APPROVAL:

- **The Board of Directors approved the revised Terms of Reference subject to the inclusion of a clause on the Board's responsibility for Equality and Diversity standards.**

6. Third Party Schedule

6.1 Mrs Dodson referred to the annual review of the schedule of third party bodies in relation to which the NHS Foundation Trust has a duty to cooperate, and noted there had been no changes made.

6.2 Dr Scullion requested that HM Inspectorate of Prisons be deleted from sections 2 and 5.

6.3 Mrs Foster requested that Safeguarding Boards for wider community be included.

6.4 Dr Tolcher and Mr Harrison requested that Healthwatch and Overview and Scrutiny Committees be included for the wider catchment area, not only North Yorkshire.

APPROVAL:

- **The Board of Directors approved the Third Party Schedule subject to the inclusion and amendments outlined in the body of the minutes.**

Overview by the Chairman

Mrs Dodson said that Non-Executive Directors had identified three key areas which they expected to be the underlying themes of the meeting, and which all related to valuing our people:

- Focus on recruitment, retention and engagement; particularly issues relating to nursing staff in acute and community;

- Job planning; and
- Appraisals, personal development plans, and training.

Mrs Dodson asked Board members to consider the impact of these issues on the delivery of the wider Sustainability and Transformation Planning (STP).

7. Report by the Chief Executive

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

7.1 Dr Tolcher noted that the report covered performance for the full 2015/16 year, and took an opportunity to formally thank staff in every part of the Trust for their hard work, dedication and commitment throughout the year, which continued to be evidenced by the high quality care being delivered to patients and service users every day.

7.2 Dr Tolcher referred to specific areas of improvements throughout the year including: significant improvements in external partnership working and progress with regard to the Vanguard work; further reductions in avoidable admissions; increase in Patient Safety Thermometer scores; continued improvements to the Trust's safety culture reflected in the National Learning League report; National Staff Survey results placing the Trust 3rd in its category and 14th nationally for overall engagement; increase in the number of staff who would recommend the Trust as a place to work or receive care; and achievement of 100% of the internal cost improvement target.

7.3 Dr Tolcher briefed the Board on areas of challenge throughout the year which included nurse recruitment, non-achievement of the Emergency Department 4 hour waiting time target for Quarter 4 and Clostridium Difficile (C. Diff). 34 cases of C. Diff had been reported during the period. Although the number of cases in which a lapse in care contributed to infection remained below the ceiling set by NHS Improvement, it was acknowledged that performance in this area had been disappointing and the Trust remained committed to increasing the focus on improvements in this area.

7.4 Dr Tolcher confirmed that the Trust delivered an operating surplus in-year. Whilst the Trust did not deliver the overall financial plan, delivery of the operating surplus on the back of careful, well-informed investments, demonstrated a sound financial grip. Dr Tolcher gave credit to the Trust's budget holders across the organisation. Mrs Dodson requested that the message of thanks be disseminated to everyone via all possible mediums of communication.

7.5 Dr Tolcher referred to work which had commenced to explore the potential for adopting an 'Accountable Clinical Network' approach for Cancer Services across West Yorkshire. The Trust had been engaged in scoping and proof of concept work.

7.6 Work had commenced to prepare the local and West Yorkshire STP plans and Dr Tolcher confirmed the appointment of Mr Rob Webster, Chief Executive designate of the South West Yorkshire Partnership NHS Foundation Trust, as the overall lead for developing the West Yorkshire STP. The Board were reminded of the purpose of the STP plans to address the three 'gaps' described in the NHS 5-Year Forward View: care and quality; health and wellbeing; funding and efficiency. An initial high level STP for West Yorkshire, including a 'local' STP for Harrogate had been submitted on 15 April in line with national requirements. Detail of the local and regional governance arrangements had been placed in the 'Reading Room'.

7.7 Professor Proctor stated that she was encouraged by the opportunity to address big strategic issues and asked if the West Yorkshire discussion would also take into consideration the Carter Review and opportunities relating to efficiencies. Mr Coulter confirmed that the West

Yorkshire Association of Acute Trusts (WYATT) meets on a monthly basis and shares all local information to ensure opportunities are acted upon where possible. Mr Coulter also noted risks associated in terms of financially weaker partners across the region and the impact this could have on stronger performing organisations.

7.8 With regard to recruitment and retention, Mrs Taylor referred to members of staff who leave the Trust for higher salaries elsewhere and asked if there would be an attempt to harmonise salaries across the region. Dr Tolcher referred to Agenda for Change as the NHS grading and pay system for all NHS Staff. The new regulation on agency caps had pushed the NHS to a new level of transparency.

7.9 In terms of STP planning, Mr Marshall noted that plans had commenced to establish three Health Education England programme boards and Mr Marshall had been approached to potentially chair or co-chair the West Yorkshire Board. The focus would be on the Carter Review, use of agency and bank staff, and use of resource at individual provider level.

7.10 Mrs Dodson noted that in line with the areas identified as being the underlying theme of the meeting by Non-Executive Directors, the discussion on workforce risks and long term planning had been particularly important. The Trust remained committed to a focus on integration and identifying greater efficiencies in the system to deliver a more effective service. Mrs Dodson also emphasised the need to balance the vision with recognising that as an independent Foundation Trust, the Board would also remain focussed on its statutory responsibilities and ensure appropriate accountability by acknowledging the challenges early and applying strong governance to address the associated risks.

7.11 Dr Tolcher was pleased to confirm that Mrs Foster had accepted Executive Lead responsibility for Children. Having an executive lead for children at Board level reflected the importance of services for children and young people in the Trust's overall portfolio of services. Mrs Dodson also confirmed that Mr McLean had accepted the invitation to represent the Board as Non-Executive Lead for Children.

7.12 Professor Proctor asked what additional data would be provided to the Board as a result of the appointment of Mrs Foster and Mr McLean relating to care of young people and children. Dr Tolcher confirmed that the appointments would not result in new data being submitted to the Board, but requirements in terms of key performance indicators were subject to review on a regular basis. The appointments reflected the value of a nominated member of the Board having an opportunity to contribute to strategic discussions on behalf of children and young service users. Mrs Foster also confirmed that risks associated with safeguarding would be included in the Chief Nurse report from May.

7.13 Professor Proctor also referred to responding to the needs of a new client group in terms of Children's Services and Dr Tolcher confirmed that the recent directorate review provided an opportunity to speak to the new cohort of staff as well as an opportunity to amend structures to accommodate the new service.

7.14 As part of the NHS 5-Year Forward View, Dr Tolcher referred to the invitation for expressions of interest to explore the 'reinvention of the acute medical model in small district general hospitals'. The Trust's submission had been accepted and a site visit by NHS England's New Models of Care (NMC) Team took place on 25 April. The site visit involved round table discussions, walk-arounds and discussions with Directors and Senior Managers. Dr Tolcher noted that the programme would last 12 months, supported by access to expertise and a budget of approximately £2m. The Trust requested flexibility to be judged on outcomes rather than inputs to enable new ideas to the taken forward. Positive feedback had been received and formal feedback is awaited.

7.15 Mr McLean asked how closely the Trust liaised with other high performing Trust's out-with existing formal structures to ensure continued learning from best practice. Dr Tolcher referred to a number of organisations which had contributed to the Trust's learning and also stated that individual Directors had their own networks within which to share learning. Mr Alldred and Mrs Foster also stated that discussions take place both formally and informally at clinical level and site visits could be used in terms of sharing best practice of clinical delivery and leadership.

7.16 Dr Tolcher referred to the establishment of the Cavendish Group, a collaboration of smaller Trusts, but acknowledged that the remit of this group had broadened since its inception. Mr McLean expressed concern regarding the risk of STPs to smaller organisations and the opportunity for enhanced influence via collaboration. Dr Tolcher agreed that further work should be undertaken in this regard and agreed to explore further opportunities to liaise with other comparable peers.

7.17 Dr Tolcher briefed the Board on the current period of Junior Doctor Industrial Action on 26 and 27 April. The action resulted in the full withdrawal of labour and it was acknowledged that this represented the first time the NHS had been required to respond to such an eventuality. Guidance had been received from NHS England/NHS Improvement on reducing demand in urgent and emergency care during industrial action, and best practice for mitigating the loss of Junior Doctor capacity during industrial action. Dr Tolcher provided assurance that the guidance had been considered and followed to support plans to ensure patient safety during the period.

7.18 Dr Tolcher took an opportunity to thank members of staff for their effort at directorate level including Consultants and Middle Grade doctors who provided additional support. Feedback from wards confirmed that there had been no patient safety concerns and services operated well including discharge and admissions. Regrettably some elective work and out-patient appointments had been deferred resulting in inconvenience and delays to a number of patients.

7.19 The Department of Health had made a commitment to require Trusts to appoint a 'Custodian of Safe Working'. Mr Marshall confirmed that the Trust hoped to have the role confirmed by the end of July. Mrs Dodson noted the importance of ensuring the Trust and the Board continued to make efforts to understand the views of the Junior Doctors. Dr Tolcher referred to a series of listening events and acknowledged that they had not perhaps been perceived by all those that attended as a support mechanism as originally planned, and additional time and effort would continue to be required to develop a long term approach to communicating with, listening to, and understanding Junior Doctors.

7.20 In response to a request from Mrs Dodson for definitive numbers, Mr Harrison confirmed that 29 elective care operations and 262 out-patients appointments had been cancelled.

7.21 Dr Tolcher referred to the challenging discussions undertaken at the recent meeting of the Harrogate Health Transformation Board (HHTB) regarding the lack of agreement of contractual value for community services and the National Value Proposition 2 award which had been awarded at a level substantially below the value indicated in the initial submissions. It was unlikely that the hoped-for benefits would be realised at the scale and pace originally described and new plans were being developed. A requirement of achieving clinically and financially sustainable services would be a reduced reliance on acute hospital bed-based care for frail older people.

7.22 The Senior Management Team had been pleased to receive and endorse the strategy for Care for Frail Older People, which underpinned the Trust's ambition to become a centre for

excellence for older people. The Senior Management Team supported that the strategy be submitted to the May meeting of the Board.

7.23 Mrs Taylor referred to non-achievement of the target for the Emergency Department 4 hour waiting time target of 95% and the statement regarding enhanced monitoring by NHS Improvement if further breaches occur. Dr Tolcher confirmed if the Trust breached the target for four consecutive weeks, NHS Improvement would implement weekly monitoring; however it would have no regulatory consequence. If the Trust breached the Quarter position within the next three Quarters, and again in the next 3 Quarters thereafter, NHS Improvement would place the Trust under formal investigation.

7.24 In the context of Junior Doctors recommending the Trust as a place to work, Mr Thompson asked if the Health Education England – Yorkshire and Humber report highlighted any significant issues following their recent visit to the Trust. Mr Marshall referred to the current period of enhanced monitoring and confirmed that an action plan had been developed and agreed with the Integrated Care Directorate in response to conditions included in the report. It was noted that a Junior Doctors' forum had been established and had been in place for a significant period in order to gain insight into the views of Junior Doctors. Mrs Dodson suggested that the report and action plan be uploaded to the 'Reading Room'.

7.25 In terms of appraisals which were currently reported as 75.1% compliance for the last 12 months, Mr Ward suggested promoting a culture of zero tolerance for completion of annual appraisals. Mr Marshall referred to the recent launch of the new appraisal policy and toolkit which not only simplified the appraisal process, but also included a condition linked to pay progression. Mr Marshall highlighted that line managers in those areas with low appraisal compliance would be receiving direct communication to encourage them to improve appraisal compliance, and also seek their views as to how they could become more engaged in the appraisal process. Mr Alldred stated that evidence suggested that organisations with high levels of appraisals had higher levels of productivity and engagement, and suggested learning from areas of good practice and high compliance levels within the Trust.

7.26 Dr Johnson referred to feedback from nursing teams referencing staffing issues as the key reason for non-compliance against appraisal targets. Mrs Foster briefed the Board on meetings with senior nurses and discussed pressures, but re-enforced the importance of appraisals in terms of supporting competence and development to deliver high quality care. Dr Tolcher suggested that the target be 90% and suggested a fresh look at the Trust's approach to raising the profile of the value of appraisals.

7.27 Professor Proctor requested an update on the status of the Trust's Whistleblowing Policy. It was confirmed that the national policy had been published and the Trust would contribute to feedback on the impact on the Trust's internal policy and review later in the year.

7.28 Dr Tolcher referred to an increase to the residual risk score of one risk, BAF#15, Misalignment of Commissioner/partner strategic plans, to Red 12 which reflected the ongoing contract negotiations between the Trust and the CCG.

ACTION:

- **Risks relating to safeguarding children would be incorporated into the Chief Nurses report for the May meeting of the Board.**
- **Explore further opportunities to collaborate with peer organisations to enhance learning and influence.**
- **Upload the Health Education England – Yorkshire and Humber Report and associated action plan to the Reading Room.**
- **Undertake a refresh of the Trust's approach to raising the profile of appraisals.**

8. Integrated Board Report

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

8.1 Professor Proctor referred to health visiting new born examinations and requested an update on actions required to achieve the target of 97%. Dr Lyth referred to the discussion at the March meeting and confirmed that following discussions with commissioners and receipt of local intelligence, the original target had been deemed to be unrealistic. Dr Tolcher reassured members of the Board that a discussion had taken place at Senior Management Team and it had been confirmed that appropriate safeguards were in place to ensure there were no risks to children and mothers.

8.2 Mr Thompson referred to the graph associated with safer staffing levels which showed an increase in Care Support Workers and a decrease in Registered Nurses, and asked when levels would become more stable. Mrs Foster confirmed that nursing ratios are dependent on the requirements of individual services and patient acuity. The Board were informed that staffing levels were scrutinised at matron level and by the site coordinating team twice daily to mitigate risks.

8.3 Mr Thompson requested the inclusion of a rolling three month forecast for cash flow. Mr Coulter confirmed that the forward plan would be included for the next 12 months from May.

8.4 Mrs Taylor stated that the introduction of sensors appeared to be having a positive impact on falls and asked when full roll-out would be undertaken. Mrs Foster confirmed that full roll-out in all appropriate areas would be undertaken within the next six months. A reduction in falls causing harm had been evident prior to the introduction of sensors, but they should result in full step change.

8.5 Mr Ward referred to the Emergency Department 4 hour standard and stated that despite not achieving the 95% target, achievement of 94.4% was positive given the continuing pressures in the system. Mr Ward asked if additional resource could be introduced to the department. Mr Alldred gave an in-depth overview of the challenges involved in achieving the target which had not only been an issue of additional resource, but also whole system challenges, capacity in terms of environmental space, and unprecedented increases in attendances particularly at weekends. A significant amount of working continued to take place to look at reconfiguring the department. In terms of workforce and skills, additional nursing staff and Emergency Nurse Practitioners had been in place to ensure robust provision of service. Mr Coulter also noted that the commissioners were not currently proposing to fund system resilience monies which had supported the service in the past. This issue was compounded by the proposed reduction in resources for community services.

8.6 Mrs Webster expressed disappointment at the Amber rating for infection control. Mrs Foster confirmed that an action plan had been developed to support improvement projects to prevent outbreaks occurring. The threshold for 2016/17 remained as 12 cases of C. Diff due to lapses in care. Plans continued to be monitored via the Quality Committee. Mr Alldred also referred to the two new appointments in the Microbiology Team which had already had a positive impact in reducing incidents of C. Diff. Mr Coulter also took an opportunity to clarify that the Trust remained Green rated for cases as a result of lapses in care. The Amber rating resulted from an internal threshold triggered by three cases in-month.

8.7 Professor Proctor asked if there would be financial penalties relating to hospital acquired pressure ulcers. Mrs Foster confirmed that there were no contractual obligations. Performance had been Red rated due to non-achievement of the Trust's *internal* target to reduce avoidable

pressure ulcers by 50%. In terms of the target for 2016/17, the target would be agreed during May.

8.8 Mrs Dodson noted the continuous improvement trend for mortality rates.

9. Report from the Chief Operating Officer

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

9.1 Mr Harrison briefed the Board on the directorate restructure and noted an overwhelmingly positive response to the consultation. The new structures reflected the emphasis on the three significant strategic areas: long term and unscheduled care; planned and surgical care; and children's and county wide community care.

9.2 Mr Harrison noted that there had been a strong message throughout the review on the avoidance of silo working and a strong culture had been observed in this regard. The consultation on the management structure had commenced which included one to one meetings with members of staff affected by the review. It was envisaged that the new structure would be formally implemented in mid-May.

9.3 Mr Harrison confirmed that the recruitment process for the Operational Director for the Children's and County-wide Community Care Directorate would commence following the management consultation process. Job descriptions and bandings for Clinical Directors and Operational Directors had also been reviewed.

9.4 Mr Harrison requested Board approval for the Quarter 4 Governance section of the Risk Assessment Framework as Green for submission to NHS Improvement, whilst acknowledging the significant challenges with regard to the Emergency Department 4 hour waiting time target.

9.5 Mr Thompson asked if the directorate review resulted in additional cost pressures. Mr Harrison confirmed there had been an associated cost in terms of strategic leadership within directorates. Costs associated with the review had been driven by the growth of the Trust following the transfer of Children's Services and would have been incurred regardless of the directorate review.

9.6 Mr Thompson applauded the training and development for new staff and asked if the Board would receive additional data in the form of key performance indicators (KPIs). Dr Tolcher reminded Board members of the high number of data items and the need to take the time to create meaningful KPIs.

9.7 Mr McLean asked if the naming of the 'Children's and County Wide Community Care' directorate had been appropriately named. Mr Harrison noted that non-children services were delivered county wide but children's services were only delivered in North Yorkshire.

9.8 Following the directorate review, Mrs Webster asked if concerns had been highlighted relating to responsibility and accountability for costs and activity year-on-year and associated changes in reporting. Mr Harrison confirmed that there would be budget realignment work to be undertaken in order to ensure the appropriate structure for the Trust to deliver the future objectives. Board members would still have the ability to monitor historical activity and data at speciality level. In terms of finances, Mr Coulter confirmed that a further period of sign-off for responsible officers would be undertaken in May/June.

APPROVAL:

- **The Board approved the submission of the Quarter 4 Governance section of the Risk Assessment Framework as Green to NHS Improvement and acknowledged the significant challenges with regard to A&E 4 hour waiting time target.**

10. Report by the Director of Finance

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

10.1 Mr Coulter reported an underlying surplus of £27k for 2015/16, which resulted in a Financial Sustainability Risk Rating (FSRR) of 3 for the year. The draft accounts for 2015/16 had been discussed in detail at Finance Committee and Audit Committee, and would be submitted to the Board of Directors for approval at end of May.

10.2 The Trust achieved the cost improvement programme targets for 2015/16 and all staff were acknowledged for their support and contribution to plans during the year. Mr Coulter noted the continued strong performance with a number of plans delivered non-recurrently demonstrating a strong reactive culture across the Trust. 2016/17 would again be a challenging year however a significant number of plans were already in place.

10.3 Mr Coulter noted the Trust's year-end cash balance as £5.5m, £2.2m behind plan. It was noted that the Trust would be invoicing Harrogate and Rural District CCG for £3.8m in relation to the 2015/16 overtrade. Mr Coulter requested the Board approve a Quarter 4 FSRR submission of 3 to NHS Improvement.

10.4 Dr Tolcher asked if a process had been implemented with regard to agreement of balances between NHS organisations at the year end. Mr Coulter confirmed that the Trust had communicated outstanding debts as appropriate.

10.5 With regard to Junior Doctors, Mr Ward asked for clarity on associated income and expenditure costs. Mr Coulter suggested that the Trust would experience a loss of approximately £50k of activity associated with the industrial action. The impact would continue to be monitored closely and activity would be re-programmed over the forthcoming months.

10.6 Mr Coulter made reference to the extraordinary meeting of the Board of Directors held on 8 April 2016 at which the Board approved the Operational Plan for 2016/17, subject to the incorporation of minor amendments agreed at the meeting. The Board also agreed to delegate authority to the Finance Committee to approve any further amendments, particularly with regard to any substantial changes related to contract negotiations.

10.7 The Board of Directors also considered the Board declarations/certificates that accompany the Operational Plan, and delegated authority to the Chief Executive and Deputy Chief Executive/Finance Director as signatories on behalf of the Board of Directors. Mr Coulter confirmed that the Operational Plan and associated statutory documents had been submitted to NHS Improvement on 18 April 2016.

APPROVAL:

- **The Board of Directors approve a Quarter 4 Financial Sustainability Risk Rating of submission of 3 to NHS Improvement.**
- **The Board acknowledged the submission of the Operational Plan 2016/17 and associated statutory documents, to NHS Improvement on 18 April 2016.**

11. Licence and Lease Agreements

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

11.1 Mr Coulter requested approval from the Board of Directors to enter into a licence agreement for clinic accommodation in the newly built Alwoodley Medical Centre. As the licence remained under review by the Trust solicitors, Mr Coulter asked the Board to approve delegated authority to Mrs Dodson, and Dr Tolcher as signatories on behalf of the Board, with Professor Proctor being granted delegated authority in the absence of Mrs Dodson.

11.2 Mrs Taylor asked for the specific value of the lease. Mr Coulter agreed to circulate details of the associated costs out-with the meeting. Mrs Dodson suggested that the paper be deferred to the meeting held in private when additional commercially sensitive information would be available.

12. Report by the Director of Workforce and Organisational Development

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

12.1 Mr Marshall referred to the Quarter 4 results of the staff friends and family test and noted an increase to 74% of those members of staff recommending the Trust as a place to work. Mr Marshall also informed the Board that the test had been subject to national review. The outcome had yet to be received.

12.2 With regard to the implementation of the Junior Doctors' contract, the Terms and Conditions for the phased implementation of the new contract had been published in anticipation of implementation in August 2016. The task of reviewing and revising the rotas for Junior Doctors had commenced.

12.3 Junior Doctor listening events had also commenced as an opportunity to discuss current concerns regarding rota arrangements, as well as potential changes required to implement the new contract.

12.4 Mr Marshall updated the Board on the significant work undertaken on job planning, which had been supported by a 'significant assurance' report from Internal Audit. Further work included correspondence to all clinicians without a job plan and including job planning as a requirement for pay progression. Job plans would also include clear objectives.

12.5 Mr Marshall made reference to appraisals and a previous discussion held at the Quality Committee to review the compliance target. Skills for Health had been commissioned by the Trust to undertake a review of the current appraisal process. The report which compared performance against best practice had been received and would be used to drive improvements.

12.6 Mr Thompson referred to support for staff members with drug and alcohol dependency issues and asked if there had been any benchmarking information to measure the Trust's experience in this area. Mr Marshall confirmed that there was no benchmarking information available, but there had been internal incidents where dependency had been a factor in conduct issues. The Trust continued to look at trends to signpost people early to avoid impact further down the line. The policy and process had been shared with Trade Union colleagues and Partnership Forums.

13. Report from the Medical Director

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

13.1 Dr Scullion referred to the continued downward trend in mortality rates. A Cumulative Sum of Outcomes Alert had been received for January 2016 in the category of Acute Cerebrovascular Disease, due to there being an observed death rate of six over an expected rate of 5.41. Dr Scullion advised that an intensive case note review would not be required at this stage.

13.2 Dr Scullion referred to the receipt of two resignations from Consultants and a Reverend in the Trust Chaplaincy Team. Two Consultants would also be retiring from the Trust in May and September. The Board took an opportunity to wish them well in both the next phase of their career and in retirement.

13.3 Dr Johnson confirmed that two locum Consultants would commence with the Trust in May/June in advance of the appointment of substantive posts. These posts would also provide support to the Alwoodley Practice.

13.4 With regard to inquests, Dr Scullion clarified the date of one of the inquest was 25 and 26 March, not April as detailed in the report. Dr Scullion reported a verdict of accidental death and took an opportunity to thank the risk management team and staff members involved in the hearing who performed creditably under stressful circumstances.

13.5 Mrs Dodson suggested writing a personal note on behalf of the Board of Directors to those members of staff who were due to leave the Trust.

ACTION:

- **Personal note from Chairman to the sent to those members of staff retiring and resigning on behalf of the Board of Directors.**

14. Report from the Chief Nurse

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

14.1 Mrs Foster made reference to the Directors' inspections and patient safety visits carried out in April. Patient safety visits for 2016/17 had commenced in April 2016 with particular focus on increasing the number of patient safety visits in the community. Mrs Dodson provided feedback following the patient safety visit to the radiology department and stated that the department had a proactive, positive feel and observed good engagement within the team.

14.2 Mrs Foster reported that 213 complaints had been received in 2015/16, compared to 275 in 2014/15 which reflected work done to improve quality and address concerns early.

14.3 Mrs Foster provided the Board with data showing the staff establishment and vacancy factors across all inpatient wards and emergency department for Bands 5 and 6 nurses, for the time period January 2015 to March 2016. The data had then been used to predict the establishment and vacancy factors for April 2016 to December 2016 based on the averages since the implementation of the weekly Nurse Recruitment Group and introduction of the open days in August/September 2015. The report highlighted a positive establishment until April 2015. From this date a consistent decline had been seen until August 2015.

14.4 Mrs Foster confirmed that until August 2015 the number of Registered Nurses leaving the organisation had been greater than the number recruited. As a result of the current recruitment campaign the trend had been reversed and recruitment numbers had been exceeding those leaving. However the number had been marginal and there remained a significant gap.

14.5 Mrs Foster emphasised that although vacancy levels had improved, this had not been reflected in the experience on the front line due to increased attendances, percentage occupancy of beds, increased acuity of patients and other operational factors.

14.6 The Board were provided with detailed information on forecasts for nurse staffing for the period April – December 2016 and noted the potential gaps in recruitment of nursing staff as at December 2017. The Trust continued to undertake recruitment and retention initiatives and continued to develop training and appraisal packages.

14.7 Mrs Dodson referred to the national context and emphasised the belief in promoting the Trust as an employer of choice. Mrs Dodson also took time to recognise and congratulate the work undertaken by Mrs Foster and teams across the Trust in developing the recruitment initiatives.

14.8 Mr Thompson asked what intelligence had been gained from exit interviews in order to support retaining the workforce. Mrs Foster stated that feedback had highlighted work-life balance; career progression; and promotion as factors for leaving.

14.10 Mr Marshall referred to the decision taken that as of 2017; nursing would no longer be a commissioned undergraduate programme. Mr Marshall referred to the Trust's work with Leeds Beckett University to develop a new non-commissioned undergraduate nursing programme to commence in January 2017, with all placements being provided at the Trust with a guarantee of future employment post-qualification. A meeting had also been arranged with Health Education England with regard to an education exchange programme in India.

14.11 Mrs Webster noted that conversion courses for nurses were available in some places and asked if the Trust could design an in-house training programme. Mr Marshall confirmed that this was in place via a sponsored opportunity to develop Care Support Workers into the role of the Registered Nurse, and further work could be undertaken to encourage apprenticeships to develop through to becoming a registered professional. Professor Proctor also suggested establishing an adaptation programme via the Sustainability and Transformation Planning work to support international recruitment.

14.12 Professor Proctor referred to a potential difference between community and acute services. Mrs Foster provided significant detail of nurse staffing levels in non-inpatient services, all of which were fully recruited to. For non-acute services within the hospital setting, the biggest challenge remained in theatres with gaps as a result of members of staff who were employed but unavailable to work. Actions had been implemented to mitigate the risk associated with theatres including a specific recruitment campaign for theatres. In response to a query from Professor Proctor regarding the appropriateness of the current Corporate Risk Register entry relating to nurse vacancies, Mrs Foster confirmed that the risk should remain as Red rated with a residual risk score of 15.

14.13 Dr Tolcher thanked Mrs Foster for the comprehensive update and granular detail to help the Board focus on workforce issues and offer assurances. It was acknowledged that although the risks were being mitigating the focus and diligence in this area would provide a strong platform to make improvements.

14.14 Mrs Foster was of the opinion that the Trust continued to provide safe and effective care to patients. The opinion had been supported by metrics related to safe and effective care such as the reductions in pressure ulcers, falls and complaints. However the risk to patient safety had increased by the current vacancy level.

14.15 Mrs Foster referred to the work plan developed by the Equality and Diversity Group which had been previously endorsed by Senior Management Team and requested the Board's approval to publish the plan on the Trust website.

APPROVAL:

- **The Board of Directors gave approval for publication of the Equality and Diversity work plan on the Trust's website.**

15. Oral Reports from Directorates

Urgent, Community and Cancer Care

15.1 Mr Alldred noted that the GP Out of Hours Service had continued to be rated as Red against the National Quality Requirements. The issue had also been discussed at length in the Quality Committee. Work had commenced to develop a new metric to measure truly urgent patients within the service and enhance assurance on quality of outcomes. A further report would be presented to the June meeting of the Quality Committee.

15.2 Mr Alldred referred to positive discussions regarding the wheelchair service around restructuring clinical input and addressing concerns raised. Issues of concern regarding commissioning of the service continued.

15.3 Mr Alldred suggested that the Board attempt to identify a Patient Story at a future meeting from a patient who had received care as part of the Knaresborough Pilot on the New Models of Care work.

15.4 Mr Alldred highlighted the progress made at looking how the Trust uses technology and noted that discussion continued to implement discharge assessments at home.

Elective Care

15.5 In terms of workforce sustainability, Dr Johnson referred to gaps in middle grade doctors. A meeting had been arranged with clinical leads to develop a strategy for delivery of services in the longer term. This included a review of rotas to address the issue of on-site support by middle grades and Junior Doctors. In response to a query from Mrs Dodson, Dr Johnson confirmed that the lack of middle grades was a national issue.

15.6 Dr Johnson referred to the impact of the Junior Doctor Industrial Action and suggested that low morale and unfilled speciality posts post-August, would impact on future service delivery. Dr Johnson noted that this was also a national issue.

15.7 In terms of the directorate review, a directorate board time-out session had been arranged to take place in June to discuss the impact of the new structure, support new clinical leads, review directorate objectives, and discuss the leadership structure.

15.8 Dr Johnson confirmed that indicators had been published for caesarean section rates and the Board would receive an update at the May meeting.

Integrated Care

15.9 Dr Lyth referred to the mobilisation of Children's Services in County Durham, Darlington and Middlesbrough. Six welcome events had been held and positive feedback had been

received from members of staff regarding the transfer process. Members of staff felt particularly encouraged by the presence of the Chief Executive and Chief Nurse at the events.

15.10 With regard to the Junior Doctors Industrial Action, Dr Lyth noted two events planned for Junior Doctors to focus on the Deanery Report and an opportunity to ensure that their issues are fully understood to enable support to be provided.

15.11 Dr Lyth confirmed that the Baby Friendly Initiative for the 0 – 5 Services achieved Level 1 Accreditation and work had commenced to achieve Level 2.

15.12 Dr Lyth took an opportunity to thank Mrs Foster and the nursing team for their support and responsiveness to issues of staffing levels.

15.13 Dr Lyth referred to the development of a Head of Children's Safeguarding post in the 0 – 19 Services. The role would play a specific role at the Safeguarding Boards and strengthen management of risks within the service.

15.14 Dr Tolcher expressed her thanks for the opportunity to attend the induction meetings for County Durham, Darlington and Middlesbrough staff. The positive atmosphere was a reflection not only by those members of staff in attendance, but also by members of staff from the Corporate and Directorate Teams who made an enormous effort to welcome their peers. Dr Tolcher had also had a positive response to her request for shadowing opportunities within the service to spend time with the new staff and understand their issues.

16. Reports

Report from the Quality Committee held 6 April 2016 and minutes from 2 March 2016

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

16.1 Mrs Webster referred to two actions relating to the Trust's Quality Priorities. The committee agreed the process by which it would be updated on the progress for delivery of the priorities for 2016/17, with reports from leads for each priority on a quarterly basis.

16.2 With regard to the Quality Priorities for 2015/16, Mrs Webster confirmed that the committee agreed to monitor the priorities by receiving minutes from the appropriate sub-group. Any issues or delays to progress would then be escalated to the Quality Committee for action.

16.3 The committee discussed the GP Out of Hours action plan and received assurance that work was underway to develop strong methods to measure the quality of outcomes. The Committee endorsed a suggestion that the Trust would explore developing internal National Quality Requirements for responsiveness.

16.4 The committee received the Clinical Effectiveness and Audit Programme year-end update for 2015/16 and approved the draft programme for 2016/17.

16.5 Mrs Webster confirmed that the Quality Committee Annual Report was under development for submission to the Audit Committee meeting on 5 May and the forward plan would be submitted with the Quality Committee Chairs report for the May meeting of the Board for approval.

16.6 Mr Thompson requested clarity on the current status of the UV tech for cleaning. Mr Harrison confirmed that a business case was under development.

Report from the Finance Committee held 18 April 2016

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

16.7 Mrs Taylor noted that the cost improvement programme for 2016/17 remained a work in progress.

16.8 The committee held a detailed discussion regarding debtors.

16.9 It was acknowledged that the local report based on the Carter Review was yet to be received.

16.10 The committee received an update on the current position with regard to the contract negotiations with Harrogate and Rural District CCG (HaRD CCG).

16.11 Mrs Taylor confirmed that the final Operational Plan 2016/17 had been discussed in detail and submitted to NHS Improvement on 18 April.

16.12 Two business cases relating to the Alwoodley practice and Community Pharmacy were discussed in detail prior to submission to the Board of Directors in private for approval.

16.13 A discussion took place on each of the strategic risks on the Board Assurance Framework which fall in the finance domain and confirmed that BAF#15 had been increased to a residual risk rating of Red 12, to reflect the ongoing contract negotiations with commissioners. Dr Tolcher supported the committee undertaking deep dives into appropriate strategic risks following a recommendation from the independent assessment against Monitor's Well Led Review Framework.

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

Mrs Dodson confirmed the Board's approval earlier in the meeting for the submission to NHS Improvement of the Trust's Quarter 4 declaration and confirmed the submission of the Trust's Operational Plan 2016/17 on 18 April 2016.

18. Any other relevant business not included on the agenda

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

19. Board Evaluation

Mr McLean stated that the Chairman setting the scene at the beginning of the meeting had been particularly useful. It was also valuable for directorates and shaping the level of discussion throughout the meeting to feed back issues to the Directorates.

Dr Tolcher stated that detailed discussions on nurse recruitment, cultural issues, and workforce issues had been helpful resulting in a good balance between examining the detail and planning for the future.

Mrs Dodson asked if the opportunity to reflect on the patient story at the beginning of the meeting had an impact. Dr Lyth supported the patient story as highlighting the relationship between the patient and the clinician. It had been an opportunity to test if the experience of patients had been reflective of the Trust's values and ambition.

Mr McLean emphasised the importance of balancing positive patient stories with one which highlight lessons to be learnt. It would also be useful to look at the patient stories twice per year to identify themes and allow the Board an opportunity for collective reflection. Mr Harrison endorsed this as an opportunity to support the wider leadership task, to identify departments and individuals who display the values, and enable others to learn from those areas.

Mr Dodson referred to the Rapid Process Improvement Workshop and reflected on the need to be both transformational and transactional in embracing incremental change.

20. Confidential Motion

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

The Board agreed the motion unanimously.

The meeting closed at 1.00pm

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Harrogate and District NHS
NHS Foundation Trust

HDFT Board of Directors Actions Schedule – May 2016

Completed Actions

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

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

Item Description	Director/ Manager Responsible	Date of completion/ progress update	Confirm action Complete
Actual nurse staffing numbers overall at directorate level, and month on month comparisons to be included in future reports including (13.4 – March 16)	Mrs Jill Foster, Chief Nurse	April 2016	Complete
The Patient Safety Visit Programme to be circulated to Board members (13.1 – March 16)	Mrs Jill Foster, Chief Nurse	April 2016	Complete
Circulate STP correspondence/ objectives to Board members (5.3 – March 16)	Dr Ros Tolcher, Chief Executive	April 2016	Complete
Risks relating to safeguarding children would be incorporated into the Chief Nurses report for the May meeting of the Board (7.12 – April 16)	Mrs Jill Foster, Chief Nurse	May 2016	Complete – included in the CNs report
Upload the Health Education England – Yorkshire and Humber Report and associated action plan to the Reading Room (7.24 – April 16)	Mr Phillip Marshall, Director of Workforce & Organisational Development	May 2016	Complete
To include an update on New Care Models Vanguard and DDM Children's Services Contracts to the Board to Board meeting in May (10.1 & 10.8 – March 16)	Mr Jonathan Coulter, Finance Director and Mr Robert Harrison, Chief Operating Officer	May 2016	Complete – agenda confirmed and distributed
Approval be sought from the Council of Governors at the May meeting to delay the external auditor appointment process until Q2 16/17	Mr Jonathan Coulter, Deputy Chief Executive/Finance Director	May 2016	Complete – paper presented to CoG 18.5.16

HDFT Board of Directors Actions Schedule – Outstanding Actions May 2016

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

Ref	Meeting Date	Item Description	Director/Manager Responsible	Completion date	Detail of progress
1	March 2016	Reflect and review the thresholds related to SIRI's and NEs to consider Amber rating for SIRIs and the inclusion of month on month performance (6.8 – Mar 16)	Dr Ros Tolcher, Chief Executive/ Dr David Scullion, Medical Director	April 2016	
2	November 2015	Report on number of emergency and elective Caesarean sections performed (6.6)	Dr Johnson – Clinical Director, Elective Care Directorate	May 2016	
3	April 2016	Explore further opportunities to collaborate with peer organisations to enhance learning and influence	Dr Ros Tolcher, Chief Executive	May 2016	
4	April 2016	Personal note to be sent to those members of staff retiring and resigning on behalf of the Board of Directors	Mrs Sandra Dodson, Chairman	May 2016	
5	February 2016	Develop process for improving patient feedback on quality of care (12.6)	Mrs Foster – Chief Nurse	June 2016	
6	March 2016	Submission of a Research and Development Strategy for Board approval	Dr Alison Layton - Associate Medical Director for Research	June 2016	
7	January 2016	Update Board on progress with EDS2 action plan (11.10)	Mrs Foster – Chief Nurse	July 2016	
8	January 2016	Board to review Strategic KPIs on biannual basis (7.15)	Mr Coulter – Director of Finance	July 2016	
9	April 2016	Undertake a refresh of the Trust's approach to raising the profile of appraisals (7.23)	Mr Phillip Marshall, Director of Workforce & Organisational Development	July 2016	
10	January 2016	Review and revise questions in annual Audit Committee survey (14.1.3)	Mr Thompson – Chair Audit Committee – Non-Executive Director	November 2016	
11	March 2016	Additional information on learning from cases of C. Diff and associated action planning during 2015/16 to be included in the annual report (6.3)	Mrs Jill Foster, Chief Nurse	February 2017	

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Board of Directors – 25 May 2016

Report From: **Dr Kat Johnson, Clinical Director - Planned and Surgical Care**

Report Purpose: **Information about Clinical Indicators in Maternity at HDFT**

Status: **Open**

Introduction

Intervention rates in labour have increased significantly over the past 30 years and concern has been raised about increasing complexity on labour wards in the United Kingdom.

In recent years a number of data sources with which to examine the quality of maternity care have become available. These include:

- Local maternity dashboard
- Yorkshire and Humber Regional Dashboard launched in 2015
- Royal College of Obstetrics and Gynaecology (RCOG) maternity indicators project and report on Patterns of Maternity Care in English NHS Trusts

This paper will consider the findings of these reports in relation to our local service.

Local Maternity Dashboard

The local maternity dashboard is produced on a monthly basis and includes the following information about clinical outcome:

- Caesarean section rates; elective and emergency
- Operative Vaginal delivery rates
- Third and fourth degree tears

The dashboard can be viewed at:

http://harrogatedata/Reports/Pages/Report.aspx?ItemPath=%2fMaternity+Services%2fMaternity+Dashboards%2fMaternity+Dashboard

The figures for 2015/16 were:

Mode of delivery	Rate 2014/15	Rate 2015/16
Elective LSCS	12.6%	13.4%
Emergency LSCS	14.9%	13.7%
Total LSCS	27.5%	27.1%
Forceps	10%	7.9%
Ventouse	2.6%	2.7%
Normal delivery	60.4%	62.6%

Local dashboard data allows us to benchmark month on month and to look for trends; although due to the relatively small number of births the monthly variance can be considerable.

Yorkshire and Humber Regional Dashboard

The Yorkshire and Humber Regional Dashboard was launched in 2015. It benchmarks individual trusts against the other trusts in Yorkshire and Humber. Trust level data is released to individual trusts but all other data is anonymised. The data is crude and not adjusted for maternal characteristics or case mix. The key findings of the first two quarters of reporting (quarter 2 and 3 2015/16) were:

1. In quarter 3 HDFT was an outlier for third degree tears with assisted delivery; although in the previous quarter the rate had been below the Y and H average.
2. There was a spike in third degree tears with normal deliveries in quarter 2.
3. The number of elective caesarean sections was above the 'threshold' in both quarters.
4. The number of emergency caesarean sections was below the 'threshold' in both quarters.
5. The total caesarean section rate was above the threshold for quarter 2 and just below the threshold for quarter 3.
6. The rate of postpartum haemorrhage at or above 1500ml was at the top of the Y and H range in quarter 2 and close to the top in quarter 3.

The lack of standardisation of the data means that the results must be interpreted with some caution. It is of interest that the elective caesarean section rates are above the 'threshold'. The maternity service follows national guidance for requests for caesarean section. Previous caesarean section is one of the most common indications for caesarean section. Women with one or two caesarean sections are supported to make a shared decision between elective caesarean section or planned vaginal birth. The provision of a midwife led birth choice clinic to support this does not appear to have reduced the number of caesarean sections. However, there is good evidence that these women have made a shared decision based on a full exploration of the risks and benefits of their chosen delivery mode.

A small number of women request caesarean section for anxiety, previous traumatic vaginal delivery or birth phobia. There is a clear pathway for ensuring that the concerns are explored and women are supported to make an informed choice. Caesarean sections are not available 'on demand'.

The Y and H data identifies HDFT as an outlier for third degree tears overall and this has been recognised by the service. The following actions have been identified:

1. Training on the angle of episiotomy with operative vaginal delivery.

2. Increased consultant supervision on labour ward during the working week for operative vaginal deliveries; with particular focus on angle of episiotomy, perineal protection and angle of traction.
3. Encourage the use of ventouse delivery in preference to forceps, where applicable.
4. Continued incident reporting for all third and fourth degree tears, triggering case note review and feedback to individual practitioners.
5. Review of midwifery practice relating to competence/ confidence in episiotomy and prevention of third degree tears with vaginal deliveries.

Actions taken need to be proportionate in order to ensure that third and fourth degree tears aren't 'downgraded' clinically. The RCOG green top guidance on third degree tears states *'If there is any tear, it is advisable to classify it to the higher degree rather than the lower degree'*.

Yorkshire and Humber regional dashboard

Quarter 2 Data 2015/16		Threshold	Harrogate	Y&H average	Range	Interquartile range
Normal births	% of women - normal births	≥ 60.9%	65.6%	65.9%	55.2% to 74.5%	64.8% to 66.6%
Assisted vaginal births	% of women - assisted vaginal births	12.9%	8.4%	10.6%	6.0% to 14.5%	9.6% to 10.9%
Elective C/S deliveries	% of women - El C/S	≤ 11%	13.8%	10.2%	7.3% to 13.8%	8.9% to 11.2%
Emergency C/S deliveries	% of women - Em C/S	≤ 15.2%	13.2%	13.6%	11.0% to 19.4%	12.2% to 14.7%
C/S deliveries	% of women - Total all C/S	≤ 26.2%	27.0%	23.8%	20.0% to 27.0%	21.3% to 26.0%
3rd/4th degree tear - normal birth	% of women delivered - normal births		8.3%	2.8%	0.9% to 8.3%	1.7% to 2.9%
3rd/4th degree tear - assisted birth	% of women delivered - assisted births		2.5%	4.2%	0.8% to 10.0%	2.1% to 6.8%
PPH ≥ 1500ml	% of women delivered		4.2%	2.2%	0.1% to 4.2%	1.5% to 3.3%

Quarter 3 Data 2015/16						
Normal births	% of women - normal births	≥ 60.9%	62.3%	64.7%	58.0% to 70.0%	63.1% to 67.2%
Assisted vaginal births	% of women - assisted vaginal births	12.9%	11.6%	11.0%	7.0% to 15.1%	10.1% to 12.0%
Elective C/S deliveries	% of women - El C/S	≤ 11%	14.3%	10.4%	7.4% to 14.4%	9.1% to 11.6%
Emergency C/S deliveries	% of women - Em C/S	≤ 15.2%	11.8%	13.8%	11.0% to 18.3%	11.9% to 15.6%
C/S deliveries	% of women - Total all C/S	≤ 26.2%	26.1%	24.2%	20.0% to 30.1%	21.1% to 26.0%
3rd/4th degree tear - normal birth	% of women delivered - normal births		3.1%	2.6%	1.1% to 4.6%	1.9% to 3.0%
3rd/4th degree tear - assisted birth	% of women delivered - assisted births		11.7%	5.6%	0.6% to 11.7%	1.2% to 9.7%
PPH ≥ 1500ml	% of women delivered		3.5%	2.2%	0.3% to 3.7%	1.8% to 3.2%

RCOG Maternity Indicators Project

Comparison between units has been criticised in the past for reasons of differences in case mix. In 2013 the RCOG produced its first report on patterns of maternity care in English NHS Trusts. Trust level data was made available to individual trusts; but the identity of the other trusts was anonymised. In March 2016 the RCOG published its second report on Patterns of Maternity Care in English NHS Trusts 2013/14. This second report openly shares the data from the other trusts providing maternity care in England. The data is adjusted for maternal characteristics and case mix allowing a more valid comparison. The aim of this is stated as:

'*to stimulate thought among healthcare professionals, managers, commissioners and policy-makers; lead people to ask challenging questions and discuss and reflect locally, regionally and nationally; and allow maternity services and commissioners to identify priority areas for improving outcomes and productivity. The first step is for local services to understand their own outcomes in context so they can focus on reducing variation, further improving safety and ensuring their services meet the needs of women and their families.'*

The findings are summarised in the table overleaf:

Trust code: RCD INDICATOR	Subset of population†	Numerator	Denominator	Unadj rate	Adj rate*	National mean (%)
1. UNASSISTED VAGINAL DELIVERIES						
1a) Percentage of spontaneous, unassisted vaginal deliveries	P,S,T,C	332	808	41.1%	43.3%	44.9
	M,S,T,C	502	873	57.5%	59.6%	57.9
2. INDICATORS RELATED TO INDUCTION OF LABOUR						
2a) Proportion of induced labours	P,S,T,C	209	598	34.9%	32.2%	30.5
	M,S,T,C	148	625	23.7%	23.7%	25.1
2b) Proportion of induced labours in deliveries between 37 and 39 weeks of gestation	P,S,T,C	51	150	34.0%	29.6%	29.6
	M,S,T,C	54	200	27.0%	26.0%	28.3
2c) Proportion of induced labours in deliveries ≥42 weeks gestation	P,S,T,C	40	52	76.9%	77.4%	74.6
	M,S,T,C	19	28	67.9%	68.4%	64.9
3. INDICATORS RELATING TO CAESAREAN SECTION						
3a) Proportion of deliveries by caesarean section	P,S,T,C	184	812	22.7%	22.0%	22.1
	M,S,T,C	203	879	23.1%	20.9%	21.3
3b) Proportion of induced labours resulting in emergency caesarean section	P,S,T,C	69	209	33.0%	32.3%	29.9
	M,S,T,C	13	148	8.8%	9.1%	12.6
3c) Proportion of spontaneous labours resulting emergency caesarean section	P,S,T,C	49	389	12.6%	12.0%	11.4
	M,S,T,C	13	430	3.0%	3.2%	3.1
3d) Percentage of prelabour caesarean sections	P,S,T,C	24	812	3.0%	2.7%	3.3
	M,S,T,C	144	879	16.4%	13.7%	12.7
3e) Percentage of prelabour caesarean sections performed before 39 weeks of gestation without clinical indication in deliveries that are non-cephalic OR where 1 or 2 previous CS have occurred	S,T,Pre	11	116	9.5%	10.0%	24.0
3f) Proportion of vaginal births following a primary caesarean section	M,S,T,C	32	143	22.4%	25.8%	27.9
4. INVOLVEMENT OF INSTRUMENTS						
4) Proportion of deliveries involving instruments	P,T,S,C	206	784	26.3%	23.7%	24.4
	M,S,T,C	41	728	5.6%	4.9%	7.4
5. EPISIOTOMY						
5a) Proportion of episiotomy procedures among vaginal deliveries	P,S,T,C	270	628	43.0%	39.4%	35.5
	M,S,T,C	62	676	9.2%	8.0%	9.2
5b) Proportion of episiotomy procedures among instrumental deliveries	Va,S,T,C	47	56	98.4%	97.5%	88.7
	F,S,T,C	188	191	83.9%	80.7%	71.7
6. INDICATORS RELATING TO 3rd AND 4th DEGREE TEARS						
6a) Proportion of third- and fourth-degree perineal tears among vaginal deliveries	P,T,S,C	41	628	6.5%	6.1%	5.1
	M,T,S,C	16	676	2.4%	2.0%	1.8
6b) Proportion of third- and fourth-degree perineal tears among unassisted vaginal deliveries	P,T,S,C	16	422	3.8%	3.4%	4.1
	M,T,S,C	15	635	2.4%	1.9%	1.5
6c) Proportion of third- and fourth-degree perineal tears among assisted vaginal deliveries	P,S,T,C	25	206	12.1%	12.5%	7.3
	M,S,T,C	1	41	2.4%	2.4%	4.8
7. ADMISSIONS TO HOSPITAL FOLLOWING DELIVERY (no risk adjustment)						
7a) Maternal non-elective hospital readmissions within 42 days of delivery	S,T,C,V	10	1155	0.9%	-	1.9
	S,T,C,CS	5	349	1.4%		3.0
7b) Neonatal readmission to hospital within 28 days of birth	S,T,NB	71	1613	4.4%		3.0

Notes:

† The indicators have been derived for appropriate subsets of all deliveries. For all indicators, multiple and preterm deliveries are excluded. In this way attention is focused on a more homogeneous group of women whose maternity care is most affected by clinical uncertainty. Women who delivered a baby with non-cephalic presentation were also excluded from all indicators, with the exception of 3e and 7b. Additional exclusions have been applied to each indicator, and specifications are available on request from the project team.
C = cephalic deliveries; **CS** = caesarean section deliveries; **F** = forceps; **M** = multiparous women; **NB** = normal birthweight infants; **P** = primiparous women; **Pre** = subset of prelabour caesarean section deliveries including women with non-cephalic presentation OR with 1 or 2 previous caesarean sections; **T** = term deliveries; **V** = vaginal deliveries; **Va** = vacuum.
* After adjustment for maternal demographic and clinical risk factors available in the dataset. Trust results may be "n/a" if a set of quality checks for a data item forming the indicator in question were failed or "n/d" if the indicator was not derivable due to small denominators. Please note indicators relating to admissions to hospital (7a and 7b) are not risk adjusted.

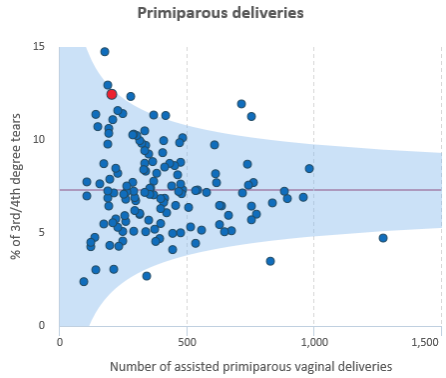
The RCOG clinical indicators website is freely accessible on:

https://indicators.rcog.org.uk/results/trusts/harrogate-and-district-nhs-foundation-trust

The website includes interactive funnel plots indicating HDFT's position compared with all other trusts in England.

The key findings for HDFT are:

1. For many indicators we were very close to the national average eg caesarean section rates, induction of labour.
2. The rate of episiotomy for operative vaginal delivery was higher than the national average, for both ventouse and forceps.
3. The rate of third and fourth degree tears amongst vaginal deliveries was below the national average for unassisted deliveries but well above the national average for primiparous instrumental deliveries (assistance in first delivery).



The data on third degree tears mirrors the concerns identified form the Y and H dashboard. The actions taken are described above.

The RCOG advice on episiotomy with instrumental deliveries is conflicting - the RCOG green top guideline on operative vaginal delivery (2011) states: *'In the absence of robust evidence to support routine use of episiotomy in operative vaginal delivery, restrictive use of episiotomy, using the operator's individual judgement, is supported.'*

However, the RCOG green top guideline on third and fourth degree tears (2015) states: **'***there is evidence that a mediolateral episiotomy should be performed with instrumental deliveries as it appears to have a protective effect on OASIS' (obstetric anal sphincter injuries).*

On balance a focus on reducing episiotomy rates with operative vaginal delivery would appear counterintuitive, given the high third and fourth degree tear rates in the trust.

The strength of this report is the case mix adjustment. It is reassuring to note that the indicators for caesarean section rates are around the average, especially as the trust appears an outlier on the Y and H unstandardised dataset.

Conclusions

Triangulating the various data sources allows us to benchmark the quality of our outcomes in maternity. The RCOG data shows the performance of HDFT maternity service is close to the national average for most of the clinical indicators. However, there is evidence from all sides that HDFT is an outlier for the incidence of third and fourth degree tears amongst instrumental deliveries. There is ongoing improvement work to address this. The leadership team in maternity is also taking an active part in the regional work through the clinical network.

Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 25 May 2016	Paper No: **5.0**

Title	**Report from Chief Executive**
Sponsoring Director	Dr Ros Tolcher, Chief Executive
Author(s)	Dr Ros Tolcher, Chief Executive
Report Purpose	To update the Board of Directors on significant strategic, operational and performance matters

Key Issues for Board Focus:

- The Month 1 (April) financial position is £433k adverse.
- The Trust failed the Emergency Department 4 hour target in Month 1.
- The new Directorate structure has gone live.
- The Trust is working with Commissioners to review community services in the light of commissioning decisions.

Related Trust Objectives:

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

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

Action Required by the Board of Directors

- The Board is requested to **note** the strategic and operational updates
- The Board is asked to **note** progress on risks recorded in the BAF and Corporate Risk Register

1.0 MATTERS RELATING TO QUALITY AND PATIENT EXPERIENCE

1.1 2016/17 contracts

The annual contract negotiations have been particularly difficult this year and contracts have, at the time of writing, yet to be signed. We have a Memorandum of Understanding with our main commissioner for the services which they commission. There are no unresolved matters in respect of contracts with local authorities, specialist services or CCGs which are associates to our main contract. Services funded by the CCG from non-recurrent sources in 2015/16 are under joint review. The CCG is due to communicate its final decision at the end of the month.

2.0 STRATEGIC UPDATE

2.1 West Yorkshire Sustainability and Transformation Plan (WYSTP)

Each of the 44 national STP areas is required to submit a Sustainability and Transformation plan by 30 June. Development of the West Yorkshire STP is being overseen by the Healthy Futures Group, led by Rob Webster CEO of South West Yorkshire Partnership NHS Foundation Trust. Work is underway to agree the leadership and governance arrangements. The four priority areas are: cancer; specialist services; urgent and emergency care; and mental health. A deep dive workshop in each area has been held in the last month attended by commissioners, providers and other stakeholders. The outcomes will help shape the thinking about future services at a West Yorkshire level and within the local STP areas.

There will be six local STPs (Bradford and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield) which will pursue the local clinical transformation necessary to meet local priorities. The West Yorkshire STP will focus on the priority areas outlined above where a larger footprint will ensure the best possible outcomes for the wider population. The first high level West Yorkshire plan, including local STP sections was submitted to NHS England on 15 April 2016 and is available in the Reading Room.

2.2 Directorate Review

Following a period of staff engagement, the three new clinical directorates have been agreed and commenced on 16 May 2016. The change in directorate structures reflects the growing importance of county wide services and in particular the significant portfolio of services to children, young people and families. The underpinning principle when determining the directorate structure was to enable the best possible experience for people using our services. The three clinical directorates are:

- Long Term and Unscheduled Care
- Children's and County Wide Community
- Planned and Surgical Care

2.3 Care Quality Commission review of learning

The CQC has published more information about its planned review of how NHS trusts identify, report, investigate and learn from deaths of people using their services. This follows a request from the Secretary of State for Health, which was part of the Government's response to a report into the deaths of people with a learning disability or mental health problem in contact with Southern Health NHS Foundation Trust.

The CQC's review will consider the quality of practice in relation to identifying, reporting and investigating the death of any person in contact with a health service managed by an NHS trust;

whether the person is in hospital, receiving care in a community setting or living in their own home. The review will pay particular attention to how NHS trusts investigate and learn from deaths of people with a learning disability or mental health problem. Board members will be aware that the Trust has chosen Learning Disability as one of its key Quality Priorities for 2016/17. A new Learning Disability Specialist Nurse has been appointed and arrangements to improve identification of people with a learning disability are being strengthened.

3.0 NATIONAL COMMUNICATIONS RECEIVED AND ACTED UPON

3.1 NHS England national cancer breach allocation guidance

NHS England's Cancer Waiting Times Delivery Group has developed national cancer breach allocation guidance to give providers a clear process to follow when creating local breach allocation policies which can help to remove bottlenecks from patient pathways and deliver timely cancer treatment. NHS England advises that these policies should adopt a single maximum handover date of day 38, the date by which cancer patients on an inter provider (IPT) pathway should be transferred from the referring trust/s to the treating trust. The Executive Team have commenced discussions to establish what this means for HDFT. Further information on this is included in the Medical Directors report.

3.2 Department of Health: The 2016/17 NHS Choice Framework

The Department of Health's NHS Choice Framework for 2016/17 sets out the choices available to patients in the NHS. NHS organisations are asked to share the information with patients to explain: when they have choices about healthcare; where they can get more information to help them choose; and how to complain if they are not offered a choice.

The framework has been refreshed to ensure that the language clearly sets out government policy in a way that is easy to understand and includes a number of fictional case studies demonstrating how patients might exercise their entitlements to choice in practice. HDFT will place a link on the Trust's website to promote this guidance.

4.0 WORKING IN PARTNERSHIP

4.1 Harrogate Clinical Board

The Harrogate Clinical Board has now agreed three specialty areas to participate in the Elective Care Rapid Testing Programme (ECRTP) described at the last Board of Director meeting. 'Challenge statements' relating to Gastroenterology, Osteoarthritis and Dermatology have been agreed and three '100-day teams' are being established. The overriding aim is to transform the way care is provided for specific groups of patients in ways that increase patient choice, further improve quality and reduce demand in secondary care.

4.2 Harrogate Health Transformation Board (HHTB)

The Harrogate Health Transformation Board met on 18 May. The Board evaluated progress on New Care Models and received updates from its subgroups in respect of STP development, the Ripon Partnership and Systems Resilience. The Board welcomed the confirmation of national Value Proposition funding of £1.55m which although less than previously hoped for, will nonetheless support the shared ambition for service transformation.

In the light of reducing income for community services a significant focus of the HHTB is to prioritise schemes most likely to achieve the desired outcomes. NHS England has asked the local Vanguard project to progress at pace on its IT developments and to expedite work on contractual and financial models, and organisational form.

The New Care Model programme has three main strands: Local Integrated Teams; Acute Response; and Prevention and Early Intervention.

Areas of progress to note are:

- the pilot sites continue to report examples of improved care and team working;
- a draft system level dashboard to monitor activity and outcomes has been developed;
- the contingency planning ('leap of faith' work) group is taking a quality improvement approach to addressing the funding shortfall. This includes a deep dive case note review and a series of observational exercises to understand why avoidable admissions happen;
- Station View and Ripon Hospital community beds are fully utilised as 'step down' beds from HDH. As part of the contingency planning process, key members of staff are analysing the pathways and protocols needed to transform at least some of the beds to 'step up' beds, to prevent hospital admission;
- a single shared record is a key enabler of integrated care. A small trial to look at maximising the existing sharing capability of SystmOne is underway. An information sharing protocol is being developed; and
- work has commenced to ensure that prevention activities across all partners are aligned and achieve the greatest impact on the health and wellbeing of the local population.

The Key Messages from the meeting will be placed in the Boardpad Reading Room.

5.0 FINANCIAL POSITION

The year-end accounts for 2015/16 have been prepared, submitted and audited. Subject to final Board of Directors' review and approval, these accounts, alongside our Quality Account and Annual Report will be submitted to NHS Improvement and subsequently to Parliament in line with national timescales. This brings a successful end to the financial year of 2015/16.

In terms of Month 1 (April) for 2016/17, the Trust delivered a deficit of £162k. This is over £300k behind our plan, and we are also prudently reporting a shortfall in Sustainability and Transformation funding due to this performance. The key drivers for this position are income delivery, compounded by the recent junior doctor strike, cost improvement programme (CIP) delivery and ward expenditure, offset by favourable pay variances elsewhere across the Trust. The Board should be aware that significant discussion took place at Senior Management Team (SMT) in order to ensure necessary action is taken to correct the position.

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

5.0 SENIOR MANAGEMENT TEAM (SMT) MEETING

The SMT met on 18 May. Key issues discussed and for noting by the Board of Directors are as follows:

- Clostridium Difficile: there have been three cases year to date. The business case for UV-cleaning has been approved and will be procured as soon as possible;
- the SMT approved a recommendation to re-structure the HCAI (Healthcare Associated Infections) Steering Group and HCAI Organisational Group into a single Infection Prevention and Control Committee;
- the adverse financial position at the end of Month 1 was discussed and contributory factors explored. The 2016/17 CIP risk adjusted value is insufficient at 77% and will be subject to more work;

- the Emergency Department 4 hour waiting time KPI was discussed. A recovery action plan will be brought to the next SMT meeting;
- Clinical Directors provided updates on progress to improve the effectiveness of Quality of Care teams;
- the case for undertaking a proof of concept in respect of the Integrated Electronic Patient Record was supported; and
- thirteen Internal Audit reports were received. Issues underpinning limited assurance reports and in particular repeat limited assurance reports were discussed. Directorates will pursue the necessary actions.

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

6.0 BOARD ASSURANCE AND CORPORATE RISK

The summary current position of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) is presented below. There will be an opportunity to discuss both the BAF and CRR during the confidential session of the Board, due to the detail of their content. The full BAF is lodged in the 'Reading Room' and provides full detail on the key controls, gaps in assurance, and actions being taken.

6.1 Board Assurance Framework (BAF)

The Board Assurance Framework was reviewed by the Executive Directors on 17 May 2016. No risks were removed, and all risks have comprehensive action plans to address the gaps in controls. All BAF entries have action plan progress scores of 1 or 2, providing assurance that actions to mitigate existing gaps in controls are being progressed. Some action plan progress scores have improved during the period, a summary of which can be found in the table below. A review of key controls has been undertaken as a result of the completion of actions, and additional actions have been added to mitigate increased levels of risk.

Eight risks (BAF Numbers 2, 6, 7, 8, 9, 11, 12, and 13) are currently assessed as having achieved their target risk score. A Board Strategy Session will focus on a review of the BAF and its content in its entirety.

There are five strategic risks (BAF #'s 1, 4, 14, 12 and 15) which are assessed at a risk score of 12. No BAF entries have scores greater than 12.

There has been a reduction in the residual risk score relating to BAF 2, risk that frail older people suffer from harm due to falls, pressure ulcers, and other risks associated with frailty, from a score of Red 12, to Amber 8. The decrease reflects the improvements with regard to reducing the number of falls resulting in harm and pressure ulcers.

There has been an increase in the residual risk score relating to BAF 10, risk that the Trust will breach the terms of its Licence due to financial failure or failure of governance, from a score of Yellow 5, to a score of Amber 10. This increase reflects the challenges in achieving the 95% target for A&E 4-hour waiting time in Quarter 4 2015/16.

The Executive Team would propose the inclusion of a new risk on the BAF relating to the delivery of Sustainability and Transformation Plans and the potential negative impact on high performing Trusts. An exercise will be undertaken to examine the controls, gaps in controls and actions in place to mitigate the risk, for inclusion on the BAF for the full Board review in June.

The Board will examine BAF 6 in detail at the Board Development session in June as part of the detailed review of all risks in the BAF across the year. The strategic risks are as follows:

Ref	Description	Risk score	Progress score
BAF 1	Risk of a lack of medical, nursing and clinical staff	*Red 12 ↔*	*Improved to 1*
BAF 2	Risk of a high level of frailty in the local population	*Amber 8 ↓*	*Unchanged at 2*
BAF 3	Risk of a failure to learn from feedback and Incidents	*Amber 9 ↔*	*Unchanged at 2*
BAF 4	Risk of a lack of integrated IT structure	*Red 12 ↔*	*Improved to 1*
BAF 5	Risk of maintaining service sustainability	*Amber 8 ↔*	*Unchanged at 2*
BAF 6	Risk of a lack of understanding of the market	*Amber 8 ↔*	*Unchanged at 2*
BAF 7	Risk of a lack of a robust approach to new business	*Yellow 4 ↔*	*Unchanged at 2*
BAF 8	Risk to visibility and negative impact on reputation	*Amber 8 ↔*	*Unchanged at 1*
BAF 9	Risk of a failure to deliver the Operational Plan	*Amber 8 ↔*	*Unchanged at 2*
BAF 10	Risk of breaching the Trust's Licence to operate	*Amber 10 ↓*	*Unchanged at 2*
BAF 11	Risk to current business	*Yellow 4 ↔*	*Unchanged at 1*
BAF 12	Risk of external funding constraints	*Red 12 ↔*	*Unchanged at 1*
BAF 13	Risk of a reduced focus on quality	*Yellow 4 ↔*	*Unchanged at 2*
BAF 14	Risk of delivery of integrated models of care	*Red 12 ↔*	*Unchanged at 2*
BAF 15	Risk of misalignment of strategic plans	*Red 12 ↔*	*Improved to 1*

Key to progress score on actions:
1. *Fully in plan across all actions*
2. *Actions defined – some progressing, where delays are occurring, interventions are being taken*
3. *Actions defined – work commenced*
4. *Actions defined – work not yet commenced/behind plan*

6.2 Corporate Risk Register (CRR)

The CRR was reviewed at the monthly meeting of the Corporate Risk Review Group on 13 May 2016. The Corporate Risk Register contains five risks, following the escalation of two Directorate level risks as follows:

- Risk CR7 (risk of failure to meet the national 4 hour standard) was presented to the Corporate Risk Review Group and it was agreed that this represented a risk of Red 16 at Directorate level due to the consequences of ongoing failure to meet this national standard. It was therefore agreed to escalate the risk for inclusion on the Corporate Risk Register. This risk is reputational. Effective systems of triage and clinical pathways mitigate the potential impact of waiting times on patient safety.

- Risk CR8 (risk of harm to ophthalmology patients due to the potential to be 'lost to follow-up') was presented to the Corporate Risk Review Group and it was agreed that this represented a risk of Red 12, following a recent SIRI and serious event within the specialty. It was therefore agreed to escalate the risk for inclusion on the Corporate Risk Register.

The mitigated score for risk CR5 (nurse staffing) remains the top scoring risk at 15: remains:

CR5 – Risk of patient harm due to lack of experienced qualified nurses due to a national shortage in registered nurses.

Risk score was increased in January to C3 x L5= 15 due to concerns raised by trained staff on the medical wards. Strengthened controls have been put in place and the risk for patients is being closely managed. This risk will reduce when recently recruited staff start in post.

Progress on actions levels for all risks remained at 2, demonstrating that actions for implementation remain on track.

Report to the Trust Board of Directors: 25 May 2016	Paper No: 6.0

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

Key Issues for Board Focus:

- Performance against the A&E 4 hour standard remained below the required 95% level in April.
- There were no falls causing significant harm reported during April.
- The agency bill for April was 2.4% of Trust pay expenditure. Detailed work is ongoing with Clinical Directorates to reduce total agency spend and ensure compliance with the agency cap.
- The 2015/16 national sepsis CQUIN was not achieved. However the Trust is awaiting confirmation from HARD CCG and NHS England that all other national and local schemes were achieved for 2015/16.
- A data quality assessment has been introduced to this report this month. This gives a high level assessment of data quality for each indicator within the report. Further information is provided on any indicator with a red or amber data quality assessment.

Related Trust Objectives:

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

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

Action Required by the Board of Directors

To note current performance

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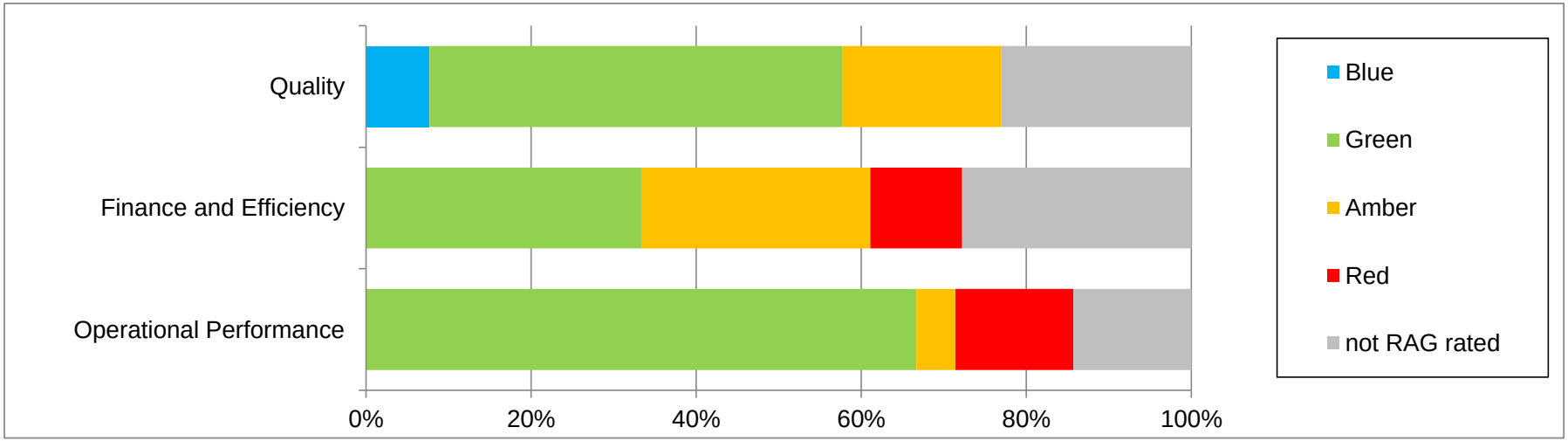
Integrated board report - April 2016

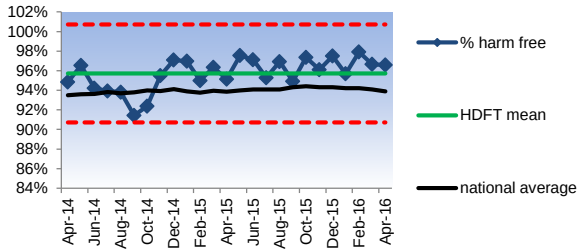
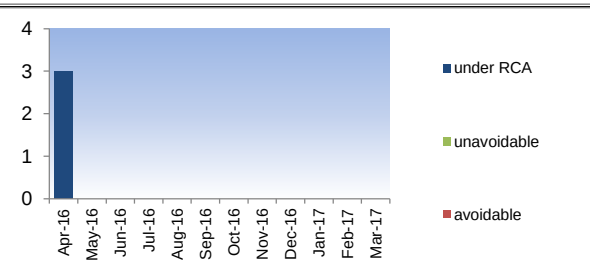
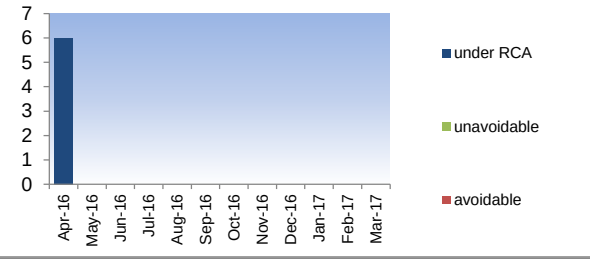
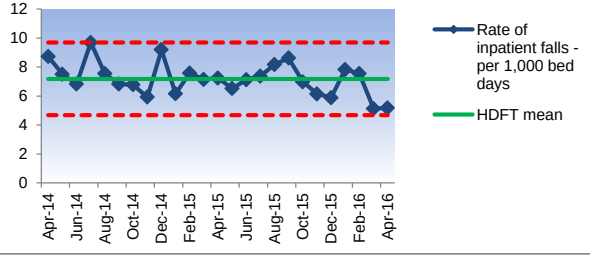
Key points this month

1. Performance against the A&E 4 hour standard remained below the required 95% level in April.
2. There were no falls causing significant harm reported during April.
3. The agency bill for April was 2.4% of Trust pay expenditure. Detailed work is ongoing with Clinical Directorates to reduce total agency spend and ensure compliance with the agency cap.
4. The 2015/16 national sepsis CQUIN was not achieved. However the Trust is awaiting confirmation from HARD CCG and NHS England that all other national and local schemes were achieved for 2015/16.
5. A data quality assessment has been introduced to this report this month. This gives a high level assessment of data quality for each indicator within the report. Further information is provided on any indicator with a red or amber data quality assessment.

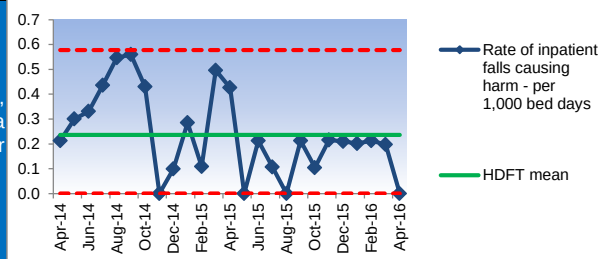
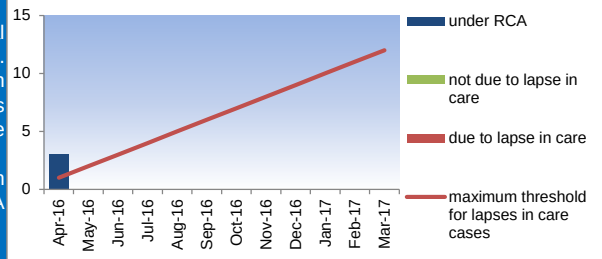
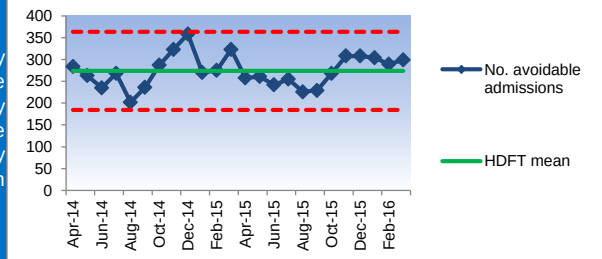
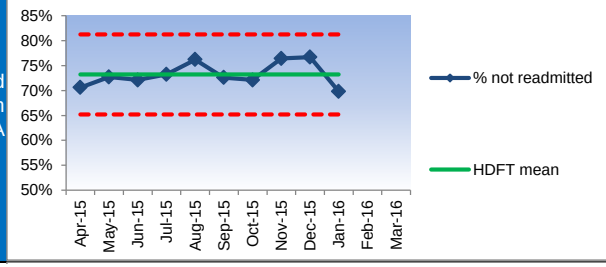
Summary of indicators



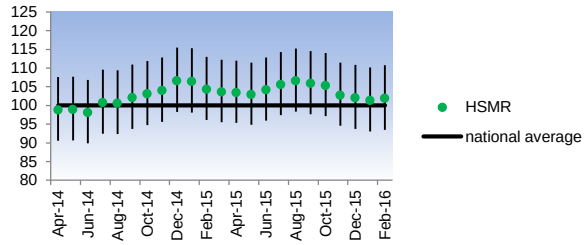
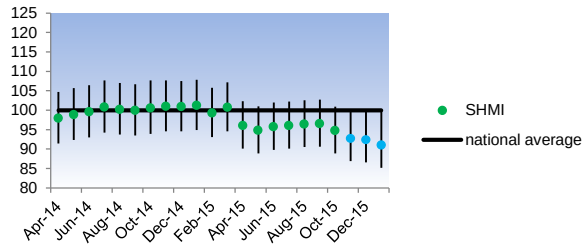
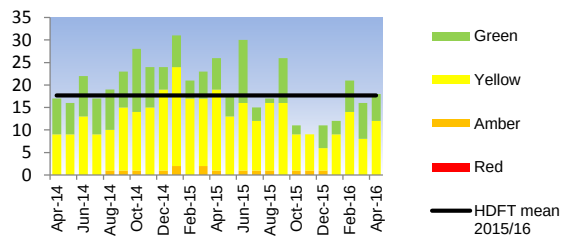
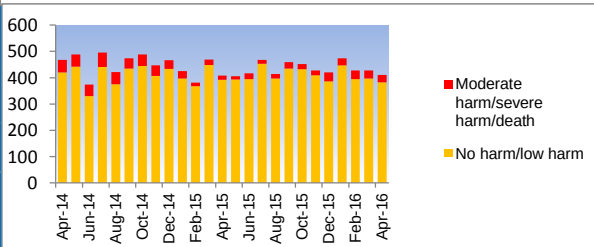
Quality - April 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Safety thermometer - harm free care	Measures the percentage of patients receiving harm free care (defined as the absence of pressure ulcers, harm from a fall, urine infection in patients with a catheter and new VTE) in the Safety Thermometer audits conducted once a month. The data includes hospital and community teams. A high score is good. Whilst there is no nationally defined target for this measure, a score of 95% or above is considered best practice.		The harm free percentage for April was 96.6%, a slight decrease on the previous month but still above the 95% standard and well above the latest national average of 93.9%.	✓
Pressure ulcers - hospital acquired	The chart shows the cumulative number of grade 3 or grade 4 hospital acquired pressure ulcers in 2016/17. The data includes hospital teams only. The Trust has set a local trajectory for 2016/17 of zero avoidable hospital acquired grade 3 or grade 4 pressure ulcers.		There were 3 hospital acquired grade 3 or grade 4 pressure ulcers reported in April - these cases are still under root cause analysis (RCA).	✓
Pressure ulcers - community acquired	The chart shows the cumulative number of grade 3 or grade 4 community acquired pressure ulcers in 2016/17. The data includes community teams only.		There were 6 community acquired grade 3 or grade 4 pressure ulcers reported in April - these cases are still under root cause analysis (RCA). The pressure ulcer working group is focussing on better assessment and verification of grading within the community teams.	✓
Falls	The number of inpatient falls expressed as a rate per 1,000 bed days. The data includes falls causing harm and those not causing harm. A low rate is good.		The rate of inpatient falls was 5.1 per 1,000 bed days in April, no change on the previous month and remaining significantly below the average HDFT rate during 2015/16. The falls sensors are now in place on Byland, Jervaulx and Farndale wards and there is a plan to roll out to the other ward areas.	✓

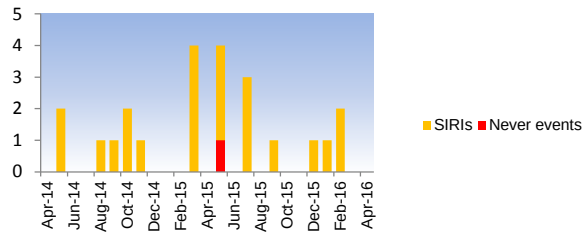
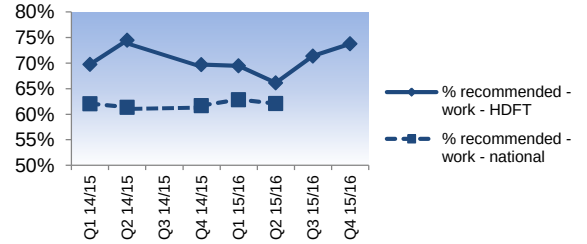
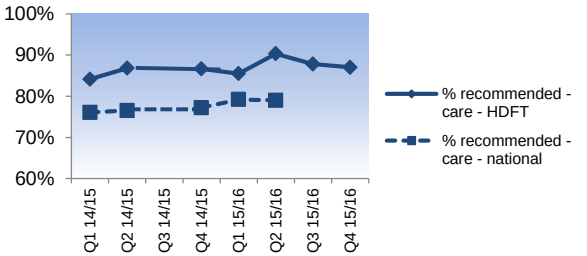
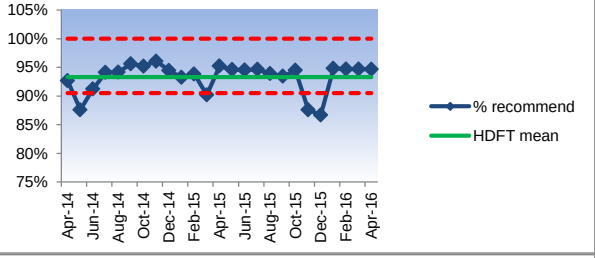
Quality - April 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Falls causing harm	The number of inpatient falls causing significant harm, expressed as a rate per 1,000 bed days. The data includes falls causing moderate harm, severe harm or death. A low rate is good.		There were no inpatient falls causing significant harm in April, an improvement on recent months. There were 20 inpatient falls causing moderate or severe harm in 2015/16, of which 16 resulted in a fracture. This compares to 36 moderate or severe harm falls in 2014/15, representing a 45% reduction.	✓
Infection control	The chart shows the cumulative number of hospital acquired C. difficile cases during 2016/17. HDFT's C. difficile trajectory for 2016/17 is 12 cases, no change on last year's trajectory. Cases where a lapse in care has been deemed to have occurred would count towards the Monitor risk assessment framework. Hospital acquired MRSA cases will be reported on an exception basis. HDFT has a trajectory of 0 MRSA cases for 2016/17.		There were 3 cases of hospital acquired C. difficile reported in April - these cases are still under root cause analysis (RCA). No cases of hospital acquired MRSA have been reported in 2016/17 to date.	✓
Avoidable admissions	The chart shows the number of avoidable emergency admissions to HDFT as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require admission. Conditions include pneumonia and urinary tract infections in adults and respiratory conditions in children.		There were 274 avoidable admissions in March, which equates to 9.6 per day, compared to 10.0 per day in February. An admission avoidance/urgent care project group has been established and the Trust is working with HARD CCG to develop care models and pathways that support patients to stay in their own home and reduce the risk of hospital admissions. This is also the focus of the New Care Models work and one of the metrics being used to evaluate this pilot.	✓
Reducing readmissions in older people	The chart shows the proportion of older people aged 65+ who were still at home 91 days after discharge from hospital into rehabilitation or reablement services. A high figure is good. *This indicator is in development.*		We have amended the calculation of this indicator so that it correctly handles patients who had multiple admissions and multiple contacts with community services. For patients discharged in January, 70% were still in their own home at the end of April, a decrease on the previous month. This is also the focus of the New Care Models work and one of the metrics being used to evaluate this pilot.	▲

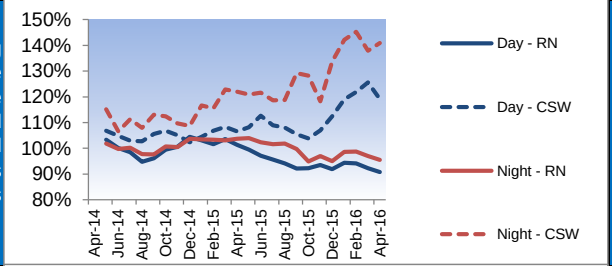
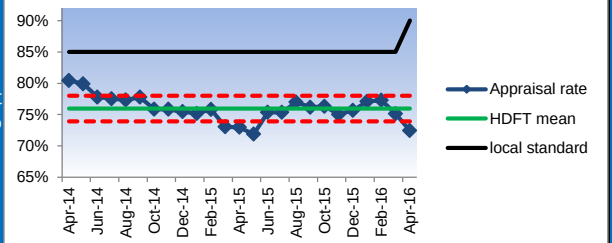
Quality - April 2016

Indicator	Description	Trend chart	Interpretation	Data quality
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 101.87 in February. However it remains within expected levels. At specialty level, 2 specialties (Geriatric Medicine and Gastroenterology) have a standardised mortality rate above expected levels. At site level, Ripon Hospital standardised mortality is now within expected levels.	✓
Mortality - SHMI	The Summary Hospital Mortality Index (SHMI) looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care. A low figure is good.		HDFT's SHMI decreased again in January to 91.07 - this is below the national average and below expected levels for the third consecutive month. It is also the lowest level reported by the Trust in the last 3 years. At specialty level, 2 specialties (Geriatric Meidicine and Gastroenterology) have a standardised mortality rate above expected levels and looking at the data by site, Ripon hospital has a higher than expected mortality rate.	✓
Complaints	The number of complaints received by the Trust, shown by month of receipt of complaint. The criteria define the severity/grading of the complaint with green and yellow signifying less serious issues, amber signifying potentially significant issues and red for complaints related to serious adverse incidents. The data includes complaints relating to both hospital and community services.		18 complaints were received in April (none of which were classified as amber or red) compared to 16 last month. The recent introduction of matrons at the weekends and on evening shifts is believed to be continuing to contribute to a reduction in the number of complaints received overall.	✓
Incidents - all	The chart shows the number of incidents reported within the Trust each month. It includes all categories of incidents, including those that were categorised as "no harm". The data includes hospital and community services. A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture		There were 411 incidents reported in April. The number of incidents reported each month remains fairly static but the proportion classified as moderate harm, severe harm or death has reduced over the last 3 years. The latest published national data (for the 6 month period to end September 2015) showed that Acute Trusts reported an average ratio of 31 no harm/low harm incidents for each incident classified as moderate harm, severe harm or death (a high ratio is better). HDFT's local reporting ratio for the same period was 21.	✓

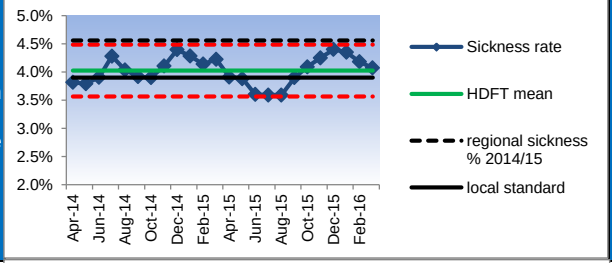
Quality - April 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Incidents - SIRIs and never events	The chart shows the number of Serious Incidents Requiring Investigation (SIRIs) and Never Events reported within the Trust each month. The data includes hospital and community services.		There were no SIRIs and no never events reported in April.	✓
Friends & Family Test (FFT) - Staff - % recommend as a place to work	The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organisation they work in. The chart shows the percentage of staff that would recommend the Trust as a place to work. A high percentage is good. The Trust's aim is to feature in the top 20% of Trusts nationally.		In Q4 2015/16, staff from Integrated Care Directorate and some staff from Corporate Directorate (Estates and Hotel Services) were surveyed. 74% of staff recommended the Trust as a place to work - this compares to the most recently published national average for Q2 of 62%. National data for Q4 will be published on 26th May (national data is not collected during Q3). The verbatim narrative received with the survey results is shared with the relevant directorates to identify trends in the data, in turn influencing the national staff survey action plan.	✓
Friends & Family Test (FFT) - Staff - % recommend as a place to receive care	The Staff Friends and Family Test (FFT) was introduced in 2014/15 and gives staff the opportunity to give feedback on the organisation they work in. The chart shows the percentage of staff that would recommend the Trust as a place to work. A high percentage is good. The Trust's aim is to feature in the top 20% of Trusts nationally.		In Q4 2015/16, staff from Integrated Care Directorate and some staff from Corporate Directorate (Estates and Hotel Services) were surveyed. 87% of staff recommended the Trusts as a place to receive care - this compares to the most recently published national average for Q2 of 79%. National data for Q4 will be published on 26th May (national data is not collected during Q3).	✓
Friends & Family Test (FFT) - Patients	The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of hospital and community services including inpatients, day cases, outpatients, maternity services, the emergency department, some therapy services, district nursing, community podiatry and GP OOH. A high percentage is good.		The % of patients recommending our services was 94.6% in April. The latest published national average is 92.8%.	✓

Quality - April 2016

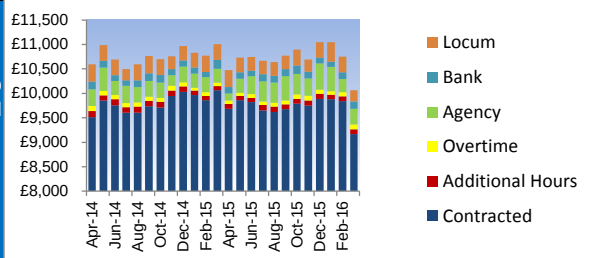
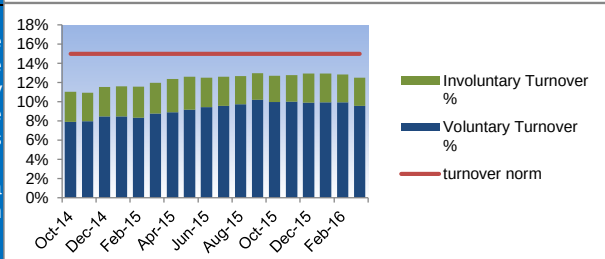
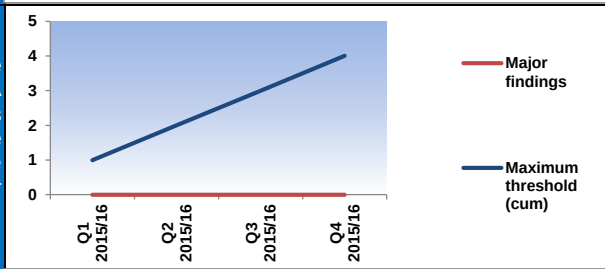
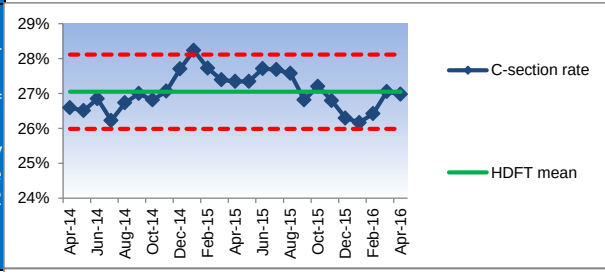
<table>
<tr><th>Indicator</th><th>Description</th><th>Trend chart</th><th>Interpretation</th><th>Data quality</th></tr>
<tr><td>Safer staffing levels</td><td>Trusts are required to publish information about staffing levels for registered nurses/midwives (RN) and care support workers (CSW) for each inpatient ward. The chart shows the overall fill rate at HDFT for RN and CSW for day and night shifts. The fill rate is calculated by comparing planned staffing with actual levels achieved. A ward level breakdown of this data is published on the Trust website.</td><td> 
</td><td>Overall staffing compared to planned was at 103%, compared to 105% last month. CSW staffing remains very high compared to plan - this is reflective of the increased need for 1-1 care for some inpatients.
A significant focus is being placed on recruitment of RN staff including open events and targeted recruitment campaigns including the use of social media. A decision has been taken to pursue a further round of registered nurse recruitment in Europe. In addition, the Trust is working with HEE regarding a potential educational exchange scheme for registered nurses from India to work in England. An imminent decision is expected on whether the latter scheme will progress.</td><td>✓</td></tr>
<tr><td>Staff appraisal rates</td><td>The chart shows the staff appraisal rate over the most recent rolling 12 months. The Trusts aims to have 90% of staff appraised. A high percentage is good.</td><td> 
</td><td>The locally reported cumulative appraisal rate for the 12 months to end April 2016 was 72.5%, a decrease of 2.7% on the previous month. Emails have been sent to all low performing areas to raise awareness and identify if there are any barriers in the appraisal notification process.

Staff governors will assist in an engagement exercise with directorates to improve compliance. It should be noted that from this month, the appraisal target will be raised from 85% to 90%.</td><td>✓</td></tr>
<tr><td>Mandatory training rates</td><td>The table shows the most recent training rates for all mandatory elements for substantive staff. A high percentage is good.</td><td><table>
<tr><th>Competence Name</th><th>Total Employees</th><th>% Completed</th></tr>
<tr><td>Equality, Diversity and Human Rights - Level 1</td><td>3448</td><td>95</td></tr>
<tr><td>Fire Safety Awareness</td><td>3448</td><td>92</td></tr>
<tr><td>Health & Safety e-learning</td><td>3448</td><td>96</td></tr>
<tr><td>Infection Prevention & Control 1</td><td>664</td><td>100</td></tr>
<tr><td>Infection Prevention & Control 2</td><td>2741</td><td>88</td></tr>
<tr><td>Information Governance: Introduction</td><td>3181</td><td>93</td></tr>
<tr><td>Information Governance: The Beginners Guide</td><td>261</td><td>94</td></tr>
<tr><td>Prevent Basic Awareness (December 2015)</td><td>3448</td><td>100</td></tr>
<tr><td>Safeguarding Children & Young People Level 1</td><td>3448</td><td>94</td></tr>
</table></td><td>The data shown is for end April. The overall training rate for mandatory elements for substantive staff is 94.5%, compared to 94.8% last month.

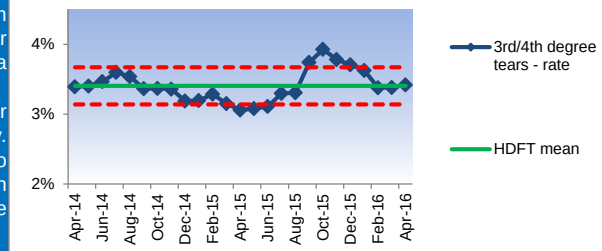
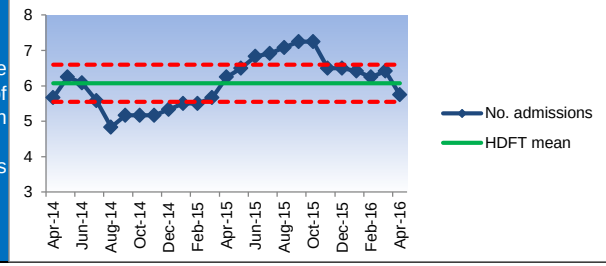
A workshop has been held with directorates to improve the follow up procedure for those members of staff whose mandatory and essential skills training is not up to date.</td><td>✓</td></tr>
<tr><td>Sickness rates</td><td>Staff sickness rate - includes short and long term sickness.
The Trust has set a threshold of 3.9%. A low percentage is good.</td><td> 
</td><td>HDFT's staff sickness rate has seen a decrease in March to 4.07%.

SHU Wellness is still ongoing. A Health and Wellbeing health assessment programme is open to all employees, but is particularly targeted at nursing staff. There is evidence of some managers continuing to submit sickness returns late in the month which impacts on data quality causing, in some cases, inflated sickness rates.</td><td>✓</td></tr>
</table>

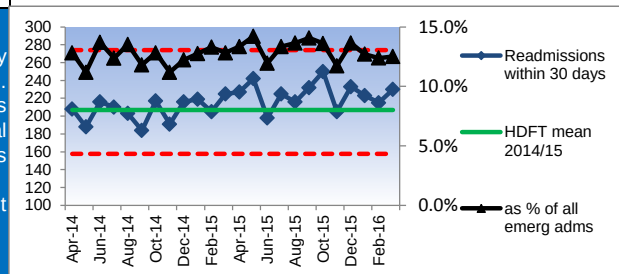
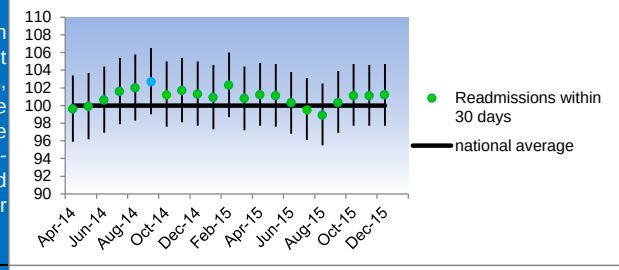
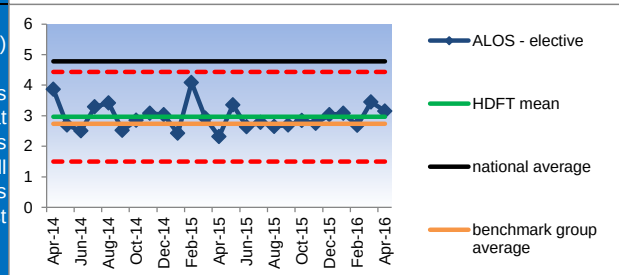
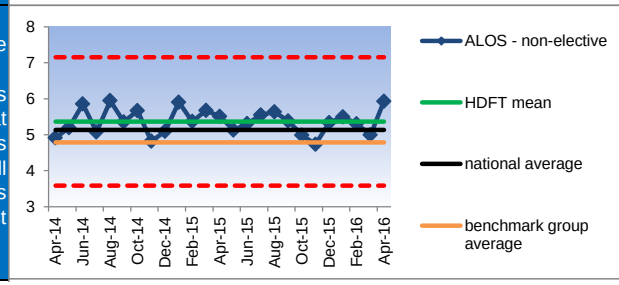
Quality - April 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Temporary staffing expenditure - medical/nursing /other	The chart shows staff expenditure per month, split into contracted staff, overtime and additional hours and temporary staff. Lower figures are preferable. *The traffic light criteria applied to this indicator is currently under review.*		The proportion of spend on temporary staff during 2015/16 was 7.6%, compared to 7.1% last year. It is to be noted that the total staffing spend is in line with budgeted spend in month. However concern remains regarding the number of registered nurse vacancies and the impact this is having on agency spend. Sickness will also be a driver of increased use of temporary and agency staff. Registered Nurses have recently been added to the National Shortage Occupation List given that the current demand is greater than supply nationally.	✓
Staff turnover rate	The chart shows the staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. The turnover figures include both voluntary and involuntary turnover. Voluntary turnover is when an employee chooses to leave the Trust and involuntary turnover is when the employee unwillingly leaves the Trust. Data from the Times Top 100 Employers indicated a turnover rate norm of 15%, i.e. the level at which organisations should be concerned.		Turnover rates are remaining fairly static with the Trust rate for the rolling 12 months to March 2016 being 12.5%, compared to 12.9% last month. Work continues to focus on areas with high levels of turnover, such as nursing and ODPs. The first published data from HEE of eWIN workforce information indicates a national Acute Trust average of 17.19% for turnover.	✓
Research internal monitoring	The Trust internally monitors research studies active within the Trust. The department mirrors the MHRA categorisation of critical, major and other findings (departures from legislative or GCP requirements). The department has set a standard of no critical and no more than four major findings per annum. Major and other findings are non-notifiable and dealt with locally.		There were no critical or major findings reported in 2015/16.	✓
Maternity - Caesarean section rate	The caesarean section rate is determined by a number of factors including ability to provide 1-1 care in labour, previous birth experience and confidence and ability of the staff providing care in labour. The rate of caesarean section can fluctuate significantly from month to month - as a result we have amended the presentation of this indicator this month to show a 12 month rolling average position.		HDFT's C-section rate for the 12 months ending April 2016 was 27.0% of deliveries, a slight increase on last month. The Royal College of Obstetricians and Gynaecologists recently published a paper which included a range of metrics standardised for local populations, including C-section rates. Overall HDFT was "as expected" in terms of standardised C-section rates. The report is being reviewed in detail by the maternity team to benchmark our position.	✓

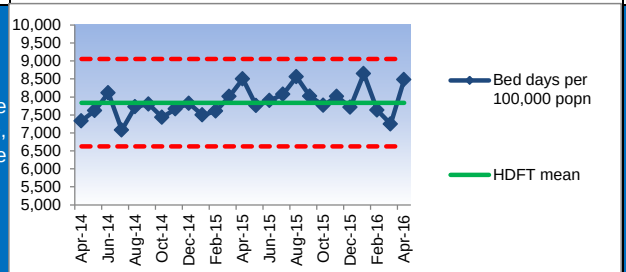
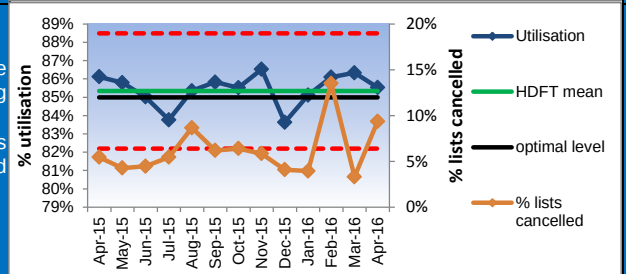
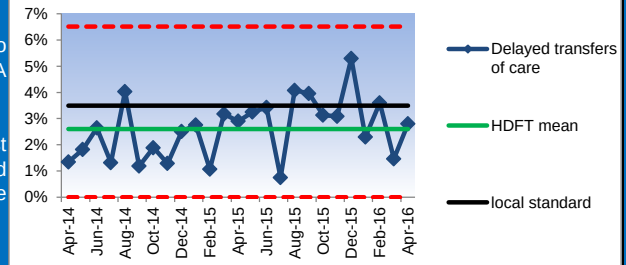
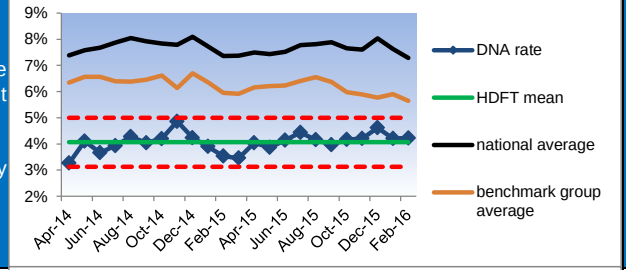
Quality - April 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Maternity - Rate of third and fourth degree tears	Third and fourth degree tears are a source of short term and long term morbidity. A previous third degree tear can increase the likelihood of a woman choosing a caesarean section in a subsequent pregnancy. Recent intelligence suggested that HDFT were an outlier for third degree tears with operative vaginal delivery. Quality improvement work is being undertaken to understand and improve this position and its inclusion on this dashboard will allow the Trust Board to have sight of the results of this.		The rate of 3rd/4th degree tears was 3.4% of deliveries in the 12 month period ending March 2016, no change on last month. The maternity team carry out a full review of all cases of 3rd/4th degree tears. Consideration is currently being made to a clinical re-audit of 3rd/4th degree tears occurring with normal deliveries.	✓
Maternity - Unexpected term admissions to SCBU	This indicator is a reflection of the intrapartum care provided. For example, an increase in the number of term admissions to special care might reflect issues with understanding of fetal heart rate monitoring in labour. We have amended the presentation of this indicator this month to show a 12 month rolling average position.		The chart shows the number of babies born at greater than 37 weeks gestation who were admitted to the Special Care Baby Unit (SCBU). The maternity team carry out a full review of all term admissions to SCBU. There were 4 term admissions to SCBU in April, compared to 7 in March. The average number per month over the last 12 months is 6.	✓

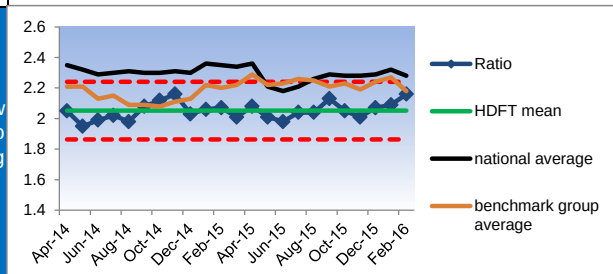
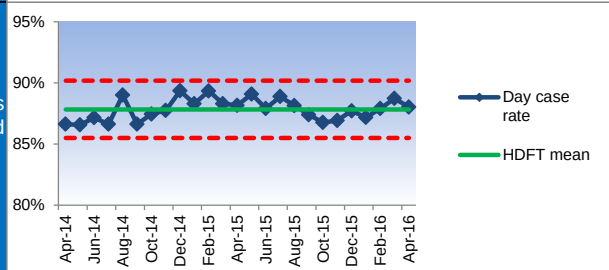
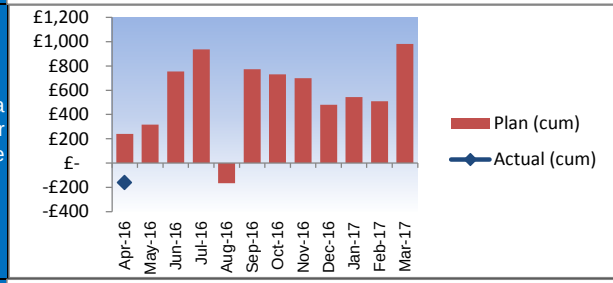
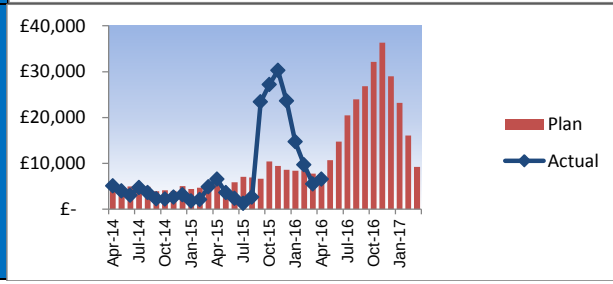
Finance and Efficiency - April 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Readmissions	% of patients readmitted to hospital as an emergency within 30 days of discharge (PbR exclusions applied). To ensure that we are not discharging patients inappropriately early and to assess our overall surgical success rates, we monitor the numbers of patients readmitted. A low number is good performance. This data is reported a month behind so that any recent readmissions are captured in the data.		The number of readmissions increased in March, both actual numbers and as a percentage of all emergency admissions. As part of CQUINs, 50 January and February readmissions were clinically audited. Overall, 12 cases (26%) were found to be unrelated admissions. 34 cases (74%) were found to contain related admissions, with 16 (47%) of those cases concluded to have had identified potentially modifiable factors. Actions have been identified and are being taken forward.	✓
Readmissions - standardised	This indicator looks at the standardised readmission rate within 30 days. The data is standardised against various criteria including age, sex, diagnosis, comorbidites etc. The standardisation enables a more like for like comparison with other organisations. The national average is set at 100. A low rate is good - rates below 100 indicate a lower than expected readmission rate and rates above 100 indicate higher than expected readmission rate.		*There is no update on this data this month.* HDFT's standardised readmission rate for the 12 month period ending December 2015 was 101.2 - above the national average but within expected levels.	✓
Length of stay - elective	Average length of stay in days for elective (waiting list) patients. The data excludes day case patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.		The average elective length of stay for April was 3.1 days, a decrease on the previous month. A focus on sustainably reducing this through the Planned Care Transformation programme is underway, which includes reducing the number of patients admitted the day before surgery.	✓
Length of stay - non-elective	Average length of stay in days for non-elective (emergency) patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.		The average non-elective length of stay for April was 5.9 days, an increase on the previous month. Increased length of stay was seen across both medical and surgical emergency admissions during April.	✓

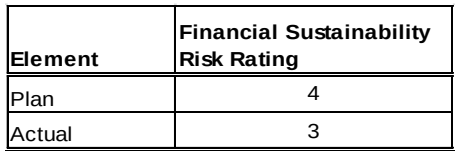
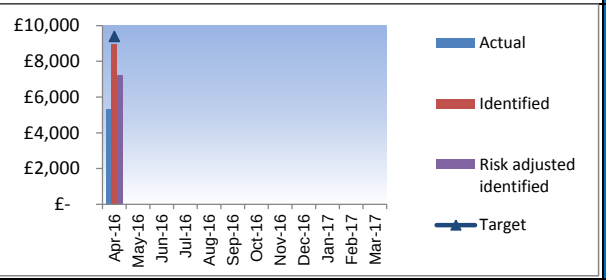
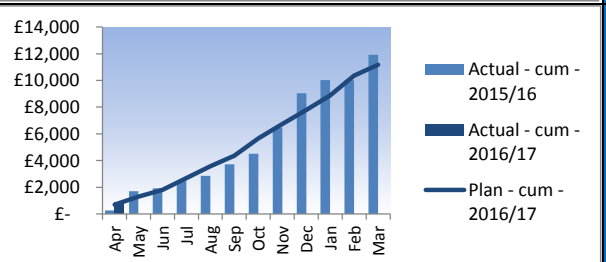
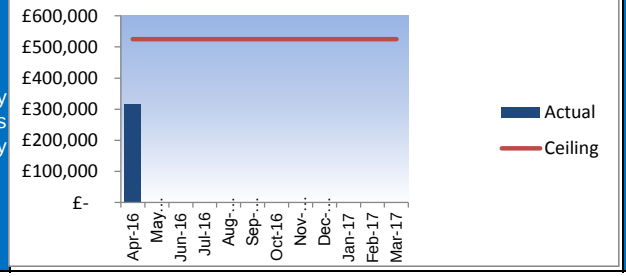
Finance and Efficiency - April 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Non-elective bed days	The charts shows the number of non-elective (emergency) bed days at HDFT for patients aged 18+, per 100,000 population. The chart only includes the local HARD CCG area. A lower figure is preferable.		As can be seen, the number of non-elective bed days for patients aged 18+ has remained fairly static over the last two years. Further analysis of this new indicator will be completed to look at the demograghic changes during this period and the number of admissions for this group will assist in understanding this further. This is also the focus of the New Care Models work and one of the metrics being used to evaluate this pilot.	
Theatre utilisation	The percentage of time utilised during elective theatre sessions only (i.e. those planned in advance for waiting list patients). A higher utilisation rate is good as it demonstrates effective use of resources. A utilisation rate of around 85% is often viewed as optimal.		Theatre utilisation decreased to 85.5% in April. 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. As can be seen, the number of cancelled sessions increased in April - this was due to staff availability.	
Delayed transfers of care	The proportion of patients in acute hospital beds who are medically fit for discharge but are still in hospital. A low rate is preferable. A snapshot position is taken at midnight on the last Thursday of each month. The maximum threshold shown on the chart (3.5%) has been agreed with the CCG.		Delayed transfers of care increased to 2.8% when the snapshot was taken in April, but remain below the maximum threshold of 3.5% set out in the contract.	
Outpatient DNA rate	Percentage of new outpatient attendances where the patient does not attend their appointment, without notifying the trust in advance. A low percentage is good. Patient DNAs will usually result in an unused clinic slot.		The DNA rate was 4.0% in January, a reduction on the previous month. This month, we have moved to using data from HED for this indicator. This allows us to compare like for like data against the national average and the average for a group of similar benchmarked trusts. As can be seen, HDFT's DNA rate is consistently significantly below that of both the benchmarked group of trusts and the national average.	

Finance and Efficiency - April 2016

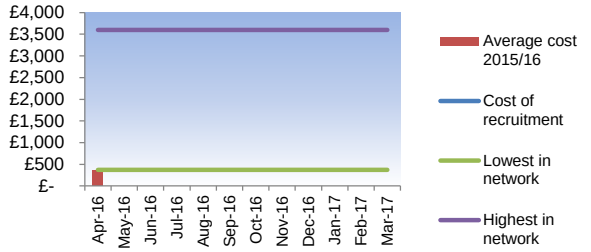
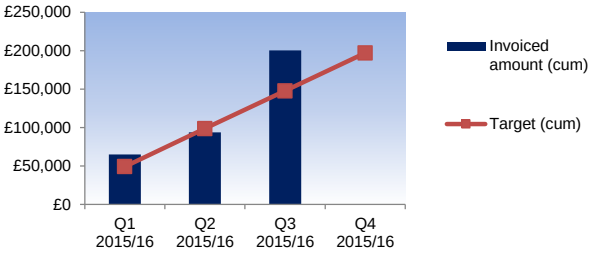
Indicator	Description	Trend chart	Interpretation	Data quality
Outpatient new to follow up ratio	The number of follow-up appointments per new appointment. A lower ratio is preferable. A high ratio could indicate that unnecessary follow ups are taking place.		Actions with HARD CCG continue and are on plan. This month, we have moved to using data from HED for this indicator. This allows us to compare like for like data against the national average and the average for a group of similar benchmarked trusts. HDFT's new to follow up ratio increased in April - it is now in line with the benchmark group average, having been below for a number of months.	✓
Day case rate	The proportion of elective (waiting list) procedures carried out as a day case procedure, i.e. the patient did not stay overnight. A higher day case rate is preferable.		The Day Surgery Transformation group continues their work and are on plan.	✓
Surplus / deficit and variance to plan	Monthly Surplus/Deficit (£'000s). In some months, a deficit is planned for. This indicator reports positive or adverse variance against the planned position for the month.		The Trust reported a deficit for April of £162k. This was £433k behind plan. Performance against income was a significant reason for this variance. This was compounded by the Trust not meeting all of the S&T fund criteria which equated to £100k.	✓
Cash balance	Monthly cash balance (£'000s)		The Trust was £808k behind plan for cash in April with a balance of £6,530k.	✓

Finance and Efficiency - April 2016

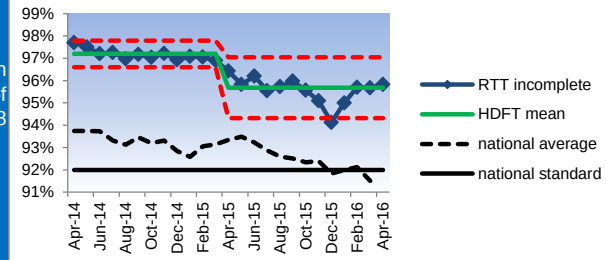
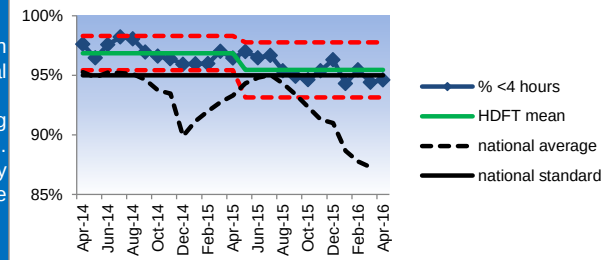
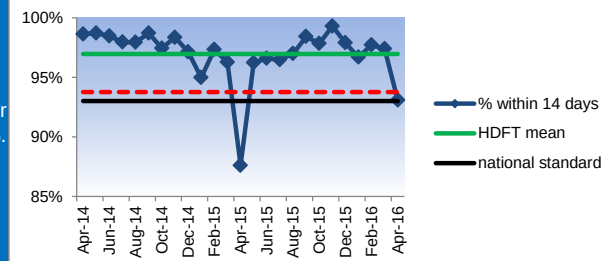
Indicator	Description	Trend chart	Interpretation	Data quality
Monitor continuity of services risk rating	The Monitor Continuity of Services (CoS) risk rating now includes four components, as illustrated in the table to the right. An overall rating is calculated ranging from 4 (no concerns) to 1 (significant concerns). This indicator monitors our position against plan.		The Trust will report a risk rating of 3 for April.	✓
CIP achievement	Cost Improvement Programme (CIP) performance outlines full year achievement on a monthly basis. The target is set at the internal efficiency requirement (£'000s). This indicator monitors our year to date position against plan.		57% of the full year CIP target was actioned in month. The risk adjusted total is a concern as only 77% of the target would be achieved.	✓
Capital spend	Cumulative Capital Expenditure by month (£'000s)		Capital expenditure was £135k ahead of plan for the month of April.	✓
Agency spend in relation to pay spend	Expenditure in relation to Agency staff on a monthly basis as a percentage of total pay bill. The Trust aims to have less than 3% of the total pay bill on agency staff.		The agency bill for April was 2.4% of Trust pay expenditure. Detailed work is ongoing with Clinical Directorates to reduce total agency spend and ensure compliance with the agency cap.	✓

Element	Financial Sustainability Risk Rating
Plan	4
Actual	3

Finance and Efficiency - April 2016

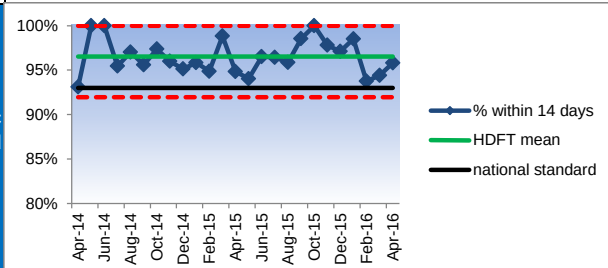
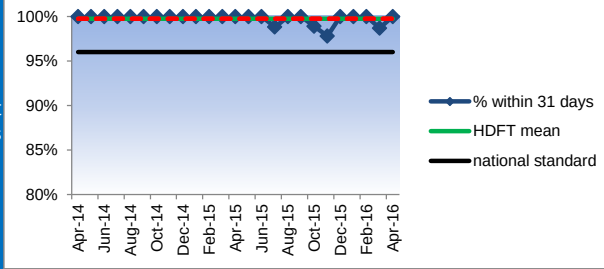
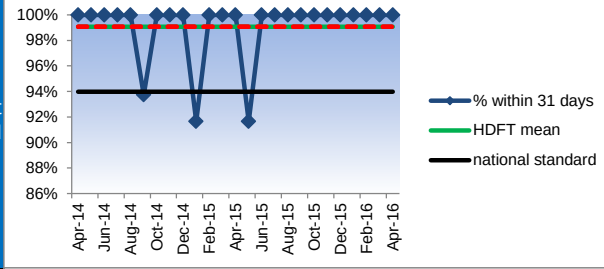
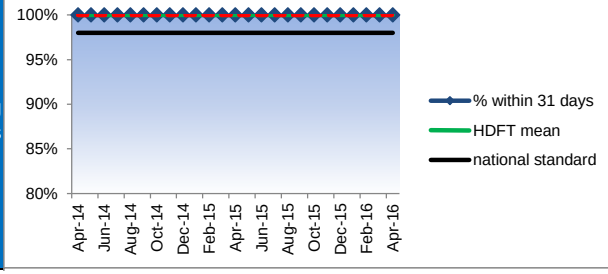
Indicator	Description	Trend chart	Interpretation	Data quality
Research - Cost per recruitment	Cost of recruitment to NIHR adopted studies. The Research department has a delivery budget of £69,212 per month. A low figure is preferable.		The Research department has a delivery budget of £69,212 per month. The Yorkshire and Humber Clinical Research Network calculate the cost of recruitment at each NHS site. It is desired that HDFT return a cost of recruitment that is in line with previous years.	✓
Research - Invoiced research activity	Aspects of research studies are paid for by the study sponsor or funder.		As set out in the Research & Development strategy, the Trust intends to maintain its current income from commercial research activity and NIHR income to support research staff to 2019. Each study is unique. Last year the Trust invoiced for a total of £223k. Data for Q4 will be reported in next month's report.	✓

Operational Performance - April 2016

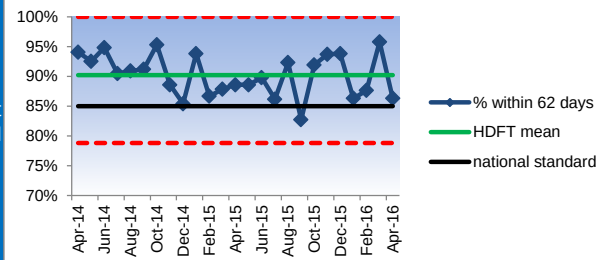
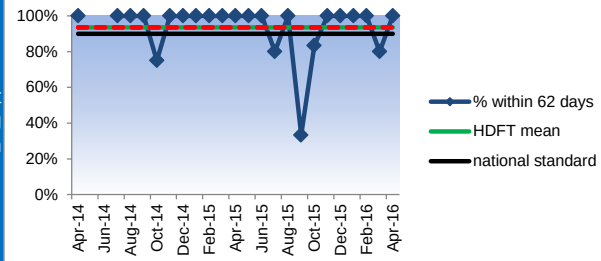
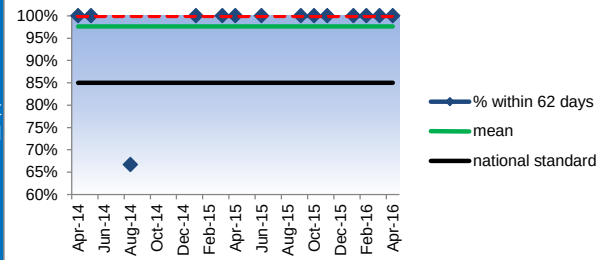
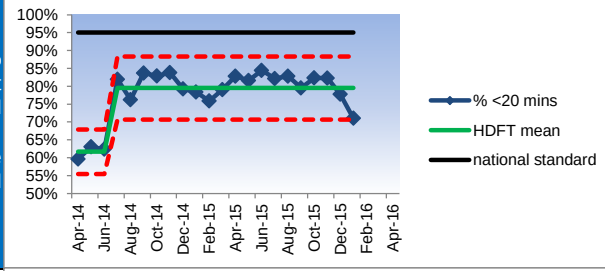
Indicator	Description	Trend chart	Interpretation	Data quality
Monitor governance rating	Monitor use a variety of information to assess a Trust's governance risk rating, including CQC information, access and outcomes metrics, third party reports and quality governance metrics. The table to the left shows how the Trust is performing against the national performance standards in the "access and outcomes metrics" section of the Risk Assessment Framework.	See table below	HDFT's governance rating for Q1 to date is Green. The Trust's performance against the A&E 4 hour standard is below 95% for Q1 to date. However this does not affect the Trust's overall governance rating unless the Trust reports performance below the 95% standard for Q1 and any subsequent quarter during 2016/17. The Trust reported 3 cases of hospital acquired C. difficile in April - these cases are still under root cause analysis review. The Trust's C. difficile trajectory for 2016/17 is a maximum of 12 cases due to lapses in care.	✓
RTT Incomplete pathways performance	Percentage of incomplete pathways waiting less than 18 weeks. The national standard is that 92% of incomplete pathways should be waiting less than 18 weeks. A high percentage is good.		95.8% of patients were waiting 18 weeks or less at the end of April, above the required national standard of 92% and a slight increase on last month. At specialty level, Trauma & Orthopaedics performance is below the 92% standard in April. Concern remains about sustaining performance for this specialty, particularly in light of the new agency cap from 1st April and the impact it has on theatre staffing.	✓
A&E 4 hour standard	Percentage of patients spending less than 4 hours in Accident & Emergency (A&E). The operational standard is 95%. The data includes all A&E Departments, including Minor Injury Units (MIUs). A high percentage is good. Historical data for HDFT included both Ripon and Selby MIUs. In agreement with local CCGs, York NHSFT are reporting the activity for Selby MIU from 1st May 2015.		HDFT's overall Trust level performance for April 2016 was 94.6%, below the required 95% standard. This includes data for the Emergency Department at Harrogate and Ripon MIU. Performance for Harrogate ED was 93.6%. Further information is provided on this performance position in the Chief Operating Officer's report.	✓
Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%. A high percentage is good.		Provisional performance for April is 93.1%, above the 93% operational standard but a reduction on performance in recent months. The main reason for this reduced performance was a lack of capacity in gastroenterology clinics and endoscopy. There is also some pressure in urology due to the recent retirement of a consultant and this capacity is being worked through.	✓

Indicator	Q1 to date score	Indicator	Q1 to date score
18 weeks - incomplete	0.0	Cancer - 14 days	0.0
A&E - 4 hour standard	1.0	Cancer - 14 days - breast symptoms	0.0
Cancer - 62 days to treatment	0.0	C-Difficile	0.0
Cancer - 62 days to treatment - screening		MRSA	0.0
Cancer - 31 day subsequent treatment - surgery	0.0	Compliance with requirements regarding access to healthcare for patients with learning disabilities	0.0
Cancer - 31 day subsequent treatment - drugs		Community services data completeness - RTT information	0.0
Cancer - 31 day subsequent treatment - radiotherapy	N/A	Community services data completeness - Referral information	0.0
Cancer - 31 day first treatment	0.0	Community services data completeness - Treatment activity information	0.0

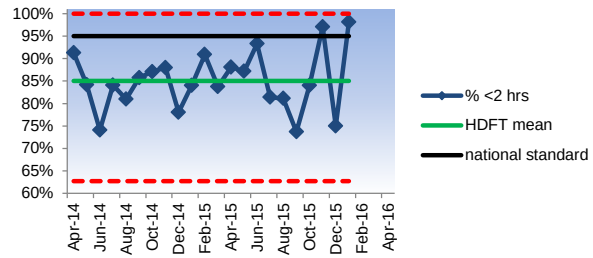
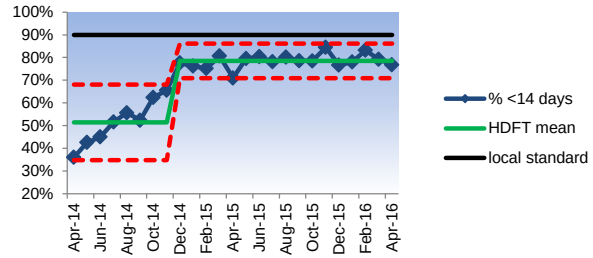
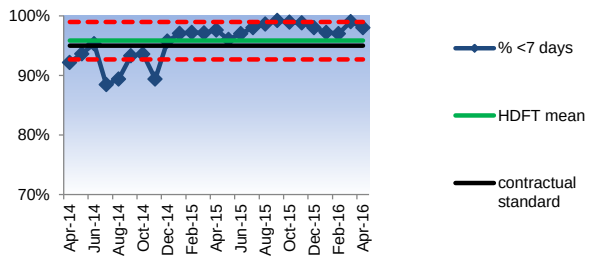
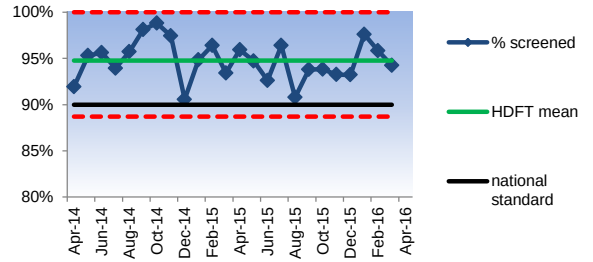
Operational Performance - April 2016

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

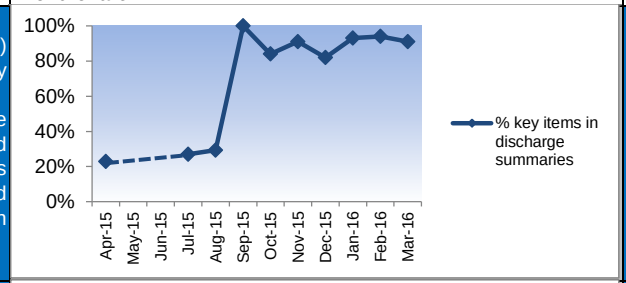
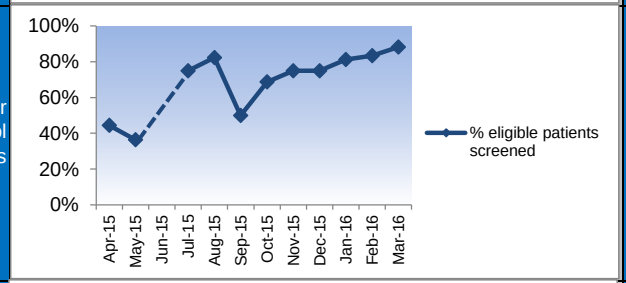
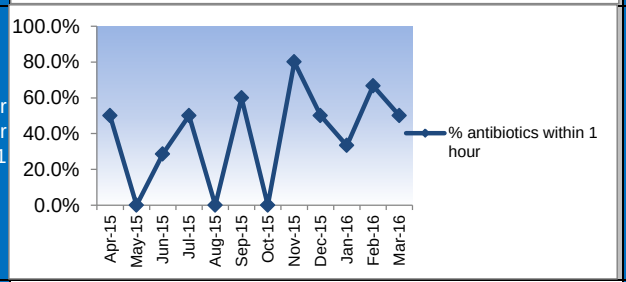
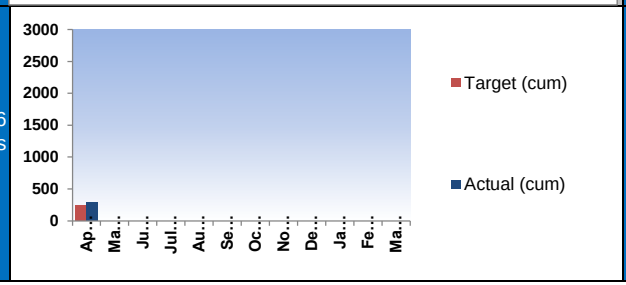
Operational Performance - April 2016

Indicator	Description	Trend chart	Interpretation	Data quality
Cancer - 62 day wait for first treatment from urgent GP referral to treatment	Percentage of cancer patients starting first treatment within 62 days of urgent GP referral. The operational standard is 85%. A high percentage is good.		Trust total delivery at expected levels. Of the 11 cancer sites treated at HDFT, 4 had performance below 85% in April - colorectal (2.5 breaches), head and neck (0.5 breach), upper gastro-intestinal (0.5 breach) and urological (1 breach). One patient waited over 104 days for treatment in April. This was due to a complex diagnostic pathway.	
Cancer - 62 day wait for first treatment from consultant screening service referral	Percentage of cancer patients starting first treatment within 62 days of referral from a consultant screening service. The operational standard is 90%. A high percentage is good.		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.		Delivery at expected levels.	
GP OOH - NQR 9	NQR 9 (National Quality Requirement 9) looks at the % of GP OOH telephone clinical assessments for urgent cases that are carried out within 20 minutes of call prioritisation. The data presented excludes Selby and York as these do not form part of the HDFT OOH service from April 2015. A high percentage is good.		*There is no update of this data this month.* The Trust recently changed the way that some patient groups are managed within the GP OOH service to improve efficiency and patient experience. Reports from the Adastra system no longer calculate the correct start time for these patients and as a result, the performance reported for some of the NQRs is now incorrect. We have been working with YAS to resolve this and have made some progress but are not yet confident that the data reported accurately reflects performance. The recent problems with the data have reiterated that the NQRs are out of date. We are proposing revised metrics which more comprehensively reflect both the quality and responsiveness of the GP OOH service.	

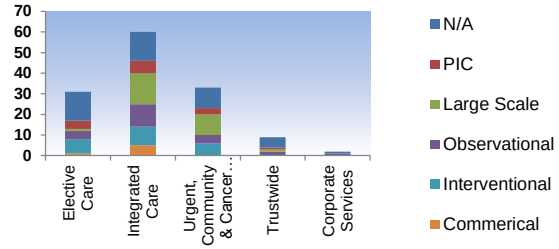
Operational Performance - April 2016

Indicator	Description	Trend chart	Interpretation	Data quality
GP OOH - NQR 12	NQR 12 (National Quality Requirement 12) looks at the % of GP OOH face to face consultations (home visits) started for urgent cases within 2 hours. The data presented excludes Selby and York as these do not form part of the HFT OOH service from April 2015. A high percentage is good.		*There is no update of this data this month.* The Trust recently changed the way that some patient groups are managed within the GP OOH service to improve efficiency and patient experience. Reports from the Adastra system no longer calculate the correct start time for these patients and as a result, the performance reported for some of the NQRs is now incorrect. We have been working with YAS to resolve this and have made some progress but are not yet confident that the data reported accurately reflects performance. The recent problems with the data have reiterated that the NQRs are out of date. We are proposing revised metrics which more comprehensively reflect both the quality and responsiveness of the GP OOH service.	
Health Visiting - new born visits	The number of babies who had a new born visit by the Health Visiting team within 14 days of birth. A high percentage is good.		In April, 77% of babies had a new born visit within 14 days of birth, remaining below the 95% standard. As can be seen from the chart, the performance on this metric improved significantly during 2014/15 - this was partly due to improved data capture over this period.	
Community equipment - deliveries within 7 days	The number of standard items delivered within 7 days by the community equipment service. A high percentage is good.		Performance remains above expected levels.	
CQUIN - dementia screening	The proportion of emergency admissions aged 75 or over who are screened for dementia within 72 hours of admission (Step 1). Of those screened positive, the proportion who went on to have an assessment and onward referral as required (Step 2 and 3). The operational standard is 90% for all 3 steps. A high percentage is good.		Recurrent achievement of this standard. Ongoing monitoring. No new actions identified.	

Operational Performance - April 2016

Indicator	Description	Trend chart	Interpretation	Data quality
CQUIN - Acute Kidney Injury	Percentage of patients with Acute Kidney Injury (AKI) whose discharge summary includes four defined key items. The aim of this national CQUIN is to improve the provision of information to GPs for patients diagnosed with AKI whilst in hospital. The target for the CQUIN is to achieve at least 90% of required key items included in discharge summaries by Q4 2015/16. A high percentage is good.		The Trust recently submitted Quarter 4 information to both NHS England and HARD CCG. The clinical audits carried out in the quarter show that 93% of patients sampled had the required clinical information documented in their discharge letter. The target for 2015/16 was to achieve at least 90% for Quarter 4, so the Trust has delivered this CQUIN for 2015/16.	✓
CQUIN - sepsis screening	Percentage of patients presenting to ED/other wards/units who met the criteria of the local protocol and were screened for sepsis. A high percentage is good.		As the chart demonstrates, there has been significant in-year improvement in the screening of patients for sepsis. However full achievement of this CQUIN was not achieved as the Trust screened 84% of eligible patients during Quarter 4 against a target of 90%. This means that the Trust will receive part payment for this CQUIN for 2015/16.	✓
CQUIN - severe sepsis treatment	Percentage of patients presenting to ED/other wards/units with severe sepsis, Red Flag Sepsis or Septic Shock and who received IV antibiotics within 1 hour of presenting. A high percentage is good.		The in-year fluctuations in performance reflect the very low numbers of patients which fall within this requirement. During Quarter 4, 46% of patients diagnosed with severe sepsis, red flag sepsis or septic shock received IV antibiotics within 1 hour, against a target of 90%. This means that the Trust has not achieved the indicator for 2015/16.	✓
Recruitment to NIHR adopted research studies	The Trust has a recruitment target of 2,750 for 2015/16 for studies adopted onto the NIHR portfolio. This equates to 230 per month. A higher figure is good.		Recruitment in April was 22% above plan with 286 recruited onto studies during the month.	✓

Operational Performance - April 2016

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

Data Quality - Exception Report

Report section	Indicator	Data quality rating	Further information
Operational Performance	GP Out of Hours - National Quality Requirement 9	**Red** 	The Trust recently changed the way that some patient groups are managed within the GP OOH service to improve efficiency and patient experience. Reports from the Adastra system no longer calculate the correct start time for these patients or assign them to the most appropriate level of urgency in data reports. As a result, the performance reported for some of the NQRs is now incorrect. We have been working with YAS to resolve this and have made some progress but are not yet confident that the data reported accurately reflects performance. The recent problems with the data have reiterated that the NQRs are out of date. We are proposing revised metrics which more comprehensively reflect both the quality and responsiveness of the GP OOH service.
Operational Performance	GP Out of Hours - National Quality Requirement 12	**Red** 	
Quality	Reducing readmissions in older people	**Amber** 	This indicator is under development. We have recently amended the calculation of this indicator so that it correctly handles patients who had multiple admissions and multiple contacts with community services.
Finance and efficiency	Theatre utilisation	**Amber** 	The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. An extra line has been added to the chart to allow monitoring of cancelled sessions.
Operational Performance	Health Visiting - new born visits	**Amber** 	Historical data for this indicator may be incomplete. Caution should therefore be exercised when reviewing the time series and any trend in performance.

Indicator traffic light criteria

Section	Indicator	Further detail	Traffic light criteria	Rationale/source of traffic light criteria
Quality	**Safety thermometer - harm free care**	% harm free	Blue if latest month >=97%, Green if >=95% but <97%, red if latest month <95%	National best practice guidance suggests that 95% is the standard that Trusts should achieve. In addition, HDFT have set a local stretch target of 97%.
Quality	**Pressure ulcers - hospital acquired**	No. grade 3 and grade 4 avoidable hospital acquired pressure ulcers	Green if no avoidable cases reported year to date, red if 1 or more avoidable case in year to date.	The Trust has set a local trajectory for 2016/17 of zero avoidable hospital acquired grade 3 or grade 4 pressure ulcers.
Quality	**Pressure ulcers - community acquired**	No. grade 3 and grade 4 community acquired pressure ulcers	tbc	tbc
Quality	**Falls**	IP falls per 1,000 bed days	Blue if YTD position is a reduction of >=50% of HDFT average for 2014/15, Green if YTD position is a reduction of between 20% and 50% of HDFT average for 2014/15, Amber if YTD position is a reduction of up to 20% of HDFT average for 2014/15, Red if YTD position is on or above HDFT average for 2014/15.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Quality	**Falls causing harm**	IP falls causing moderate harm, sever harm or death, per 1,000 bed days		
Quality	**Infection control**	No. hospital acquired C.diff cases	Green if below trajectory YTD, Amber if above trajectory YTD, Red if above trajectory at end year or more than 10% above trajectory in year.	NHS England, Monitor and contractual requirement
Quality	**Avoidable admissions**	The number of avoidable emergency admissions to HDFT as per the national definition.	tbc	tbc
Quality	**Reducing readmissions in older people**	The proportion of older people 65+ who were still at home 91 days after discharge from hospital into rehabilitation or reablement services.	tbc	tbc
Quality	**Mortality - HSMR**	Hospital Standardised Mortality Ratio (HSMR)	Blue = better than expected (95% confidence interval), Green = as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval).	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 2014/15, Amber if above HDFT average for 2014/15, Red if above UCL. In addition, Red if a new red rated complaint received in latest month.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Quality	**Incidents - all**	Incidents split by grade (hosp and community)	Blue if latest month ratio places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%	Comparison of HDFT performance against most recently published national average ratio of low to high incidents.
Quality	**Incidents - SIRIs and never events**	SIRI and never events (hosp and community)	Green if latest month =0, red if latest month >0.	
Quality	**Friends & Family Test (FFT) - Staff**	% staff who would recommend HDFT as a place to work	Blue if latest month score places HDFT in the top 10% of acute trusts nationally and/or the % staff recommending the Trust is above 95%, Green if in top 25% of acute trusts nationally, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
Quality	**Friends & Family Test (FFT) - Staff**	% staff who would recommend HDFT as a place to receive care		
Quality	**Friends & Family Test (FFT) - Patients**	% recommend, % not recommend - combined score for all services currently doing patient FFT	Green if latest month >= latest published national average, Red if < latest published national average.	Comparison with national average performance.
Quality	**Safer staffing levels**	RN and CSW - day and night overall fill rates at trust level	Green if latest month overall staffing >=100%, amber if between 95% and 100%, red if below 95%.	The Trusts aims for 100% staffing overall.
Quality	**Staff appraisal rate**	Latest position on no. staff who had an appraisal within the last 12 months	Annual rolling total - 90% green. Amber between 70% and 90%, red<70%.	Locally agreed target level based on historic local and NHS performance
Quality	**Mandatory training rate**	Latest position on the % staff trained for each mandatory training requirement	Blue if latest month >=95%; Green if latest month 75%-95% overall, amber if between 50% and 75%, red if below 50%.	Locally agreed target level - no national comparative information available until February 2016
Quality	**Staff sickness rate**	Staff sickness rate	Green if <3.9% , amber if between 3.9% and regional average, Red if > regional average.	HDFT Employment Policy requirement. Rates compared at a regional level also
Quality	**Temporary staffing expenditure - medical/nursing/other**	Expenditure per month on staff types.	tbc	tbc
Quality	**Staff turnover**	Staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts.	Green if remaining static or decreasing, amber if increasing but below 15%, red if above 15%.	Based on evidence from Times Top 100 Employers
Quality	**Research internal monitoring**	No. critical or major findings reported	Green if <1 per quarter (cumulative)	Locally agreed target.
Quality	**Maternity - Caesarean section rate**	Caesarean section rate as a % of all deliveries	Green if <25% of deliveries, amber if between 25% and 30%, red if above 30%.	tbc
Quality	**Maternity - Rate of third and fourth degree tears**	No. third or fourth degree tears as a % of all deliveries	Green if <3% of deliveries, amber if between 3% and 6%, red if above 6%.	tbc
Quality	**Maternity - Unexpected term admissions to SCBU**	Admissions to SCBU for babies born at 37 weeks gestation or over.	tbc	tbc
Finance and efficiency	**Readmissions**	No. emergency readmissions (following elective or non-elective admission) within 30 days.	Green if latest month < HDFT average for 2014/15, Red if latest month > HDFT average for 2014/15.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Finance and efficiency	**Readmissions - standardised**	Standardised emergency readmission rate within 30 days from HED	Blue = better than expected (95% confidence interval), Green = as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval).	Comparison with national average performance.
Finance and efficiency	**Length of stay - elective**	Average LOS for elective patients	Blue if latest month score places HDFT in the top 10% 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	**Non-elective bed days for patients aged 18+**	Non-elective bed days at HDFT for HARD CCG patients aged 18+, per 100,000 population	Improvement trajectory to be agreed.	Improvement trajectory to be agreed.
Finance and efficiency	**Theatre utilisation**	% of theatre time utilised for elective operating sessions	Green = >=85%, Amber = between 75% and 85%, Red = <75%	A utilisation rate of around 85% is often viewed as optimal.
Finance and efficiency	**Delayed transfers of care**	% acute beds occupied by patients whose transfer is delayed - snapshot on last Thursday of the month.	Red if latest month >3.5%, Green <=3.5%	Contractual requirement

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

Data quality assessment

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

Report to the Trust Board of Directors: 25 May 2016	Paper No: 7.0

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

Key Issues for Board Focus:

1. Emergency Department 4 hour performance was below the 95% standard for April.
2. All Cancer Waiting Times standards were achieved in April.
3. The new Clinical Directorate service alignment and management structure has now been confirmed and came into effect on 16th May 2016.

Related Trust Objectives:

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

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

Action Required by the Board of Directors

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

1.0 EMERGENCY DEPARTMENT (ED) 4 HOUR PERFORMANCE

ED 4-hour performance remained below the 95% standard during April. The standard was also missed in Q4 2015/16. Nationally Trusts continue to struggle to meet the 4 hour standard - in March only 6 of the 138 Trusts reported achieving the standard for all types of attendance. HDFT was eighth in the country at 94.4% in March. Achieving the standard remains a key focus for the Trust. Failure of Q1 2016/17 and any subsequent quarter in the remainder of the financial year will trigger a Monitor governance concern, potentially leading to investigation and enforcement action. It would also place the Trust at risk of not receiving the full value of STP funding in 2016/17.

2.0 CANCER WAITING TIMES PERFORMANCE

April has been challenging across all cancer performance metrics. April performance against the 14 day standard for urgent GP referrals was 93.1%, just above the 93% operational standard. The main reason for this reduced performance was a lack of capacity in gastroenterology clinics and endoscopy. There is also some pressure in urology due to the recent retirement of a consultant and this capacity is being worked through.

A comparison of HDFT's performance for April will not be available until national data is published in June. However, HDFT's performance was above the national average throughout 2015/16. Locally, April has been challenging for all Trusts in the network and May will also be challenging. All teams are working closely to minimise the risk to performance, but more importantly to ensure patients are seen quickly and then treated quickly where appropriate.

NHS England recently wrote to all Trusts regarding Inter Patient Transfers (IPTs) and breach re-allocation. HDFT has been working over the last year with the local cancer network and colleagues at Leeds to develop clear IPT guidelines from secondary to tertiary care to meet the nominal 38 day IPT standard. Workshops are to be held in June and representatives from Leeds Teaching Hospitals will be visiting HDFT in July to discuss further the IPT guidance and the breach re-allocation proposal.

3.0 DIRECTORATE INTEGRATION OF SERVICES

The alignment of services into the new Clinical Directorates has now been confirmed, along with the associated management structures. These came into effect from Monday 16th May. Due to the timescales for implementation it has been necessary to put in place a number of transitional arrangements. In the meantime, staff will continue to work in their existing locations and start dialogue with new/current line managers where appropriate. As we expected, there are some vacant posts within the new management structures, therefore acting up arrangements are being put in place and the permanent posts be advertised on NHS Jobs.

The post of Operational Director for Children's and County Wide Services was successfully appointed to. Once all recruitment processes are complete, the candidate's name will be confirmed.

4.0 CQUIN SCHEMES 2015/16

The Trust participated in national and local CQUIN schemes during 2015/16. Data returns and update reports for Quarter 4 have recently been submitted to NHS England and HARD CCG.

The local schemes for 2015/16 included:

- development of an electronic fluid balance chart for inpatients;
- working with HaRD CCG to develop automated data flows to enable information about patient admissions and A&E attendances to be shared with their GP; and
- understanding the reasons for readmissions by carrying out clinical audits.

We are awaiting confirmation of agreement from HaRD CCG that we have delivered the requirements of all local indicators during 2015/16 and hence achieved the CQUIN schemes.

The national schemes for 2015/16 that were applicable to HDFT focussed on:

- acute Kidney Injury – sharing specific clinical information with GPs on discharge from hospital;
- sepsis – ensuring that patients admitted as an emergency or attending A&E are screened for sepsis (if eligible) and any patients diagnosed with severe sepsis are prescribed antibiotics within 1 hour;
- dementia – dementia screening of emergency admissions aged over 75 and patients referred to the Fast Response Team's admission avoidance service, auditing discharge letters of patients with dementia, providing dementia training to staff and carrying out a survey of carers of patients with dementia; and
- reducing avoidable admissions.

The Trust achieved all requirements of national schemes except for the sepsis indicator where the Trust did not meet the required improvement trajectory during the year for either the screening (90% achieved) or antibiotic therapy (60% achieved) part of the indicator. Despite this, the Trust demonstrated significant improvements in both indicators during the year. Benchmarking data is not publically available so it is not possible for us to compare our performance with other Trusts on this challenging CQUIN.

The Trust was also required by NHS England to participate in schemes for specialist commissioned services. These included:

- trialling the use of a drug to determine the suitability of cancer patients for chemotherapy; and
- reducing wastage for chemotherapy drugs.

We are awaiting confirmation of agreement from NHS England that we have delivered the requirements of all local indicators during 2015/16 and hence achieved the CQUIN schemes.

The CQUIN schemes this year have been challenging but with the exception of the sepsis national indicator, all should be achieved. Real progress has been seen in a number of areas and this is through significant and sustained hard work of both clinical and non-clinical staff from across the organisation.

The Trust is now in discussion with HARD CCG to agree a set of local CQUIN indicators for 2016/17. Discussions are progressing well and it is anticipated that these will be agreed during May.

5.0 CARBON AND ENERGY FUND

The second of the two new boilers has been connected into the distribution system and is currently undergoing its commissioning and validation period. Work to install the underfloor heating in the upper deck of the external car park has commenced; this utilises the waste heat

from the CHP unit in the winter to maintain the surface above freezing and thus removing the need to apply grit.

The internal lighting replacement works are also progressing well with approximately 75% of the fittings now replaced. The work to replace the external lights in the car parks and footpaths has now been completed.

6.0 SERVICE ACTIVITY

Variances above or below 3% are as follows – At the end of April, new outpatient activity was 11% below plan, follow-up outpatient activity was 7.4% below plan, elective admissions were 11.2% below plan, and non-elective admissions were 3.6% below plan. For Leeds North CCG, new outpatient appointments were 12.3% above plan, elective admissions were 16.1% below plan, and non-elective admissions were 14.8% below plan. The impact of four days of Industrial Action in April has contributed to this variance, along with a number of significant medical staffing vacancies.

7.0 FOR APPROVAL

There are no items for approval this month.

Report to the Trust Board of Directors: 25 May 2016	**Paper No: 8.0**

Title	Finance Report
Sponsoring Director	Director of Finance
Author(s)	Finance Department
Report Purpose	Review of the Trusts financial position

Key Issues for Board Focus:

1. The Trust reported a deficit of £162k in April, £433k behind plan. This resulted in a Financial Sustainability Risk Rating of 3.

2. £100k of the variance is a prudently assumed risk to Sustainability & Transformation (S&T) funding due to our current performance. Clinical income was £475k behind plan, including the S&T assessment.

3. Directorates have actioned 57% of the full year CIP target. Risk adjusted plans have reduced to 77% which presents a risk to the financial position. This will be an area of focus moving forward.

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

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

Action Required by the Board of Directors

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

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April 2016/17 Financial Position

Financial Performance

- The Trust reported a deficit of £162k in April, £433k behind plan, of which £333k is our operational budgets and £100k is the prudently assumed risk to Sustainability &Transformation (S&T) funding due to our current performance.

- Clinical income was £475k behind plan, including the assessment of the S&T Fund position. The S&T assessment is based on both financial and improvement trajectory performance. The loss of income due to the junior doctor strikes has been estimated at around £120k in April.

- Despite the deficit position, a favourable variance of £109k was reported against pay. This also includes a pay overspend on our ward of c£100k. The cost improvement programme is behind plan, contributing significantly to the adverse variance of £403k on other costs. Focus on moving schemes forward must continue in order to meet the challenges of this significant risk.

- CIP performance is outlined on pages 6 and 7. 57% of schemes have been actioned in month. Following continued assessment a number of plans have reduced in value which is a concern, particularly as at present the risk adjusted position forecasts CIP achievement Trustwide at 77%.

- Actions are being taken with Directorates to both recover the income position and progress the delivery of CIP plans. Work is also ongoing in relation to rostering to ensure that we deploy our staff efficiently and for the benefit of our patients.

- The Trust cash balance was £6,530k for April, £808k behind plan.

Monitor Financial Sustainability Risk Rating (FSRR)

- The table below outlines the Trusts FSRR for April:

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

Overview Income & Expenditure Position

Summary Income & Expenditure 2016/17
For the month ending 30th April 2016

	Budget		Actual	Cumulative	Change in
	Annual Budget	Proportion To Date	To Date	Variance	Variance
	£000	£000	£000	£000	£'000
INCOME					
NHS Clinical Income (Commissioners)					
NHS Clinical Income - Acute	145,006	11,661	11,391	(269)	(269)
NHS Clinical Income - Community	56,595	4,781	4,728	(54)	(54)
System Resilience & Better Care Funding	47	47	47	(0)	(0)
S&T fund	4,600	383	283	(100)	(100)
Non NHS Clinical Income					0
Private Patient & Amenity Bed Income	1,880	157	126	(30)	(30)
Other Non-Protected Clinical Income (RTA)	523	44	23	(21)	(21)
Other Income					0
Non Clinical Income	12,874	1,221	1,127	(93)	(93)
Hosted Services	0	0	0	0	0
TOTAL INCOME	**221,525**	**18,293**	**17,725**	**(568)**	**(568)**
EXPENSES					
Pay					
Pay Expenditure	(144,396)	(13,003)	(12,893)	109	109
Non Pay					0
Drugs	(4,051)	(1,248)	(1,251)	(3)	(3)
Clinical Services & Supplies	(16,048)	(1,488)	(1,506)	(18)	(18)
Other Costs	(14,545)	(1,140)	(1,543)	(403)	(403)
					0
					0
Reserves : Pay	(4,385)	0	0	0	0
Pay savings targets	0	0	0	0	0
Other Reserves	(9,524)	(494)	0	494	494
High Cost Drugs	(8,965)	0	0	0	0
Non Pay savings targets	(418)	0	0	0	0
Other Finance Costs	(18)	(1)	(8)	(6)	(6)
Hosted Services	0	0	0	0	0
TOTAL COSTS	(202,349)	(17,373)	(17,201)	172	172
EBITDA	**19,176**	**920**	**524**	**(395)**	**(395)**
Profit / (Loss) on disposal of assets	0	0	0	0	0
Depreciation	(5,081)	(423)	(443)	(19)	(19)
Interest Payable	(90)	(8)	(16)	(9)	(9)
Interest Receivable	41	3	2	(2)	(2)
Dividend Payable	(2,646)	(221)	(229)	(9)	(9)
Net Surplus/(Deficit) before donations and impairments	**11,400**	**272**	**(162)**	**(433)**	**(433)**
Donated Asset Income	0	0	0	0	0
Impairments re Donated assets	0	0	0	0	0
Impairments re PCT assets	0	0	0	0	0
Net Surplus/(Deficit)	**11,400**	**272**	**(162)**	**(433)**	**(433)**
Consolidation of Charitable Fund Accounts	0	0	0	0	0
Consolidated Net Surplus/(Deficit)	**11,400**	**272**	**(162)**	**(433)**	**(433)**

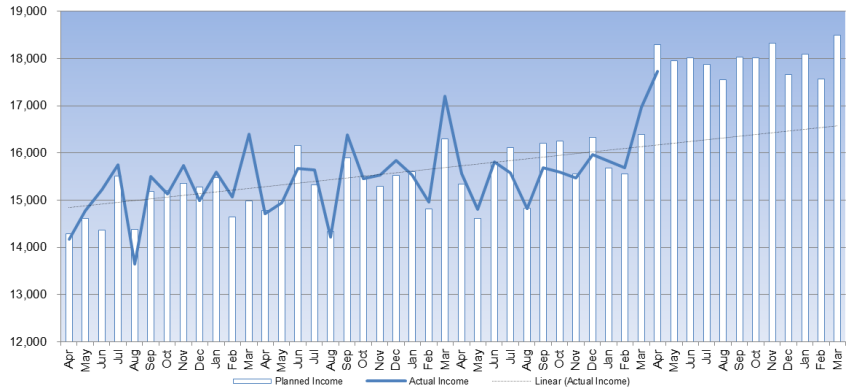
Negative sign under variance indicates an UNDER-recovery of forecast income, or an OVER-spending against budget

Directorate Income & Expenditure Position

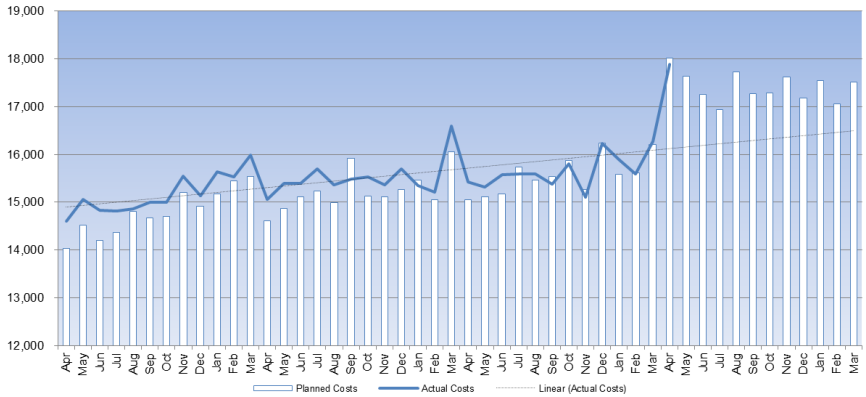
	Annual Budget £000	Workforce			In Month			Cumulative		Variance (o.s)/u.s £000
		Budget wte	Contracted wte	Actual wte	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	
Non-Comissioner Income	1,088				163	131	(32)	163	131	(32)
Pay	(47,595)	1235.60	1166.19	1159.50	(4,240)	(4,238)	2	(4,240)	(4,238)	2
Non-Pay	(3,609)				(750)	(824)	(74)	(750)	(824)	(74)
Total Integrated Care Directorate	**(50,117)**	**1235.60**	**1166.19**	**1159.50**	**(4,828)**	**(4,932)**	**(104)**	**(4,828)**	**(4,932)**	**(104)**
Non-Comissioner Income	3,015				315	293	(21)	315	293	(21)
Pay	(33,888)	809.40	720.53	728.01	(3,028)	(2,922)	106	(3,028)	(2,922)	106
Non-Pay	(7,464)				(875)	(1,046)	(172)	(875)	(1,046)	(172)
Total Urgent, Community & Cancer Care Services	**(38,337)**	**809.40**	**720.53**	**728.01**	**(3,588)**	**(3,675)**	**(87)**	**(3,588)**	**(3,675)**	**(87)**
Non-Comissioner Income	1,515				130	125	(5)	130	125	(5)
Pay	(43,445)	924.71	899.50	874.78	(4,098)	(4,093)	4	(4,098)	(4,093)	4
Non-Pay	(10,512)				(1,162)	(1,197)	(35)	(1,162)	(1,197)	(35)
Total Elective Care Directorate	**(52,443)**	**924.71**	**899.50**	**874.78**	**(5,131)**	**(5,166)**	**(35)**	**(5,131)**	**(5,166)**	**(35)**
Corporate (Clinical)	**(16,568)**	**452.74**	**433.79**	**449.79**	(1,395)	(1,398)	(3)	(1,395)	(1,398)	(3)
Total Clinical Spend	(157,464)	3422.45	3220.01	3212.08	(14,941)	(15,171)	(229)	(14,941)	(15,171)	(229)
Corporate (inc. CNST)	(12,886)	**159.43**	**154.34**	**154.76**	(1,052)	(1,151)	(100)	(1,052)	(1,151)	(100)
Total Corporate Position	**(29,454)**	**612.17**	**588.13**	**604.55**	**(2,446)**	**(2,549)**	**(103)**	**(2,446)**	**(2,549)**	**(103)**
Commissioner Income	201,590				16,860	16,437	(423)	16,860	16,437	(423)
Central	(24,440)		(401.33)	(401.33)	(596)	(277)	319	(596)	(277)	319
Total before donations & impairments	**6,800**	**3,581.88**	**2,973.02**	**2,965.51**	**272**	**(162)**	**(433)**	**272**	**(162)**	**(433)**
Donations for Capital Expenditure	0					0	0	0	0	0
Impairments on Donated assets	0						0	0	0	0
Impairments on PCT assets	0						0	0	0	0
Trust reporting position	**6,800**	**3,581.88**	**2,973.02**	**2,965.51**	**272**	**(162)**	**(433)**	**272**	**(162)**	**(433)**
Charitable funds consolidation	0					0	0	0	0	0
Total Trust reported position	**6,800**	**3,581.88**	**2,973.02**	**2,965.51**	**272**	**(162)**	**(433)**	**272**	**(162)**	**(433)**

Income & Expenditure Run Charts

Planned and Actual Income Apr 2013 - Mar 2017



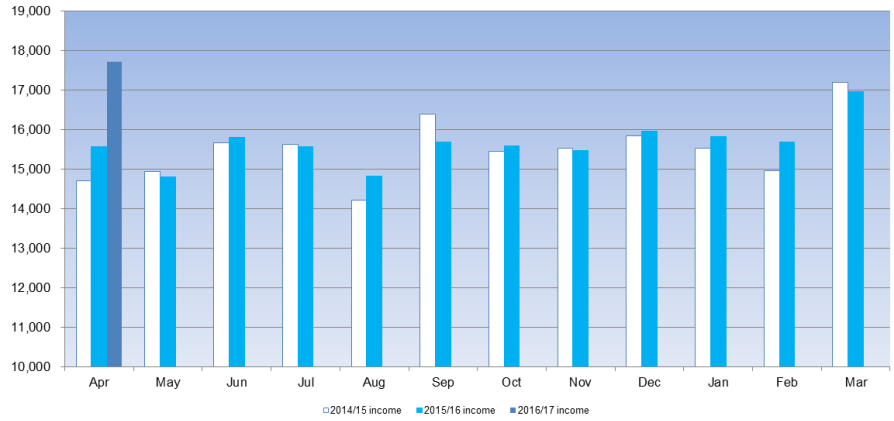
Planned and Actual Costs Apr 2013 - Mar 2017



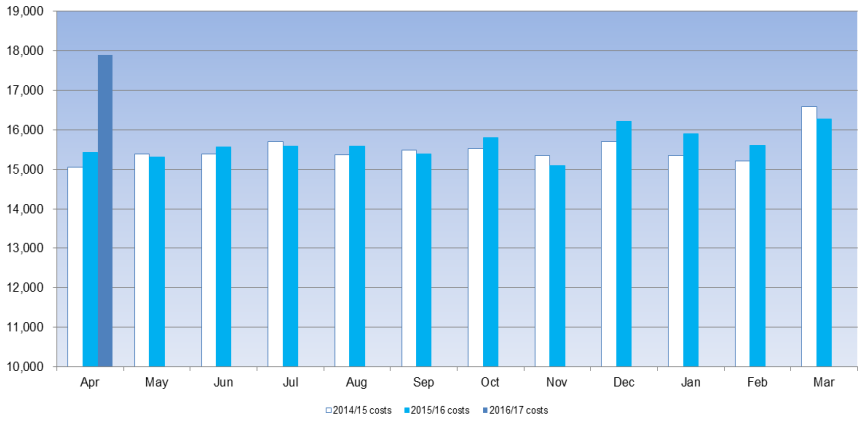
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15 income plan	14,779	14,981	16,165	15,325	14,332	15,901	15,506	15,293	15,523	15,606	14,809	16,305
2014/15 income actual	14,717	14,945	15,674	15,637	14,221	16,388	15,451	15,533	15,845	15,539	14,967	17,201
2014/15 variance	**-62**	**-36**	**-491**	**312**	**-111**	**487**	**-55**	**240**	**322**	**-67**	**158**	**896**
2014/15 % variance	-0.4%	-0.2%	-3.0%	2.0%	-0.8%	3.1%	-0.4%	1.6%	2.1%	-0.4%	1.1%	5.5%
2015/16 income plan	15,335	14,610	15,799	16,105	14,830	16,202	16,245	15,554	16,329	15,677	15,560	16,385
2015/16 income actual	15,564	14,802	15,810	15,578	14,826	15,689	15,595	15,467	15,968	15,828	15,686	16,967
2015/16 variance	**229**	**192**	**11**	**-527**	**-4**	**-513**	**-650**	**-87**	**-361**	**151**	**126**	**582**
2015/16 % variance	1.5%	1.3%	0.1%	-3.3%	0.0%	-3.2%	-4.0%	-0.6%	-2.2%	1.0%	0.8%	3.6%
2016/17 income plan	18,293	17,958	18,013	17,877	17,555	18,035	18,009	18,319	17,664	18,084	17,561	18,489
2016/17 income actual	17,725											
2016/17 variance	**-568**											
2016/17 % variance	-3.1%											

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15 expenditure plan	14,602	14,875	15,107	15,236	14,983	15,912	15,128	15,105	15,268	15,465	15,052	16,051
2014/15 expenditure actual	15,058	15,394	15,387	15,695	15,362	15,476	15,533	15,358	15,695	15,346	15,214	16,591
2014/15 variance	**456**	**519**	**280**	**459**	**379**	**-436**	**405**	**253**	**427**	**-119**	**162**	**540**
2014/15 % variance	3.1%	3.5%	1.9%	3.0%	2.5%	-2.7%	2.7%	1.7%	2.8%	-0.8%	1.1%	3.4%
2015/16 expenditure plan	15,052	15,109	15,164	15,739	15,466	15,536	15,874	15,267	16,229	15,581	15,615	16,204
2015/16 expenditure actual	15,427	15,314	15,572	15,584	15,584	15,384	15,807	15,099	16,222	15,890	15,597	16,275
2015/16 variance	**375**	**205**	**408**	**-155**	**118**	**-152**	**-67**	**-168**	**-7**	**309**	**-18**	**70**
2015/16 % variance	2.5%	1.4%	2.7%	-1.0%	0.8%	-1.0%	-0.4%	-1.1%	0.0%	2.0%	-0.1%	0.4%
2016/17 expenditure plan	18,021	17,640	17,258	16,941	17,721	17,262	17,278	17,620	17,184	17,539	17,052	17,509
2016/17 expenditure actual	17,887											
2016/17 variance	**-134**											
2016/17 % variance	-0.7%											

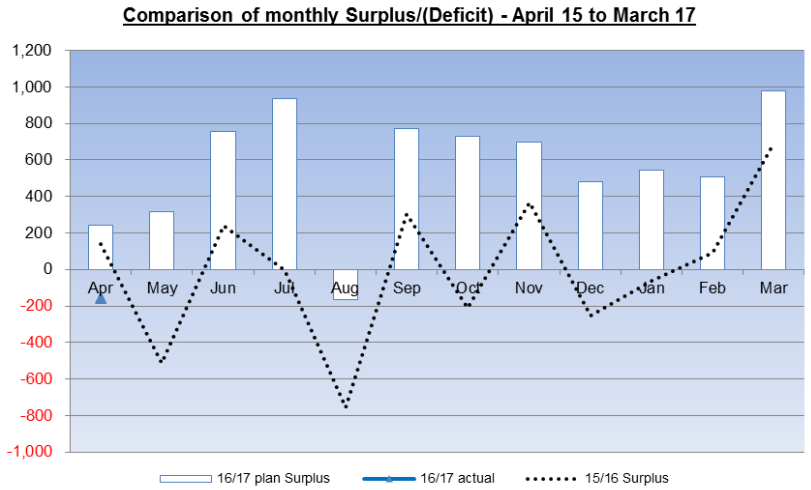
Actual Income 2014/15, 2015/16 & 2016/17

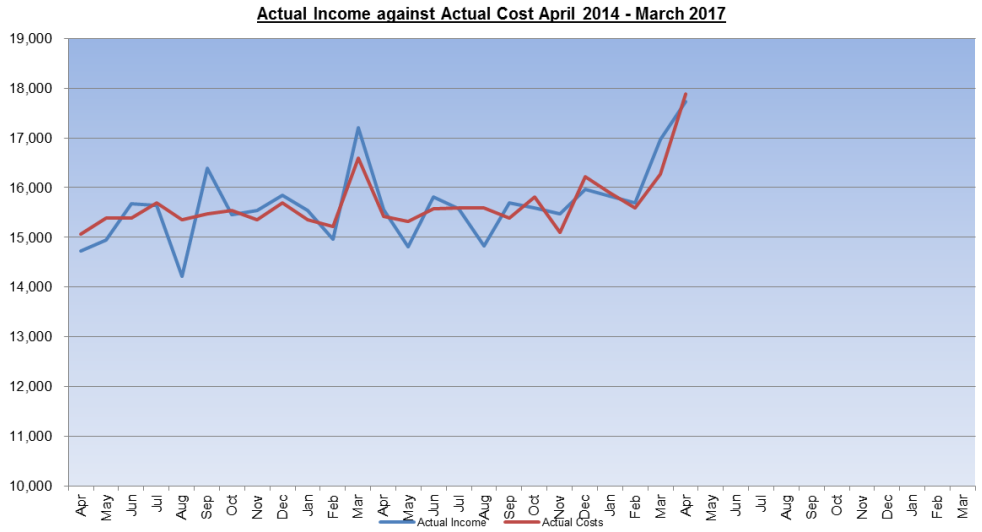


Actual costs 2014/15, 2015/16 & 2016/17



Income & Expenditure Run Charts





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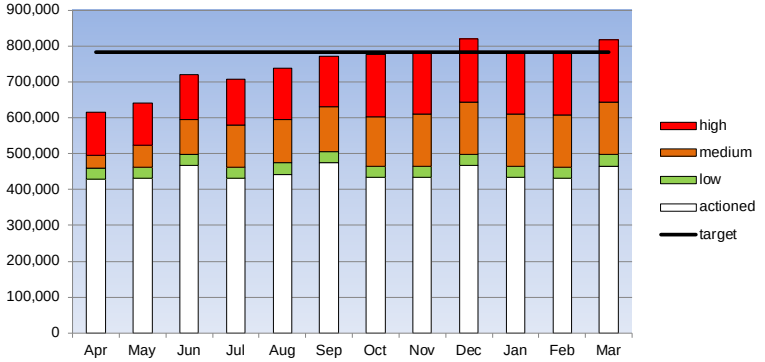
2014/15 income	14,717	14,945	15,674	15,637	14,221	16,388	15,451	15,533	15,845	15,539	14,967	17,201
2015/16 income	15,564	14,802	15,810	15,578	14,826	15,689	15,595	15,467	15,968	15,828	15,686	16,967
2016/17 income	17,725											
2014/15 costs	15,058	15,394	15,387	15,695	15,362	15,476	15,533	15,358	15,695	15,346	15,214	16,591
2015/16 costs	15,427	15,314	15,572	15,584	15,584	15,384	15,807	15,099	16,222	15,890	15,597	16,275
2016/17 costs	17,887											
14/15 Surplus	-341	-449	287	-58	-1,141	912	-82	175	150	193	-247	610
15/16 Surplus	137	-512	238	-6	-758	305	-212	368	-254	-62	90	693
16/17 Surplus	-162											

2016/17 Efficiency Update

Trustwide Cost Improvement Programme 2016/17

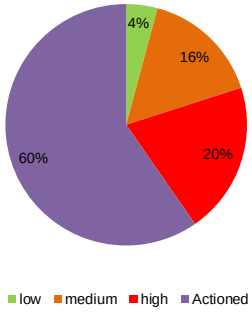


Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Trustwide	9,400,000	5,345,000	375,050	1,420,665	1,819,101	8,959,816	95%	7,201,650	77%
		% age of target	4%	15%	19%				

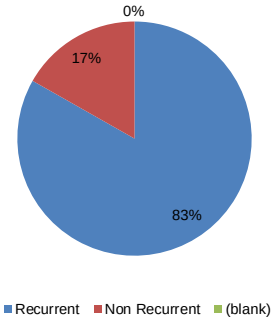
Top 10 schemes Top 10 as % of schemes - 26%

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

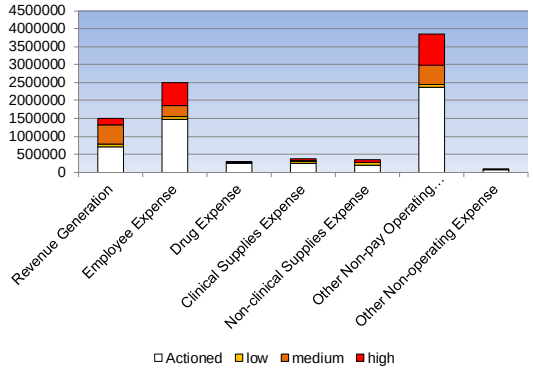
CIP schemes by Risk



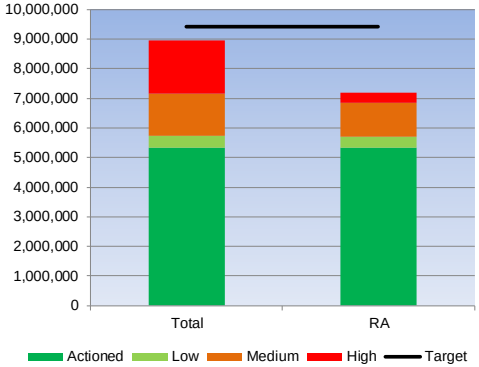
Recurrent V Non Recurrent Plans



Efficiency Category



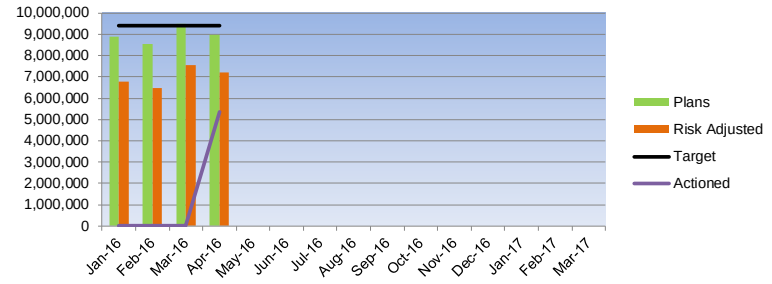
Risk Profile

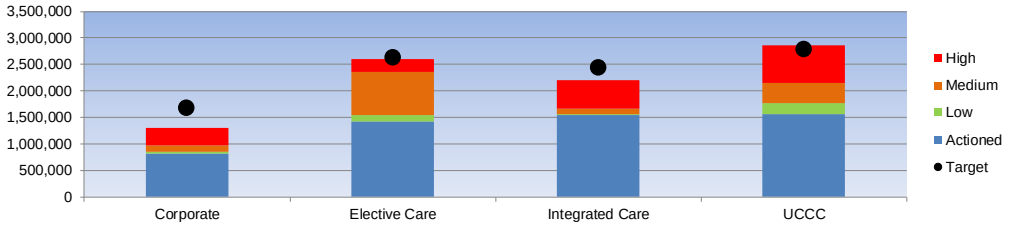


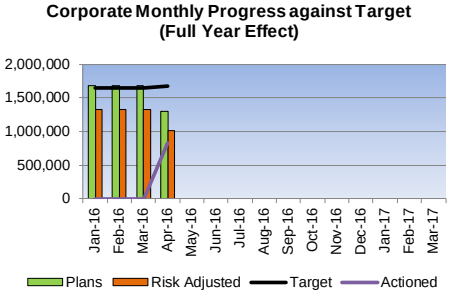
2016/17 Efficiency Update

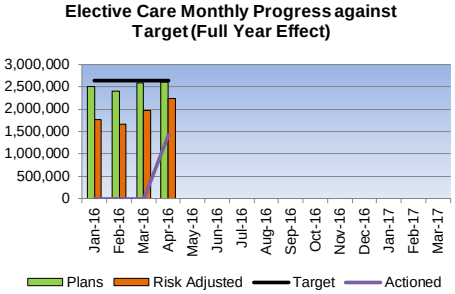
Trustwide Cost Improvement Programme 2016/17

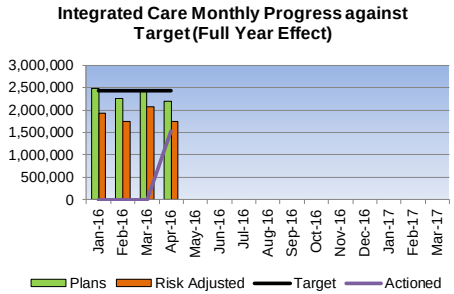
Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Corporate	1,675,100	825,700	20,000	127,915	332,500	1,306,115	78%	1,013,532	61%
Elective Care	2,632,600	1,419,300	130,800	803,450	246,652	2,600,202	99%	2,235,650	85%
Integrated Care	2,430,300	1,539,200	15,000	112,800	528,700	2,195,700	90%	1,749,430	72%
UCCC	2,783,500	1,560,800	209,250	376,500	711,249	2,857,799	103%	2,203,037	79%

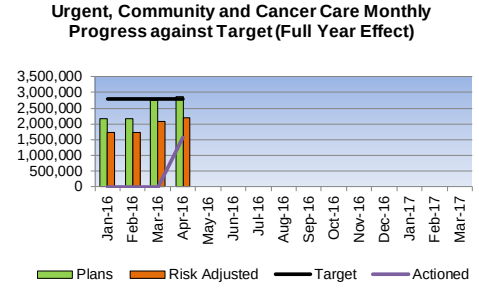


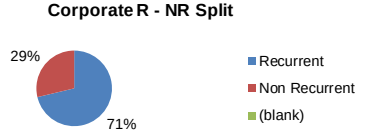


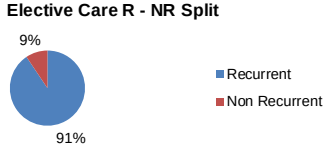


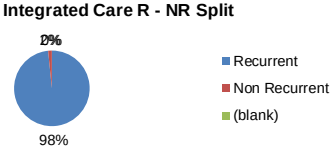


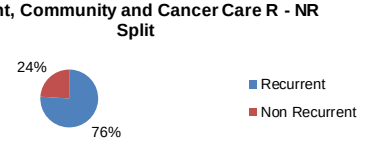












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Report to the Trust Board of Directors: 25 May 2016	**Paper No: 9.0**

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

Key Issues for Board Focus:

This report provides information on the following areas:

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

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

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

Action Required by the Board of Directors

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

Key Messages for May 2016

a) Workforce and Organisational Development Strategy 2015-2020 – Excellent Workforce, Excellent Care

The Workforce and Organisational Development Strategy was approved at the Senior Management Team meeting on Wednesday 18 November 2015. A copy was placed in the reading room for Board members' information. The progress against the strategy is, in the main, being monitored through the Clinical Transformation Board and an up-date was provided to Board in January 2016. Progress continues to be made across all areas.

Developing the Best Behaviours:

The Trust launched the values based appraisal toolkit, which incorporates the Trust values as well as a mechanism for measurement and evaluation. The toolkit was trialled in pilot areas and feedback received has been incorporated into the new format. The new toolkit was launched with a variety of webinars, face to face briefing sessions both at Harrogate District Hospital and in community areas for staff and managers. The response in general is that the new format is a positive improvement; a review will take place after six months to incorporate any feedback for further improvements.

Learning and Organisational Development:

The Leadership Strategy has been approved by the Senior Management Team although the funding associated with delivery is still to be confirmed. The Pathway to Management Training continues to be rolled out, with good levels of attendance and evaluation. The decision as to whether to mandate this course for all managers (new and existing) still needs to be made. The Shadow Board Programme launched this month and the first round of the Non-Executive Director 360 programme has taken place. Work continues with New Care Models and the use of the Calderdale Framework for the assessment of competencies and design of new roles.

Health and Wellbeing:

The Sheffield Hallam Wellness 12 month pilot commenced in January, health assessments continue to be booked by staff across the Trust, however to date we have not had the uptake in Nursing that we had hoped for in order to support the evaluation of the pilot. Mentally Healthy Workplace training roll out has been delayed for operational reasons. It is envisaged that this will commence in the summer. We are about to commence the launch of Mental Health First Aid Champions and Schwartz rounds. We have exceeded our target KPI's for health and wellbeing to date; 90% of staff feel that the Trust values Health and Wellbeing in the 2015 annual staff survey and the average sickness absence spend for stress, anxiety and depression continues to fall year on year saving over £50,000 during August to December 2015.

Workforce Redesign and Reward:

The Oceans Blue pilot continues with final interventions now taking place. The next step will be to agree a consistent approach to address the time balances identified during the retrospective review process of rosters. Further action to improve rostering was discussed at the Senior Management Team meeting this month.

Monthly monitoring against Job Planning progress continues with a job planning steering group now established. Individual contact is being made with Consultants and SAS doctors who do not have a signed Job Plan in the current 12 months.

Equality and Diversity:

The Trust has published the Workforce Race Equality Scheme information on the intranet as well as a self-assessment against the workforce standards set out in the national Equality Delivery Scheme. An action plan is being developed in support of any areas where the Trust assesses the need for improvement or changes to be made. Progress is being reported into the Equality Group and the Workforce and Organisational Development Steering Group.

b) Chairman and Chief Executive – Making A Difference Award

Building on our seven year commitment to the Celebrating Success Awards, which aim to celebrate good practice and innovation across the Trust, Making a Difference Awards are the Chief Executive and Chairman's colleague recognition scheme that celebrates the everyday successes our colleagues' achieve. It is the first step in the delivery of our new Quality Charter.

Making a Difference Awards will tailor an individual token of thanks for each recipient so that it is as meaningful as possible. Making a Difference Awards are open to all colleagues at Harrogate and District NHS Foundation Trust.

The nomination process is simple to help ensure that it is as accessible as it can be to all colleagues. Nominations may also come from patients, their family and friends, as well as external partners. There is no formal application form since any supportive communication received by the Chief Executive and/or Chairman will suffice: word-of-mouth, email, SMS text, social media content or written letters will be considered. For convenience you can also email ideas@hdft.nhs.uk directly.

c) New Directorate Management Structure

Following the recent consultation period in relation to the need to change the existing Clinical Directorate and Management Structures in order to achieve full integration of all Children's Services, this process is now complete. The aim was to integrate services following the acquisition of services from Durham, Darlington and Middlesbrough as soon as possible after the transfer on 1 April 2016.

There were two periods of consultation and the Trust has now confirmed the services that will be aligned to each Clinical Directorate and the associated management structures. These were implemented with effect from Monday 16 May 2016. Due to the timescales for implementation it was necessary to agree some transitional arrangements. In the meantime, staff continue to work in their existing locations and will commence dialogue with new/current line managers where appropriate.

As expected there are some vacant posts within the new management structures and these will be advertised on NHS Jobs within the coming days.

The final structure can be seen in Appendix 1.

d) Appraisal

The Trust is committed to every member of staff receiving an appraisal every year. This is an opportunity for the Trust to engage, support and provide feedback to staff, to discuss development and ensure objectives are aligned to organisational goals.

The Trust's target for completion is 90%, based on appraisals reported and centrally recorded. The compliance rate has been consistently reported at around

75% for the last two years. The HR Business Partners have invited feedback from managers and staff on how to assist them to achieve the target completion rate and beyond. The Staff Governors are also leading engagement events and will be talking to departments to understand what can be done to assist with the completion of appraisals.

Over the last six months there has been considerable effort spent on revising and modernising the appraisal process. In late 2015 the Trust commissioned the Skills for Health team to undertake an audit and provide recommendations on the process and completion for appraisals in the Trust. They undertook interviews with a range of managers and staff and provided a number of recommendations on how to improve the process. These recommendations have been taken forward, many of which were already in development.

January 2016 saw the launch of the values based appraisal toolkit, which incorporates the Trust values as well as a mechanism for measurement and evaluation. This was developed in response to feedback from staff and managers that the previous toolkit was outdated and could be repetitive at times. The new format embeds the Trust's strategic and annual goals together with the values and clear links with individual goals and objectives. The toolkit was trialled in pilot areas and feedback received has been incorporated into the new format. The new toolkit was launched with a variety of webinars, face to face briefing sessions both at Harrogate District Hospital and in community areas for staff and managers. The response in general is that the new format is a positive improvement; a review will take place after six months to incorporate any feedback for further improvements.

The Trust is aware that some departments, such as our Domestic teams who have a large team to manage, find it useful to undertake a combination of team based objective setting and individual review, as there are a number of individuals who undertake the same work in the same role. The appraisal can also be tailored to a group setting for objectives with individual 15-20 minute meetings to talk about individual aspects such as values and behaviours and personal objectives including further personal and professional development needs. Those areas that consider they could benefit from a team-based approach to appraisals have been encouraged to discuss this with their HR Business Partner who will provide further information and support.

Managers are still required to notify the Workforce Information team of the completion of the appraisal, this information is centrally logged onto the Trust's Electronic Record System, which in turn is used to generate the statistical information as well as a monthly reminder RAG rated report for managers.

The Appraisal Policy has been reviewed and renewed in light of these developments and the skills based appraisal training has been incorporated into the Trust's Pathway to Management course run by the Operational HR Team. All managers who join the Trust will be required to attend this course and for the first 12 months it is being run on a 4-6 week basis to capture existing managers who need a skills refresher in all areas, not just appraisals.

I can appreciate that balancing the demand on a line manager's time and finding the time for appraisal completion can be difficult however it is important for our staff to feel engaged, valued and part of the organisation. Appraisals are one of the key routes to ensure that the Trust achieves this. I have reviewed the appraisal completion rates in detail for the last 12 months. A HR Business Partner has been in touch with any areas where there is less than a 70% appraisal completion rate to see if any assistance, guidance or advice can be given to try and achieve the target that all eligible members of our workforce receive their annual appraisal as soon as possible.

I have also invited feedback as to any perceived barriers that remain to being able to achieve high appraisal completion rates.

e) Job planning

Over the page, are the latest job planning figures for Consultants and SAS Grades as at 30 April 2016:-

JOB PLANNING CENTRAL REPORT - CONSULTANTS							
Directorate	Number of Consultants	Job Plans within 12 months	%	Job Plans older than 12 months	%	Number of Consultant with no Job Plans recorded	%
UCCC	25	18	72.00%	6	24.00%	1	4.00%
Elective Care	57	39	68.42%	8	14.04%	10	17.54%
Integrated Care	40	35	87.50%	2	5.00%	3	7.50%
Total	122	92	75.41%	16	13.11%	14	11.48%

JOB PLANNING CENTRAL REPORT - SAS GRADES							
Directorate	Number of SAS Doctors	Job Plans within 12 months	%	Job Plans older than 12 months	%	Number of SAS Doctors with no Job Plans recorded	%
UCCC	4	3	75.00%	0	0.00%	1	25.00%
Elective Care	39	13	33.33%	3	7.69%	23	58.97%
Integrated Care	3	3	100.00%	0	0.00%	0	0.00%
Total	46	19	41.30%	3	6.52%	24	52.17%

f) Junior Doctors' Industrial Action

I would like to express my sincere thanks to all staff who have worked tirelessly to maintain our usual high quality of care for our patients during the recent junior doctors' industrial action.

There was a full withdrawal of junior doctors, including the provision of emergency care between the hours of 8am and 5pm on 26th and 27th April. I know that many colleagues across the Trust worked flexibly and collaboratively to keep our services safe during this time.

It was evident that the values and dedication of colleagues across the organisation enabled our patients, and those who use our services, to continue to receive high quality care despite this industrial action taking place.

Regrettably the industrial action did have an adverse impact on some elective operations and outpatient appointments, as well as increasing the general pressures experienced in our wards and departments. A number of planned operations and outpatient appointments were deferred as part of our contingency planning arrangements. Alternative arrangements have been made for the patients' affected by the industrial action.

We have not been notified of any further planned industrial action and a pause in contract implementation was announced nationally from 9 May 2016 to 13 May 2016 in order to facilitate further national negotiations concerning the new contract. The Trust has halted any further implementation work associated with the new contract.

It is important for me to stress that the junior doctors' industrial action relates to the nationally mandated imposition of a new contract. Our junior doctors make an important and highly valued contribution to the work of the Trust and I would like to thank them for continuing to engage positively with us on the implementation of a new contract despite the ongoing dispute.

One area of agreement between the British Medical Association (BMA) and NHS Employers relates to the need for all Trusts to appoint to a Guardian of Safe Working role. This is in support of the implementation of the new contract. The Trust is progressing this appointment and the vacancy has recently been circulated for expressions of interest.

On 13th May 2015 the Arbitration and Conciliation Service (ACAS) made a statement that both sides have agreed to continue talks until 18 May 2016. The Government have agreed to suspend any action towards the implementation of the proposed new contract and the BMA have agreed to suspend any decision on further industrial action.

This is a strictly time limited extension and represents a final opportunity to find an agreement as the basis for the resolution of this difficult dispute. Both parties have been urged to respect the confidentiality of the negotiations and to make no public comments on the talks and the issues under review and no hostile or negative comments about the other parties' involved.

g) Summer Fair

Tickets are now on sale for the Summer Fair; this is a family orientated fun day and takes place at the Harrogate Rugby Ground on Sunday 26 June between 11am and 4 pm. The ground has plenty of free parking, easy access from the A1 and public transport routes stop right outside.

The ticket price includes all activities on the day and food and drink will be available to purchase in the rugby clubhouse.

The confirmed activities are: circus skills workshop; fire engine; bouncy castle; bungee run; barrel ride; rounder's match; connect four; hook a duck; egg and spoon and sack races.

We will also be presenting the Long Service Awards and Celebrating Success Awards on the day during a dedicated slot.

Tickets are available from https://www.justgiving.com/fundraising/HDFTsummerfair2016

h) Nurse Recruitment

In response to the current registered nurse staffing requirements, the recruitment and retention group has implemented a number of initiatives to promote and recruit nurses from a variety of sources.

The initiatives include regular open days whereby applicants can meet the senior nursing team, have a tour of the Trust and following a successful interview, walk away with a conditional offer of employment. The Trust's open days have proved very popular and positive feedback has been received from both applicants and interview panels.

Innovative Facebook direct messaging has been used, via a third party contractor to target those who are nurses or associated to nursing via groups, friends and family. This platform offers the Trust the chance to connect with a wide variety of nurses throughout the country and has provided over 50 enquiries from potential applicants interested in applying to HDFT.

The Trust has attended a number of student nursing events throughout the region to promote the career opportunities available within our departments. To date the Trust has offered over 40 positions to students nurses based in various departments across the directorates. To maximise the number of students retained by the Trust, regular on-boarding events will be held to encourage the nurses to select HDFT as their employer of choice. To date one event has taken place and was themed around the students creating their ideal preceptorship. The ideas then formulated the Trust's plans for a new course to be launched in 2016.

All student nurses recruited by the Trust in 2016 will also have their first year's NMC registration fee reimbursed in their first salary.

Building on the success of the Trust's 2014 EU recruitment campaign, this week the Trust has agreed to begin recruiting from selected EU countries. Since our last campaign, the EU nurse landscape has changed greatly. Increased competition from NHS Trusts and the introduction of International English Language Tests (IELTs) has reduced the number of available nurses, with recruitment now taking place over an extended period of time and interviews conducted via Skype.

Our partner agency will continue to robustly screen applicants prior to conducting interviews and representatives from the Trust will be in constant liaison with the agency and successful candidates to ensure they feel a part of the HDFT workforce. Work is also progressing with Health Education England on an international educational exchange programme for registered nurses in India to work in the UK.

i) West Yorkshire Sustainability and Transformation Plan (STP)

The inaugural meeting of Workforce Directors in West Yorkshire is due to take place on 19 May to take forward the work associated with the development of the STP.

I will keep the Board of Directors informed of the objectives and progress of this work.

j) Staff Friends and Family Test

Below are the Staff Friends and Family test results for quarter 4, compared to the last 3 quarters:-

	Q1	Q2	Q3 *	Q4
recommend the organisation for treatment	85% extremely likely or likely (unlikely 5%)	90% extremely likely or likely (unlikely 2%)	87% extremely likely or likely (unlikely 2%)	87% extremely likely or likely (unlikely 4%)
recommend as a place to work	69% extremely likely or likely (unlikely 11%)	66% extremely likely or likely (unlikely 7%)	71% extremely likely or likely (unlikely 12.3%)	74% extremely likely or likely (unlikely 12%)

*Not submitted to NHS England as not a quarter that took place because of staff survey. Q1, Q2 and Q4 were Directorate specific survey. Q3 survey was sent to all staff members of the HDFT workforce.

Long Term and Unscheduled Care

Emergency Medicine
Acute Medicine
Cardiology
Respiratory
GP Out Of Hours
MIUs
Community Response and Overnight Service
Stroke Care
Elderly
Neurology
Neuro rehabilitation
Community Care Teams
Trinity Ward
Diabetes and Endocrinology
Discharge Planning
Nutrition and Dietetics
Tissue Viability
Continence
Resuscitation
Cancer Services
End of Life Care
Specialist Palliative Care
Haematology
Oncology
Pharmacy
Pathology
Radiology
Infection Prevention Control / TB / New Entrant Assessment Team
Therapy Services aligned to specialities above
Specialist Nursing Services aligned to services above

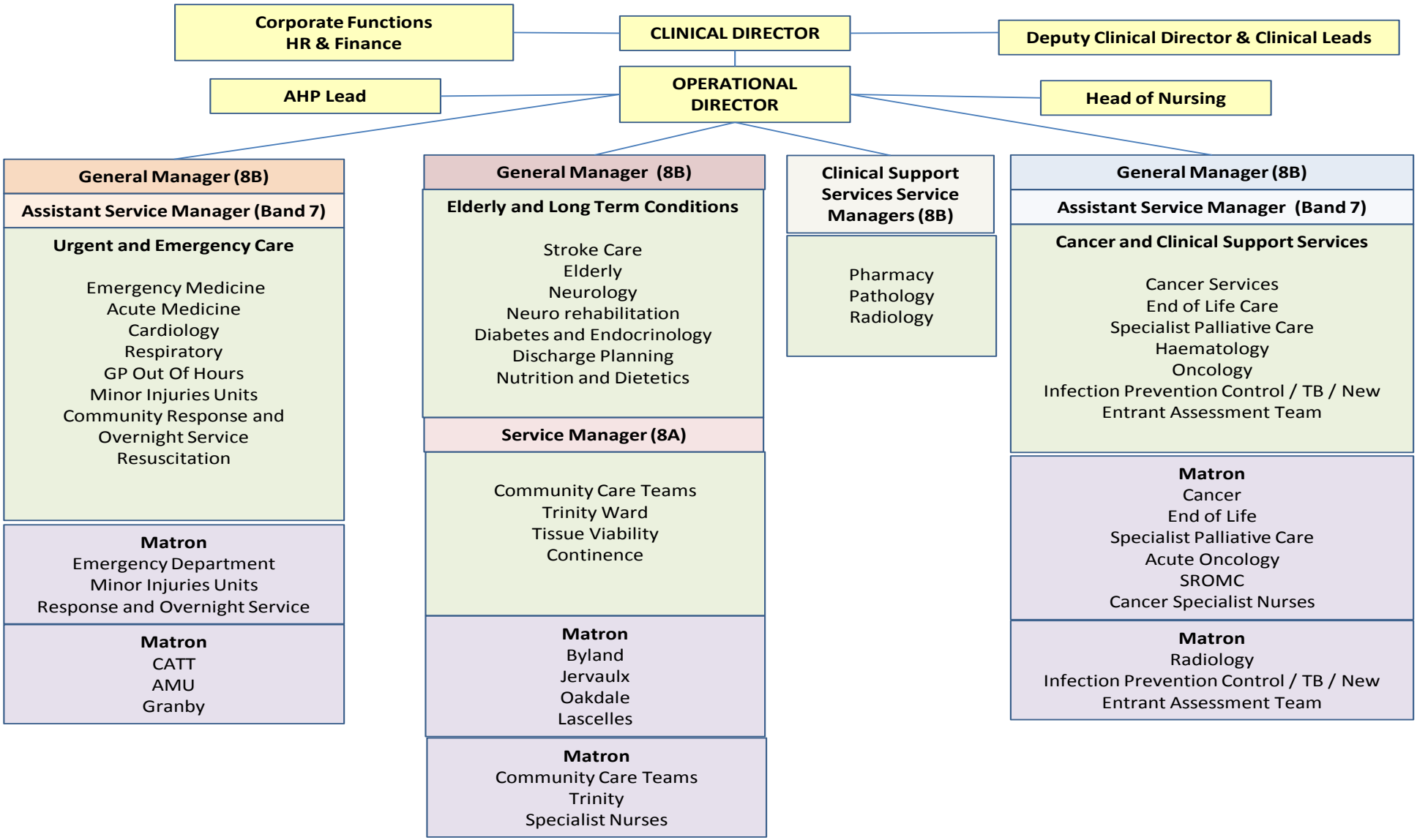
Planned and Surgical Care

T&O
Rheumatology
MSK
Main Theatres
Anaesthetics
Critical Care
Acute Pain
Ophthalmology
ENT
Max Fac
Orthodontics
Dermatology
Plastics
Audiology
Day Surgery
Obstetrics and Gynaecology
Urology
Vascular
General Surgery
Gastroenterology
Bowel Screening
Endoscopy
PAAU
All outpatient departments and locations
Catheter Lab
Therapy Services aligned to specialities above
Specialist Nursing Services aligned to services above

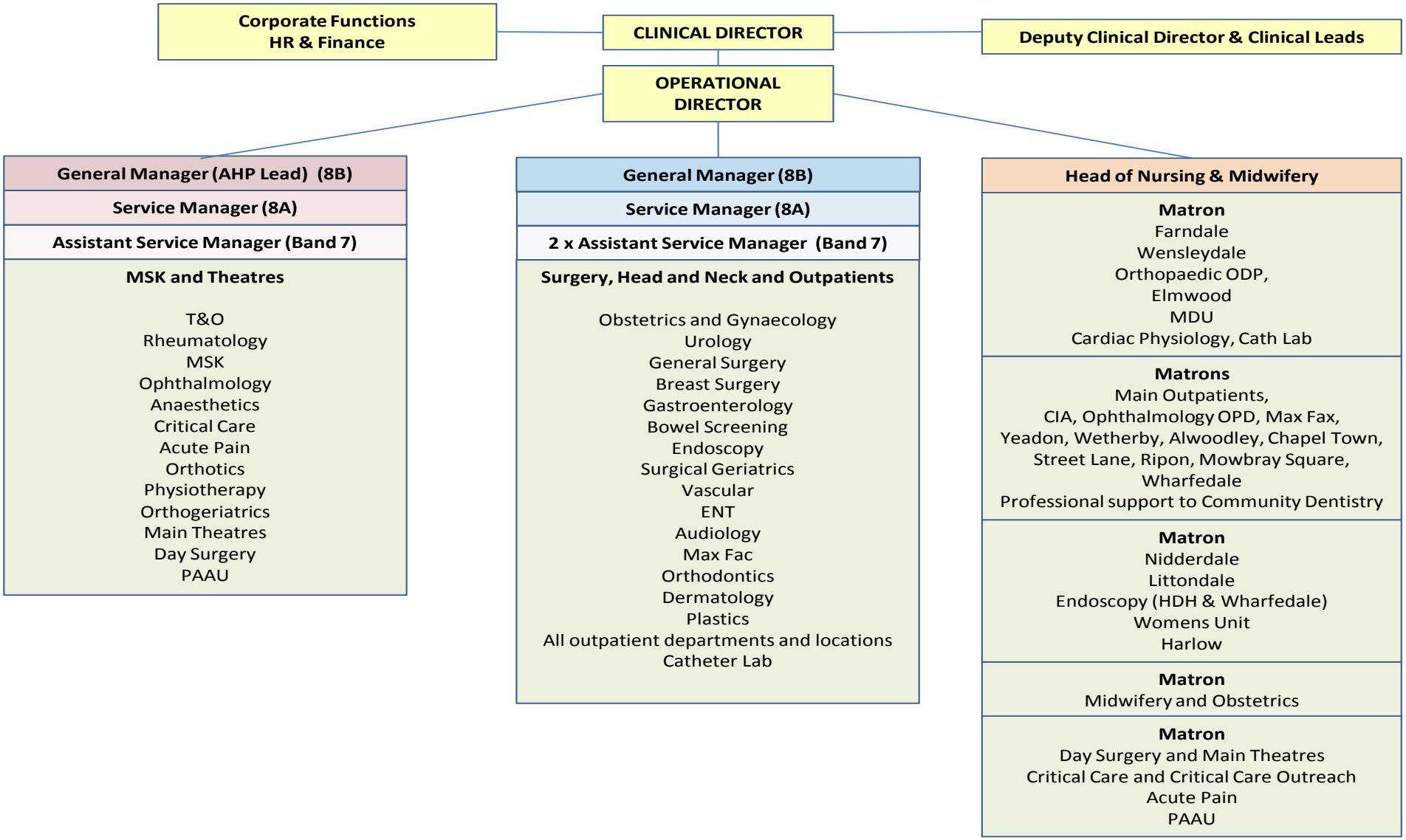
Children's and County Wide Community Care

North Yorkshire 0 - 19 Children's Services
County Durham 0 - 19 Children's Services
Darlington 0 - 19 Children's Services
Middlesbrough 0 - 19 Children's Services
North Yorkshire Autism service
Community Paediatrics and Child Development Centres
CHIS
Safeguarding Children
Looked after Children
Vaccination and Immunisation
Acute Paediatrics
SCBU
Living with Pain Team and Chronic Fatigue Service
Psychology
Speech and Language Therapy
Podiatry
Wheelchair Services
Community Equipment
Community Dental Services
Therapy Services aligned to specialities above
Specialist Nursing Services aligned to services above

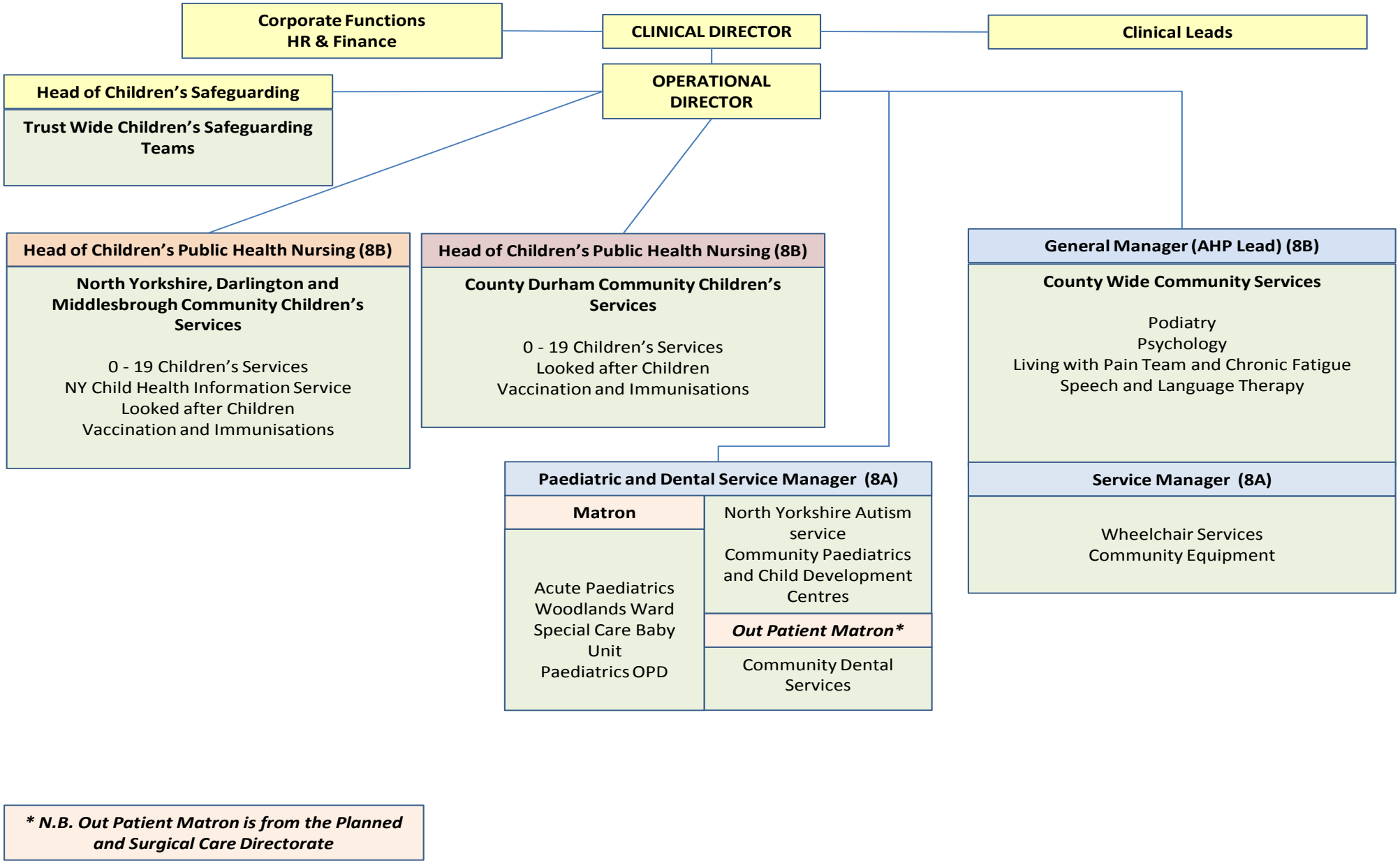
Long Term and Unscheduled Care



Planned and Surgical Care



Children's and County Wide Community Care



** N.B. Out Patient Matron is from the Planned and Surgical Care Directorate*

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Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 25 May 2016	**Paper No: 10.0**

Title	**Report by the Medical Director**
Sponsoring Director	Medical Director – Dr David Scullion
Author(s)	Medical Director – Dr David Scullion
Report Purpose	To update the Board on current clinical issues

Key Issues for Board Focus:

- Increase in Hospital Standardised Mortality Ratio's (HSMR)l
- Continued decrease in Summary Hospital-level Mortality Indicator (SHMI);
- Update on work to improve Stroke Services in Yorkshire and Humber; and
- Introduction of guidance on cancer breach allocations;

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

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

Action Required by the Board of Directors

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

Medical Director Board of Directors report May 2016

1. Mortality update

Hospital Standardised Mortality Ratio's (HSMR) has increased from 101.3 to 101.9. There has been a further fall in Summary Hospital-level Mortality Indicator (SHMI) from 92.4 to 91.1. The SHMI remains below expected levels for the Trust.

There is some indication that the current proposed regional model of mortality review will be taken up nationally. A meeting will take place at regional level to discuss live issues including:

- Update on national programme
- Structure for Training the Trainers
- Discussion of governance arrangements
- Review of thematic analysis
- Quality improvement projects emerging from themes
- Collating data from specific case types

The Board will receive updates on progress via this report.

2. Liver Transplant Services

Following a recent article in the Health Service Journal which was taken up by both local and national media, I have received a letter from the Chief Medical Officer of Leeds Teaching Hospitals NHS Trust, Dr Yvette Oade. The focus of the story was around critical care capacity, the agency cap, and the potential knock-on effect to the transplantation programme.

I have been assured that the transplant programme continues unaffected and that as a referring Trust, none of our potential recipients will be disadvantaged. The current level of critical care beds across the Leeds site will be maintained in full.

3. Retirements

Mr Shriman Narayan has announced his retirement after 22 years as a Senior Orthopaedic Staff Grade surgeon. Mr Narayan has served the Trust well and is also a long standing member of the LNC. I am sure the Board would like to wish Mr Narayan well in his retirement.

4. Improving stroke services in Yorkshire and Humber

Following a regional service review of stroke services, and with the agreement and cooperation of commissioners, a recommendation has been made to reduce the number of hyperacute stroke units in West Yorkshire from five to four. Harrogate is part of this geographical patch. A copy of the "blueprint" document is available in the reading room and attached at Appendix 1.

The criteria for reconfiguration will be determined largely on numbers of acute strokes presenting to individual units, the premise being that outcomes are in the main influenced by unit size. The optimum size of an individual unit is deemed to be 900 stroke admissions per year. The minimum unit size is likely to be 600 per year. Currently Harrogate admits around 300 per year.

The recommendations will be sent to the Clinical Senate for review prior to being devolved to urgent and emergency care networks for implementation. The precise timescale is as yet unknown.

5. Cancer breach allocations

The Board will recall previous written communication between Trust Chairs regarding timely referral of patients with a diagnosis of cancer into the cancer centre (Leeds). Late referrals result in further delayed treatment and the potential for a cancer breach. This can have an adverse impact on 62 day cancer performance for the tertiary centre.

In March 2016, NHS England and NHS Improvement released the National Cancer Breach Allocation Guidance which has been produced to enact a more refined system of cancer breach allocation between the centre and the referring unit. A number of different breach scenarios are currently available for discussion. Leeds Teaching Hospitals NHS Trust are keen to work with partners to embed this guidance into the good work already undertaken.

The intention is to initiate a round of meeting between Leeds and provider Trusts to include local lead cancer Clinicians and the Strategic lead Cancer Clinician in Leeds. It is crucial any guidance is implemented in a fair and proportionate manner.

It goes without saying that Harrogate and District NHS Foundation Trust strives to ensure that all patients with cancer are referred to the centre in a timely manner. I welcome this initiative and look forward to working with Leeds in order to ensure that all patients are treated in the right place as early as possible in the pathway.

6. Junior Doctors contract negotiations

Following a bilateral agreement to pause the implementation of the contract and the input of ACAS, further information on progress may be available at the time of the Trust Board meeting. At the time of writing, negotiations are still ongoing. I will update Board on progress in due course.

7. National Reporting and Learning System

In the period 01/04/15 to 30/09/15 this organisation reported 1986 incidents. This equates to a rate of 38.41 per 1000 bed days. This is a very slight improvement on the previous figures and places the Trust almost exactly on the 50th centile for acute Trusts (median reporting rate 38.25). The degrees of harm reported almost exactly match the national profile.

8. Implementing the Carter report-where are we?

As expected I have been invited to a meeting in London on the 9th June, chaired by both National Directors for Clinical Quality. The focus is on clinical delivery of the Carter recommendations at local level-what does this mean for us. I hope I will be in a position to pass this information on after the 9th of June.

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Report to the Trust Board of Directors: 25 May 2016	**Paper No: 10.1**

Title	Annual report on progress against the recommendations of the National Confidential Enquiries.
Sponsoring Director	Mr David Scullion, Medical Director
Author(s)	Mr David Lavalette, Consultant Trauma & Orthopaedic Surgeon
Report Purpose	To provide assurance to the Board of Directors

Executive Summary

The purpose of National Confidential Enquiries is to assist in maintaining and improving standards of medical and surgical care.

This report clarifies the current studies and reports, includes the action plans that are currently being progressed to meet gaps in practice at HDFT based on National Confidential Enquiry recommendations and outlines the changes to the assurance process.

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

Risk and Assurance	This paper relates to the risks associated with failure to implement the recommendations of National Confidential Enquiries, and the associated assurance processes in place.
Legal implications/ Regulatory Requirements	Detail of participation in National Confidential Enquiries is required in Quality Accounts.

Action Required by the Board of Directors

To receive the report for comment.

1. INTRODUCTION

This report outlines Harrogate and District NHS Foundation Trust's response to recommendations from National Confidential Enquiries. The enquiries covered by this report are:

- NCEPOD - National Confidential Enquiry into Patient Outcomes and Death.
- MBRRACE-UK - Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
- NCISH – National Confidential Enquiry into Suicide and Homicide by people with mental illness.

The Standards Policy describes the method for quality assuring the submission of organisational questionnaires, receipt of reports, gap analysis of recommendations and monitoring of action plans.

On publication of the results of a new enquiry, receipt of the report is recorded by the Deputy Director of Governance on the standards database, a lead is proposed and this is reported to Quality Committee. The lead for NCEPOD reports will be an identified lead clinician and the NCEPOD Ambassador. The leads for the other National Confidential Enquiries will be the local reporters.

The leads are asked to ensure that recommendations are discussed in the appropriate fora in the Trust and a gap analysis is prepared for each enquiry to establish the Trust's position in relation to the recommendations. The leads are expected to develop an action plan to address any gaps and this will be reviewed and progress monitored at the Improving Patient Safety Steering Group.

The standards database is used to record the process and to facilitate monitoring. In the event of it proving impossible to action the recommendations, the risks are added to the appropriate risk register in accordance with the Standards Policy.

Reports from enquiries are available on the intranet so that all staff can access them.

2. REPORT METHODOLOGY

The preparation of this report has involved reviewing the standards database and Improving Patient Safety Steering Group minutes to confirm that the relevant organisation data has been prepared, reviewed and submitted, and that gap analyses and action plans have been prepared, reviewed and progressed for all relevant reports during the time period February 2015 – February 2016. The results of the gap analyses and action plans against the reports published during this period are included to provide assurance of compliance, or progress towards compliance with recommendations.

3. NCEPOD REPORTS

The purpose of NCEPOD is to assist in maintaining and improving standards of medical and surgical care for the benefit of the public by reviewing the management of patients, by undertaking confidential surveys and research, by maintaining and improving the quality of patient care and by publishing and generally making available the results of such activities. NCEPOD is independent of the Department of Health and the professional associations.

Each year, NCEPOD invites organisations or individuals to submit original study proposals for consideration as possible forthcoming studies. Proposals should be relevant to the current clinical environment and have the potential to contribute original work to the subject.

Once a topic has been identified an expert group will identify study themes, determine what questions need to be asked and develop clinical and organisational questionnaires. These are then sent to the NCEPOD local reporter to distribute to relevant clinicians.

NCEPOD local reporters act as a link between the non-clinical staff at NCEPOD and individual hospitals. The role includes compiling and sending datasets requested by NCEPOD and acting as a named contact for information sent by NCEPOD. The HDFT local reporter is Michael England, Governance Officer.

NCEPOD ambassadors support both NCEPOD local reporters and their fellow clinicians, working alongside NCEPOD. The HDFT Ambassador is Mr David Lavalette, Consultant Orthopaedic Surgeon.

In November 2014 NCEPOD were awarded the contract by HQIP to undertake the Child Health Clinical Outcome Review Programme (previously run as a part of Centre for Maternal and Child Enquiries (CMACE) and then more recently Royal College of Paediatrics and Child Health (RCPCH)). As a result NCEPOD will be undertaking an additional two studies over the three year contract which will focus on children and young people with complex neuro-disability and adolescent mental health. It is also anticipated that these studies will involve NCEPOD branching out into primary care and social care.

The Improving Patient Safety Steering Group now monitors the progress of all the NCEPOD action plans.

NCEPOD: Summary of studies and reports currently open at HDFT

Study Name	Study pack received	Organisational data submission date	Organisational data validated by	Report published	Lead	Directorate	Working group	Progress
Emergency & Elective Surgery in the Elderly Report: An age old problem	Sep-2010		AHL & RH	Nov-10	B Barron	Cross directorate	EC Board	Actions ongoing. Action plan update to IPSSG April 2016
Alcohol related liver disease study: Measuring the Units	Dec-2012	Dec-12	AHL & RH	Jun-13	Dr G Sivaji	IC	IC Board	Action plan update to IPSSG April 2016. Confirmed complete May 2016
Subarachnoid haemorrhage: Managing the flow	Mar-2013	Mar-13	AHL & RH	Nov-13	Dr J Smith	Cross directorate		Actions ongoing. Updated action plan received at IPSSG in Jan 2016
Lower Limb Amputation: Working Together	Mar-2013	Oct-13	RH & SW	Nov-14	F Maher	IC		Actions being progressed with York Teaching Hospital NHS Foundation Trust.
Gastrointestinal Haemorrhage: Time to get control?	Feb-2014	May- 14	RH & SW	June-15	Dr G Davies	IC	IC Board	Gap analysis received at IPSSG in Oct 2015. Action plan update to IPSSG April 2016.
Sepsis: Just say Sepsis!	Feb-2014	Nov- 14	RH & SW	Nov-15	Dr D Earl	Cross directorate		Report published in Nov 2015. Gap analysis received at IPSSG in Jan 2015. Action plan update due April 2016
Acute Pancreatitis Study	Dec-2014	Sept- 15	RH & SW	Due to be published 07/07/16				All clinical and organisational data submitted.
Provision of Mental Health Care in Acute Hospitals Study	June 2015	May- 16	RH & SW	Not yet published				All clinical and organisational data submitted including Liaison Psychiatry Questionnaires.
Young Person's Mental Health*	Dec 2015							Study contacts identified and a prospective data collection exercise undertaken between 07/03/16 and 20/03/16.
Chronic Neurodisability*	Dec 2015							An initial identification of services questionnaire has been completed and returned on 15/01/16. Organisational survey sent to appropriate service leads
Non Invasive Ventilation Study	Jan-2016							Data collection exercise completed for adult patients admitted acutely between 01.02.15 and 31.03.15 and treated with NIV. Questionnaires to follow.
Cancer in Children and Young People Study								Study in early stages of development

*Studies from part of the Child Health Clinical Outcome Review Programme the contract for which was awarded to NCEPOD in 2014.

Updates from all current action plans are to be reviewed at IPSSG on 2 June 2016.

3.1. Current reports with incomplete action plans

3.1.1. Elective & Emergency Surgery in the Elderly: An Age Old Problem (2010): Update

This NCEPOD report highlights the process of care of elderly patients who died within 30 days of emergency or elective surgery. The report takes a critical look at areas where the care of patients might have been improved, from lack of input from Medicine for the Care of Older People to the level of pain relief provided. Remediable factors have also been identified in the clinical and the organisational care of these patients.

This report follows on from the NCEPOD Report Extremes of Age (1999) and reviews the care received by elderly patients undergoing surgery. The report makes a number of recommendations which are relevant to HDFT, falling into seven categories. Several of the recommendations cross cut with work streams relating to the National Falls and Bone health report.

There have been long delays with progressing some of the recommendations from this report, which were dependent on having sufficient consultant surgical geriatric resource to deliver the recommendations for Medicine for the Care of Older People to be available to provide routine daily input to elderly patients undergoing surgery, and to be part of the multidisciplinary input required to recognise comorbidities, disability and frailty which are independent markers of risk in the elderly. The appointment of a second specialist medicine for the care of the elderly consultant to support the orthogeriatric consultant within Elective Care has been approved with a date for interview of June 2016. This appointment will develop a more robust service for elderly patients in general surgery and enable cross cover at times of annual leave between surgery and orthopaedic geriatricians.

The action plan has been recently reviewed in detail within Elective Care. Some of the original recommendations have been re-examined to ensure appropriate actions have been taken or are being progressed. Some additional work has been added to ensure the care provided for the elderly within our surgical wards meets all of the recommendations of this report.

The latest action plan is at appendix 1.

3.1.2. Alcohol Related Liver Disease: Measuring the Units (2013)

This NCEPOD report highlights the process of care for patients who are treated for alcohol-related liver disease and the degree to which their mortality is amenable to health care intervention. The report takes a critical look at areas where the care of patients might have been improved. Remediable factors have also been identified in the clinical and the organisational care of these patients.

This report was published in June 2013 and received at Standards Group in July 2013. A gap analysis was received in February 2014, and the subsequent action plan reviewed at Standards Group in August 2014 and March 2015. However progress was slow with initial issues of engagement and ownership of this action plan.

The action plan was summarised in a report to Improving Patient Safety Steering Group in October 2015. The outstanding actions related to the development of protocols for the assessment, investigation and treatment of patients with alcohol related liver disease. Dr Ganesh Sivaji has worked with the acute care physicians and, supported by the Integrated Care directorate managers, has recently completed the relevant protocols.

The latest action plan is at appendix 2.

3.1.3. Subarachnoid Haemorrhage: Managing the flow (2013)

This NCEPOD report highlights the process of care for patients who are admitted with aneurysmal subarachnoid haemorrhage, looking both at patients that underwent an interventional procedure and those managed conservatively. The report takes a critical look at areas where the care of patients might have been improved. Remediable factors have also been identified in the clinical and the organisational care of these patients.

This report was published in November 2013 and was discussed at Standards Group in December 2013. Dr John Smith was appointed as clinical lead and a gap analysis was received in April 2014. The action plan was reviewed in September 2014, January and March 2015.

Progress of actions was dependent upon a coordinated regional response which was being led by Leeds General Infirmary. In January 2015 Standards Group were informed that the Yorkshire Regional Subarachnoid Haemorrhage Network had been established and progress was being made.

An update on progress was provided to the Improving Patient Safety Steering Group in January 2016 where an updated action plan was received. The group was assured that there was good progress with other actions being progressed by the regional network. A further progress update is planned for May 2016.

The latest action plan is at appendix 3.

3.1.4. Lower Limb amputation: Working together

This NCEPOD report highlights the process of care for patients aged 16 and over who undergo lower limb amputation. The report takes a critical look at areas where the care of patients might have been improved. Remediable factors have also been identified in the clinical and the organisational care of these patients.

This report was published in November 2014. As the vascular service is provided in an alliance with York Teaching Hospital NHS Foundation Trust an assessment of compliance was undertaken by the Lead Clinician for Vascular Surgery at York to include all Trusts involved in the network.

In response to the report and in line with the recommendations of the Vascular Society, a dedicated multidisciplinary clinic has been established which will include input from the Vascular Service, Endocrinologists, Trauma and Orthopaedics and other allied health professionals in order to ensure appropriate input from a multi professional team at the earliest opportunity for the patient. This is in additional to the current alliances services provided. It is expected to commence soon at HDFT for Harrogate patients and will represent an important improvement in the pathway of care for this group of patients.

As HDFT is not leading the recommendations from this report, we are not intending to continue to report on this.

3.1.5. Gastrointestinal Haemorrhage: Time to get control?

This NCEPOD report highlights the process of care for patients aged 16 years or older that were coded for a diagnosis of GI haemorrhage. The report takes a critical look at areas where the care of patients might have been improved. Remediable factors have also been identified in the clinical and the organisational care of these patients.

This report was published in June 2015. Dr Gareth Davies was appointed as the clinical lead, supported by the Integrated Care directorate. The gaps in compliance against the recommendations from the report were reported to the Improving Patient Safety Steering Group in October 2015, and the recent update on progress with the required actions will be reported to the next meeting in April.

Dr Davies has drafted a new protocol which will close most of the outstanding NCEPOD issues. Further work is required to develop a formal pathway for the management of acute upper GI bleeds in Harrogate, in particular when a patient may need transfer to York with a view to interventional radiology/embolisation.

The action plan can be found at appendix 4

3.1.6. Sepsis: Just Say Sepsis!

This NCEPOD report highlights the process of care for patients aged 16 years or older with sepsis. The report takes a critical look at areas where the care of patients might have been improved. Remediable factors have also been identified in the clinical and the organisational care of these patients.

This report was published in November 2015. The launch was attended by Dr David Earl, Deputy Medical Director who also led on the review of the report. A gap analysis was received by the Improving Patient Safety Steering Group in January 2016. It was reported that the organisation was in a reasonable position compared to other Trusts, and an update of progress on actions is planned for April 2016.

The gap analysis can be found at appendix 5

3.2. NCEPOD closed action plans

Action plans for the following reports have been closed on the standards database:

- Cardiac Arrest Procedures: Time to Intervene? (June 2012)
- Peri-operative Care: Knowing the Risk (December 2011)
- Surgery in Children: Are We There Yet? (October 2011)
- Bariatric Surgery: Too Lean a Service? (October 2012)
- Saving Mothers' Lives 2011 (March 2011)
- Tracheostomy Care: On the right trach (June 2014)
- Lower Limb Amputation: Working Together (November 2014)

4. MBRRACE-UK REPORTS

This section of the report has been co-ordinated by Sara Keogh, Head of Midwifery. It considers the National Confidential Enquiries and national reports that relate to maternity services and demonstrates how the HDFT Maternity service have applied, implemented and worked towards compliance with the recommendations of each report.

The MBRRACE-UK reports published since the last report are:

Report	Published	Comments
Perinatal Confidential Enquiry into term, singleton, normally-formed, antepartum stillbirth	Dec 2015	Logged on the standards log and summary due at Quality Committee April 2016.
Confidential Enquiry into Maternal Death 2015-Saving Lives, Improving Mothers Care	Dec 2015	
Perinatal Mortality Surveillance Report Jan - Dec 2013	June 2015	There was also a supplementary report published in Dec 2015

The MBRRACE-UK collaboration led by the National Perinatal Epidemiology Unit continue the work investigating maternal deaths, still births and neonatal deaths carried out in the past by CMACE, including the Confidential Enquiry into Maternal Deaths. We have a nominated senior midwife within the HDFT Maternity services who is the contact for MBRRACE-UK.

MBBRACE-UK published the latest report on maternal deaths and morbidity, 'Saving Lives, Improving Mothers' Care' in December 2015. This report is reviewed by the Head of Midwifery and a senior Obstetrician and any recommendations considered and implemented as appropriate, following benchmarking against current practice at HDFT

We continue to participate in all of the regional work streams including perinatal mental health, stillbirths, and most recently maternal critical care.

We seconded a lead midwife to participate in the SaBiNe (Saving Babies Lives in the North of England) project during 2015, the focus being on customised growth charts and their role in reducing stillbirths and identifying compromised babies. This project fortuitously fed in to our combined SIRI (serious incident requiring investigation) action plan, following three intrauterine deaths where poor application of the customised growth chart contributed to the outcomes. The SaBiNe lead re-launched customised growth chart training and assessment of staff competence. There have been definite improvements with the identification of compromised babies and implementation of appropriate management plans resulting in positive outcomes.

In response to national recommendations we now have a substantive Bereavement Midwife working 1 day per week. Her role is to support bereaved parents in the postnatal period, develop support for women returning to our service with a subsequent pregnancy after pregnancy loss, lead on education and training in bereavement issues for staff, and lead on national and regional projects including the launch of the national stillbirth care bundle later in March.

5. NCISH REPORTS

The last NCISH annual report was published in July 2015 and presents findings from 2003 to 2013, highlighting areas of healthcare where safety should be strengthened. There is an infographic available, illustrating the key messages which include:

- The rise in **suicide among male mental health patients** appears to be greater than in the general population - suicide prevention in middle aged males should be seen as a suicide prevention priority.
- It is in the **safety of crisis resolution/home treatment** that current bed pressures are being felt – the safe use of these services should be monitored; providers and commissioners (England) should review their acute care services.
- **Opiates** are now the most common substance used in overdose – clinicians should be aware of the potential risks from opiate-containing painkillers and patients' access to these drugs.
- **Families and carers** are a vital but under-used resource in mental health care – with the agreement of service users, closer working with families would have safety benefits.
- **Good physical health** care may help reduce risk in mental health patients – patients' physical and mental health care needs should be addressed by mental health teams together with patients' GPs.
- **Sudden death among younger in-patients** continues to occur, with no fall – these deaths should always be investigated; physical health should be assessed on admission and polypharmacy avoided.

This was discussed at a recent meeting with Tees, Esk & Wear Valley NHS Trust (TEWV). The suicide element of the report is feeding the development of the North Yorkshire Public Health Suicide Prevention Strategy.

6. CONCLUSIONS

The recommendations from the confidential enquiry reports and gap analyses have been reported to the Board of Directors for several years. This report clarifies the current studies and reports and includes the action plans that are currently being progressed to meet gaps in practice at HDFT based on the recommendations.

Following the restructuring of the governance arrangements, the Improving Patient Safety Steering Group now monitors progress with all NCEPOD action plans, and presents an update to the Quality Committee every 6 months. There remains some delay in getting progress updates from the leads of some action plans but the new process is defined and clear and will continue to be embedded.

It should be noted that the engagement of colleagues around data collection and submission of clinical and organisational questionnaires and clinical records has improved.

7. APPENDICES

Appendix 1: Elective & Emergency Surgery in the Elderly: An Age Old Problem (2010): Current action plan
Appendix 2: Alcohol Related Liver Disease: Measuring the Units (2013)
Appendix 3: Subarachnoid Haemorrhage: Managing the flow (2014)
Appendix 4: Gastrointestinal Haemorrhage: Time to get control? (2015)
Appendix 5: Sepsis: Just say Sepsis! (2015)

7.1. Appendix 1: Elective & Emergency Surgery in the Elderly: An Age Old Problem (2010): Current action plan

Action plan: ***NCEPOD - An Age old Problem (2010)***
Date: 16/03/2016
Action plan owner: Beth Barron / Kat Johnson
Monitoring group / committee: Improving Patient

ID no.	Issue / Audit Finding / Theme	Initial risk	Action/s	Operational Lead	Responsible Lead	Target Date
1	Routine daily input from Medicine for the Care of Older People should be available to elderly patients undergoing surgery and is integral to inpatient care pathways in this population.	High	Proposal to be brought to SMT and included in the planning process	Dr Hammond / Mr Conroy / Clinical Lead for Elderly Medicine	Dr Hammond / Mr Conroy / Clinical Lead for Elderly Medicine	Mar-12
2	All hospitals should address the need for mental capacity to be assessed and documented in the elderly on admission as a minimum standard.	Low	Roll out of new forms for documenting capacity and best interests. Best Interest" training to be delivered to surgeons and nursing staff by October 2011	Janet Farnhill	Janet Farnhill	Dec-2011
3	Comorbidity, disability and frailty need to be clearly recognised and seen as independent markers of risk in the elderly. This requires skill and multidisciplinary input including early involvement of Medicine for the Care of Older People	High	Appointment of orthogeriatrician. Ward rounds on all surgical wards by CoE physicians.	Dr Hammond / Mr Conroy / Clinical Lead for Elderly Medicine	Dr Hammond / Mr Conroy / Clinical Lead for Elderly Medicine	Mar-12
4	Medicine reviews need to be a regular daily occurrence in the peri-operative period. Input of both Medicine for the Care of Older People (MCOP) clinicians and an experienced ward pharmacist may greatly assist this process.	Medium	Aide memoire checklist introduced to prompt medical staff to undertake daily medication review on ward round. There is, however, reduced pharmacist input at weekends and on bank holidays. Review in October 2011 checklist efficacy at Surgical Board (three months after its implementation).Review weekend pharmacy provision.	Mr Conroy / Andrew Alldred	Mr Conroy / Andrew Alldred	Dec-2011

Action plan progress March 2016

ID no.	Risk at review	Progress made	Further action/s to ensure completion	Operational Lead (if changed)	Responsible Lead (if changed)	New target date if original passed
1	High	Business case written and approved. Approval for a the appointment of a second specialist medicine for the care of the elderly consultant to support the orthogeriatric consultant within Elective Care - date for interview June 16 This appointment will develop a more robust service for elderly patients in general surgery and enable cross cover at times of Annual leave between surgery and orthopaedic geriatricians	Appointment to be made Ensure cross cover at times of annual leave between surgery and orthopaedic geriatiricans	Rebecca Leigh /Jonny Hammond	Beth Barron	Mar-16
2a	Complete	Dec 2011-MCA and best interest forms in use on all wards	Ensure all medical and nursing teams undertake relevant training - new action added			Complete
2b	Low	Training needs analysis for MCA to be developed by MCA task and finish group. Compliance will then be on personal training accounts and will be monitored and managed according to the Training Policy		MCA task and finish group	J Foster	May-2016
3a	High	Rebecca Leigh was appointed into the orthogeriatic post Approval to appoint Surgical geriatrician in June '16 Currently patients will be referred via blue referral to the geriatrician service via surgical consultants if further assessment is required.	Appointment to be made. Develop protocol / processes to ensure early involvement of Medicine for the Care of Older People for all relevant elderly surgical patients Data analysis required to understand which patients require early involvement of Medicine for the Care of Older People	Rebecca Leigh /Jonny Hammond	Beth Barron	tbc
3b	Low	To undertake a data analysis for all surgical specialties split by acute and planned procedures identifying number of patients treated for those 80 years and older		Rachel McDonald	Beth Barron	Jun-16
4	Complete	Trust implementation of e-Prescribing will prompt daily medicines review. On going audits to be undertaken in surgery around the med chart access. 23/08/14: e-Prescribing now being used across the Trust. Issues identified with IT equipment malfunctioning, being slow to load and availability fo equipment. Ward rounds now also taking longer as a result of e-Prescribing. April 2013 - complete				Complete

Action plan: ***NCEPOD - An Age old Problem (2010)***
Date: 16/03/2016
Action plan owner: Beth Barron / Kat Johnson
Monitoring group / committee: Improving Patient

ID no.	Issue / Audit Finding / Theme	Initial risk	Action/s	Operational Lead	Responsible Lead	Target Date	ID no.	Risk at review	Progress made	Further action/s to ensure completion	Operational Lead (if changed)	Responsible Lead (if changed)	New target date if original passed
									Action plan progress March 2016				
5	Delays in surgery for the elderly are associated with poor outcome. They should be subject to regular and rigorous audit in all surgical specialities, and this should take place alongside identifiable agreed standards.	Medium	Delays to be monitored and audited for all surgical specialties. Process to commence October 2011.	Audit Leads for Surgical Specialties in Gynaecology, Urology, General Surgery and Orthopaedics.	Audit Leads for Surgical Specialties in Gynaecology, Urology, General Surgery and Orthopaedics.	Mar-12	5a	Low	National Laparotomy audit data is being reviewed to understand length of time to theatre and outcome - John Simpson Jon Conroy/Rebecca Leigh are re-establishing the Hip Fracture group	Data analysis required to understand delays against defined standards and outcomes	Audit Leads for Surgical Specialties in Gynaecology, Urology, General Surgery and Orthopaedics.	Kat Johnson	Sep-16
							5b	Low	Undertake a data analysis for all surgical specialties split by Acute and planned procedures identifying number of patients treated for those 80 years and older Review and understand the mortality rate 30 days post surgery.		Rachel McDonald	Beth Barron	Jun-16
6	Senior clinicians in surgery, anaesthesia and medicine need to be involved in the decision to operate on the elderly. Risk assessment must take into account all information strands, including risk factors for acute kidney injury.	High	Regular ward rounds by Care of Elderly Physician are not in place. This will be resolved with appointment of ortho-geriatrician / surgical-geriatrician which has been agreed between Elective and Integrated Care Directorates.	Dr Hammond / Mr Conroy	Dr Hammond / Mr Conroy	Nov-11	6	High	Multiprofessional assessment for patients undergoing a planned procedure is completed at pre-assessment. Any patients identified as to requiring geriatrician input would require a blue referral to the geriatrician team. Elderly Care surgical steering group to be initatied to review guidlines - want to ensure new geriatirican appointment is embeded withint the anaesthetic and surgeon teams, therefore need to understand how this role will work.		Chris Mahon Anne-Marie Davies Tracy Jackson Jeremy Childs Mark Farndon	Kat Johnson	Jun-16
7	A fully resourced acute pain service (APS) is essential within the context of modern secondary care services.	Medium	Review of provision of the APS	Heather Lain / General Manager Elective Care	Heather Lain / General Manager Elective Care	Mar-12	7	Low	There has been a lot of progress within the Acute Pain service on the development of clear pain protocols, training of staff and now the introduction of Patient Track. As no additional resource has been placed into the team this remains on the Risk Register.		Heather Lain / Jonny Hammond	Mark Simenacz	Mar-16
8	Post operative Acute Kidney Injury (AKI) is avoidable in the elderly and should not occur. There is a need for continuous postgraduate education of physicians, surgeons and anaesthetists around the assessment of risk factors for the development of AKI in the elderly surgical patient.	High	Renal physician to attend Surgical Audit meetings to identify how this can be included in Deanery programme.	Clinical Leads T&O, Urology and General Surgery	Clinical Leads T&O, Urology and General Surgery	Mar-12	8	Low	An e-learning package is now part of mandatory training for all doctors/fluid prescribers which covers the common causes and acute management of AKI. The laboratory also has an automatic alerting system when AKI identified by creatinine rise		Dave Earl / John Smith	Kat Johnson	Mar-16
9	Greater vigilance is required when elderly patients with non-specific abdominal symptoms and signs (diarrhoea, vomiting, constipation, urinary tract infection) present to the Emergency Department. Such patients should be assessed by a doctor with sufficient experience and training to exclude significant surgical pathology	Medium	Audit attendance in ED. Review surgical and urology middle grade rotas to assess availability for ED attendance. Review Surgical CAT and middle grades support.	Clinical Leads for ED / Surgery / Urology / DJL / John Smith	Clinical Leads for ED / Surgery / Urology / DJL / John Smith	Oct-11	9	Medium	A new Surgical Protocol has been developed for CAT to ensure fast response. A new Audit has been undertaken of this process throughout March and a meeting held 15 June to review. Clinical Lead in General Surgery signed up to process and quality indicators. Further audit taken place.	Was marked as complete July 2012 but re-opened as the evidence did not cover ED. Awaiting an update from Matt Shepard	Matt Shepard	Andy Alldred	Jun-16
10	Clear protocols for the post-operative management of elderly patients undergoing abdominal surgery should be developed which include where appropriate routine review by a MCOP consultant and nutritional assessment.	Medium	Clear protocols to be developed between surgery and medicine (Elective and Integrated Care Directorates)	General Managers in Elective and Integrated Care	General Managers in Elective and Integrated Care	Mar-12	10	Medium	Review of the hip fracture handbook to see if it can be updated to become an acute abdo handbook. Handbook reviewed at Directorate Governance Group for agreement.	Was marked as complete September 2012 but re-opened as this requires review	Chris Mahon	Kat Johnson	Jun-16

7.2. Appendix 2: Alcohol Related Liver Disease: Measuring the Units (2013)

NCEPOD Alcoholic Liver Disease: Measuring the units

Action plan started September 2013. Updated March 2016

							Action Plan Progress Monitoring	
Ref No	***Issue***	***Action***	***Responsible Lead***	***Operational Lead***	***Target date***	***Progress***	**Progress on actions**	**New target date if original passed**
1	Hepatology service provision within HDFT	Established Hepatology clinic at Wetherby led by Dr Charlie Milson, Gastroenterology Consultant from York hospital. Initial frequency monthly until establsihed. Numbers have increased so decision to move to fortnighly clinic commencing October 2015	Ganesh Sivaji	Fiona Maher	30/09/2015	Achieved		
2	Shared protocols between gastroenterology and AMU/ CAT team	Need identified for shared protocols: * Alcohol detoxification * Management of ascites * Spontaneous bacterial peritonitis	Ganesh Sivaji	Fiona Maher	05/10/2015	Underway	Draft protocols completed March 2016. Need to be ratified and implemented	May-16

NB. It was confirmed during May 2016 that protocols have been shared with the gastroenterology consultants and approved by the Integrated Care Governance Group. They are now available from the intranet and being further disseminated to relevant staff. This action plan is therefore now complete.

7.3. Appendix 3: Subarachnoid Haemorrhage: Managing the flow (2014)

NCEPOD SAH April 2014					Action Plan Progress Monitoring - Update December 2015					
ID number	Issue / Audit Finding / Theme	Initial Risk (H/M/L)	Action/s	Operational Lead	ID number	Risk at review	Progress on actions	Further action/s to ensure completion	Operational Lead (if changed)	Target Date
O1	Formal networks of care should be established. linking all secondary care hospitals receiving subarachnoid haemorrhage patients to a designated regional neurosurgical/neuroscience centre.	Low	Formal links already in place with LGI and Leedsneurosurgery.com. These need to be incorpartaed into common care pathway. There is still scope to agree criteria for referal with Leeds and responsibility for furtehr imaging ie CTA	Dr J Smith	O1	Complete	We have now forming a local network to drew a ccommon response to all NCEPOD SAH issues. This is being co-ordinated by Mr Ross, Neurosurgeon in LGI and the first meeting is in October - There will not be any further development of these pathways locally until a regional approach is dicted.	Meetings are now established and regular and will develeope to include audit and M&M		
O2	All hospitals should undertake regional audit or multi-disciplinary team meetings, in order to share learning that could improve the care provided to aneurysmal subarachnoid haemorrhage patients.	Low	No regular audit has been undertaken. First initial updit has been initiated. Alter and complete initial audit and set tine for annual re-audit. It would be difficult to organise MDT - rolling audit a better option.	Dr J Smith	O2	Complete	First audit done and results awaited - plan yearly audit of target number. Suggest this is a rolling audit to be completed by CAT junior Doctor allocated on a yearly basis. Nature of audit likely to be dictated by regional response	Yearly on-going SAH audit. Likley to feed into regional data. M&M style audit at SAH regioal meetings		
O3	The availability of interventional neuroradiology services should be such that hospitals can comply with the 'National Clinical Guideline for Stroke' stating that patients should be treated within 48 hours of their aneurysmal subarachnoid haemorrhage.	Low	Baseline data needs to be obtained via audit. Transfer to Leeds is usually pormpt but the service is not consistent.	Dr J Smith	O3	Complete	Inherent variability in transfer - usually within target - will need to be monitored via annual audit. Formal criteria will need to be finalised with regional approach.	Yearly on going SAH audit. Likely to remain ongoing low risk. The condition of this is likely to remain unchnaged for the forseebale future. Low risk however as base line service is excellent.		
S1	The clinical presentation of aneurysmal subarachnoid haemorrhage should be highlighted in primary and secondary care education programmes for all relevant health care professionals, including the guidelines for the management of acute severe headache published by the College of Emergency Medicine.	Medium		Dr J Smith	S1	Complete	Headache included in both ED and CMT training programs. Common presntation core competency in ACCS and CMT			
S2	All patients presenting with acute severe headache in a secondary care hospital should have a thorough neurological examination performed and documented. A CT scan should be performed immediately in this group of patients as defined by the 'National Clinical Guideline for Stroke'.	Medium	This should be standard practice but documentation of such needs to be auditted. Need agreement from radiology on avaialbility of cross sectional imaging both in and out of hours.	Dr J Smith	S2	Low	Deviation in out of hours CT scanning of low risk presentation needs to be explored. May need to allow case by case variation and dicussion with on call radiology. Likely to remain low risk. High risk factors for acute severe headaches developed	It is accepted in regional network that ?SAH should be imaged within one hour- contacted Dr sapherson - need a formal but reasoned approach to out of hours scanning here with inclusion criteria - should be done 3 months then will move to COMPLETE	Dr J Smith / Dr D Sapherson	Feb-2016
S3	Standard protocols for the care of aneurysmal subarachnoid haemorrhage patients in secondary care should be developed and adopted across formal networks. These should cover, as a minimum, initial assessment and diagnosis, management, referral, transfer to a neurosurgical/neuroscience centre and subsequent repatriation to secondary care, including rehabilitation. These protocols should take into account existing guidelines where relevant.	Medium	This is not in place although aspects are available there is no universal protocol. This should include multiple patient entry points (ED and AMU), Initial management and risk assessment; agreements for cross sectional imaging both in and out of hours; agreement on suitability of referal to tertiary centers, requirement for supported transfer, agreement on criteria for re-location from tertiary care and rehabilitation	Dr J Smith	S3a	Low	Secondary care pathway bundle being developed by J Smith in HDFT. Drafted	Needs formated and ready to circulate	Dr J Smith / SAH network group	2016
					S3b	Low	Others in the network are developing the other care pathways	Network to ratify the entire set of protocols / pathways	SAH network group	2016
S4	All patients diagnosed with a subarachnoid haemorrhage should be commenced on nimodipine immediately as recommended in the 'National Clinical Guideline for Stroke', unless there are contraindications to its use.	Medium	This is not current initial practice. Nimodipine is not available on the wards or within the Emrgency Department	Dr J Smith	S4	Complete	Nimodipine is now stocked in ED, CCU and AMU Fountains. Its use will be highlighted in guidelines	Nimodipine easiy available now for routine use		Jul-2015
P1	Organ donation rates following fatal aneurysmal subarachnoid haemorrhage should be audited and policies adopted to increase the frequency with which this occurs.	Low	Occurs under the unbrella of organ transplation on going audit - needs to be flagged as specific issue	Dr J Smith	P1	Complete	This is included as part of on going organ donation audits			

7.4. Appendix 4: Gastrointestinal Haemorrhage: Time to get control? (2015)

NCEPOD Gastroenterology Haemorrhage – time to get control

Reviewed March 2016

Ref No	*Issue*	*Action*	*Responsible Lead*	*Operational Lead*	*Target date*	*Progress*	Progress on actions	New target date if original passed
1	Patients with any acute GI bleed should only be admitted to hospitals with 24/7 access to on-site endoscopy	HDFT has 24/7 access to on-site endoscopy	Gareth Davies	Fiona Maher	30 September 2015	Achieved		
2	Interventional radiology (on-site or covered by a formal network)	Network with York currently exists, however requires formalisation with specific relation to this NCEPOD	Gareth Davies	Fiona Maher	30 November 2015	Underway	Not able to locate an agreement /SLA There are effective working arrangements in place to support our most critically ill GI bleed patients. Discuss at next York / HDFT Alliance meeting May 2016. Add to alliance documentation.	01 August 2016
3	On-site GI bleed surgery, on-site critical care and anaesthesia.	HDFT has access to on-site GI bleed surgery, on-site critical care and anaesthesia.	Gareth Davies	Fiona Maher	01 September 2015	Achieved		
4	Hospitals that do not admit patients with GI bleeds must have 24/7 access to endoscopy, interventional radiology and GI bleed surgery for patients who develop a GI bleed while as an inpatient for another condition by either an on-site service or a formal network.	Not applicable	Gareth Davies	Fiona Maher		Achieved		
5	The traditional separation of care for upper and lower GI bleeding in hospitals should stop.	Combining of medical and surgical gastroenterology on same wards and an open policy in place which allows movement of cases between the two specialties.	Gareth Davies	Fiona Maher	01 September 2015	Achieved		
6	All acute hospitals should have a Lead Clinician who is responsible for local integrated care pathways for both upper and lower GI bleeding and their clinical governance, including identifying named consultants, ideally gastroenterologists, who would be responsible for the emergency and on-going care of all major GI bleeds.	Gareth Davies identified as Lead Clinician in interim period until Endoscopy Unit Lead in place/	Gareth Davies	Fiona Maher	01 September 2015	Achieved		
		Work underway to produce agreed overarching pathway document which will be replaced by bespoke care pathway to replace the generic medical admissions document for GI bleeds.	Gareth Davies	Fiona Maher	31 October 2015	Underway	Upper GI bleeding management protocols drafted March 2016 - ready for circulation / comment / ratification. Will probably sit beside the generic medical admission document as happens with septic six and transfusion documentation etc. at present.	01 July 2016

NCEPOD Gastroenterology Haemorrhage – time to get control

Reviewed March 2016

Ref No	*Issue*	*Action*	*Responsible Lead*	*Operational Lead*	*Target date*	*Progress*	**Progress on actions**	**New target date if original passed**
7	All patients who present with a major upper or lower GI bleed, either on admission or as an inpatient, should be discussed with the duty or on-call (out-of-hours) consultant responsible for major GI bleeds, within one hour of the diagnosis of a major bleed.	Robust out of hours consultant GI bleed service in place, providing 24/7 cover.	Gareth Davies	Fiona Maher	30 September 2015	Achieved		
		Work underway to highlight need for staff to notify within an hour, this includes development of problem-specific admission paperwork, which would trigger the call.	Gareth Davies	Fiona Maher	01 February 2015	Underway	Advice included in GI bleed management protocol	01 July 2016
8	The ongoing management of care for patients with a major bleed should rest with, and be directed by the named consultant responsible for GI bleeds; to ensure timely investigation and treatment to stop bleeding and reduce unnecessary blood transfusion.	Work ongoing to develop two teams providing in-patient cover, this will allow management of major haemorrhage to rest with that physician. Recruitment to 4th Substantive Consultant position will allow this to happen.	Gareth Davies	Fiona Maher	01 February 2015	Underway	This is achieved for upper GI bleeds as all significant cases are triaged under the care of gastroenterologist on wards that month. We do not feel there is national consensus to place lower GI bleeds under duty gastroenterologist so for now these remain under the general surgeon, on-call. Gastrenterology will move to a 2 consultant team at a time model for in-patient care from April, and once that is in place my plan is to link the daytime GI bleed management rota directly to the in-patient gastro teams as with half the cases we will have more time in the week to deal with the immediate management triaging of these cases.	01 June 2016
9	All patients with a GI bleed must have a clearly documented re-bleed plan agreed at the time of each diagnostic or therapeutic intervention.	Work underway to remind staff of importance - includes provision of notices in endoscopy unit. This will be made easier by introduction of a new endoscopy reporting system which will provide mandatory field so can't get forgotten	Gareth Davies	Fiona Maher	01 May 2015	Underway	This is part of the new GI bleed management protocol paperwork	01 July 2016

7.5. Appendix 5: Sepsis: Just say Sepsis! (2015)

Action plan: NCEPOD: Sepsis study: Just say sepsis (Nov 2015)
Date: December 2015
Action plan owner: David Earl
Monitoring group / committee: Improving Patient safety Steering Group

ID no.	Issue / Audit Finding / Theme	Indicator (if relevant - remove column if not)	Initial risk (H/M/L)	Action/s	Operational Lead	Responsible Lead	Target Date
1	All hospitals should have a formal protocol for the early identification and immediate management of patients with sepsis. The protocol should be easily available to all clinical staff, who should receive training in its use. Compliance with the protocol should be regularly audited. This protocol should be updated in line with changes to national and international guidelines and local antimicrobial policies.	Trust protocol, created from the national and international guideline, is in place. This is now included in all admission proformas and extra copies are available for septic episodes post admission. All FY1s have a teaching session in their first few weeks. Currently monthly audits as part of CQUINs.	Low	Current audits do not look at compliance with the protocol (just 1 hour antibitoic administration). Establish an annual audit of compliance	CCOT	CCDG	Oct-16
2	Training in the recognition and management of sepsis in primary and secondary care should be included in educational materials for healthcare professionals undertaking new posts. Where appropriate this training should include the use of a standardised hospital protocol	All junior doctors and ward nursing staff attend the "ALERT" course which contains a sepsis training scenario. It is also included as part of the fluid prescribers essential e-training for all doctors.	No action required				
3	A Clinical Lead in sepsis should be appointed in every Trust/Health Board to champion best practice and take responsibility for the clinical governance of patients with sepsis. This Lead should also work closely with those responsible for antimicrobial stewardship in their hospital(s).	Dr Earl (Dep Med Director) in role. Has close working ties with microbiology	No action required				
4	Trusts/Health Boards should use a standardised sepsis proforma to aid the identification, coding, treatment and ongoing management of patients with sepsis (some examples are available at sepsistrust.org and survivingsepsis.org). To ensure continuity of care, this proforma should be compatible, where possible with any similar proforma or system used in primary care and should permit the data to be shared electronically.	Proforma as described in use. Not currently in electronic format.	Low	Patientrack sepsis module planned for 2016	Robin Pitts	Patientrack Steering Group	Jun-16
5	An early warning score, such as the National Early Warning Score (NEWS) should be used in both primary care and secondary care for patients where sepsis is suspected. This will aid the recognition of the severity of sepsis and can be used to prioritise urgency of care.	NEWS is used throughout HDFT (GPOOH excepted)	No action required				
6	On arrival in the emergency department a full set of vital signs, as stated in the Royal College of Emergency Medicine standards for sepsis and septic shock should be undertaken.	In place at Triage	No action required				

ID no.	Issue / Audit Finding / Theme	Indicator (if relevant - remove column if not)	Initial risk (H/M/L)	Action/s	Operational Lead	Responsible Lead	Target Date
7	Where sepsis is suspected, early consideration should be given to the likely source of infection and the ongoing management plan recorded. Once identified, control of the source of infection should be undertaken as soon as possible. Appropriate staffing and hospital facilities (including theatre/interventional radiology) should be available to allow this to occur.	24 hour emergency theatre avaialble, and interventional radiology available via local networks. Need some staff education about early source control for deep collections	Low	Education of senior medical staff required		D Earl	Apr-16
8	The importance of early identification and control of the source of sepsis should be emphasised to all clinicians, and be reinforced in any future guidelines or tools for the management of sepsis.	As in section 7.	Medium	On-going education a priority. Essential learning package is in place for fluid balance / sepsis, and this is part of medical school curriculum. To add to the next update of annual elearning requirement		D Earl	Nov-16
9	In line with previous NCEPOD and other national reports' recommendations on recognising and caring for the acutely deteriorating patients, hospitals should ensure that their staffing and resources enable: a. All acutely ill patients to be reviewed by a consultant within the recommended national timeframes (max of 14 hours after admission) b. Formal arrangements for handover c. Access to critical care facilities if escalation is required; and d. Hospitals with critical care facilities to provide a Critical Care Outreach service (or equivalent) 24/7.	Section a and b in other work streams. C and D in place, although CCOT is not 24/7 (currently 9am-10pm, 7 days)	Medium	Outreach not 24/7. Consultant reviews not timely (part of 7 day working workstream) Provision of CCOT 24/7 is not a high priority - to include on Critical Care risk register, scored as the higher of risk to patient safety or risk to reputation		D Earl	Feb-16
10	All patients diagnosed with sepsis should benefit from management on a care bundle as part of their care pathway. The implementation of this bundle should be audited and reported on regularly. Trusts/Health Boards should aim to reach 100% compliance and this should be encouraged by local and national commissioning arrangements.	Part of the sepsis screen in all medical proformas. Annual audits via CCOT to continue	Medium	Bundle in place but compliance not audited - see section 1.			
11	For any invasive procedure a surgical site bundle should be employed as specified in NICE Clinical Guideline 74.	In place, part of WHO check and LocSSIPs	No action required	Part of ongoing NatSSIP workstream. Surgical site bundle already in place in theatres.			
12	All healthcare providers should ensure that antimicrobial policies are in place including prescription, review and administration of antimicrobials as part of an antimicrobial stewardship process. These policies must be accessible, adhered to and frequently reviewed with training provided in their use.	Ongoing emphasis on good antimicrobial stewardship across the trust, including TACCORD or equivalent	No action required	Ongoing work in antimicrobial stewardship			
13	There should be senior microbiology input into the management of all patients identified with sepsis. This input should be available 24/7 and sought early in the care pathway	Good clinical input available 24/7. All positve blood cultures communicated by microbiology consultant to ward teams	No action required				

ID no.	Issue / Audit Finding / Theme	Indicator (if relevant - remove column if not)	Initial risk (H/M/L)	Action/s	Operational Lead	Responsible Lead	Target Date
14	A booklet that provides patients and their relatives with easy to understand information on the recognition of sepsis, its long-term complications, recovery and risk of recurrence should be available from all healthcare providers and be provided to patients with sepsis at discharge from hospital. Some examples can be found at the UK Sepsis Trust (sepsistrust.org) and ICU Steps (icusteps.org).	Not yet in place	Medium	Not yet established. To discuss at next Critical Care Consultants' Meeting	D Earl	R Tuffin	Apr-16
15	As for all acutely ill patients who are admitted to critical care, a follow-up service for patients with sepsis should be provided by the hospital which includes support and rehabilitation services, as recommended in NICE Clinical Guideline 83 and the Faculty of Intensive Care Medicine and Intensive Care Society Guidelines for the Provision of Intensive Care Services (GPICS).	Follow up clinic, based on CG83 available	No action required				
16	All patients discharged following a diagnosis of sepsis should have sepsis recorded on the discharge summary provided to the general practitioner so that it can be recorded in the patient's GP record.	No firm system in place	Low	No formal reporting structyure in place for sepsis (unlike AKI) Include in audit - see section 1			
17	For patients who die with sepsis, the care provided should always be discussed at a hospital multidisciplinary mortality meeting to encourage learning, and, where the source of sepsis has not been identified, an autopsy should be undertaken.	All deaths reviewed at MORG. Postmortem will be at request of coroner - registrar will not accept sepsis of unknown origin without discussion with coroner.	No action required				
18	When diagnosed, sepsis should always be included on the death certificate, in addition to the underlying source of infection.	Needs to be dissemintaed to juniors	Medium	Not yet disseminated to Juniors To discuss with DoME for inclusion in teaching on death certification	D Earl		
19	The use of national coding for sepsis must be improved in order to aid clinical audit, national reporting and shared learning. Use of a standardised proforma as described in recommendation 4 should help improve this process, and may help in the development of a national registry.	National, not local.	No action required				

Report to the Board of Directors on 25 May 2016	Paper No: 10.2
Title	**Efficiency Programme Quality Impact Assessment**
Sponsoring Director	Medical Director and Chief Nurse
Author(s)	Dr David Scullion, Medical Director Mrs Jill Foster, Chief Nurse
Report Purpose	To brief the Board of the Efficiency Programme Quality Impact Assessment
Previously considered by	N/A

Executive Summary

This report provides the Board with an overview of the final stage of the quality impact assessment of the Efficiency Programme

Related Trust Vision

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

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

Action Required by the Board of Directors

To receive the report for comment.

1. Efficiency Programme Quality Impact Assessment

The Quality Impact Assessment of the Efficiency Programme has been subject to the rigorous examination of the efficiency schemes developed by the clinical directorates and corporate services. To date approximately 200 schemes have been developed and put forward for consideration. Each scheme has been considered and scored by potential impact on quality.

Scoring for quality was undertaken against impact on patient safety, effectiveness and patient experience. Prior to Board approval, the final stage of the process requires the Medical Director and Chief Nurse to review each scheme and approve, reject or ask for further clarity with regard to impact on quality. It is worth noting the rigor of the process within each directorate and corporate service gave assurance so that only the small numbers of schemes for efficiency with significant potential impact on quality were subject to discussion.

1.1 Urgent, Community and Cancer Care

The final list is the condensation of a number of schemes already extensively debated at departmental and directorate level. All current schemes remain Green rated for both quality and safety impact. There are no concerns around any individual component of the CIP programme. There was some discussion around some of the more transformational projects within the list, though reassurance was given.

1.2 Elective Care

All individual schemes rated as Green for quality impact. There is some slack in the system as the overall predicted cost savings are at 108% of CIP. Similar discussions took place regarding more transformational aspects of the scheme, but overall reassurance had been given from the directorate.

1.3 Integrated Care

All individual schemes rated as Green for quality impact. Concern was raised relating to transformational aspects of the in-patient work stream regarding the potential slowdown of the recruitment of registered nurses, but overall reassurance given from the directorate.

1.4 Corporate Services

An initial review of the schemes demonstrates they are rated Green for both quality and safety however there are a number of schemes without detail and will, therefore need to be considered at a future date.

Each directorate and corporate services continue to identify further schemes to meet the full CIP commitment, and the Quality Impact Assessment process will have to be applied to these schemes.

Dr David Scullion
Medical Director
May 2016

Mrs Jill Foster
Chief Nurse

Report to the Trust Board of Directors: 25 May 2016	Paper No: 11.0

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

Key Issues for Board Focus:

1. To **note** the results of Director Inspection's and Patient Safety Visits
2. To **receive** the complaints report
3. To **understand** current registered nurse vacancies and the steps being undertaken to maintain safe staffing levels including robust registered nurse recruitment
4. To **acknowledge** the work being undertaken by the Trust to meet its statutory duty regarding the safeguarding of children

Related Trust Objectives:

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

Risk and Assurance	N/A
Legal implications/ Regulatory Requirements	No additional Risks

Action Required by the Board of Directors:

- To **note** the results of Director Inspection and Patient Safety Visits
- To **receive** the complaints report
- To **understand** current registered nurse vacancies and the steps being undertaken to maintain safe staffing levels including robust registered nurse recruitment
- To **acknowledge** the work being undertaken by the Trust to meet its statutory duty regarding the safeguarding of children

Unannounced Directors' Inspections 2015-2016

Date	Ward/Dept.	Risk Rating	Critical Issues	Review Date	Outcome	Critical Issues
09/06/2015	Farndale	Red	No VIP scores No nurse in charge badge	13/07/2015	Green	Good evidence on review
12/06/2015	Wensleydale	Red	No VIP scores	13/07/2015	Green	Good evidence on review
01/07/2015	Nidderdale	Green				
13/07/2015	Littondale	Green				
06/08/2015	AMUF	Green				
28/08/2015	Trinity	Red	No cannula documentation no VIP scores	22/10/2015	Green	Good evidence upon review
21/09/2015	ED	Amber/ Red	Emergency doors not working General fabric to the environment	11/02/2015	Amber	General fabric to the environment
13/10/2015	Jervaulx	Green				
16/11/2015	Byland	Red	Failed due to no VIP scores	26/02/2016	Green	
03/11/2015	Granby	Green				
08/12/2015	Oakdale	Red	Cleanliness soiled toilet seat	24/12/2015	Green	
21/12/2015	Woodlands	Green				
05/01/2016	Theatres	Red	Medicine cupboard unattended & open	24/03/2016	Green	
29/01/2016	Day Surgery	Red	Cleanliness Medicine Fridge open Patient call bell issues. No nurse in charge badge worn	06/05/2016	Green	Excellent progress – with the exception of the chairs, this must be escalated.
11/02/2016	Nidderdale	Green				
01/03/2016	Pannal and MAU	Red	No Cannula / VIP/. Gaps in control drugs checks/ toilet not clean / lack of assurance with cleanliness equipment.	27/05/2016	TBC	Un-announced visit on 20/04/2016 and 05/05/2016 found to be complaint with VIP scores.
17/03/2016	Delivery Suite	Green				

Unannounced Directors' Inspections 2016-2017

Date	Ward/Dept.	Risk Rating	Critical Issues	Review Date	Outcome	Critical Issues
14/04/2016	Mortuary	Green				
26/04/2016	Endoscopy	Green				

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

Date	Area
13/04/2016	Radiology
06/05/2016	ITU
12/05/2016	Lascelles

Complaints Update for April 2016

The Trust received 18 complaints in April 2016 in comparison to 26 received in April 2015. Of the 18 complaints received in April 2016, 12 were graded Yellow and six Green.

Complaint responses to deadline:

In 2015/16 as a Trust we responded within an agreed deadline to 54% of our complainants. This was a small improvement from the year before where 45% of complaints were responded to within the agreed deadline. However 2015/16 saw a 20% reduction in the total number of complaints compared to the year before, therefore our response performance did not significantly improved.

In addition from the action plans developed in response to the complaints, the number of actions completed to deadline is 33%. This has been discussed at Senior Management Team with the following commitment.

In 2014/15, nine cases were referred to the Ombudsman within the year and one case was partially upheld. In 2015/16 there was an improvement as five cases went this year and only four were investigated and one case was partially upheld.

Information taken from 2015/16 Q4 Patient Experience Report
Complaints for 2015/16

Quarter Data	15/16				
	Q1	Q2	Q3	Q4	Total
Total Number of formal complaints*	74	58	32	49	213
% responded to by deadline (target 95%**)	70%	31%	40%	67%	54%
% upheld	58%	76%	80%	67%	69%
Number returned for further local resolution	9	6	8	2	25
Number of new PHSO requests	2	1	1	1	5
Total informal requests (PALS contacts)***	159	201	168	148	676

Year to Date Position	
Complaints received by PHSO (YTD)	5
Complaints investigated by PHSO as % of received by PHSO	80% (4 out of 5)
Complaints upheld by Ombudsman as % of received (nat av=48% at Q3)	33%
Number of complaint actions developed	434
% of actions completed within deadline (target 100%)	33%

Nurse Recruitment

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

Local recruitment continues with an event planned for the evening of Thursday 19th May 2016 to recruit both registered nurses and care support workers. Events are planned to take place every month moving forward.

In excess of 40 student nurses qualifying in September have committed their future to the organisation so far, a further keeping in touch event is planned to take place in June.

Following our previous successful international recruitment programme in 2014, it has been agreed to explore recruitment opportunities in the EU.

Actual versus Planned Nurse Staffing Levels

February and March 2016 data has been included for comparison.

	Mar-2016				Feb-2016			
	Day		Night		Day		Night	
Ward name	Average fill rate - registered nurses/midwives	Average fill rate - care staff	Average fill rate - registered nurses/midwives	Average fill rate - care staff	Average fill rate - registered nurses/midwives	Average fill rate - care staff	Average fill rate - registered nurses/midwives	Average fill rate - care staff
AMU	92%	113%	96%	142%	94%	111%	101%	131%
Byland	85%	147%	79%	232%	87%	143%	87%	224%
CATT	92%	127%	120%	113%	96%	111%	120%	107%
Farndale	94%	135%	100%	153%	93%	141%	100%	179%
Granby / Oakdale	89%	112%	93%	126%	93%	128%	100%	122%
Harlow	98%	81%	87%	-	105%	98%	100%	-
ITU/HDU	101%	-	101%	-	94%	-	95%	-
Jervaulx	82%	159%	87%	214%	87%	145%	83%	209%
Lascelles	91%	107%	100%	100%	92%	106%	100%	100%
Littondale	98%	130%	100%	177%	98%	120%	101%	162%
Maternity Wards	90%	93%	98%	87%	86%	79%	102%	84%
Nidderdale	97%	127%	100%	113%	95%	105%	94%	110%
Oakdale	data merged with Granby				96%	125%	96%	160%
Special Care Baby Unit	95%	95%	100%	-	94%	94%	109%	-
Trinity	91%	120%	105%	126%	139%	129%	100%	210%
Wensleydale	92%	139%	100%	108%	85%	133%	102%	114%
Woodlands	100%	111%	90%	106%	101%	109%	97%	103%
Trust total	**92%**	**126%**	**97%**	**138%**	**94%**	**122%**	**99%**	**145%**

Key

Red = < 90%

Blue = >110%

ED staffing	104%	161%	89%	100%	97%	122%	93%	90%

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

	Apr-2016			
	Day		Night	
Ward name	Average fill rate - registered nurses/midwives	Average fill rate - care staff	Average fill rate - registered nurses/midwives	Average fill rate - care staff
AMU	91%	109%	93%	137%
Byland	84%	146%	77%	236%
CATT	92%	121%	114%	119%
Farndale	88%	122%	100%	133%
Granby / Oakdale	99%	134%	100%	187%
Harlow	97%	88%	93%	-
ITU/HDU	97%	-	96%	-
Jervaulx	78%	161%	78%	268%
Lascelles	92%	103%	100%	100%
Littondale	94%	107%	99%	103%
Maternity Wards	87%	82%	99%	95%
Nidderdale	95%	116%	99%	150%
Oakdale	96%	106%	94%	147%
Special Care Baby Unit	92%	69%	98%	-
Trinity	92%	132%	97%	107%
Wensleydale	89%	121%	100%	108%
Woodlands	92%	98%	91%	100%
Trust total	**91%**	**119%**	**96%**	**141%**

ED staffing	99%	102%	97%	93%

Further information on this month's data

On the medical wards Jervaulx, Byland, AMU and CATT where the Registered Nurse fill rate was less than 100% against planned; this 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. Extra care staff were deployed to support the wards during this period and this is shown in the enhanced care staff, day and night time hours. In addition further care staff hours were required at times in these areas to provide intensive 1:1 patient support.

On Farndale ward the daytime RN hours in April were less than planned due to staff sickness and vacancies.

On Granby ward the increase in care staff hours above plan was to support the opening of additional escalation beds and to provide 1:1 intensive patient support as required.

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

In April the planned staffing levels on Lascelles remain adjusted to reflect the closure of two beds on the unit in response to RN vacancies in this area.

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

In some wards the actual care staff hours show additional hours used for 1:1 care for those patients who require intensive support. In April this is reflected on the wards; Acute Medical Unit (AMU), Byland, CATT, Granby, Farndale, Oakdale, Jervaulx, and Trinity.

On Nidderdale ward the increase in night duty care staff hours above plan was to support the activity on the ward.

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

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

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

Workload/Staffing Incidents recorded on Datix system 2015/16

Quarter 2015/16	Q1	Q2	Q3	Q4
No. of Incidents	48	78	114	88

Analysis

I have included three months actual versus planned staffing data to allow comparison. From February 2016 to April 2016 there has been a slight decrease in percentage in total numbers across the Trust of registered nurses actual numbers to planned numbers in the day from 94% to 91% and at night for the same period from 99% to 96%.

For the two areas most challenged by vacancies the acute floor CATT and AMU and the frail elderly floor Byland and Jervaulx there has been a corresponding slight month by month decrease in the number of registered nurses (actual) on duty as opposed to planned. The reduction in registered nurses is mitigated by moving registered nurses from their normal places of work and an increased number of care support workers on duty.

	February 2016		March 2016		April 2016	
Wards	RN Day	RN Night	RN Day	RN Night	RN Day	RN Night
CATT	96%	120%	92%	120%	92%	114%
AMU	94%	101%	92%	96%	91%	93%
Byland	87%	88%	85%	79%	84%	77%
Jervaulx	87%	83%	82%	87%	78%	78%

There has been increase in reported workload/staffing incidents reported in the last two quarters of 2015/16. Further work is required to determine if the reduction in planned numbers of staff resulted in actual harm to patients.

As I have previously reported when there is a reduction in the planned numbers of registered nurses required which results in moving nurses from their normal areas of work there is an increased risk to patient safety. Our staff has increased the reporting of workload staffing incidents on Datix and this is an indication of the pressure they are feeling on a day to day basis and they have discussed their concerns with me. After careful consideration I continue to believe we provide safe and effective care to our patients. The metrics we observe as proxy indicators for quality care continue to improve and the number of formal complaints have decreased this year. However the risk to patient safety and staff concern should continue to be noted.

Children's Safeguarding

The purpose of this section of my paper is to assure the Board how Harrogate and District NHS Foundation Trust (HDFT) continues to meet its statutory duty for the safeguarding of children following the acquisition of the 0 – 19 Children's Services for County Durham, Darlington and Middlesbrough.

Fulfilling Safeguarding Responsibilities

HDFT operate a robust and established governance structure that provides internal and external assurance that safeguarding practice is evidence based, safe, current, and the child is central to practice. HDFT fulfils its safeguarding responsibilities through strong corporate leadership underpinned by clear policies and procedures and strong governance arrangements. Implementation is supported by a North Yorkshire County Wide safeguarding children team (SCT), clinical supervision from line managers and ultimate responsibility resting with front line staff to ensure the protection and safeguarding of children and young people (CYP).

The Trust's Chief Nurse has the executive responsibility for Safeguarding Children and is a member of the North Yorkshire Safeguarding Children Board alongside Dr Natalie Lyth, Clinical Director, who is also a Designated Doctor for Safeguarding Children in North Yorkshire.

The Trust has been invited to be a member of the County Durham Safeguarding Children Board and is anticipating invitations form the two other Boards.

HDFT Safeguarding Children Team (SCT)

The SCT has a range of responsibilities, including the provision of advice and support to any employee or volunteer who has a concern about the welfare of a child. To ensure consistency of the quality of advice, training and supervision provided the SCT;

- Leads on the provision of Reflective Safeguarding Supervision and the associated policies; Supervision and Child Protection;
- Provides 'in house' training for all employees and volunteers;
- Supports the development and delivery of the DSCB multi-agency training strategy; and
- Supports and promotes interagency working and effective communication with children's social care and early intervention service by building relationships with partner agencies to safeguard the welfare of children.

HDFT's suite of policies and procedures listed below are accessible via the Trust intranet to support staff in fulfilling their safeguarding responsibilities. These provide structure and guidance for staff and ensure they are confident and competent in dealing with any safeguarding concerns.

- Child Protection Policy
- Community Supervision Policy
- Escalation Procedure
- Child Protection Training Strategy

Policies are reviewed every three years or sooner if there has been any change in practice and will be aligned with the Safeguarding Children Board policies and procedures of County Durham, Darlington and Middlesbrough.

Caseload and Safeguarding Supervision

Consistent, high quality supervision is the cornerstone of the Trust approach to the effective safeguarding of children and young people to ensure that supervision operates effectively at all levels within the organisation to promote a confident and resilient workforce.

Staff ensure every CYP has an up to date holistic assessment which is used to identify any additional health need and to ascertain whether a child is at risk of harm.

HDFT use supervision to reduce the level of professional stress and anxiety that can be associated with

practitioners. HDFT ensures staff have access to and receive support from colleagues, Team Leaders, Professional Leads and the Safeguarding Children Team, who possess the skills to facilitate and support decision-making and care interventions. This will ensure the promotion of CYP well-being and safety. The Trust deploys its Peer Reflective Supervision model, which is facilitated by Band 6 (or above) practitioners with a minimum of two years' experience of involvement in child protection processes. Each peer Supervisor has experience of supervision, either as a supervisor or a supervisee. They are committed to the supervision process as a means of enhancing practice and sharing learning. This model has been in place in the Trusts existing services since 2003.

We will continue to ensure our staff including those in County Durham, Darlington and Middlesbrough will receive excellent education, support and supervision.

Governance

The key function of HDFTs Safeguarding Children Governance Group (SCGG) is the robust and safe management of services from the perspective of Safeguarding Children.

Membership comprises of;

- Chief Nurse
- Head of Midwifery
- Head of Children's Public Health Nursing
- The Named Safeguarding Children Professionals
- Safeguarding Leads from each clinical directorate
- Representatives from HR and Workforce Development.

The focus of the group is to maintain and ensure delivery of an action plan of all recommendations from

- Internal and external inspections
- Internal and external (Section 11) audits
- Serious case reviews
- Sudden untoward incidents with a safeguarding children element
- Any other sources that may require changes or actions by HDFT

The action plan is a live document, which provides evidence of progress and outlines how recommendations will be implemented.

The governance processes will extend to our new services.

Effective and efficient multi-agency working

Working seamlessly with multiple agencies and other stakeholders is key to the 'One Team' approach, placing the child at the centre. HDFT have a strong track record of

- Attendance at multi agency meetings including strategy meetings
- Initial Child Protection Conferences
- Core Group meetings
- Common Assessment and Team around the Child planning meetings
- Working with multi-agency partners and contributing to multi-agency audits across 2 local authorities (including the section 11 audit).

There are occasions when a practitioner may disagree with decisions made by multi-agency partners and therefore HDFT have a clear escalation policy to implement in such occasions. This escalation policy is implemented to support staff, where appropriate, to respectfully challenge multi-agency partners to ensure that the risks to a child have been fully explored and an alternative viewpoint is sought.

We expect to build relationships to work effectively in County Durham, Darlington and Middlesbrough.

Ensuring the service is Section 11 compliant

HDFT have an obligation under the Children Act 2004 (S13) to comply with the completion of the North Yorkshire Safeguarding Children Board Section 11 audit (Children Act, 1989). By completion of the Section 11 Audit, the team ensure it discharges its responsibilities for the safeguarding of CYP. The Trust has a strong track record of completing and submitting the Section 11 Audit in the required timeframes and will maintain compliance with the Section 11 audits of County Durham, Darlington and Middlesbrough. HDFT will review the previous Section 11 Audits of County Durham, Darlington and Middlesbrough to ascertain if there are any outstanding actions that require attention during the implementation phase.

Risk

In North Yorkshire our 0 -5 and 5 -19 Children's Services already support the county's most vulnerable children. There are 470 children on Child Protection Plans and 842 Looked after Children. In our new services there are:

Child Protection Plans

- Durham 354
- Darlington 86 (at last annual report 2015)
- Middlesbrough 237

Looked after Children

- Durham 772
- Darlington 215
- Middlesbrough 389

Next Steps

To appoint to the Head of Children's Safeguarding post.

Jill Foster
Chief Nurse
May 2016

Harrogate and District NHS
NHS Foundation Trust

Report to the Trust Board of Directors: 25 May 2016	**Paper No: 11.1**
Title	Patient Experience and Incident Report Quarter 4 2015/16
Sponsoring Director	Jill Foster, Chief Nurse
Author(s)	Andrea Leng, Head of Risk Management
Report Purpose	To provide a summary of information for Patient Experience 2015/16

Key Issues for Board Focus:

1. To **note** the Trust is participating in a number of national and local surveys. Of particular interest is the local bereavement survey indicating End of Life Care is of a good standard.
2. To **recognise** there has been almost a 20% reduction in the number of formal complaints 2015/16. However the response to agreed deadline remains below standard and the number of actions completed to deadline is poor.
3. To **understand** the Trust has improved the position regarding out of date patient information on the Trust Internet. However out of 586 documents 96 remain beyond review date.
4. To **note** the information regarding incidents and SIRI's will part of the Trust Patient Safety report in 2016/17

Related Trust Objectives:

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

Risk and Assurance	No significant issues of concern
Legal implications/ Regulatory Requirements	No additional risks

Action Required by the Board of Directors

- To **note** the Trust is participating in a number of national and local surveys.
- To **recognise** there has been almost a 20% reduction in the number of formal complaints 2015/16 however other key complaint metrics are poor.
- To **understand** work remains ongoing to improve the position regarding out of date patient information on the Trust Internet.
- To **note** the information regarding incidents and SIRI's will part of the Trust Patient Safety report in 2016/17

Patient Experience and Incident Report

Quarter 4

2015/2016

Contents

1. Patient and Public Involvement (Including FFT)

Since 1 April 2015, 27 patient surveys have been registered with the Clinical Effectiveness Team as follows:

Survey Title	Directorate	Specialty	Expected completion date	Project Status	Additional Information	E&D questions included?
Annual plan						
National CQUIN – Dementia supporting carers	Integrated Care	Elderly Medicine	29/04/2016	Complete	4x quarterly reports completed in line with CQUIN requirements.	No
Bereavement Survey	Urgent, Community & Cancer Care	Palliative Nursing	First quarter 29/02/2016	Complete	An initial report for the first 3 months of responses was produced for the End of Life Steering Group. This is an ongoing survey and a further report will be produced during 16/17 (timescale dependent on numbers of responses received).	Age, gender, ethnicity, religion
Pain Management	Trust wide	Acute Pain team	31/03/2016	Complete	This was a clinical audit which had a small patient survey component.	No
Parkinson's survey	Integrated Care	Neurology	31/03/2016	Complete		No
Colposcopy Patient Satisfaction Survey	Elective Care	Women's Unit/Gynae	31/12/2015	Complete	Annual survey previously dealt with by Quality Assurance Reference Centre (NHS Cancer Screening Programmes) but now Trust responsibility.	No
Ad-hoc projects						
SCBU parent satisfaction survey 2015	Elective Care	SCBU	continuous	Data collection Feb 2016 forwards	Regular rolling survey	No
Community Stroke Patient Survey	Integrated Care	Community Stroke team	31/12/2015	Complete		No

Survey Title	Directorate	Specialty	Expected completion date	Project Status	Additional Information	E&D questions included?
Diabetic Control in Inpatients	Integrated Care	Diabetes	16/03/2016	Unknown	Update requested from Junior Doctor.	No
Patient Feedback regarding Clinical Psychology input into Cancer Services	Urgent, Community & Cancer Care	Clinical Psychologist	Revised date of 31/08/2016	Data collection	This project was delayed due to the project lead leaving the Trust, and there were capacity issues within the team for anybody else to take this work forward. The reason the team registered the project was to gather feedback regarding the quality of service patients feel they receive and suggestions for service improvement, therefore the impact of the delay is minimal.	Age & gender
Health Visitor Survey	Integrated Care	Health visiting	To be confirmed	Complete		No
Patient Satisfaction with MDU	Integrated Care	Dermatology	19/08/2015	Complete	Priority for Integrated Care	No
Chaperones in children's clinics: Parent and child survey	Elective Care	Paediatrics	31/12/2015	Data input	Update requested	No
Patient Survey on Information Sharing/Data Protection	Urgent, Community & Cancer Care	Information Governance	31/10/2015	Complete	IG Toolkit & standard contract requirement Assessing practice against NICE guidance CG138 & QS15	No
Breast cancer campaign survey	Urgent, Community & Cancer Care	Radiology	30/11/2015 Revised to 31/05/2016	Awaiting sign off	Data analysis complete - Draft report submitted to Alison Liddle for clinical interpretation	No

Survey Title	Directorate	Specialty	Expected completion date	Project Status	Additional Information	E&D questions included?
Let's Talk	Integrated Care	Cross specialty	31/10/2015	Complete	Let's Talk is a pilot project aimed at improving the communication between a patient, their family/ advocate and the hospital. A Quality Improvement Priority Report has been written by Integrated Care and submitted to the Quality Committee.	No
Patient Survey of Podiatry standards of quality of care and patient satisfaction following treatment	Urgent, Community and Cancer Care	Podiatry	30/10/2015	Postponed	Awaiting feedback from Podiatry on progress	No
Nutrition & Dietetics Patient Survey	Integrated Care	Nutrition and dietetics	To be confirmed	Data collection	Update requested	No
Harrogate Podiatry Nail Surgery Patient Survey	Urgent, Community and Cancer Care	Podiatry	28/02/2016	Data analysis	Update requested	No
Cancer services and Dermatology patient survey	Integrated Care	Dermatology	To be confirmed	Report writing - draft completed	Preliminary results are positive	No
Registered since the previous report						
Patient Survey Palliative Care Team	Urgent, Community and Cancer Care	Specialist Palliative Care	19/04/2016	Data Collection		Age, gender, disability, sexuality, religion, ethnicity
Patient satisfaction with PMB clinic	Elective Care	Obs and Gynae	31/05/2016	Data Collection		Age & gender

Survey Title	Directorate	Specialty	Expected completion date	Project Status	Additional Information	E&D questions included?
Living with pain team assessment clinic satisfaction survey (Harrogate and Skipton)	Elective Care	Chronic Pain	Not stated	Data Collection		Age & gender
7 Day Working Patient Survey	Elective Care / Trust wide	Management	31/05/2016	Design		Age & gender
Upper GI Cancer Patient Survey	Urgent, Community and Cancer Care	Cancer Services	21/03/2016	Complete		No *(This survey was registered retrospectively and had already been sent out to patients before the Clinical Effectiveness team was aware of it).*
Physiotherapy respiratory team patient feedback questionnaire	Elective Care	Physiotherapy	Not stated	unknown		Unknown
Community Heart Failure Patient Survey	Integrated Care	Community Virtual Wards	27/05/2016	Data Collection		Age, gender and disability
Hydroxycarbamide Telephone Clinic - Patient Satisfaction Survey 2016	Urgent, Community and Cancer Care	Pharmacy	31/07/2016	unknown		Unknown

A total of 27 patient surveys were registered with the Clinical Effectiveness team during 2015/16. Of these, 8 have been registered since the agreement to use equality monitoring questions in all local surveys (December 2015). As can be seen from the table above, 7 patient surveys are currently known to include one or more of the agreed questions (most commonly age and gender). For 2 surveys, the team has only received a survey registration form so it is not known whether the E&D questions have been included or what stage the survey is at. For some areas, concern was raised by the clinical teams that due to the relatively small number of

patients discharged from the service, that some of the questions might make patients identifiable depending on their response (i.e. race, religion). This is particularly an issue when responses are being sent back directly to the service and will be analysed by those providing care to the patients. It has therefore been agreed to take a pragmatic approach and adjust the questions to be included depending on the survey and population if there is any concern about patient identification, to ensure that all responses remain anonymous.

The Clinical Effectiveness Team will continue to ensure appropriate equality monitoring questions are included in new surveys moving forward and will report results back to the Equality & Diversity Group in due course.

Recent Survey Results

Bereavement Survey Baseline Report

The results of the initial 10 returns for the local bereavement survey are mainly positive, with a small improvement against the 2013 results in some areas. There are a few areas where relatives felt the care received could have been better, in particular dealing with pain relief and restlessness, noisy breathing, and the emotional/spiritual support provided to both the dying patient and their relative. The overall question, “In your opinion, were you adequately supported during his/her last two days of life?” has scored 100% in both 2013 and 2015, indicating that in general people are happy with the level of support being received. The plan is to continue with the local survey during 2016 to gain a larger sample size and richer understanding of the care we are providing in this area.

Examples of some of the comments received are as follows:

Dr Cath Siller and her team were exemplary - the support was second to none, given the hospital environment.

I couldn't fault the care and attention given to me and my family while my husband was in hospital and after his death. The support from the chaplaincy team was also excellent.

He died in Trinity Ward Ripon Hospice, the same place my mother died the year before. My mother's last week there was a wonderful week of fantastic caring for her and us, a week to say goodbye. My father treasured that week always. Hence when he realised that he didn't want to survive his stroke and asked to end his days in Trinity Ward, knowing it would be the best place ever for all of us and him. A week that will always be special in our hearts. The care was wonderful, as much or as little whatever we asked. I feel sorry for families that cannot have the last days like this.

Friends and Family Test (FFT)

The friends and family test has been implemented since April 2013 for inpatients and Emergency Department and October 2013 for Maternity Services. It has recently been implemented in Outpatients, Day Surgery and Community Services. The processes for collecting data vary depending on the service but involve paper questionnaires, volunteers and automated telephone calls.

There is some concern around the automated process. There are technical issues which are affecting the response rate, and the ability to produce reports for the staff to access and process the voice files. The process does not currently enable patients to respond whenever they attend an appointment as we limit the telephone contact to the first appointment and then every 2 months to minimise the intrusion some patients have reported. There are other methodologies available, and this is to be discussed further at the Learning from Patient Experience Group.

Inpatient Wards

Friends and Family Test Summary		Q1 Resp. Rate	Q1 FFT	Q2 Resp. Rate	Q2 FFT	Q3 Resp. Rate	Q3 FFT	Jan 2016	Feb 2016	Mar 2016	Q4 Resp Rate	Q4 FFT
Wards	Recommend (%)	56.69%	74	42.92%	70	47.01%	76	95	95	97	37.22%	75
	Not recommend (%)							1	1	1		
	FFT Score							73	73	79		
	Resp. Rate (%)							36%	38.28%	37.37%		
	Inputted Resp.							445	475	488		

Accident & Emergency

Friends and Family Test Summary		Q1 Resp. Rate	Q1 FFT	Q2 Resp. Rate	Q2 FFT	Q3 Resp. Rate	Q3 FFT	Jan 2016	Feb 2016	Mar 2016	Q4 Resp Rate	Q4 FFT
A&E	Recommend (%)	14.77%	60	15.14%	59	10.36%	62	90	91	92	14.09%	65
	Not recommend (%)							5	5	5		
	FFT Score							63	68	65		
	Resp. Rate %							12.85%	17.21%	12.56%		
	Inputted Resp.							292	364	307		

Outpatients

Friends and Family Test Summary		Q1	Q2	Q3	Jan-16	Feb-16	Mar-16	Q4
Outpatients	Total responses	9763	11097	7410	2797	3108	2633	8538
	No. recommend	9291	10466	6544	2682	2979	2528	8189
	% recommend	95.20%	94.31%	88.3%	95.9%	95.8%	96.0%	95.9%

Community Services

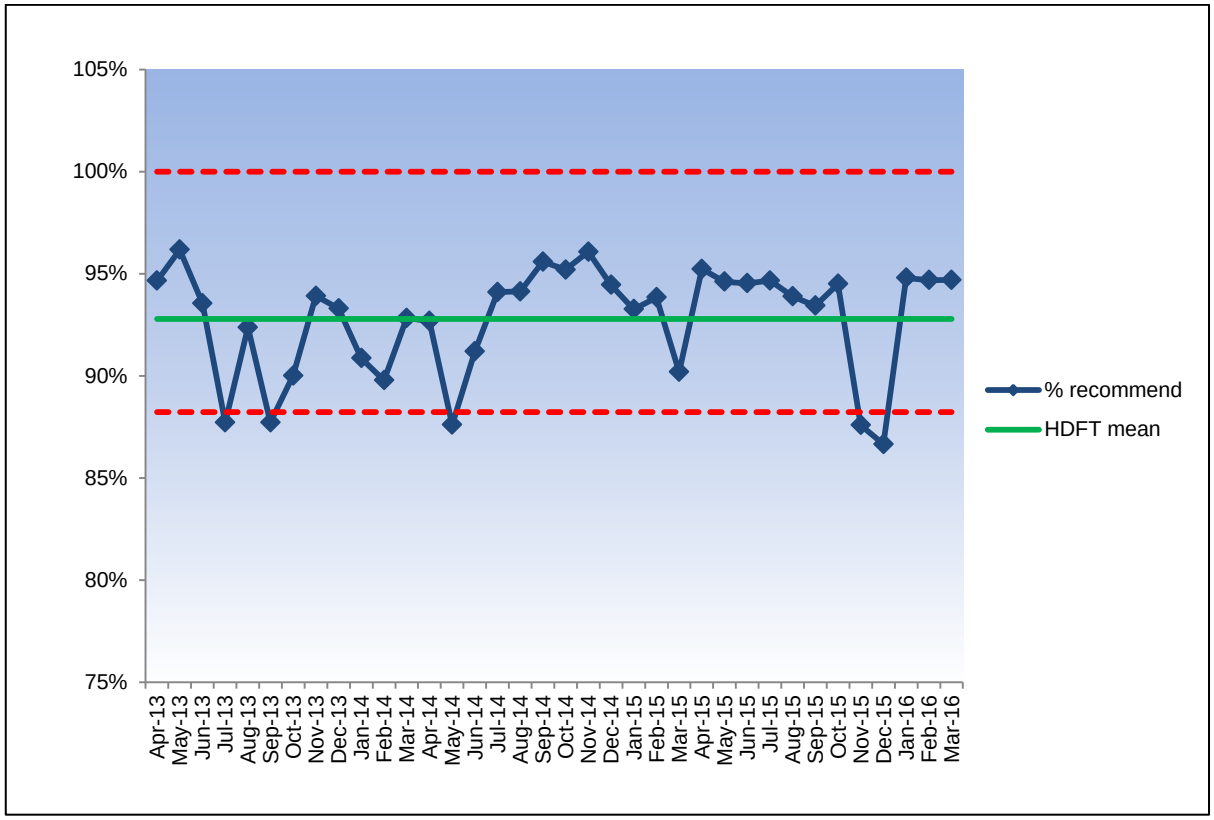
Friends and Family Test Summary		Q1	Q2	Q3	Jan-16	Feb-16	Mar-16	Q4
Community services	Total responses	2522	2887	2303	804	960	771	2535
	No. recommend	2345	2688	1996	760	914	714	2388
	% recommend	93.00%	93.11%	86.7%	94.5%	95.2%	92.6%	94.2%

Maternity

			2015/16					
		Q1	Q2	Q3	Jan-16	Feb-16	Mar-16	Q4
Maternity Services - Qu 1 - antenatal care (touch point 1)	Response rate	23.5%	19.4%	16.2%	25.0%	13.1%	23.6%	20.8%
	Score	82	77	85	88	62	88	83
	Recommend	98.3%	96.9%	97.6%	100.0%	95.2%	100.0%	99.0%
	Not Recommend	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Number of responses	120	96	84	43	21	41	105
Maternity Services - Qu 2 - birth (touch point 2)	Response rate	36.1%	29.1%	36.9%	29.6%	34.0%	48.5%	36.8%
	Score	87	89	91	85	90	91	89
	Recommend	98.8%	100.0%	99.5%	100.0%	98.0%	98.5%	98.8%
	Not Recommend	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Number of responses	168	127	185	48	50	65	163
Maternity Services - Qu 3 - care on postnatal ward (touch point 2)	Response rate	37.0%	25.7%	37.1%	30.2%	32.0%	50.0%	36.8%
	Score	82	74	81	80	74	90	82
	Recommend	98.3%	94.6%	98.4%	98.0%	95.7%	98.5%	97.5%
	Not Recommend	0.6%	1.8%	1.1%	2.0%	0.0%	0.0%	0.6%
	Number of responses	172	112	186	49	47	67	163
Maternity Services - Qu 4 - postnatal community provision (touch point 3)	Response rate	24.4%	16.3%	20.8%	82.9%	13.3%	23.3%	27.7%
	Score	96	96	98	100	85	93	94
	Recommend	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	Not Recommend	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Number of responses	81	55	64	29	13	28	70

Overall	Response rate	30.5%	22.9%	28.4%	31.8%	23.7%	35.8%	30.5%
	Score	86	83	87	87	79	90	86
	Recommend	98.7%	97.7%	98.8%	99.4%	96.9%	99.0%	98.6%
	Not Recommend	0.2%	0.5%	0.4%	0.6%	0.0%	0.0%	0.2%
	Number of responses	541	390	519	169	131	201	501

Overall



The chart shows the overall score (% who would recommend the service) for all HDFT services currently participating in the FFT survey. In March 94.7% of patients surveyed would recommend the service. The latest published national average for % recommend is 92.8%.

FFT Comments

Because of the care and because of the attention you give to patients it's like being at home - almost like it. I think the staff are very good here. The attention that staff give to patients is excellent. - written on behalf of Mr X - I think the staff are very good.

JE

Care was generally excellent although things were a bit vague and confused sometimes and it was quite hard to get a straight answer about pain relief / discharge etc.

FAR

I was first admitted to Harrogate hospital and then moved to Ripon which I liked very much. it is nicely decorated lovely soft colours, very clean, staff were pleasant and obliging enjoyed my stay at Ripon better than Harrogate food was good here also. The days are long and boring nothing to keep us occupied.

TR

Most of the tests carried out went wrong for various reasons. I feel no better than when I was admitted. I will not be a Patient at HDH ever again. Communication between staff is very poor.

LIT

Not all, but the majority of staff appear rushed and only interested in 'ticking boxes' showing little or no CARE for the patient.

GRA

I was made to do everything myself on the ward, I was forced to wear a boot whilst on the ward and when I didn't want to was told I needed to stop being naughty. The nurses can be both nice one minuite and not the next. I felt depressed whilst on the ward and when I came home.

TR

Patient Information

There is a process for developing new patient information leaflets that includes clear guidance about content, format and readability and this is evaluated by our volunteer lay reader panels. The lay readers are sent draft patient information leaflets and asked to review these against some specific standards and to return any comments and suggestions for improvement. The author is expected to consider the feedback and use this to develop the final draft, which is then quality assured by the clinical lead for patient information, Stephanie Davis, Matron in Emergency Department / Urgent Care.

The table below shows those leaflets that have been sent for reader testing and/or finally approved between 01/01/16 and 31/03/16.

Patient Information Leaflet	Author	Department	Date to reader panel	Approved
Welcome to the Early Pregnancy Assessment Unit	Mrs Allison Amin	Gynae	27/05/2015	29/01/2016
Information Regarding Disposal of Pregnancy Remains	Racheal Jones	Gynae	17/07/2015	29/01/2016
Information for patients about the GP OOH Service	Liz Eagin	Urgent Care	12/01/2016	29/01/2016
Information for patients and carers about Pressure Ulcers	Rachael Lee	Tissue Viability	25/11/2015	01/02/2016
Suspected Seizure Advice Sheet	Dr D Godden	Emergency Medicine	05/01/2015	08/02/2016
Wound care for the Surgical Orthopaedic Patients	Jemma Waddington	Orthopaedics	15/09/2014	09/02/2016
Pulled Elbow Advice Sheet	Cathy Finnerty	Emergency Medicine	04/01/2016	
Wound care after C-Section	Luke Wreglesworth	Maternity	04/01/2016	
Termination of Pregnancy for Fetal Anamoly	Allison Amin	Gynae	04/01/2016	
Cancer of the Unknown Primary (CUP) information for patients	Jess Thackwray	Cancer Services	04/01/2016	
Information for patients about Selby MIU, GP OOH Service and other services Inc. directions to York hospital.	Deborah Hibbert	Urgent Care	12/01/2016	
Information for patients about the GP OOH Service	Liz Eagin	Urgent Care	12/01/2016	29/01/2016
Information for patients about Cannulated Hip Screws: exercises and advice	Elizabeth Craven	Physiotherapy	25/01/2016	
Information for patients about total hip replacements following fracture: exercises and advice	Elizabeth Craven	Physiotherapy	25/01/2016	
Exercise after Hip Arthroscopy	Elizabeth Craven	Physiotherapy	25/01/2016	
Expressing your milk in pregnancy	Jo Orgles	Post natal	25/01/2016	
Information for patients undergoing a CT pulmonary angiogram in pregnancy	Dr Scullion / L Leatham	Radiology	25/01/2016	
Laparoscopic assisted Vaginal Hysterectomy	Allison Amin	Gynae	18/02/2016	
Information leaflet for Women who have had an inconclusive pregnancy scan	Allison Amin	Obstetrics	18/02/2016	

Expressing journal - for mothers with baby's on SCBU	Jo Orgles	Post natal	18/02/2016	
Information for patients about discharge lounge	Alison Scrimshaw	Discharge Planning	18/02/2016	
Living with COPD	Vera Davison	Therapy Services	18/02/2016	
Information for patients abour oral health and diet advice	Emma Bolland	Dental Services	10/03/2016	
Information for patients about oral health and diet advice during orthodontic treatment	Emma Bolland	Dental Services	10/03/2016	
Febrile Convulsions	Debbie Godden	Emergency Medicine	10/03/2016	
Having a YAG Laser Capsulotomy following Cataract Surgery	Dr Shindi	Ophthalmology	10/03/2016	
Post Op Knee Replacement Advice	Minu John	Physiotherapy	10/03/2016	

Once approved and uploaded it is the responsibility of the author to review their resource on the intranet to ensure that it is accurate and contains up to date information. On 22/04/16 there were 586 documents uploaded to the Information for Patients section of the intranet. Of the 586 documents, 96 are currently passed their review date. There are also 49 current documents with a review date longer than 2 years. This is against the recommended standard for written information.

The focus for ongoing work has recently been clarified and will include:

- Identification of the most common leaflets used across the Trust and a review of these to ensure they are of a consistent and high quality;
- Establishing a rolling programme to review patient information leaflets used within departments, to ensure they are up to date, meeting the Trust standards, that there is robust version control and archiving of previous versions, and that there is a process to seek patient feedback about the leaflets in use.
- Work towards meeting Accessible Information Standards set by NHS England

2. NHS Choices, Patient Opinion

NHS Choices

Harrogate District Hospital – Based on 79 ratings

25% of reviews left in Q3 were positive and 75% were negative. This was based on 8 reviews

Ripon Community Hospital –Based on 24 ratings

100% of reviews left in Q3 were positive. This was based on 1 review.

(HDH) I have been seen in the eye clinic for over a year at regular intervals and have never seen the same member of medical staff twice. The attitude has been laissez-faire despite it being about my vision. Whilst individual medical staff have adhered to policy and introduced themselves by name it has not been clear what grade they are. The lack of consistency in staff has led to repetition in giving a history and a number of different explanations of my condition resulting in my feeling an overall lack of confidence. After the first 5 consultations I left a complaint in the box at reception with contact details but did not hear back from the hospital. As an NHS employee myself I have felt very disappointed by the service offered in the ophthalmology department.

Visited in January 2016. Posted on 04 January 2016

(RCH) We had to visit the minor injuries unit yesterday because our daughter has a perforated ear drum and we could see it had an infection. The staff were extremely caring and we were seen, diagnosed and dispensed with ear drops within 10 minutes of arriving. We couldn't have asked for a more efficient and thorough examination.

Visited in January 2016. Posted on 31 January 2016

(HDH) I would like to thank the consultant and nurses in the well women unit ,for their help and support on the day of appointment and also telephone support and reassurance before. As I have post-traumatic stress from childhood and birth trauma any hospital appointment is stressful especially gynaecological. I was made to feel completely comfortable and reassured. I thankfully didn't need biopsy and hysteroscopy which I had prepared myself for but the consultant reassured me that my symptoms didn't warrant the risks of tests and I came away with peace of mind but the understanding if my symptoms become worse I can go back through GP referral. I wouldn't hesitate to have tests done in this clinic as I felt complete trust in the consultant, Drs and nurses and for me that made all the difference.

Visited in March 2016. Posted on 02 March 2016

Patient Opinion

I took my 13 year old son to Harrogate A&E for an x-ray as we were advised to by Ripon Minor Injuries because of a accident during PE and both school and Ripon MI thought he had broken his wrist (Ripon x-ray department closes at 4pm) We were given all relevant paper work and triage information and told we should be taken straight through to x-ray when we got there..... How wrong we all were. I arrived there with a visibly upset child with his arm in a sling and in a lot of pain. The receptionist refused to take the paperwork and also refused to check the computer for the information Ripon had sent across and informed us we would have to wait and go through triage again completely u-caring to the fact that my son was heaving and retching from pain! We were finally seen after over 50min and informed it looks broken and needs x-raying! We were made to wait another 40 (still no pain relief) and finally x-rayed. We then saw a very young and flustered looking doctor who said yes it was broken and needed a cast putting on it. He then proceeded to ask why we went through triage again as all the information was on the computer from Ripon!!!!! We were then sent with a very scruffy looking person to get the plaster put on and they did a terrible job. No care that my son was crying in pain they slapped some cotton wool on there followed by the plaster. My son said it was too tight several times and this was met with sighs and "it'll be fine". We were then sent home. The following morning my son's fingers had gone purple and we went back to Ripon MI where the cast had to be removed and redone properly. I would not send a dog to Harrogate A&E!!!! Never again!

February 2016

I had a longstanding appointment (I year) changed twice. The second time the doctor I should see was also changed without any explanation. I couldn't find any information about the new doctor on the hospital website so I phoned the appointment line to try and find out who they were what their job title was and where they were based. The appointment letter made no mention of this. The address on the appointment letter was the Medical and Dermatology Day Unit but my condition has no link with Dermatology so I was puzzled.

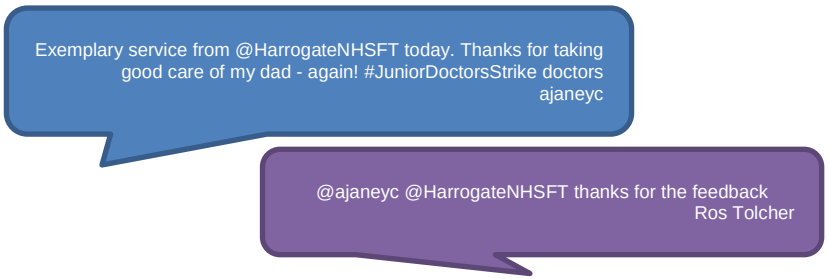
I phoned the appointment line on seve occasions. On three of those occasions ' please wait while we transfer you' led to the phone going dead. On one occasion I reached an automated line saying 'please say the name of the person you wish to contact - the option of staying on the line for other options again led to silence. On two occasions I should have been put through to the secretary number of the Haematology Dept. but after a few rings it sounded like a fax machine and I was not able to speak to anyone. On the final time of phoning the appointment line I was given the number of the department secretary so I could ring him or her myself. I tried on two further occasions to contact the department but again reached what sounded like a fax machine. Whether the department switches its phone over to fax to avoid answering the phone I do not know, but it is not a satisfactory state of affairs. For the record I phoned 10 times on 14 March 2016 at the following times to the appointment line 14:44; 14:45; 14:49; 14:54;14:56;14:58;15.01; and the following times to the Haematology Dept. 15.01;15:08; 15:31 but to no avail. I still do not know why the doctor I should see has been changed and I know absolutely nothing about the new doctor other than an initial and a surname. The letter did have a banner heading - 'You Matter Most' - Really? The Hospital's systems are not fit for purpose.

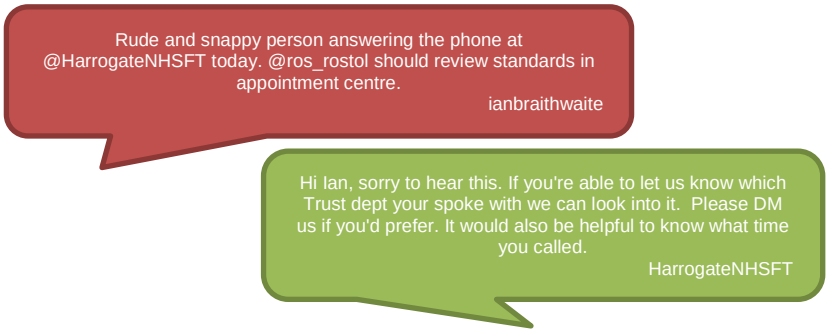
March 2016

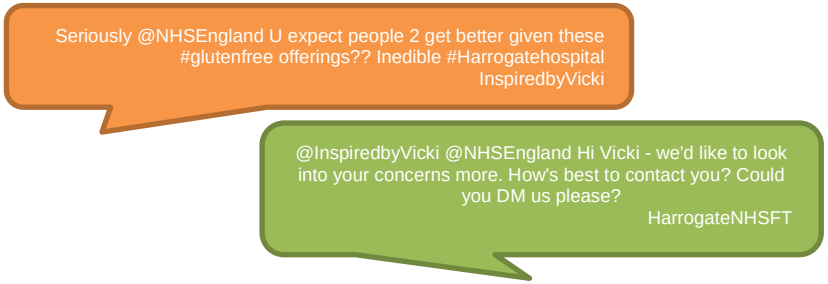
Social Networking sites

Social networking websites, primarily Facebook or Twitter, are regularly monitored for mentions of the Trust (and elements of the Trust, such as "Harrogate Hospital") by the Communications and Marketing team. Where appropriate, replies are made.

Similar to patient feedback websites, positive comments are shared with the appropriate team leaders for sharing with their teams. Negative comments are responded to by referring them to the Patient Experience team. Below are some examples demonstrating how positive and negative tweets have been responded to by the Communications and Marketing Team during quarter 4.





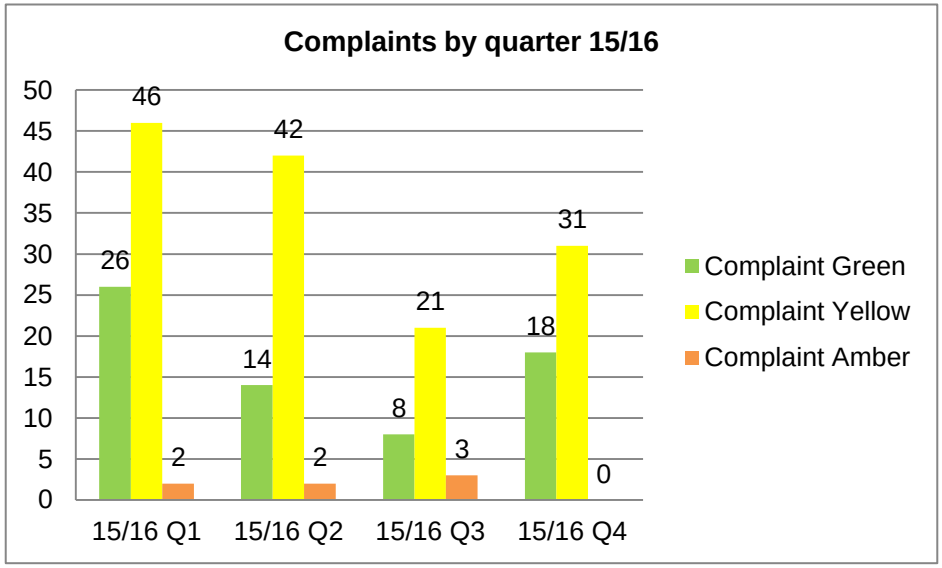


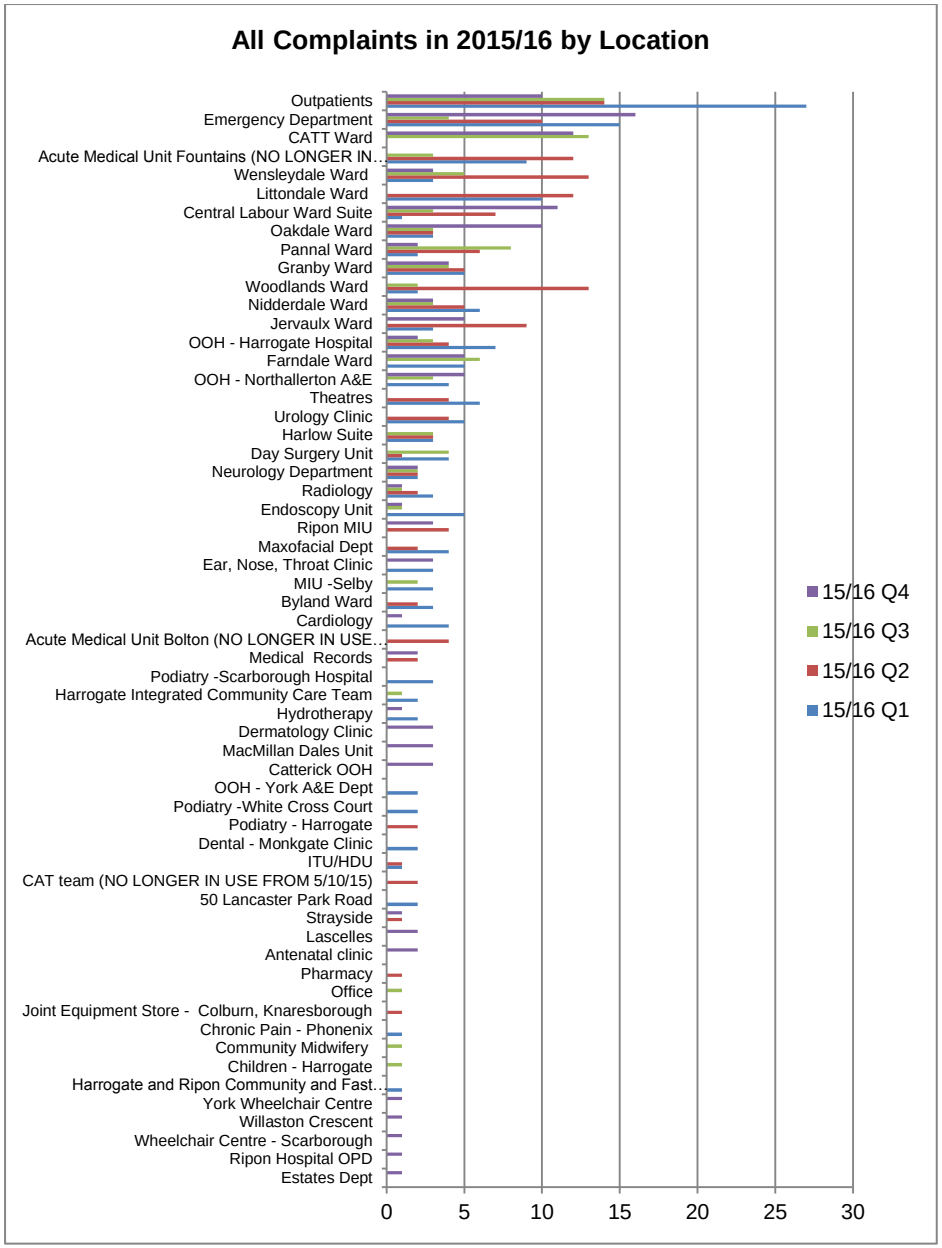
3. Complaints

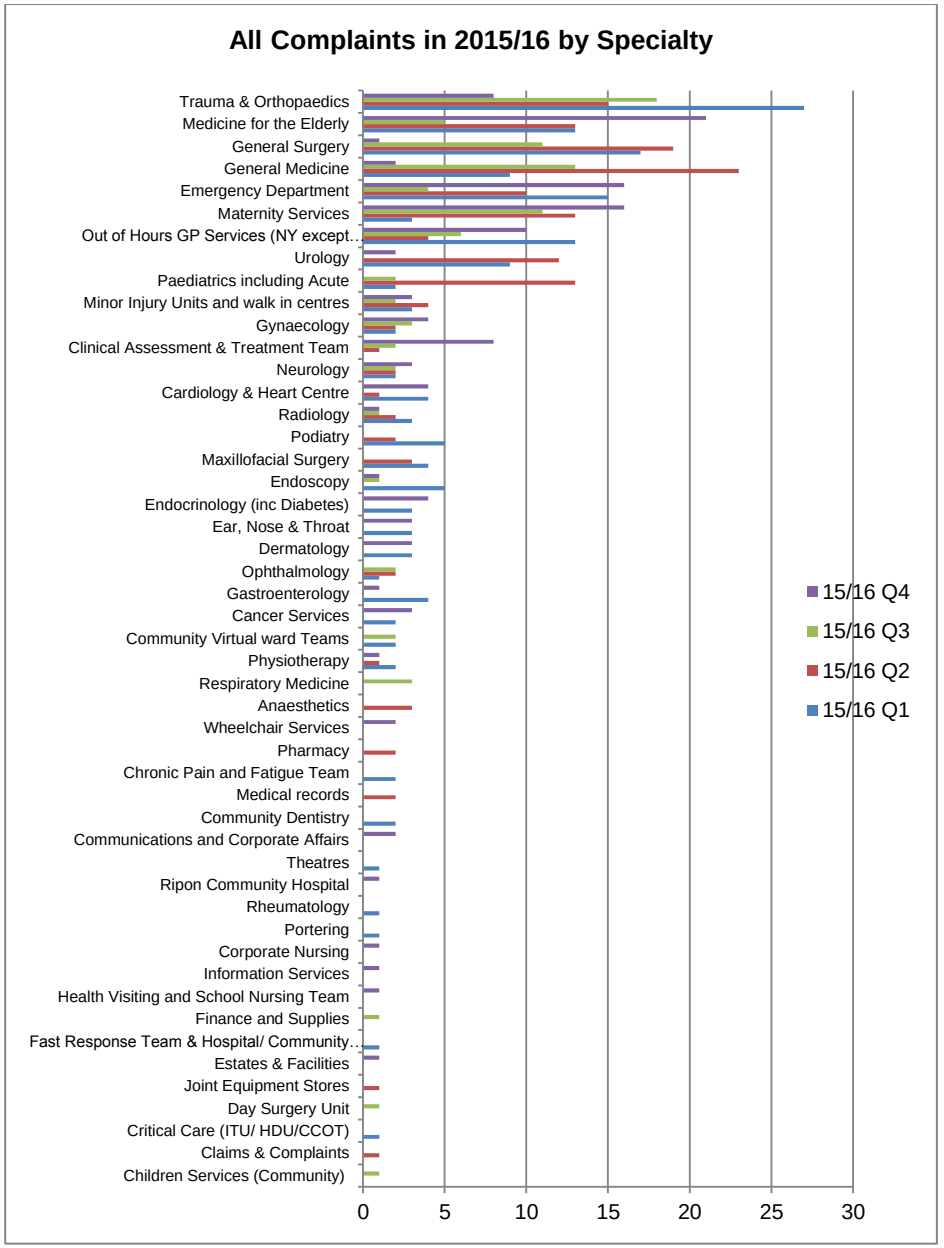
Quarter Data	15/16				
	Q1	Q2	Q3	Q4	Total
Total Number of formal complaints*	74	58	32	49	213
% responded to by deadline (target 95%**)	70%	31%	40%	67%	54%
% upheld	58%	76%	80%	67%	69%
Number returned for further local resolution	9	6	8	2	25
Number of new PHSO requests	2	1	1	1	5
Total informal requests (PALS contacts)***	159	201	168	148	676

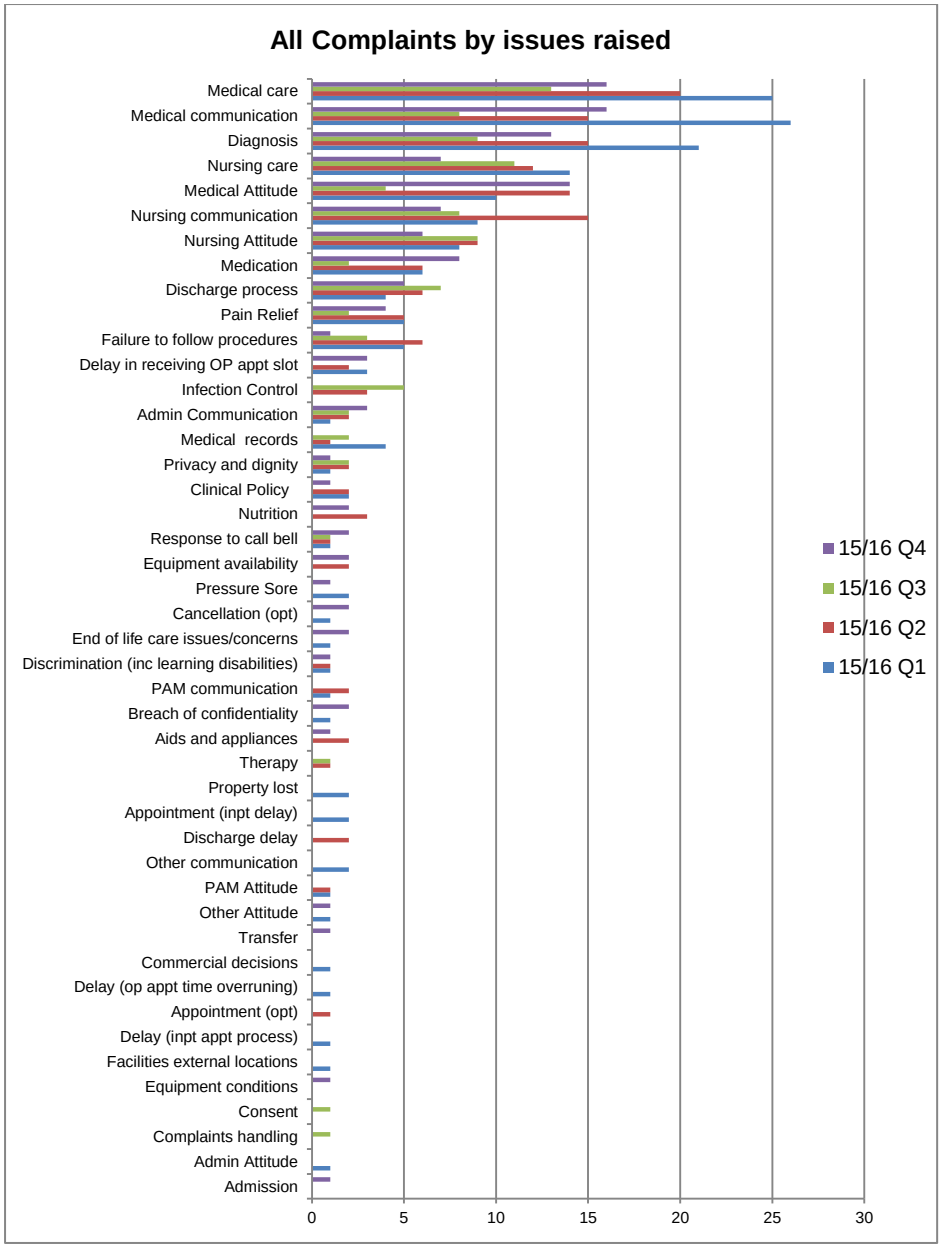
**Number of complaints compared with average of complaints received in previous year. (Green if below HDFT average for 2014/15, Amber if above HDFT average for 2014/15)*
*** of those deadlines reached at time of report. Target rate set in Jan 2016*
**** Our aim is to increase informal contacts and reduce complaints*

Year to Date Position	
Complaints received by PHSO (YTD)	5
Complaints investigated by PHSO as % of received by PHSO	80% (4 out of 5)
Complaints upheld by Ombudsman as % of received (nat av=48% at Q3)	33%
Number of complaint actions developed	434
% of actions completed within deadline (target 100%)	33%




All Complaints in 2015/16 by Location
Outpatients
Emergency Department
CATT Ward
Acute Medical Unit Fountains (NO LONGER IN…
Wensleydale Ward
Littondale Ward
Central Labour Ward Suite
Oakdale Ward
Pannal Ward
Granby Ward
Woodlands Ward
Nidderdale Ward
Jervaulx Ward
OOH - Harrogate Hospital
Farndale Ward
OOH - Northallerton A&E
Theatres
Urology Clinic
Harlow Suite
Day Surgery Unit
Neurology Department
Radiology
Endoscopy Unit
Ripon MIU
Maxofacial Dept
Ear, Nose, Throat Clinic
MIU -Selby
Byland Ward
Cardiology
Acute Medical Unit Bolton (NO LONGER IN USE…
Medical Records
Podiatry -Scarborough Hospital
Harrogate Integrated Community Care Team
Hydrotherapy
Dermatology Clinic
MacMillan Dales Unit
Catterick OOH
OOH - York A&E Dept
Podiatry -White Cross Court
Podiatry - Harrogate
Dental - Monkgate Clinic
ITU/HDU
CAT team (NO LONGER IN USE FROM 5/10/15)
50 Lancaster Park Road
Strayside
Lascelles
Antenatal clinic
Pharmacy
Office
Joint Equipment Store - Colburn, Knaresborough
Chronic Pain - Phonenix
Community Midwifery
Children - Harrogate
Harrogate and Ripon Community and Fast…
York Wheelchair Centre
Willaston Crescent
Wheelchair Centre - Scarborough
Ripon Hospital OPD
Estates Dept
0
5
10
15
20
25
30
15/16 Q4
15/16 Q3
15/16 Q2
15/16 Q1


All Complaints in 2015/16 by Specialty
Trauma & Orthopaedics
Medicine for the Elderly
General Surgery
General Medicine
Emergency Department
Maternity Services
Out of Hours GP Services (NY except…
Urology
Paediatrics including Acute
Minor Injury Units and walk in centres
Gynaecology
Clinical Assessment & Treatment Team
Neurology
Cardiology & Heart Centre
Radiology
Podiatry
Maxillofacial Surgery
Endoscopy
Endocrinology (inc Diabetes)
Ear, Nose & Throat
Dermatology
Ophthalmology
Gastroenterology
Cancer Services
Community Virtual ward Teams
Physiotherapy
Respiratory Medicine
Anaesthetics
Wheelchair Services
Pharmacy
Chronic Pain and Fatigue Team
Medical records
Community Dentistry
Communications and Corporate Affairs
Theatres
Ripon Community Hospital
Rheumatology
Portering
Corporate Nursing
Information Services
Health Visiting and School Nursing Team
Finance and Supplies
Fast Response Team & Hospital/ Community…
Estates & Facilities
Joint Equipment Stores
Day Surgery Unit
Critical Care (ITU/ HDU/CCOT)
Claims & Complaints
Children Services (Community)
0
5
10
15
20
25
30
15/16 Q4
15/16 Q3
15/16 Q2
15/16 Q1



1. Complaints- top 5 subjects (KO41a)	No
All aspects of clinical treatment	124
Attitude of staff	27
Communication/information to patients (written and oral)	20
Admissions, discharge and transfer arrangements	12
Personal records (including medical and/or complaints)	8

Table 1 illustrates the top 5 subjects for formal complaints under the national return categories KO41a year-to-date

Tables 2-6 highlight the sub subjects and the number of times they feature within each of those subjects eg 64 mentions of medical care within the 124 complaints categorised “all aspects of clinical treatment”.

2. All aspects of Clinical Treatment Q1-Q4	No
Medical care	64
Diagnosis	51
Nursing care	36
Medication	20
Pain Relief	13
Infection Control	6
Response to call bell	5
Nutrition	4
Pressure Sore	3
End of life care issues/concerns	2
Therapy	1

3. Attitude of staff Q1-Q4	No
Medical Attitude	20
Nursing Attitude	11
Other Attitude	1

4. Communication / Information to Patients Q1-Q4	No
Medical communication	14
Nursing communication	8
Admin communication	2
Other communication	1

5. Admissions, discharge & transfer arrangements Q1-Q4	No
Discharge process	12
Discharge delay	1

6. Failure to follow procedure Q1-Q4	No
Failure to follow procedures	6
Breach of confidentiality	2

Learning from Complaints

Example of a complaint responded to within this quarter (description and outcome graded yellow)

Patient unhappy that his outpatient appointment had been cancelled due to the new process of discharging a patient should they have failed to attend two appointments. He had previously not received a letter to advise him of a short notice appointment, therefore did not know he was due to attend. The next occasion he had to rearrange due to attending his Father's funeral; the previous appointment was also cancelled in error.

Actions
The Booking Team have received Refresher training to ensure that patients are contacted by both 1st class post and by telephone if an appointment is made within 7 days of an appointment. The importance of accurate working has been reiterated with the booking team to ensure the correct outcome of a cancelled appointment is recorded - in this case appointment cancelled by 'hospital' not 'patient'. From January 2016 specific letters have been made available for booking clerks to use when patients are discharged back to their GP's. This includes a letter to the patient and to the GP stating the reasons for discharge.

Parliamentary Health Service Ombudsman (PHSO)

Case	Issue	Incident Date	Area	Synopsis	Status
7073	Medical communication	14-Apr-14	Urology	Patient unhappy that following a cystoscopy he caught an infection and was admitted to HDU. Did not feel aware of the dangers with complicated medical history	Ombudsman Investigation Complete- Not Upheld
7718	Tongue tie diagnosis	09-Jan-15	Max Fax surgery	Patients parents unhappy with tongue tie diagnosis and procedure carried out	Ombudsman Investigation Complete-Partially Upheld
7588	Diagnosis via OoH	20-Jun-14	Joint complaint: Out of Hours GP / NHS 111	OoH GP prescribed over the phone rather than arranging visit	PHSO not Upheld
7907	Attitude of OOH GP	05-Apr-15	Out of Hours GP	OOH GP refused to do a home visit for a patient with a cough - felt attitude rude and dismissive	PHSO has requested copy of complaints file to assess whether to investigate
7280	Family believe inadequate care led to patient's death.	18-Jan-11	Elderly Care	Patient had a number of comorbidities and treatment was complex. Family believe inadequate care led to death.	PHSO advised of intention to investigate. Medical Director has reviewed the medical records and complaints file and written to the PHSO summarised case and to confirming no evidence of negligent care

Complaints and learning

Main Issue of Complaint	Action
Patient attended ED and felt that the doctor was rude and intimidating given she thought she was having a miscarriage. She felt he did not listen to her and after he had taken some bloods, he sent her back to the waiting area in ED. A second female doctor examined her and confirmed a miscarriage. The patient was upset at the uncaring attitude and misdiagnosis by the first doctor she had seen.	It was established that there had been a lack of emotional support for this patient and as a result the Matron for ED will share any patient information with EPAU to help patients who maybe attending with a miscarriage. ED will also link with EPAU to see if a referral for emotional support will be accepted. The feedback has also been shared at the Quality of Care meetings to ensure staff learn from the issues and ensure they are meeting a patient's needs. In addition it has also been discussed that staff will not allocate the paediatric cubicle (even when busy) to a patient who may be suffering a miscarriage.
This was a joint complaint which contained concerns about the care of the patient following discharge after giving birth. The patient experienced a traumatic birth & suffered continuous bleeding/exhaustion with a general feeling of malaise post discharge. She was eventually referred back to HDFT & underwent an emergency procedure to remove retained pregnancy products. The patient was concerned about the length of time she had to wait for her procedure and that she had to wait for 10 hours after her arrival for IV antibiotics due to 'disinterested' nurses on the ward.	The Matron addressed the issues with the nursing staff re lack of attention and stipulated that it is important that patients receive antibiotics in a timely manner. There was a lack of a debrief following the birth. The lead for obstetrics will ensure that medical staff undergo more training regarding debriefs and there will be a review if midwifery input into debriefing sessions.
Concerns were raised regarding the arrangements for discharging a 98 year old patient, who lived with and cared for her two disabled sons after the family had advised staff that the house was unhygienic due to one of the son's incontinence issues. They also requested that staff did not telephone the sons as they had difficulty reaching the phone. After being assured that that the family and the patient would have a meeting with staff to discuss all of their needs, the 'sons' received a phone call to say their mother would be discharged home later that day. Following urgent contact from the family the discharge was cancelled. The family were also concerned that they never knew who was looking after their relative on the ward and nobody seemed to be able to advise them when they asked.	Going forward Matron has ensured there is communication to the nurse in charge regarding discharge plans for all patients on the ward and that the Named Nurse caring for the patient is up to date with the patient's discharge plan. The Matron has also taken actions to ensure that any formal or informal discharge meetings go ahead with the patient and their family. To address the issue of families/carers not knowing who Named Nurse / Consultants were, the Matron has ensured that the boardsabove a patient's bed have both the name of the nurse and consultant who is caring for them displayed and also to ensure that the main staffing board has the first and last name of the nurse caring for what area of the ward.

Main Issue of Complaint	Action
Patient with a progressive disease felt he was not shown any compassion or care when he was admitted to hospital following a fall at home. He was unhappy with the toileting arrangements on the ward due to there being no raised toilet seat.	It was established that staff had attempted to assist the patient the best they could with his toileting but he did need a raised toilet seat which was not available. Staff should have raised this concern sooner with the management team and have now been advised that they need to raise such issues urgently rather than making do. The ward manager has also ensured that they now have a stock of raised toilet seats for patients to use.
Patient who attended ED with pain and distress due to kidney stones believed she was discharged inappropriately and that staff were rude with her telling her she was trespassing if she refused to go home. There was a lack of appropriate response to escalation that the patient was not happy to be discharged.	The General Manager will establish an agreement between ED, the Site Coordination Team and Manager on call to ensure who is responsible for the actions to be taken and establish a protocol when there is a patient, who is deemed medically fit for discharge but refuses to leave the department.

4. Concerns and Comments (positive suggestions for improvement)

	15/16 Q1	15/16 Q2	15/16 Q3	15/16 Q4	Total
Number of Concerns	80	107	92	94	370
Number of Comments	43	49	35	20	146
Number of Information Requests	36	45	41	34	156
Total Informal requests	159	201	168	144	672

Concern	Outcome
8588 Patient attended eye clinic - very unhappy with wait and no explanation of symptoms or diagnosis.	PET contacted Manager of Ophthalmology who arranged for the Sister to call the patient and ascertain her concerns. Patient advised PET that she was happy with the explanation and outcome.
8531 Patient contacted to say she was unhappy with outcome of her appointment with the Chronic Pain team and wanted to have a discussion with the Consultant.	It was identified that there had been numerous problems that staff had encountered with the patient and the consultant did not feel comfortable in telephoning the patient to discuss, which would be usual. Therefore PET facilitated a meeting with the consultant and patient and ensured that notes were taken. Patient was happy with the meeting.
8663 Patient contacted PET as she was still in pain following three episodes of hip surgery.	PET arranged for her to see the consultant who subsequently arranged an appointment for an injection under ultrasound to assist with the pain. Patient very pleased with the outcome.
8530 Breast Clinic patient who was very happy with all of her treatment called PET to say she was concerned that she had been contacted for a survey of her experience by landline. Patient was concerned as lived at home with her parents and did not want to cause them unnecessary worry so had not let them know she had been to hospital.	Following discussion with manager of the survey, PET arranged to have the patient's telephone number removed from the survey contacts list. Manager to look into the possibility of adding information on the appointment letter advising patients they will be contacted as the hospital is required to undertake the surveys.
8648 Patient unhappy that staff in the shop in main reception were joking around and one was telling the other one that they were 'special needs'! Patient felt this was highly inappropriate.	PET contacted the coordinator of the services who spoke directly with the manager to raise the concern and remind them of the environment. Manager apologised and the patient was kept informed of progress.
8628 Patient had a long wait in clinic for an outpatient appointment and was upset as could hear staff 'laughing and joking' behind the door. Patient's husband entered the room to express his frustration at the wait.	On investigation, there was an actual patient in the room who had just been given some bad news and the 'laughing and joking' had been between patient and staff during the long conversation that followed the diagnosis.

Concern	Outcome
8669 Patient contacted PET to tell them of their experience whilst on ward. They were upset that when they rang their bell for a nurse to empty their commode, the nurse who attended said she was not there to empty commodes and left it in the patient's room. Eventually a Health Care Support Worker attended and took the commode away for emptying.	The patient had been advised that the nurse had been spoken to and was satisfied with this but she wanted the issue logging.
8583 The son of an elderly patient who had been discharged from the physiotherapy team following a stroke was unhappy as they told him that physiotherapy would not be of any use to his mother due to the effect of the stroke. He had subsequently paid for her to have private treatment and they had helped to get her walk again. He wanted to know why she had been discharged as opposed to being put on a 'hold' list.	The manager of the service contacted the complainant and advised that his mum was declared not fit for physiotherapy at that time. It was not possible to put her on a hold list as there is a process via the GP for re-referral should an improvement occur. The complainant was satisfied and appreciated the explanation.
8624 Mother of 2 year old patient was unhappy with the attitude of the ED receptionist when she brought her child into ED with an asthma attack. She said he laughed when she told him her daughter could not breathe.	The Matron in ED discussed the issue with the staff member who apologised and acknowledged that he could have shown more compassion to the mother.

Comments/Requests/Suggestions	Outcome
Comment from endoscopy patient advising of the good treatment they had when attending for the procedure and that he was happy to have met the chaplains also for support. His suggestions were that dignity pants were not required as the procedure needed access anyway.	Positive comments and suggestion shared with all staff
Daughter concerned that her elderly father had been contacted to respond to questions regarding his recent visit to hospital when he had not been to hospital.	It was established he had used our community podiatry services and had not realised they came under the remit of HDFT.
Patient cancelled appointment in December 2015 and was concerned that rearranged appointment was scheduled for mid-February 2016.	PET arranged for her to be put onto a cancellation list.
Patient attended Day Surgery and was concerned about the information he had been given for his procedure being undertaken under a local anaesthetic as he was advised he should not drive home, therefore his son rearranged his work schedule to transport him. He was advised that he had just received a generic advice letter and he could drive home. This caused his son a great inconvenience.	The manager of the service wrote to all consultants to ask them to update their advice to their 'local anaesthetic patients' appropriately. She also advised the admissions office to do the same.

Comments/Requests/Suggestions	Outcome
Contact regarding the Therapy pool asking why there were no staff to supervise the pool to enable the classes to go ahead which benefitted patients with long term conditions.	It was acknowledged that there had been no cover - a new manager had now been appointed and was in the process of restarting classes for the pool.
Mother of 28 week old child who was not developing as expected called to say she was confused about future treatment and didn't know how to find out the information she required.	A meeting was arranged with the consultant to go through the information. Mum very happy and was able to make list for the father, who was in the army so unable to attend.
Patient wanted to know why he had to have another initial consultation with an orthopaedic consultant when he had chosen an NHS pathway as he had already seen the consultant privately.	There are strict rules to prevent patients having their initial consultation privately and then trying to 'jump' the queue when transferring to the NHS.
Contact regarding people smoking openly at the front entrance, even though there are signs stating smoking is not permitted	Passed through to Chief Nurse for information. Whilst staff are encouraged to challenge smokers, they cannot insist they stop smoking.
Concerns that the automated survey did not explain whether 1 or 10 was low/high when patients were asked to score on a scale of 1 - 10. Worried that staff would be getting wrong feedback	Contacted the team who addressed the issue immediately.

5. Compliments Received by Chief Executive / Chairman

	Q1	Q2	Q3	Q4
Total Number of Compliments	**85**	**94**	**73**	**88**

I recently moved to Yorkshire and have never been to hospital before – I wanted to feedback to you 'what a fabulous team!' Everything ran like clockwork, I moved from each section in the process with speed and efficiency, it was all so clean and what lovely people in the department, collectively smiley, reassuring and caring……today I met some truly caring people and realise I have nothing to fear.

February 2016

The Booking Team have received Refresher training to ensure that patients are contacted by both 1st class post and by telephone if an appointment is made within 7 days of an appointment. The importance of accurate working has been reiterated with the booking team to ensure the correct outcome of a cancelled appointment is recorded - in this case appointment cancelled by 'hospital' not 'patient'. From January 2016 specific letters have been made available for booking clerks to use when patient are discharged back to their GP's. this includes a letter to the patient and to the GP stating the reasons for discharge.

March 2016

The caring, helpful and professional attitude was second to none with the result that for the 1st time in over 50 years I can now see without glasses or lenses. Truly life changing.

Jan 2016

I wish not only to praise the treatment I received but the wonderful staff who implemented it to me……..From the young girl bringing round a welcome cup of tea to that wonderful consultant who acted so quickly and very professionally who in my opinion saved my life. Then I come to the angels on XX who went the extra mile with a cup of tea no matter the time. XX what a delightful and pleasant person with so much compassion and knowledge and a true nurse…..I am truly humbled by all of them, they are truly handpicked and brilliant people.

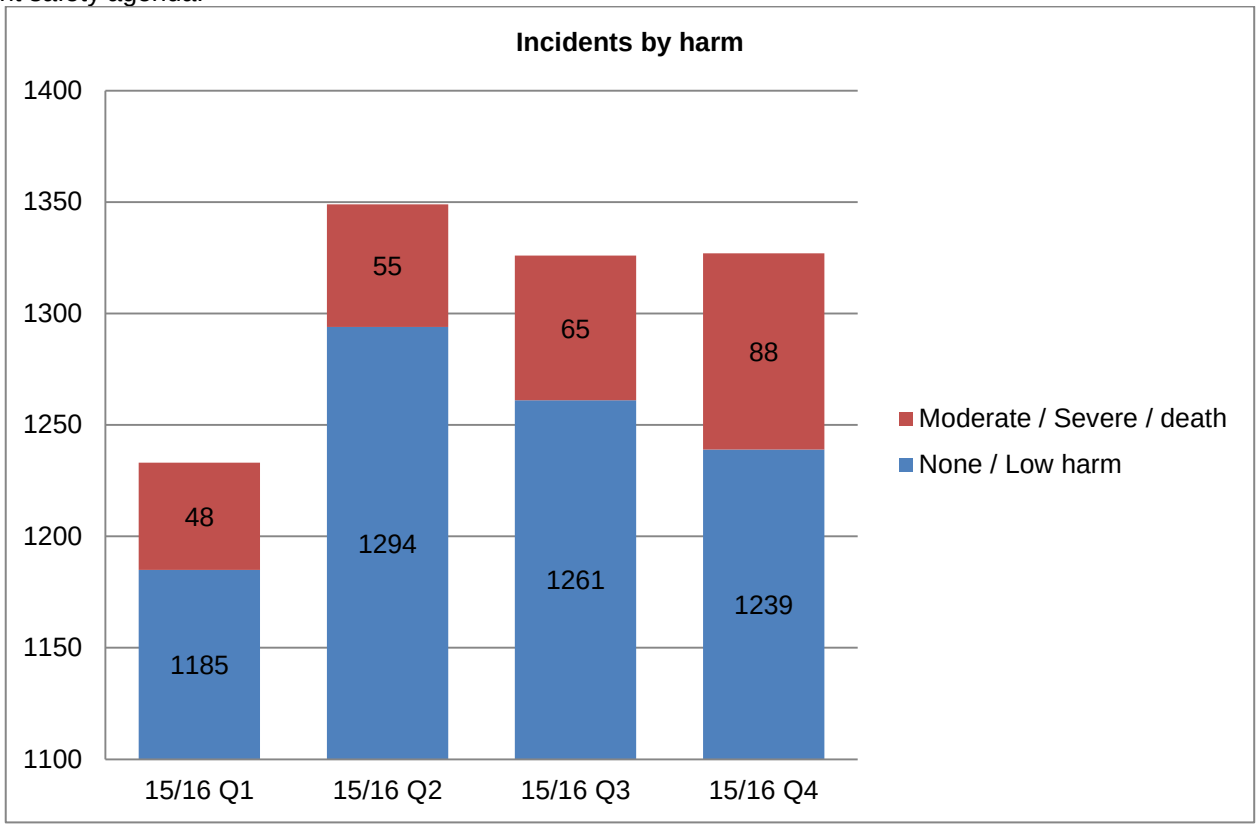
March 2016

I felt compelled to write to you to express my sincere thanks for the personalised care, expertise and support both my partner and I have received from every member of your team since my diagnosis last year. From the initial clinic visit, through both operations, community support and now into my oncology care there has been nothing but personalised professionalism displayed….people are too quick to criticise and forget to say thank you….I can hand on heart say that Harrogate is not only the happiest place to live in the UK but when the chips may be down a bit it is by far the best place to be if you find yourself if you need medical help.

January 2016

6. Incidents

This section details the numbers and themes of all incidents reported for the organisation in Q4. Key messages are highlighted with the purpose of exploring themes and trends to inform the patient safety agenda.



	2015/16 Q1	2015/16 Q2	2015/16 Q3	2015/16 Q4
Incidents reviewed at CORM	**347 (28.1%)**	**478 (36%)**	**580 (44.7%)**	**501 (37.8%)**
Incidents reported to the NRLS	**932 (75.6%)**	**990 (74.5%)**	**648 (50%)**	**977 (73.6%)**
Total incidents	**1233**	**1329**	**1299**	**1327**

Definitions of Severity:

- **Death** of the service user - where the death relates directly to the incident rather than the natural course of the service users illness or underlying condition, or severe harm or prolonged psychological harm to the service user
- **Severe harm** - means a permanent lessoning of bodily, sensory, motor, physiologic or intellectual functions, including removing the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the service users illness or underlying condition
- **Moderate harm** - means harm that requires a moderate increase in treatment, and significant, but not permanent, harm. This includes moderate increase in treatment such as an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment or transfer to another treatment areas (such as intensive care)
- **Low** – means minor injuries, minor treatment required as a result of incident

Serious Incidents Requiring Investigation (SIRI) & Significant Events (SE)

All serious incidents are discussed at CORM and any fulfilling the criteria for a SIRI or SE will trigger an investigation. All SIRI's are reported externally to the CCG and CQC via the NRLS system within 2 days of knowledge. Investigations are done using comprehensive root cause analysis (RCA) methodology and are conducted by an investigation team appointed by CORM. SE's are not reported to the CCG but will still be reported via the NRLS. These will be investigated by an appropriate clinician identified by CORM and may use the same RCA methods or a case review may be conducted.

The table on the next page provides a summary of the three comprehensive SIRI's verified as SIRIs in Q4, Please note we have also provided details of the Failed Resus SIRI from Q3 as the investigation had not been completed at the time of the last report:

SIRI details	Root Causes	Recommendations for learning / actions
Failed resus	The resuscitation team did not know each other's strengths and weaknesses prior to assigning key roles within the team.	• Training – increased awareness of Trust DNACPR policy and IPC policy, individual resuscitation refresher training needs identified, introduction of rhythm recognition test for all staff sitting CASTest, to be monitored on an ongoing basis. • Communication – ensure improved communication between those called to a resuscitation, to be aided by name badges confirming expertise of staff present. • Documentation – Trust resuscitation policy to be updated.
Undiagnosed breech water birth	The resuscitation team did not know each other's strengths and weaknesses prior to assigning key roles within the team.	• Change to practice and policy – to ensure no patient is allowed into birthing pool without first having had lie/presentation of baby determined and to ensure appropriate action taken in the event a breech birth is diagnosed in the pool. • Communication – ensure all staff know who is the Obstetric Consultant on call (baton bleep) and that where a paediatrician is called to an obstetric emergency they are permitted entry to the room. • Equipment – ensure resuscitaires are checked, available and ready to use (guideline or local SOP to cater for this). • Documentation – ensure full record of all handovers.
Glaucoma loss of peripheral vision	Two appointments following one patient episode (visual field testing and clinic follow-up-appointment) are booked in two different departments.	• Follow-up on a request to Silverlink to allow for patients being booked on more than one waiting list per patient episode. • Consider visual field testing to be arranged by medical records. • No paper forms to be transported between departments without back-up such as cash-up sheet. • Consider forming a working group looking into ways how all patients can be entered onto electronic system upon leaving department, either by being given follow-up appointment or by entering OWL. • Development of SOP regarding trust-wide outpatient appointment booking, how outpatient appointment waiting lists should be used, as well as how frequently they should be reviewed, need of named person with responsibility.

Breast cancer delay in diagnosis	Surgical trainee was making clinical decisions that were not monitored by senior staff	• Surgical trainee -Reflection and learning with Educational and Clinical supervisors & review of National Guidelines
		• Breast Team
		  ○ Review organisation of clinic to ensure pro-active supervision of trainees
		  ○ Review monitoring arrangements e.g. review of clinic letters, audit of process and outcome
		  ○ Provide written guidelines/aide memoires in clinic
		• Formalise local policy and guidelines to include which clinical decisions should be confirmed by consultant
		• Organisation:
		  ○ Review clinic workload to ensure adequate surgical manpower and radiology resources for patient throughput
		• Consider future integration of imaging facilities in Breast Clinic to improve patient flow and clinical communication

Action plans outstanding for Q1 SIRI's

Please note this data is based on verification date (ie when the incident has been verified as being a SIRI)

	Number of comprehensive SIRI's	Number of action plans complete	Number with outstanding actions	Number still within target date	Number overdue
Q1	**3**	**0**	**3**	**0**	**3***
Q2	**4**	**1**	**3**	**0**	**3***
Q3	**1**	**0**	**1**	**0**	**1**
Q4	**3**	**0**	**3**	**3**	**0**

	Number of concise SIRI's	Number of action plans complete	Number with outstanding actions	Number still within target date	Number overdue
Q1	**20**	**8**	**12**	**0**	**12**
Q2	**28**	**5**	**23**	**0**	**23**
Q3	**37**	**1**	**36**	**17**	**19**
Q4	**22**	**0** (17 remain under investigation)	**5**	**22**	**0**

Duty of Candour

Being open and honest with patients when things go wrong has been a fundamental principle in the NHS for a long time and part of the NHS Standards Contracts since April 2003. Since the introduction of the Health & Social Care Act (Duty of Candour 2014c) regulations, it is now mandatory to apply the Duty of Candour when any Notifiable Safety Incident is reported. This is defined as any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in a reasonable opinion of a health care professional, could result in, or appears to have resulted in moderate harm, severe harm or death (as defined on page 20) or prolonged psychological harm (which service user has experienced, or is likely to experience, for a continuous period of at least 28 days).

The following table demonstrates compliance for all incidents triggering the duty of candour requirements. This includes all Significant Events and SIRIs (Serious Incidents Requiring Investigation):

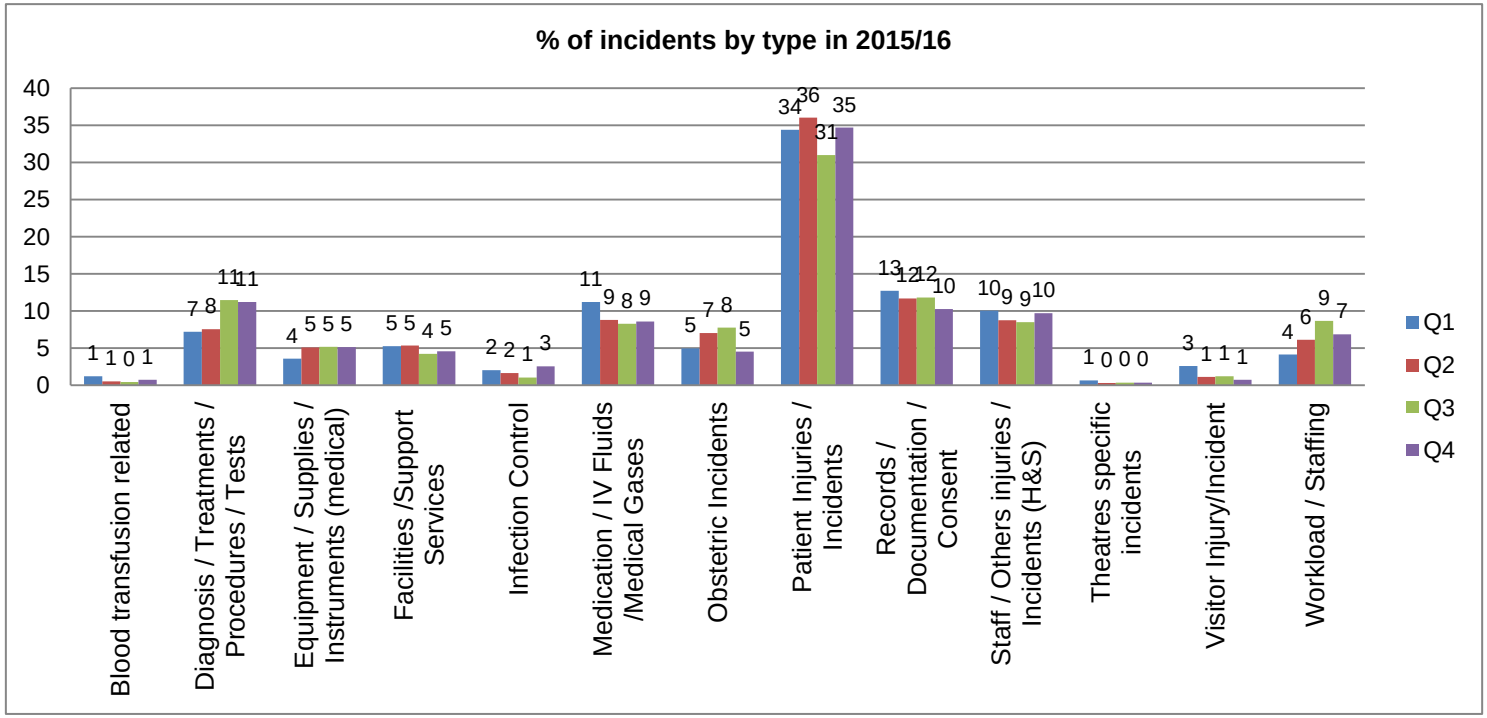
All incidents triggering DoC	Q1	Q2	Q3	Q4
Total Requiring DoC Application	**38**	**35**	**40**	**35****
Number with DoC applied	**36**	**32**	**38**	**34**
Not applied or Unclear evidence	**2**	**3***	**2**	**1**

*In two cases patient is deceased and family do not wish for DoC letter. IIn one case - no patient or Next of Kin/personal representative.
** There are a further five incidents on which confirmation regarding whether the duty of candour has been triggered remains outstanding and one incident where the DoC letter is not yet due. Please note that for Q4 the data relates to incidents reported in Q4. This will revert to data based on incident date for report for Q1 2016/2017.

This table demonstrates the numbers of SIRIs verified in 2015/2016 and reported to STEIS:

SIRI's	Q1	Q2	Q3	Q4
Comprehensive SIRI	**3**	**3**	**2**	**3**
Concise SIRI (Pressure Ulcer)	**15**	**25**	**33**	**18**
Concise SIRI (Fall)	**5**	**3**	**4**	**4**

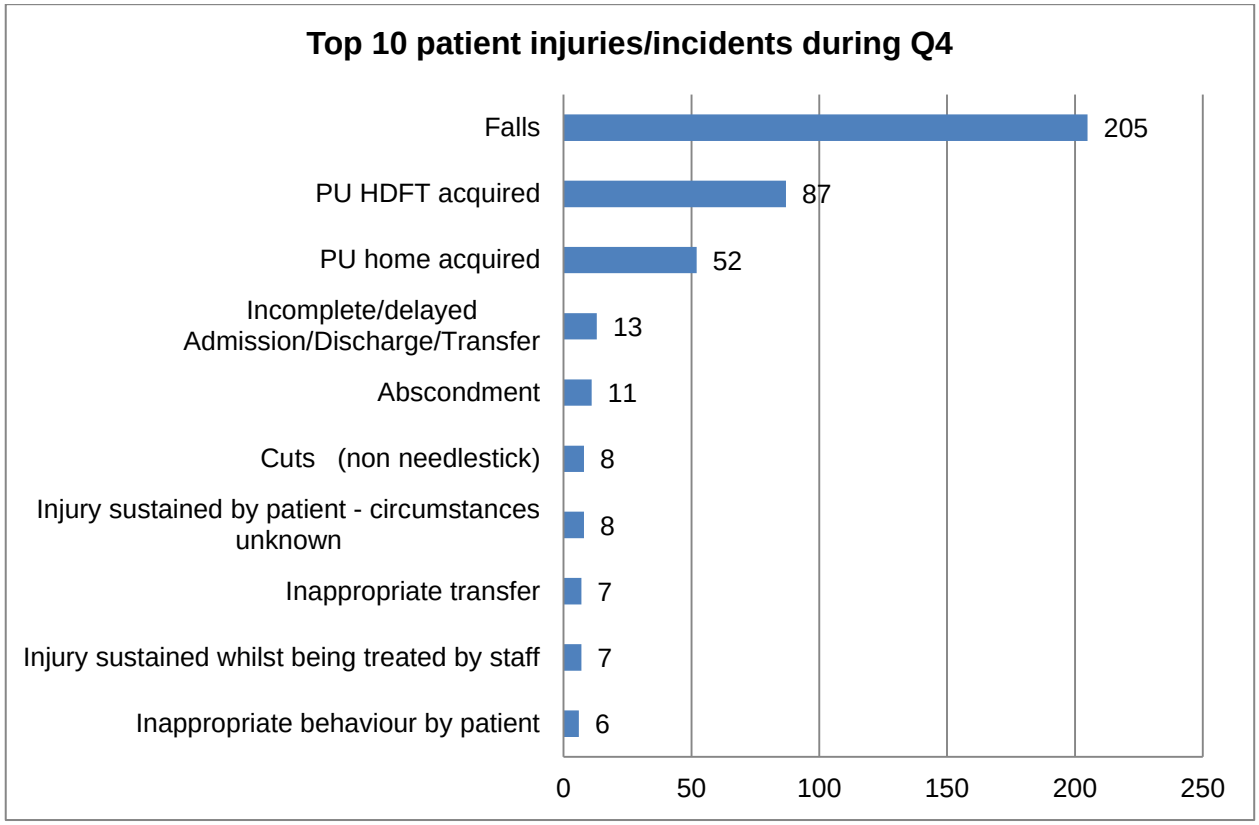
Types of incidents



The highest reported category in Q4 is patient injuries/incidents. This is a consistent theme across the previous year and reflects the high number of patient falls and HDFT acquired pressure ulcers as outlined below.

Learning from these incidents is reviewed by the pressure ulcer and falls steering groups respectively. All grade 3 or above pressure ulcers and fractures from falls are reported as SIRI's and undergo a root cause analysis investigation.

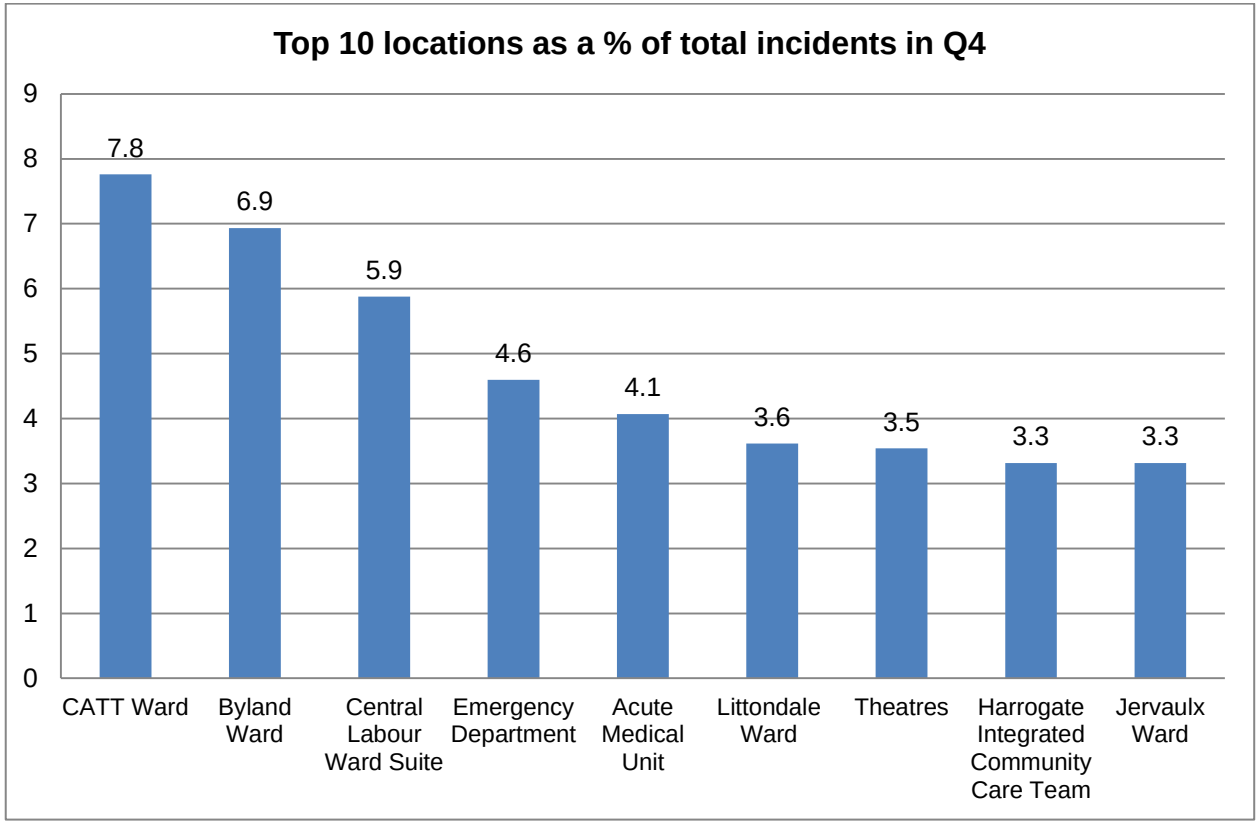
Other patient incident sub categories have tended to fluctuate per quarter but are small numbers compared with these two safety areas.


Top 10 patient injuries/incidents during Q4
Falls
205
PU HDFT acquired
87
PU home acquired
52
Incomplete/delayed Admission/Discharge/Transfer
13
Abscondment
11
Cuts (non needlestick)
8
Injury sustained by patient - circumstances unknown
8
Inappropriate transfer
7
Injury sustained whilst being treated by staff
7
Inappropriate behaviour by patient
6
0
50
100
150
200
250

Examples of top 5 incident types:

Incident Type		Detail	Actions / Learning
Records / Documentation / Consent	Incorrect labels in notes	Incorrect stickers and notes of two other patients, in a patient's notes from ward when arrived in theatre.	Stickers removed.
	Patient appointed to wrong clinic	Patient given dressing clinic appointment instead of fracture clinic with Consultant.	Patient sent for x-ray and had to await until Consultant returned from outreach clinic.
Staff / Other injuries	Bangs, Bumps, Slips, Trips & Falls	Student nurse fell over leaving a patient's house. Fell down steps going over on right ankle and banged back of head on wooden post.	Discussed with district nurse team leader. No apparent injuries. Datix completed.
	Burns and scalds	Staff member was holding a cup of boiling water when turning round she bumped into another staff member who received a scald to her right Radial area. She immediately ran her arm under cold running water for several minutes. Nurse in charge Sister applied jelonet dressing with a meopore dressing to cover. On reassessment of the dressing the area of skin had blistered.	Staff to be more vigilant with hot drinks. Appears to be a one off incident and difficult to prevent recurrence. Discussed incident with all staff.
Diagnosis / treatment / procedure / tests	Significant delay in obtaining treatment/test	Patient attended for Vac Pac dressing. Clinic not informed of patient attending therefore dressings not available, resulting in a delay in his care taking place.	Discussed with ward who discharged patient and asked if they can advise us when a patient requiring a Vac Pac dressing, so we can have appropriate dressing available and sufficient staff to accommodate this type of dressing.
	Incorrect treatment/test/ procedure/protocol	Glass blood culture bottles sent to clinical sciences via POD system. Blood cultures should never be sent via POD due to risk of breakage and contamination of POD.	Called ward and advised of incident, do not send glass blood culture bottles in POD.
Medication/ IV Fluids/ Medical Gases	Medication security issue	Drug check at the end of night shift revealed a discrepancy with the epidural bags containing Fentanyl 2mcg/ml and levobupicaine 1mg/ml (250ml bag)	Reported to morning theatre co-ordinator.
	Incorrect medication given on discharge	Patient A discharged by day staff. Husband rang ward as one box of trimethoprim given to them with another patient's name on. Noticed name just before administration, brought back to the ward. Belong to patient B in same bay.	Correct prescription checked to clarify medication, Sister informed. Nurse who discharged patient spoken to about incident. Stated oversight on her part and will review administration of medication policy and ensure that this incident does not happen again. Statement obtained from staff member and kept in staff file.

Reporting Locations



The table above demonstrates the areas with the highest reporting rate for Q4. Worthy of note is the significant increase in incidents reported on CATT Ward which has more than doubled from 3.7% in Q3 to 7.8% in Q4. AMU, on the other hand, has seen a significant reduction in incidents from 6.1% in Q3 to 4.1% in Q4.

Workload Staffing Incidents

WORKLOAD STAFFING Q1 (top 5)	Q1 - No	% of All WS	% of All incidents
Inadequate staff for workload	28	55%	2.30%
Communication Issue	11	22%	0.90%
External staff not available	5	10%	0.40%
Incorrect skill mix for workload	2	4%	0.20%
Inadequate training	2	4%	0.20%
Totals	**48**		**3.90%**

WORKLOAD STAFFING Q2 (top 5)	Q2 - No	% of All WS	% of All incidents
Inadequate Staff for workload	59	71%	4.40%
Communication issue	10	12%	0.80%
Medical Staff unable to attend	5	6%	0.40%
Incorrect Skill mix for workload	2	2%	0.20%
Medical staff do not respond to ward staff	2	2%	0.20%
Totals	**78**		**6%**

WORKLOAD STAFFING Q3 (top 5)	Q3 - No	% of All WS	% of All incidents
Inadequate staff for workload	96	83%	7.40%
Medical staff unable to attend	7	6%	0.50%
Incorrect skill mix for workload	4	3%	0.30%
External staff not available	4	3%	0.30%
Communication	3	2.50%	0.20%
Totals	**114**		**9%**

WORKLOAD STAFFING Q4 (top 5)	Q4 - No	% of All WS	% of All incidents
Inadequate Staff for workload	75	82%	5.70%
Communication issue	6	7%	0.50%
Incorrect Skill mix for workload	3	3%	0.20%
Unable to contact on call staff	2	2%	0.20%
Medical staff do not respond to ward staff	2	2.00%	0.20%
Totals:	**88**		**7%**

7. Appendix 1- Grading of Concerns and Complaints

Rating	Type	Description	Level of investigation	Internal Reporting	External Reporting	Response
1 White	**Concern**	Unsatisfactory service or issue easily resolved with simple action	**Line manager Matron**	QEG*		Within 2 days
2 Green *Low*	**Complaint** (*resolution plan in acknowledge letter & final response sign off by CE*)	Unsatisfactory service user experience related to care clinical or non-clinical, minimal impact. No risk of litigation.	**Directorate**	QEG & Q of C Teams Dashboard	Annual Korner return (Health and Social Care Information Centre (HSCIC))	Within 20 working days
3 Yellow *Moderate*		Unsatisfactory service user experience in several areas but not causing lasting problems. Some potential for litigation (if so refer to CORM).	**Directorate**	QEG & Q of C Teams CORM Dashboard	Annual Korner return (HSCIC)	Up to 30 working days
4 Amber *High*	**Complaint** (*resolution plan / terms of reference sent to complainant to agree & final response sign off by CE*)	Significant issues of standards, quality of care, safeguarding, with quality assurance or serious risk management issues that may cause lasting problems or death. Possibility of litigation and adverse local publicity (refer to CORM)	**Outwith Directorate involved** *(if Sui concise or comprehensive RCA with external input)*	QEG CORM Dashboard If SUI= Board	Annual Korner return (HSCIC) Consider SUI & CCG	Up to 60 working days
5 Red *Extreme*		Serious adverse incidents also raised as a complaint causing long-term damage or death such as criminal offence, gross substandard care or gross professional misconduct, multiple allegations of neglect resulting in serious harm or death.	**Outwith Directorate** Comprehensive RCA	QEG CORM Dashboard **Board**	Annual Korner return (HSCIC) **SUI & CCG** **Monitor**	Within 90 working days

*The Quality of Experience Group (QEG) has been superseded by the Learning from Patient Experience Steering Group. The Making Experiences Count Policy and the grading matrix of concerns and complaints (above) are due to be reviewed in light of these changes.

8. Appendix 2- Risk Grading Matrix

Harm vs Risk

Every incident is given a final risk grading based on the severity of harm (actual outcome for individual affected) and the potential risk of adverse consequences if it were to happen again. This is identified using the matrix below:

Likelihood of recurrence		Most likely consequences (if in doubt grade up, not down)				
		Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Almost certain	5 (E)					
Likely	4 (D)					
Possible	3 (C)					
Unlikely	2 (B)					
Rare	1 (A)					

RISK: Low Moderate High

Where there is doubt, the incident will be graded up. This means that, although an incident may have a low impact on an individual (no or low harm), if it is possible that it will reoccur and there is the potential for minor impact, that incident will be graded as a moderate risk incident. This is the main reason that directorates see an increase in the number of moderate graded incidents in comparison to their moderate harm incidents.

Report to the Trust Board of Directors: 25 May 2016	**Paper No: 11.2**

Title	Strategy for the Holistic Care of Older People with Frailty 2016-2021
Sponsoring Clinical Director	Dr Natalie Lyth, Clinical Director
Author(s)	Fiona Maher, Medical Specialities Services Manager Dr Natalie Lyth, Clinical Director
Report Purpose	To inform HDFT Board about the strategy for the holistic care of older people with frailty.

Key Issues for Board Focus:

1. Harrogate and District NHS Foundation Trust has the ambition to become a centre of excellence for caring for older people and to provide 'excellence every time in all the care we provide'. This strategy describes the areas that need focus to fully achieve this.
2. Each section of the strategy looks at why that area is important, what is already being delivered in that area and what we want to happen next.
3. This is a very comprehensive strategy and aims to have an impact on the care we provide to frail elderly people whenever they come into contact with HDFT services.

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

Risk and Assurance	
Legal implications/ Regulatory Requirements	None

Action Required by the Board of Directors
To be informed of the development of the strategy and to take regard of it as HDFT considers any new business.

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Harrogate and District NHS
NHS Foundation Trust

"Helping older people to live the life they want"

Our strategy for the holistic care of older people with frailty 2016-2021

Authors: Dr Natalie Lyth
Fiona Maher

Acknowledgements

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Contents

Introduction

Once there is general agreement for the format of the strategy, we will ask Dr Tolcher to kindly provide an introduction.

Background

Harrogate and District Foundation Trust (HDFT) has the ambition to become a Centre of Excellence for caring for older people and to provide 'excellence every time' in all the care we provide. This report provides our five year strategy for supporting older people with frailty: '"*Helping older people to live the life they want*".

There has been a rapid increase in life expectancy during the 20th century; just 100 years ago the average life expectancy at birth was less than 50 years. In England the average life expectancy at birth is now 79.4 years for men and 83.1 years for women. This is also expected to continue to increase in the foreseeable future and HDFT, in common with other NHS organisations, is experiencing the challenges caused by a rapidly increasing demand for it's services. There is a growing need to provide more treatment, to more patients with more complex care needs, in a financially challenged NHS. Here at HDFT, we echo Sir Robert Francis' thoughts:

"*Care needs to be as important as treatment. Older people should be valued and listened to and treated with compassion, dignity and respect at all times. They need to be cared for by skilled staff who are engaged, understand the particular needs of older people and have time to care.*"
'Hard Truths, the Journey to Putting Patients First', Government response to the Francis Report, November 2013.

National drivers such as the 'Five Year Forward View' advocate proactively targeting patients with complex ongoing needs such as older people with frailty, by working much more intensively with them. The current model of treatment, care and support for older people with frailty tends to be fragmented hospital bed-based treatment. There is strong evidence to suggest that a strategy for older people with frailty should be based on community based care with multi-disciplinary assessments. This could reduce hospital admissions, improve the timeliness of interventions, improve the flow through acute services and facilitate earlier discharges (Patterson, 2014).

HDFT, as one of the partners in the Vanguard programme, is contributing to new care models providing care in fundamentally different ways, making fuller use of digital technologies, new skills and roles and offering greater convenience for patients.

Evidence also indicates, treating frailty as a long-term condition is key to the future care of Britain's ageing population (Young, 2014). If frailty can be identified earlier, then with a focus on prevention and pro-active care in primary care, we could see a positive impact on quality of life.

Objectives

In June 2015, HDFT Board highlighted the need to develop a strategy for supporting older people with frailty. The project commenced with a review of the existing services available to older people with frailty from HDFT and describes how they can be developed. This strategy supports the strategic objectives of HDFT and will deliver our overarching ambition to be a Centre of Excellence for caring for older people wherever and whenever they cross our path.

Delivering High Quality Care

The care we deliver will:

- Be patient-centred and clinically safe
- Maintain patients respect and dignity
- Be provided by caring, competent and compassionate staff and that appropriate staffing levels are available to deliver the care that is needed
- Ensure needs are promptly identified and that patients are assessed and treated by the most appropriate person in the most appropriate place
- Include high quality end of life care
- Ensure we provide fair treatment and meet the needs of older people with any of the equalities protected characteristics e.g. ethnic origin, sexuality disability
- Ensure all decisions that are made fully involve the patient, their family and/or carers “No decision about me, without me”’ (Liberating the NHS).

Our services will:

- Have the flexibility to meet the needs of our patients and their family and/or carers e.g. time and length of appointment
- Ensure accessible and appropriate information that meets the needs of patients and their families and is readily available.

Our environments will:

- Be welcoming, appropriate and accessible for older people with frailty
- Be ‘age’ and ‘Dementia’ friendly.

Objectives (continued)

To Work With Partners to Deliver Integrated Care

The strategy includes the need to work with:-

- Primary care
- Community Pharmacists
- Local authority, Social care
- Housing
- Independent, voluntary and community sector agencies.

To Ensure Clinical and Financial Stability

The strategy includes:

- Offering care in the community where possible
- Discharge planning so when hospital admission is needed it is only for as long as is clinically necessary
- Taking advantage of available new technologies

What older people want from us

This strategy takes into account the views of our older people which include;

- I can take part in a range of activities and services that help me stay well and be part of a supportive community.
- I get the care and support I need in the most appropriate way and at the right time.
- When I am in hospital or longer term care it is because I need to be there. While I am there, I receive high quality care and I am discharged home when I am ready
- As a carer, I am supported in my caring role
- Living with dementia, I and my carers, receive good advice and support early on and I get the right help at the right time to live well
- I receive the information that I need when I need it
- I see health and social care services working well together.

What matters to us?

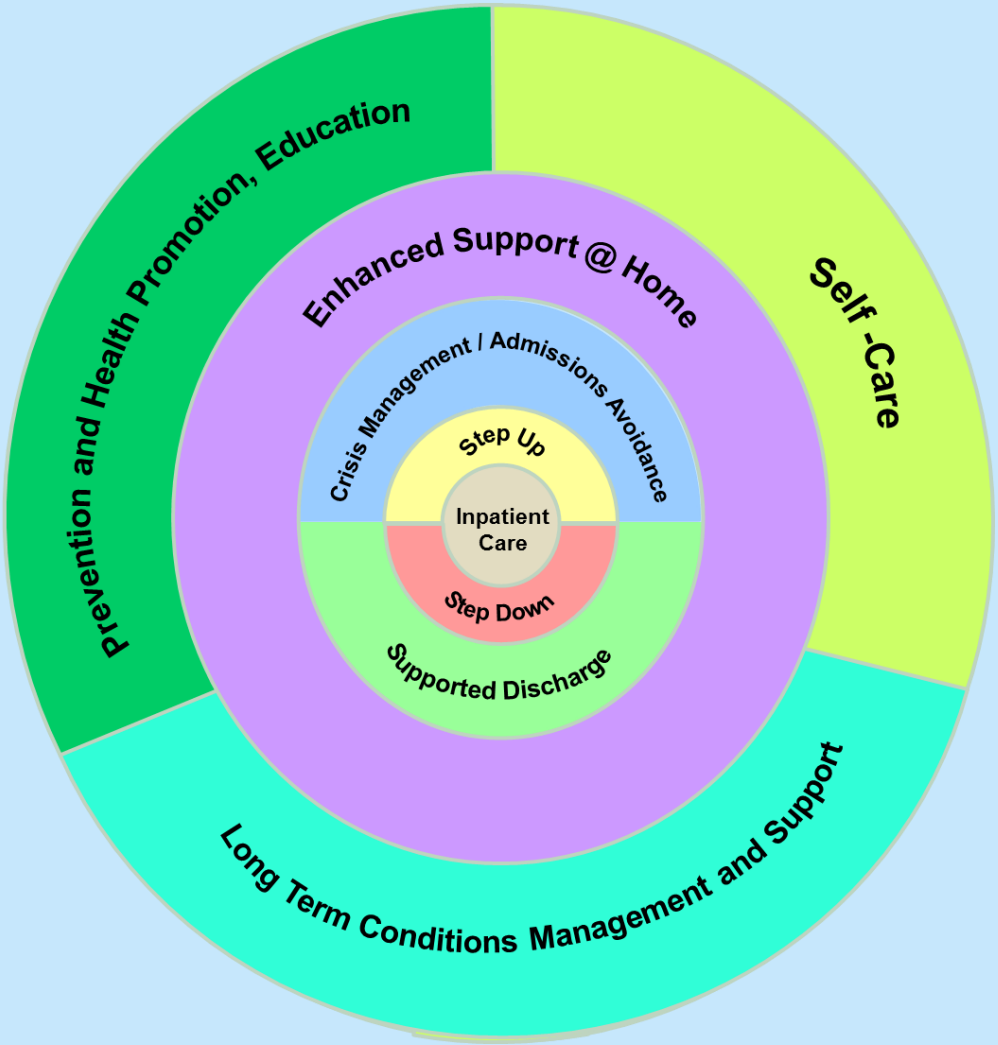
The following graphic describes the feedback from an open space event which was held in May 2015. Members of the public, services users, partners, carers and professionals were asked to get to the heart of the question “What matters to us?” for local health and social care.

Vision and Purpose

Patients and their families have a right to expect:

- **The right personnel:** staff should be appropriately trained and qualified to deliver excellent services every time
- **The right environment:** an environment that is older person-friendly, takes into account an older person's strengths and abilities and protects them from harm
- **The right processes:** early recognition of the appropriate pathway for an older person's needs
- **The right results:** ensuring that frail, older people receive the best-possible, evidence-based healthcare that does no harm
- **The right approach:** patient centred care with an emphasis on relieving suffering, good communication and excellent patient experience
- **The right system:** a smooth patient journey with timely referrals to the support that is needed e.g. primary/social care, community or voluntary services.

HDFT – A Centre of Excellence for Older People – Our Strategy on a Page



Our vision: HDFT will become a Centre of Excellence for caring for older people wherever and whenever they cross our path.

- We will ensure that older people receive high quality affordable care and play an active role in making decisions about their own health.
- Our aim is to ensure more people stay healthier and independent for longer, have choice and control over their lives and care and that costs are reduced across the system.
- We are shifting care closer to home and working as a whole system across acute, primary, community health, social care, voluntary and community sector and wider universal services to make this happen.
- Care will be at home unless the person really needs to be in hospital.
- New business plans within HDFT will take this strategy into account .

Supporting Independence and Health and Wellbeing in Later Life

Why is this important?

Maintaining good physical and mental health in later life allows people to continue participating in a full and active life. Older people should be able to enjoy long and healthy lives, feeling safe at home and connected to their community. Avoiding loneliness is an important factor in maintaining good physical and mental health. It is a risk factor for depression, poor sleep, impaired thinking skills, higher use of health care, medication and higher incidence of falls.

What is happening now?

Through our partners, there is a wide range of support activities available including:

- **Mobility assessment and exercise-** there are a range of exercise classes and health walks to support falls prevention and postural stability. Handyperson services are also available in some places
- **Nutrition**- There are a number of groups offering shopping and eating well assistance. Talks, information, taster classes on "Eating for One", food diaries, educational programmes on food choices
- **Social Interaction-** Many local groups offer social activities, coffee mornings, lunch clubs and befriending opportunities (face-to-face and telephone). Volunteering is also a key opportunity for people to get engaged and feel valued in their community. Social Prescribing projects are available in some GP surgeries.
- **Medication review/care navigation-** Some voluntary organisations can help with navigating the care environment and ensure people are able to keep their appointments e.g. Age UK and the Red Cross.

What do we want to happen?

- A focus on the promotion of healthy approaches to ageing including encouraging healthy lifestyles and reducing ill health through early identification of problems and intervention
- Ensure there is clear understanding of services available and referral processes and enable older people to manage their health and have an improved quality of life
- Investment in high quality community services to achieve better outcomes for people and reduce the need for hospital and residential care
- Elderly patients receive full access to the specialist and community care they need and that our focus remains on maintaining physical and mental wellbeing including attention to oral health, strength and mobility and social connectedness.

Frailty

Why is this important?

Frailty is not a formal diagnosis but is a distinctive state related to the aging process leaving people vulnerable to dramatic or sudden changes in health triggered by seemingly small events such as minor infection or a change in medication.

What is happening now?

- All patients with a hip fracture are seen by an orthogeriatric consultant for a comprehensive geriatric assessment (CGA)
- We use a triage tool to help us recognise when patients admitted to the medical team have frailty. This enables those identified to be transferred to our frailty unit for appropriate care.

What do we want to happen?

- Identify all patients with frailty so they can then receive a CGA
- We are hoping to implement a specialist Frail Elderly Assessment Team (FEAT)
- Support Primary Care to identify frailty in older people and put in place an appropriate care plan
- Have an IT system that allows this information to be shared between primary and secondary care .

Comprehensive Geriatric Assessment (CGA)

Why is this important?

The Comprehensive Geriatric Assessment (CGA) is key to supporting frail older people to have the best health they can. It is a multidisciplinary, diagnostic process to describe the medical, psychological and functional capabilities in order to develop a co-ordinated, integrated plan for long-term treatment and follow-up.

What is happening now?

CGA is part of the care for:

- People admitted to HDFT under care of a geriatrician
- Patient seen in the Falls Clinic
- All patients admitted with a hip fracture
- Some patients admitted to Ripon Hospital.

What do we want to happen?

CGA will be available to all people who need them based on clinical need in the community as well as in the hospital.

Mental capacity/DoLS/Power of Attorney/Deputy Court of Protection

Why is this important?

All patients have the right to make decisions about their care whenever possible. We need to be able to recognise when they do not have capacity to do this and ensure that their needs and wishes are supported at this time.

What is happening now?

- The importance of the Mental Capacity Act, Deprivation of Liberties legislation, the Power of Attorneys and the guidance on Deputies of the Court of Protection is understood by our organisation
- We provide training in all these areas.

What do we want to happen?

- Appoint a designated member of staff to coordinate DoLS assessments where appropriate
- Continue to ensure that we always recognise whether our patients have the capacity to make the decisions about their care or need the protection provided by the legislation.
- Have a very clear system of recognising when a patient has an appointed Attorney to deal with health and welfare issues or where a Deputy of the Court of Protection had been appointed and that the Attorney or Deputy of the Court of Protection are fully involved in decisions.

Cancer

Why is this important?

Nationally there is concern that older patients – particularly those with other co-morbidities or complex social care needs may not be receiving the best quality of care. More novel treatments are now better tolerated by frailer patients. Cancer services face challenges in relation to older people over the coming years including:

- Improving survival rates in the population aged 75 years and over
- Delivering high quality services to increasing numbers of older patients with cancer, including age appropriate assessment, for example CGA. Pilots have demonstrated that through using the CGA and ensuring older patients receive the right specialist input, they are more involved in making decisions about their treatment. Assumptions made on their willingness to undergo treatment and their tolerance to it are therefore avoided.

What is happening now?

We are scoping the requirements for service improvement in the hope of bidding to Macmillan Cancer to support a pilot.

What do we want to happen?

To ensure that our older patients receive the right specialist input when making decisions about their treatment.

Continence

Why is this important?

Continence is the second most common cause for long term institutional care, second only to dementia. It has strong associations with: cognitive impairment, falls, strokes, skin integrity and has implications for respect and dignity of patients. Poor management of incontinence leads to significant carer burden and increased length of hospital stay.

What is happening now?

- We currently have no dedicated formal continence pathway for older people within the trust; acute hospital or community
- A pilot urinary continence care bundle from 2015 indicated good staff uptake and increase in identification and referral of patients to the continence practitioner
- There is a range of practical guide and information packs are available e.g. Age UK free guide on " Bladder and bowel problems".

What do we want to happen?

- Earlier identification of patients' continence needs, with timely and appropriate assessment and diagnosis where possible
- Develop and implement a robust pathway and integrated service to ensure continuity between hospital and community
- Improve catheter care and reduce catheter associated urinary tract infections (CAUTI)
- Explore the potential for making continence a quality improvement priority.

Delirium

Why is this important?
Delirium is an acute syndrome which is characterised by altered levels of consciousness, attention and cognitive function. It has many causes and frequently leads to, or occurs during hospitalisation. It is best treated by a multi-disciplinary intervention.

What is happening now?

- We complete a 4AT (mental test score) test on all patients with a hip fracture
- We use the butterfly scheme to highlight patients with acute confusion. This ensures that our staff provide the most appropriate care for this patient group
- We investigate delirium medically to ensure that there are no treatable or reversible causes such as infections
- We use measures such as ensuring good hydration and diet, alleviating pain, treating constipation if present, reviewing medication that may contribute to delirium and using good interpersonal skills to reassure and re-orientate patients
- We refer patients to the Acute Hospital Liaison Team in Old Age Psychiatry if we have concerns about behavioural symptoms and distress associated with delirium.

What do we want to happen?

- Ensure all patients are appropriately screened and investigated for delirium (hyper and hypo), which may include screening for infections, checking for metabolic abnormalities, dehydration and a medication review
- Ensure that staff are trained to recognise all presentations of delirium
- Ensure that we provide a good sensory environment for our patients with staff using a reality orientation approach when appropriate
- Educate our staff on implementing a non-pharmacological sleep regime
- Ensure that verbal and written information about delirium is available to patients and their carers to allow understanding about causes and timescales for resolution of delirium.
- Ensure that delirium is included as a diagnosis on the discharge summary so that the GP and care homes can update their records and provide appropriate ongoing care.

Dementia

Why is this important?

Dementia is a progressive organic disease characterised by a specific side effects. As yet there is no cure. The Government's National Dementia Strategy' (2009) and subsequent Prime Minister's Challenge (2020) aspiration is that all people with dementia and their carers should live well with Dementia.

What is happening now?

- A Dementia screening tool is available for all people aged 75 and over admitted as an emergency. However an audit of discharge summaries shows that this is not being completed in a thorough way in many cases.
- Staff training has been undertaken to raise awareness of Dementia and equip staff with the skills they need to be able to support patients and their carers
- A number of environmental improvements have taken place to make our services more "Dementia friendly"
- Support is available through the voluntary sector where specialist information and guides can be accessed e.g. Age UK's " Caring for someone with dementia" and Alzheimer's Society "This is Me" leaflet.

What do we want to happen?

- Use Dementia Case Finding - FAIRI (Find, Assess, Investigate, Refer, Inform) routinely on older people who attend hospital
- Provide staff with the training they need to identify and manage the needs of people with dementia
- Improve access to dementia services and memory clinics
- Improve Dementia prevention opportunities (see appendix)
- Ensure information about dementia is included in the discharge summary such that the GP and care homes can update plans of care
- Ensure that patients with dementia have opportunities to be active and engaged during their in-patient stay, using ward volunteers to promote activities and past-times
- To ensure that discharge planning includes the input of people living with dementia and their carers, leading to a safe and well-planned transition out of hospital.

Diabetes

Why is this important?

There are just over 4million people in the UK with diabetes, 3.5million of whom are adults. In 2013 an audit of all 999 callouts for hypoglycaemia in the HaRD CCG area found a quarter were for people over 80. Diabetes in the older person greatly increases the risk of falls, especially if that person has peripheral neuropathy, poor eyesight, reduced glycosylated haemoglobin level (HbA1c) and impaired renal function. They are more likely to suffer a fracture as a result of their diabetes and renal disease. Signs and symptoms of hypoglycaemia are harder to detect in an older person and may be missed, especially if the person is confused. Hypoglycaemia also increases CVD risk factors, arrhythmias and myocardial infarction.

What is happening now?

- We currently have guidelines for the management of people with diabetes over 75 in hospital and in the community
- One of our specialist nurses is a Diabetes UK Local Clinical Champion for diabetes, whose remit is to look at how we improve diabetes care for people over 75. Work with nursing and residential care homes are on-going to devise a training programme for staff. Support is also available for case managers, Matrons and District Nurses in the management of elderly people on their caseload.

What do we want to happen?

- CGA to include diabetes as a risk factor when people are admitted
- HbA1c to be checked and hypoglycaemia excluded as a reason for fall/admission
- In-Patient review by diabetes specialist nurses for all elderly patients with diabetes .

Falls

Why is this important?

Falls and fractures in people aged 65 and over account for over 4 million hospital bed days each year in England alone. Injurious falls, including 70,000 hip fractures annually, are the leading cause of accident-related mortality in older people. Falls destroy confidence, increase isolation and reduce independence, with around 1 in 10 older people who fall becoming afraid to leave their homes in case they fall again.

What is happening now?

- A number of interventions In our elderly care wards have already reduced the number of falls by up to 50%:
  - Daily patient safety huddles are held to discuss patients at high risk of falls
  - Falls sensor technology pilot which has contributed to continued 'falls free' days
  - Specialist physiotherapy falls assessment in ward areas and in the community teams
  - Issue of appropriate walking aids to maximise safe mobility
- Partnership and community exercise classes have been piloted with positive results
- MDT community falls response team provides fast response for patients who have had a fall
- Exercise prescription using evidenced based physiotherapy approved training programme (OTAGO) exercises
- Sign-posting to community exercise groups e.g. Age UK, Fit4Fun.

What do we want to happen?

- To consistently identify those most at risk of falls in accordance with NICE guidelines.
- Reduce the number of hospital admissions due to falls by 15-20%
- Ensure anyone who requires a MFFRA (Multi-factorial Falls Risk Assessment) and interventions to reduce falls receives it
- Increase the number of healthcare professionals providing MFFRA and interventions
- Have access to meaningful electronic data of those who have been through the falls service
- Have recorded, routine measurable outcomes to be able to assess impact
- Ensure clear falls pathway and signposting for healthcare professionals and patients
- Develop Physiotherapy led group exercise programmes as they have been shown to be effective and can reduce falls by up to 29% and the risk of falling by 15%
- Implement falls sensor technology across all in-patient and community beds
- Partner with and develop Falls Prevention/ Postural Stability exercise classes in synergy with groups such as Age UK.

Heart Failure

Why is this important?

Around 900,000 people in the UK have heart failure. Almost as many have damaged hearts but, as yet, no symptoms of heart failure. Both the incidence and prevalence of heart failure increase steeply with age, with the average age at first diagnosis being 76 years. The prevalence of heart failure is expected to rise in future as a result of an ageing population, improved survival of people with ischemic heart disease and more effective treatments for heart failure.

What is happening now?

- Patients are admitted under elderly care and the majority are managed by the consultant team with some being referred at the discretion of the consultant either for cardiology review or heart failure nurse review depending on their needs.

What do we want to happen?

- In line with best practice all patients admitted with acute heart failure will be reviewed by a specialist (cardiologist, heart failure nurse or consultant with an interest in heart failure) during the acute admission.
- Where appropriate these patients will be followed up by the community heart failure nurse service.

Mental Health

Why is this important?

With an increasing ageing population there will be greater demands on services to meet the needs of older people with pre-existing mental illnesses and those people who first develop mental illness later in life. Older people who have a mental illness as a comorbidity to other chronic conditions are less likely to achieve optimal management of their health. There is a need for an effective response to depression, the prevention of suicide and the underlying causes behind the social marginalisation of older people with mental illness.

What is currently happening in our area?

- We have a dedicated mental health liaison service who work with our wards and ED staff in supporting the needs of older people with mental health problems.
- We have worked in collaboration with our mental health partners to provide bespoke training on dementia, delirium and depression
- We are expanding the Dementia Friends initiative and have joined the national Dementia Action Alliance scheme.
- We are working to improve our ward environments to ensure that they are more “dementia friendly” and that all staff and volunteers have a raised awareness of the mental health needs of older people.

What do we want to do?

- We want to ensure that we work in line with the “Parity of Esteem” agenda and the Crisis Care Concordat so that the mental health needs of older people whether in hospital or in the community, no matter what their diagnosis, are treated on a par with physical ill health needs.
- We want to eliminate the stigma surrounding mental health issues so that all staff understand that mental wellbeing is as important as physical wellbeing and that any person experiencing mental ill health should be afforded the same dignity and respect.

Nutrition

Why is this important?

Eating a balanced diet is vital for good health and wellbeing. Food provides the body with the energy, protein, essential fats, vitamins and minerals to live, grow and function properly. We need a wide variety of different foods to provide the right amounts of nutrients for good health. This is particularly important when people are recovering from illness.

What is happening now?

- We use a nutritional assessment tool for patients on the acute wards and receive advice on supporting the needs of patients identified by it
- We offer home visits for assessment advice for patients referred by GPs
- We offer support for patients with specific medical conditions in the outpatient department
- Voluntary groups offering shopping and eating well assistance for older people living independently
- A range of practical information and guides on nutrition are available through our voluntary sector partners.

What do we want to happen?

- Have a greater focus on the way we support the feeding needs as well as the dietary requirements of all our patients
- Offer nutritional support and advice for all our patients that need it (See Appendix for details).

Pain Management

Why is this important?

It is thought that pain in the elderly population often goes under reported due to stoicism. Older people may 'put up' with severe discomfort and pain, because they don't want to be 'a nuisance'. Some presentations of agitated behaviour can be attributed to poor pain management. Unfortunately not addressing pain can have negative long term consequences including reduced mobility and depression and so managing pain in older people is critical.

What is happening now?

- Recording of pain scores at rest and movement.
- Introduction of different pain assessment tools for various patient groups, i.e. Pain Assessment In Advanced Dementia (PAINAD) tool for advanced dementia (see appendix)
- Through regular audits we demonstrate that most of the time we provide good pain relief
- Monitoring of our service through Friends and Family tests and feed information back to staff.

What do we want to happen?

- Education of medical and nursing staff to identify when a patient is in pain and provide good pain relief in a timely/regular manner whenever it is needed
- Evidence through regular audits that we are showing improvement
- Review of pain service to enable more support for the medical and elderly wards.

Pressure Ulcers

Why is this important?

A pressure ulcer usually occurs over bony prominences when the skin and underlying tissue becomes damaged by pressure, shearing or friction. Elderly patients can be more at risk of developing pressure damage for multiple reasons. Without appropriate care pressure ulcers can cause pain, distress, increased hospital stay, risk of infections and can take a long time to heal.

What is happening now?

- All in-patients identified as “at risk” of pressure ulcer development have a three times daily head-to-toe skin inspection completed and a care plan (SSKIN) commenced.
- We have increased the frequency of conducting a pressure ulcer risk reassessment.
- We hold regular Pressure Ulcer Prevention and Management training for all HDFT staff.
- We have audited and continue to monitor hospital documentation to highlight training/education needs.
- We are currently developing a workbook and competency tools for staff relating to pressure area care.
- We are currently reviewing the Risk Assessment tools in use within the organisation and are trialling a new evidence-based tool in the Emergency Department and one District Nursing base.
- We hold investigation meetings for all category 3 and 4 pressure ulcers acquired under HDFT care to identify lessons to be learned and develop action plans to prevent reoccurrence.
- We hold a Pressure Ulcer Steering Group every month.

What do we want to happen?

- To reduce to zero the number of avoidable hospital acquired pressure ulcers
- To ensure that the prevention of pressure ulcers begins on admission to hospital or on inclusion to a District Nursing caseload following a holistic patient.

Elderly Care and the Emergency Department

Why is this important?

At times older people experience acute illnesses or traumatic injury that requires urgent presentation to hospital for intensive medical or surgical care. In these circumstances the goal is to recover quickly without suffering any long-term functional decline however older people have a very high propensity to be admitted and once in hospital often decompensate.

What is happening now?

- Routine ED care
- Introduction of a Hip fracture rapid access pathway and training for FIB (fascia iliaca nerve block) pain relief
- Introduced a number of Dementia friendly initiatives.

What do we want to happen?

- Identify frailty syndromes and triage to specialist in elderly care as soon as possible
- Avoid admission where possible by using community services to continue treatment tthrough the use of ambulatory care / direct access to specialists in elderly care and by using community services to carry out or continue treatment
- When admission is unavoidable ensure patients are admitted to the right ward under the right consultant for the optimum length of stay, minimising ward moves and changes in consultant, aligning discharge to their expected date of medical fitness
- Ensure adequate pain relief, pressure screen care, falls risk identification
- Ensure that patients with cognitive impairment are managed in a manner to cause least distress throughout their time in ED.

Acute In-patient Care

Why is this important?

Older people who are admitted into an acute hospital will receive excellent care and a positive experience if they are seen by right staff in the right setting for their needs and if their stay is for the shortest possible time. A holistic approach and CGA makes this possible.

What is happening now?

- Acute medical admissions are allocated to geriatricians on the basis of frailty however current demands on the service and the bed base means that some patients with frailty syndromes are managed on outlying wards under the care of general physicians.
- Patients admitted under the care of the orthopedic team can have their medical needs assessed by the Elderly Care Physician attached to this team (orthogeriatrician)
- Patients admitted under other specialties (e.g. general surgery, medical specialties) who have frailty syndromes do not currently receive CGA/specialist geriatrician input
- A five day therapy service is available within integrated care however sometimes struggles with capacity during times of leave which has a negative impact on patient care
- Length of stay is currently higher than the national average however the introduction of daily mini MDTs on the frailty wards are making an impact
- A discharge planning team is in place to facilitate complex discharges in conjunction with social care colleagues however there are often significant delays in discharge.

What do we want to happen?

- Identify frailty on admission to hospital regardless of parent specialty
- Provide the right service, in the right place for the shortest possible time e.g. reduce moves between wards unless clinically appropriate.
- Have elderly care physicians involved in the care of frail elderly surgical patients.
- Develop a local service specification allowing safe discharge once medically fit within two days, seven days a week
- Daily therapy intervention
- MDT working on all wards caring for older people with frailty.

Community Based In-patient Care

Why is this important?

Older people who do not need an acute inpatient bed, who require rehabilitation or those requiring end of life care (EOLC) may be transferred to Trinity ward.

What is happening now?

- Trinity ward which has two EOLC beds and one of our specialist palliative care nurses visits the ward to support GPs to care for those patients at EOL if required
- Trinity ward patients who are not registered with a Ripon GP receive medical inpatient care provided by a GP during the time they spend on Trinity Ward
- Additional medical support is provided by a elderly care consultant
- Health and adult services (social care) provide residential care at 16 Station View with rehabilitation support from the community response team
- 5 day availability of rehabilitation support provided by in reach therapy staff at Ripon community hospital
- The multi-disciplinary team (MDT) on Trinity ward are in place to facilitate complex discharges and are supported by the discharge planning team. Sometimes there are delays in discharge due to lack of availability of rehabilitation support or long-term requirements for packages of care.

What do we want to happen?

- Provide bed based rehabilitation if that is what is required by a patient
- Work closely with the integrated community care teams to promote safe prompt discharge
- Provide the right service, in the right place for the shortest possible time
- Provide daily rehabilitation
- Ensure that those patients who are admitted have access to high quality EOLC delivered by staff who have the relevant training and care supported by an individualised plan such as the ‘Care Plan for the Last Days of Life’ in accordance with the ‘5 priorities of care’ recommended by the ‘Leadership Alliance for the Care of Dying’
- Comprehensive and seamless MDT working for older people with frailty
- To achieve the same standards with patients from our neighbouring areas.

Discharge Planning

Why is this important?

Effective discharge planning can decrease the chances of patients being readmitted to the hospital, help in recovery, ensure medications are prescribed and given correctly and adequately prepare families and community services to support care**.**

What is happening now?

- We have locality teams and a response and overnight service to support patient discharge within 72 hours of admission
- We have daily huddles on two of our elderly care wards to facilitate discharge planning
- County wide “Home from Hospital“ service provided by the voluntary sector supporting discharge and practical help for safe return and stay at home.

What do we want to happen?

- Ensure patients only remain in hospital when it is clinically necessary and have the support they need to return home e.g. “Fit, Safe and Ready”
- We would like to explore whether a “discharge to assess” model would be the best way of supporting our patients.

Post Acute Care and Rehabilitation

Why is this important?

Older people are at high risk of disability and without support after an admission to hospital can deteriorate both physically and mentally and this often requires re-admission into hospital. Multidisciplinary rehabilitation supports older patients to improve functionality and maintain their quality of life and independence.

What is happening now?

- Separate pathways for referral to bed-based and home-based rehab with varying length of waiting lists
- Outcome measures are not routinely monitored
- Varying medical and specialist geriatric input into intermediate care
- Our new care models work aims to address these issues.

What do we want to happen?

- A target of two days waiting for all intermediate care services
- Clear expectations of therapy, nursing and medical input into teams
- Regular review of outcome measures, including patient reported experience (PREMs)
- Facilities suitable for older people with frailty and dementia accessible to spouses and relatives
- A clear pathway for patients with fractures immobilised by plaster of Paris
- Trusted shared assessments between partner organisations.

Advance Care Planning (ACP)

Why is this important?

ACP is a key means of improving care for people nearing end of life and of enabling better planning and provision of care, to help them live and die in the place and the manner of their choosing. The main goal in delivering good end of life care is to be able to clarify people's wishes, needs and preferences and deliver care to meet these needs.

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What is happening now?

- ACP is offered to some patients

What do we want to happen?

- Develop a local EPaCCS (Electronic Palliative Care Coordination System) to help identify patients in the last year of life and to share relevant information including ACP decisions, DNACPR decisions and Preferred Place of Care /Death with other relevant health care professionals
- Develop a system for identifying these patients when admitted to hospital so that this information can be accessed and so that these patients are adequately managed to reduce unnecessary length of hospital stay.
- Recognise when patients are nearing the end of their life and offer all these patients ACP. Ensuring they are supported to live in as much comfort as possible until they die and to make choices about their care, including:
    - What they want to happen
    - What they don't want to happen
    - Who will speak for them

Palliative and End of Life Care

Why is this important?

Within our strategy the term end of life care is used to describe care that is planned for, negotiated with, or provided to a person at the end of their life. It is used without specific reference to timeframes and hinges instead on the orientation toward providing care appropriate for a natural life event and the ordinary place of death as part of life. Older people differ in their end of life experiences. For some this period is short and sudden while others experience gradual or fluctuating decline and increasing frailty from terminal illness or complications from chronic diseases. These differing experiences will require different health service responses.

What is happening now?

- We have a Palliative Care Team who provide advice and support to patients referred to them
- Chaplains and chaplaincy volunteers routinely visit on the wards and are notified when a Personalised Care Plan for the Last Days of Life is instigated
- We are supporting some of our patients to die in their place of their choice with access to rapid and safe discharge from hospital where necessary
- Reviewing referral criteria at St Michael's Hospice to include 'frailty'.

What do we want to happen?.

- Develop a greater awareness that chaplaincy support is available to all, irrespective of any religious belief or tradition and not solely at the end of life
- Ensure that staff have the relevant training and skills to identify and care for patients in the last days of life
- Support patients to die in a place of their choice with access to rapid and safe discharge from hospital where appropriate
- Develop a 9am to 5pm, seven day a week specialist palliative care service.

Supporting Carers

Why is this important?

Partners, families, live-in carers, neighbours and friends play vital roles in assisting frail older people to live independently in their homes. Our strategy recognises carers of older people as well as carers who are older. We also are mindful of the invaluable contribution of 'family carers'. Carers often have knowledge about the health and wellbeing circumstances of the older person and it is therefore vital they are included in care planning processes.

What is happening now?

- Carers Resource is an key local partner that provides a range of services and support
- Advance care planning and best interest meetings are carried out together with carers and families
- Our acute wards have introduced the 'carers' passport', to allow carers to visit at any time of the day.

What do we want to happen?

- Our strategy recognises that carers face significant difficulties in providing support to family members while confronting a range of complex circumstances including emotional, health and financial difficulties
- A workforce that understands the 'carer role' and its associated challenges, responds effectively to carer needs and works together with them in providing quality care for older people
- Support carers to be able to deliver the care needed by the older person
- Improve identification of a carer throughout the health system.

Patient information

Why is this important?

IInformative and easy to read patient information is important as it can help to ensure patients arrive on time and are properly prepared, give patients confidence, remind patients of what they have already been told, involve patients and carers in their treatment and condition, make sure patients are fully aware of the next step in their pathway and are able to plan ahead and encourage patient ownership and self management.

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What is happening now?

- A variety of leaflets and information are available, selected by each specialty.
- Each ward routinely gives out information upon admission and discharge.
- Information is available on mobility aids, supportive footwear and home adaptations
- Many voluntary organisations have a range of information guides and leaflets which are useful for older clients and helps with understanding and being able to make informed choices about their health, lifestyle and decisions.

What do we want to happen?

- Involve patient groups in development of standardised formats for patient information, giving clear, comprehensive and useful information
- Information are fit for purpose and appropriate for each target audience
- Use nationally available patient information (e.g. Age UK/Alzheimer Society etc.)
- Set routine for information to be given at appropriate stages of a patient's care pathway
- Make information available in a variety of formats, e.g. video content.

Bereavement Care

Why is this important?

Whenever a person dies a range of effects can be felt across families and communities. Although dying is a normal part of life, the impact of a death can have a profound affect on the health and wellbeing of close family members and friends.

What is happening now?

- Advance care planning
- Chaplain and chaplaincy volunteers routinely visit on the wards and are notified when Care Plan Last Days (CPLD) is instigated
- We carry out a bereavement survey that is monitored through our end of life steering group.

What do we want to happen?

- Greater awareness of chaplaincy support being available to all, irrespective of any religious belief or tradition and not solely at the end of life
- Increase in the number of referrals to Chaplaincy to support patients at times other than end of life
- Policy for spiritual, religious and pastoral care
- Close family members and carers have confidence that we have provided the best possible care
- They are assured that their relative or friend have been treated with dignity and respect
- We are able to provide the information they need to understand what has happened
- Bereavement support is available at this difficult time.

Medicine Management

Why is this important?

Good medicine management is important to ensure patients get the maximum benefit from the medicines they need, while at the same time minimising potential harm." (MHRA 2004)

What is happening now?

Our medicine management team:

- Support some consultant led ward rounds, MDT meetings and input to Quality of Care
- Provide some patient education sessions and counselling for specific conditions
- Provide specialty specific training
- Support the self-administration of medicines in hospital in limited areas

What do we want to happen?

Our patients will have the information and the support they need to safely self-administer their medications at home, in hospital and when discharged from hospital. This will include:

- The use of tools that support compliance, e.g. large print labels
- Accurately communicating the information to primary care and community pharmacists
- Joined up working with integrated locality pharmacy teams to ensure patients are supported in all care settings, including in their own homes.

Equipment

Why is this important?

Having access to the right equipment in a timely fashion can support independent living.

What is happening now?

- We have a comprehensive catalogue of equipment encompassing a wide range of items from simple to complex aids to daily living
- Some items are available for delivery direct to the client's home, others are delivered via an access point or sub-store.
- Equipment is recycled when no longer in use.

What do we want to happen?

- Ensure good clinical reasoning is always provided by the prescriber when equipment is provided so the most appropriate equipment is provided in a timely fashion every time
- Ensure that no patient has a delayed transfer of care due to lack of equipment
- Walking aids to be available for immediate use on the admissions unit.

Technology

Why is this important?

The use of technology in the NHS has the potential to improve the quality, delivery and efficiency of healthcare services. Technology can offer a number of potential benefits to patients such as reducing the need to travel to outpatient clinics, providing a quicker diagnosis and avoiding referrals to hospital for diagnosis or treatment. The need for health care is continually increasing. We therefore need to find different ways of providing high quality care in a timely fashion.

What is happening now?

- The regional stroke rota uses a video link to facilitate decisions about thrombolysis out of hours. This allows the on-call consultant to see radiology images from all the hospitals on the rota
- Respiratory nurses used telehealth during their “hospital at home” pilot for patients with COPD
- Telephone and Skype appointments are available in some services
- Agile working is available in some areas ensuring staff have access to patient information when they need it.

What do we want to happen?

- Use technology care to support and enhance patient care in hospital
- Support our patients to attend appointments by sending text messages
- Explore the use of technology to support patients to be independent at home by the use of text reminders to give prompts to eat and drink and taking medication
- Increased use of technology to enable people to remain safe at home or trigger early alerts if there are difficulties
- Develop and share access to information
- Explore the benefits of using technology for patients to report parameters to the specialist nursing teams.

Workforce Development

Why is this important?

We need to ensure that all our staff have the knowledge and skills they need to meet the needs of frail older people and their carers.

What is happening now?

All our staff have a programme of statutory and mandatory training they are required to undertake. The uptake of this programme is monitored by workforce development.

What do we want to happen?

- Ensure the statutory and mandatory training for all staff includes the skills required to meet the needs of frail older people and their carers. This will include to listen to and respond to people's needs, treat everyone with respect and dignity, explain things clearly and simply, being compassionate, caring and courteous, build good relationships with patients and carers. All our staff should do what they say they will do and work well in teams
- All staff working with older people will be trained in adult safeguarding to a level appropriate to their job
- A commitment to a wider spectrum of support and harnessing use of experienced staff and volunteers in the voluntary sector
- Increased use of health coaching and co-production approaches by all staff to understand what personalised care needs may be important to an individual.

Environment

Why is this important?

As the population ages the needs of older people require consideration in relation to facility design. National strategy aims to ensure hospital facilities provide an environment that is older person friendly, takes into account an older person's strengths and abilities, protects against harm and empowers the person or their care giver to be actively involved in decision-making. Hospital settings should be designed and managed to minimise the impact of an unfamiliar environment and cater to the specific needs of older people who may be experiencing decline in perception, cognition and control of movements associated with ageing.

What is happening now?

In our acute hospital, we have:

- Improved our clinical environments so that they become more "Dementia Friendly"
- Painted all our bathroom and toilet door frames in red so they are easily distinguishable
- Purchased blue crockery to improve patients ability to distinguish food when served
- Provided specialist clocks telling date and time
- Introduced Dementia friendly lighting.

What do we want to happen?

- Paint individual bays in different colours so that they are more easily distinguished and recognisable in line with Dementia Environment Strategy
- Improve signage throughout the Trust
- Provide diversional activities as therapeutic interventions for use by patients on the Frailty Unit including games, puzzles, books, photographs of local places of interest
- Improve our ED environment to better support the frail elderly and people with dementia.

What will success look like?

HDFT will be recognised as a Centre of Excellence for caring for older people. Older people will receive excellent care wherever and whenever they have contact with our services.

Older people, their families and carers regardless of who they are, where they live and what their needs are, will be able to say:

a) I am generally healthy and I am aware of and supported to take actions to help me remain as healthy as possible as I become older.
b) I am aware of and able to access services and advice to keep me healthy and/or if I need help.
c) I take advantage of the free screening programmes available to me including the NHS health checks programme.
d) I am treated with dignity and respect.
e) I am given control of my care and support and supported to make choices in my daily life.
f) I do not have to describe what my needs are again and again to lots of different professionals and the services that support me are of the right level to cater for my individual needs.
g) I am protected from avoidable harm and supported to live safely in my home environment, yet I have my own freedom to make independent and informed choices.
h) I understand how my care and support works, my care is regularly reviewed in my best interests and I know what the options are for what happens next.
i) I see public money being spent well by joined up services without duplication and waste and in a fair and consistent way.
j) I am helped and supported to keep in touch with my family and friends.
k) I get the right treatment and medication for my needs and I get the support I need in the right setting.
l) I am happy with the quality of my care and support.
m) When I contact the hospital/service I find it easy to get the information or advice I need.
n) When I visit the hospital I can find my way about.

What will success look like?

- HDFT will be ‘age friendly’, (e.g. signs in large font)
- Older people with frailty should be assessed and nursed in areas where noise, interruptions and over stimulation is minimised
- Food and drink should be readily available for older patients and help with nutrition provided
- Older people attending the emergency department with or without a fragility fracture will be assessed for immediately reversible causes and subsequently referred for a falls and bone health assessment using locally agreed pathways
- Staff working within HDFT will be able to provide information about local social services, falls services, healthy eating, staying warm, benefits and information for carers of frail older people
- Information provided to patients and carers will be presented in a format that is easy to understand and is relevant to their needs (e.g. large print)
- Older people, and where appropriate their carers and families, will be involved in the decision making process around assessment and management of on-going and future care and self-care
- Discharge to an older person’s normal residence will be the norm unless continued hospital treatment is required, 7 days a week.

Appendices

Frailty Assessment Tool

We are looking to develop an effective and more equitable approach which will include screening all acute admissions for frailty on arrival in ED or CAT.

We are hoping to implement a specialist Frail Elderly Assessment Team (FEAT) working alongside our geriatricians, other specialty physicians and acute physicians to provide a Comprehensive Geriatric Assessment (CGA). Being placed within the acute medical unit prevents a two tier system forming, allowing equal access to specialist services regardless of your frailty status.

Providing an intervention to frail older patients is dependent on being able to first identify frailty. While many methods have been proposed in academic trials a universally accepted screening tool for frailty in acute admissions does not exist. In HDFT we have been using a quick pragmatic screening tool based on the clinical outcomes of frailty, which any health care professional can use without addition training. The 4 screening questions for frailty are outlined below, answering yes to anyone indicates frailty.

- 65 + years and admitted from a Care Home or Intermediate Care bed
- 75 + years and admitted from home with 2 or more pre-existing conditions
  - □ delirium
  - □ incontinence of urine
  - □ dementia with AMT <7
  - □ multiple pathologies
  - □ history of recent falls
  - □ impaired mobility
  - □ breakdown of care package
- 90 years + with co-morbidities

Exclusions
Suspected stroke/TIA
Chest pain with suspected MI
Hip fracture
Acute GI bleed
Primary respiratory problem requiring NIV

Once identified as frail, parallel assessment can begin this allows the therapists to begin their assessment alongside, and in some cases before, a full medical review has taken place, expediting CGA and timely discharge where possible. New protocols have removed barriers to therapy assessment, however all patients are triaged by the acute physician with unwell patients having aspects of the assessment deferred while acute medical care takes priority.

Comprehensive Geriatric Assessment

Comprehensive geriatric assessment (CGA) is a ‘multidisciplinary, diagnostic process to describe the medical, psychological and functional capabilities of a frail older person in order to keep a co-ordinated, integrated plan for long-term treatment and follow-up’ (Stuck et al 2002). The main elements of CGA are shown in the box below.

Elements of comprehensive geriatric assessment

Medical assessment

- Problem list
- Co-morbid conditions and disease severity
- Medication review
- Nutritional status

Assessment of functioning

- Basic activities of daily living
- Instrumental activities of daily living
- Activity/exercise status
- Gait and balance

Psychological assessment

- Mental status (cognitive) testing
- Mood/depression testing

Social assessment

- Informal support needs and assets

Environmental assessment

- Care resource eligibility/financial assessment
- Home safety
- Transportation and telehealth

(Adapted from Ellis *et al* 2011)

CGA should play a role in the care of older people in a number of settings, described in other sections of this paper. Proactive community-based CGA, with at least six months of follow-up support for older people who are frail, can reduce hospital admissions, falls and moves into long-term care (Beswick *et al* 2008; Beswick *et al* 2010)

Advance Care Planning

Key Messages

- Advance Care Planning (ACP) is important. It is a structured discussion with patients and their families or carers about their wishes and thoughts for the future. Although such discussions may have occurred informally before, it was not occurring with all relevant people or being communicated to others. So the offer of an advance care plan for every appropriate person is now recognised as a key part of good care.
- ACP is a key means of improving care for people nearing the end of life and of enabling better planning and provision of care, to help them live and die in the place and the manner of their choosing. The main goal in delivering good end of life care is to be able to clarify peoples' wishes, needs and preferences and deliver care to meet these needs.
- ACP is in essence an important yet simple conversation that can change practice and empower patients. It can be a process of discussions over time, a 'relationship' discussion with regular reviews and can help catalyse deeper communication between patients and their families and loved ones. It need not be 'over medicalised' or too formalised and could be undertaken by anyone involved in end of life care, though is best undertaken by experienced trained staff who know the person well, such as GPs, community nurses, care homes staff and specialists.
- ACP is a key part of the Gold Standard Framework (GSF) Programmes. It should be included consistently and systematically so that every appropriate person is offered the chance to have an advance care planning discussion with the most suitable person caring for them e.g. staff in care homes, primary care and hospitals. The process of Advance care planning in the UK includes many elements – essentially helping people approaching the end of their life to describe and clarify:

  - What they want to happen
  - What they don't want to happen
  - Who will speak for them

Dementia and Delirium

Dementia is a collective term for diseases of the brain that can affect reasoning, perception and memory (Banerjee 2009). Dementia is progressive and there is no known cure. The Government's National Dementia Strategy's primary aim is that all people with dementia and their carers should live well with dementia (DOH 2009). Its objectives are themed around three broad aims, these are:

- Better knowledge about dementia and removal of stigma
- Improving dementia diagnosis rate
- Developing a range of services for people with dementia and their carers which fully meets their changing needs over time.

We know from a number of national reports such as Counting the Costs 2009, Banerjee 2009 and The National Audit of Dementia 2013 states that care for patients with dementia can and should be improved. We have a moral duty to our patients to act and initiate change and an economical duty to ensure resources are used effectively to ensure the delivery of high quality care.

Dementia Case Finding

Find	All patients of 75 and over are screened for dementia when they are admitted to hospital as an emergency by asking the screening question "Have you been more forgetful in the last 12 months to the extent that it is affecting your daily life?"
Assess	Ensure all patients go on to have Abbreviated Mental Test Score assessed and recorded at time of clerking or at least within the next 36 hours
Investigate	Ensure all patients are appropriately investigated for delirium, which may include screening for infections, checking for metabolic abnormalities, dehydration and a medication review
Refer	In keeping with locally agreed guidelines, if a patient has scored 8 or below on their Abbreviated Mental Test score at their screening, the discharge summary informs the GP of this and asks the GP to reassess cognition in 4-6 weeks to allow delirium to settle. If the AMTS remains 8 or below, the GP is asked to refer to local memory services.
Inform	It is good practice to inform patients and their families of the findings of screening. This should be done in a sensitive way, with explanations and information provision about delirium and its likely course. If there is suspected underlying cognitive impairment or dementia, there should be an explanation of how this will be investigated and reviewed at a later date. Care managers, care homes and other professionals in the community should be able to review the care plan which the GP can update with the discharge summary.

Dementia and Delirium – continued

Dementia Prevention
Opportunities to modify risk factors which may contribute to the development of vascular dementia need to be targeted. This is already happening in cardiology and TIA clinics but there may be opportunities for primary care to focus on this, as well as specialist clinics in diabetes, Acute Medicine and Elderly Medicine.

The use of Tony Husband's cartoon series " How to Prevent Dementia" displayed in clinical areas would provide information to patients and visitors about what can be done on an individual level to reduce the risk of developing dementia

Staff Training
- ❖ Raising awareness and understanding of dementia amongst all staff groups
- ❖ Tier 1 training for staff with a role involving face to face patient contact
- ❖ Tier 2 training for staff with clinical contact with patients living with dementia
- ❖ Tier 3 training for staff with a more specialist role – Elderly Medicine consultants, ward managers and band 6 staff on Frailty Unit and Acute Admissions Unit and Emergency Department
- ❖ Training in use of Butterfly Scheme

Dementia Friendly Environment
Improve our clinical environments so that they become more "Dementia Friendly"

Planning a good discharge from Hospital
Working to ensure that patients are discharged in an organised way with good coordination of services to be involved in their care. Carers and patients to be involved and informed throughout the process

End of Life care in Dementia
If possible (with an available next of kin for patients who lack mental capacity) senior doctors of registrar and consultant grade, will discuss end of life care and advance care planning. Often, a further admission to hospital is not what the patient or their carer wants. Other options are discussed, such as care at home, referral to a hospice or admission to a care home at the appropriate time.

The Nutrition and Dietetic Service

What is happening now?

- Nutrition and dietetic service to acute wards
- Referrals for nutritional support via our nutrition risk screening tool, clinical need for enteral or parenteral nutrition
- Out-patient referrals from GPs/consultants for nutritional support, diabetes, gastroenterology, neurology, surgical etc.
- Type 2 diabetes management – Harriett group sessions at diagnosis
- Domiciliary visits – for nutritionally at risk patients referred by GP
- Care homes – referrals for nutritional support made via self referral pathway
- Referrals for nutritional support made via GP for Residential Homes
- Education – for staff on identification and treatment of malnutrition
- For staff and district nurses – training on enteral nutrition
- Rehabilitation sessions – pulmonary, cardiac and heart failure

What do we want to do?

- Ensure more staff are available at mealtimes to assist patients with feeding, monitoring of intake, offering Oral Nutritional Supplements (ONS) encouraging high calorie snacks and providing encouragement
- Finger food menu available for patients with dementia.
- Improve availability of feeding aids/equipment at ward level.
- Offer opportunities for mobile patients to eat at a table to improve mealtime atmosphere.
- Improve nutritional intake with use of ‘milk rounds/cocktail rounds’
- Ensure correct provision of thickened fluids to patients with dysphagia.
- Reduce pressure ulcer incidence as result of improved nutritional intake for ward patients.
- Offer nutrition and dietetic out-patient service for all diagnoses (including those currently not offered)

Harrogate and District NHS
NHS Foundation Trust

PAINAD TOOL

Pain Assessment in Advanced Dementia Scale/ Communication Difficulties

Please use to assess pain in all patients who are unable to verbally give a pain score, documenting pain score at rest and on movement.

	0	1	2
Breathing independent of vocalisation	**Normal**	**Occasional laboured breathing. Short period of hyperventilation.**	**Noisy laboured breathing. Long period of hyperventilation. Cheyne-Stokes respirations.**
Negative Vocalisation	**None**	**Occasional moan or groan. Low-level speech with a negative or disapproving quality.**	**Repeated troubled calling out. Loud moaning or groaning. Crying.**
Facial Expression	**Smiling or Inexpressive**	**Sad. Frightened. Frown.**	**Facial grimacing.**
Body Language	**Relaxed**	**Tense. Distressed pacing. Fidgeting**	**Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out.**
Consolability	**No need to Console**	**Distracted or reassured by voice or touch.**	**Unable to console, distract or reassure.**
Document Comments by family members/ care givers in nursing notes **Liaise with physiotherapy re Pain on movement**			
SCALE: 0 = NO PAIN	**1 – 3 = MILD PAIN**	**4 – 7 = MODERATE PAIN**	**8 – 10 = SEVERE PAIN**

** Total Score range from 0 to 10 (based on a scale of 0 to 2 for five items), with a higher score indicating more severe pain (0 = 'no pain', 10 = 'severe pain')

Chart for REFERENCE only – do not place in Medical/Nursing notes.

Pain Assessment in Advanced Dementia (PAINAD) Scale – Guidelines.

Breathing

1. **Normal breathing** = effortless, quiet, rhythmic and smooth respirations
2. **Occasional laboured breathing** = bursts of harsh, difficult, rasping respirations
3. **Short period of hyperventilation** = intervals of rapid, deep breathes lasting a short period of time.
4. **Noisy laboured breathing** = negative sounding respirations on inspiration and expirstion. They may be loud, gurgling or wheezing present. They appear strenuous or wearing.
5. **Long period of hyperventilation** = excessive rate and depth of respirations lasting a considerable time.
6. **Cheyne-Stokes respirations** = rhythmic waxing and waning of breathing from very deep to shallow respirations with periods of apnoea (cessation of breathing)

Negative Vocalization

1. **None** = normal speech or vocalization
2. **Occasional moan or groan** = mournful or murmuring sounds, wails or laments, often louder than usual, inarticulate and involuntary.
3. **Low level speech with a negative or disapproving quality** = muttering, mumbling, whining, grumbling, swearing in low volume with a complaining, sarcastic or caustic tone.
4. **Repeated troubled calling out** = phrases or words being said repeatedly, in a tone that suggests anxiety, uneasiness or distress.
5. **Loud moaning or groaning** = as no. 2 above, but much louder than usual volume.
6. **Crying** = utterance of emotion accompanied by tears, may be sobbing or quiet weeping.

Facial Expression

1. **Smiling** = corners of the mouth upturned, brightening of the eyes, look of pleasure or contentment. Inexpressive = neutral, at ease, relaxed or blank look.
2. **Sad** = unhappy, lonesome, sorrowful, dejected, may be tearful
3. **Frightened** = a look of fear, alarm or heightened anxiety, eyes may be wide open.
4. **Frown** = corners of mouth turned down, may have incressed facial wrinkling around forehead and mouth.
5. **Facial grimacing** = distorted or distressed look, brow and area around mouth more wrinkled, eyes may be squeezed shut.

Body Language

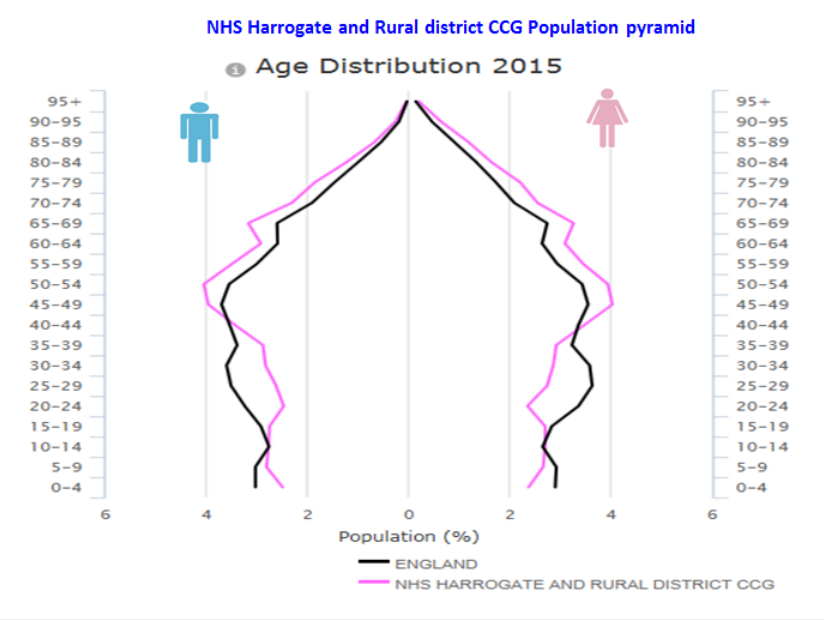
1. **Relaxed** = calm, restful, mellow appearance.
2. **Tense** = strained, apprehensive or worried appearance, jaw may be clenched (exclude contractures)
3. **Distressed pacing** = activity that seems unsettled, may be fearful, worried or disturbed element, rate may be fast or slow.
4. **Fidgeting** = restless movement, squirming, wiggling, repetitive touching, tugging or rubbing body parts, might be moving of furniture/other items.
5. **Rigid** = stiffening of the body, arms and/or legs are tight and inflexible; trunk may appear straight and unyielding (excluding contractures).
6. **Fists clenched** = tightly closed hands, may be opened and closed repeatedly or held tightly shut.
7. **Knees pulled up** = flexing the legs and drawing the knees towards the chest, overall troubled appearance (exclude any contractures).
8. **Pulling or pushing away** = restiveness upon approach or to care, person trying to escape by yanking or wrenching free or pushing carer away.
9. **Striking** = hitting, kicking, grabbing, punching, biting or other form of physical aggression.

Consolability

1. **No need to console** = sense of well-being, appears content.
2. **Distracted or reassured by voice or touch** = disruption in the behaviour when the person is spoken to or touched, behaviour stops during the period of interaction with no indication that the person is at all distressed.
3. **Unable to console, distract or reassure** = the in ability to soothe the person to stop a behaviour with words r actions, no amount of comforting, verbal or physical will alleviate the behaviour.

Reference: Warden V, Hurley AC, Volicer L. (2003) Development and psychometric evaluation of the pain assessment in advanced dementia (PAINAD) scale. J AM Med Dir Assoc. 4: 9-15.

Data on our elderly population



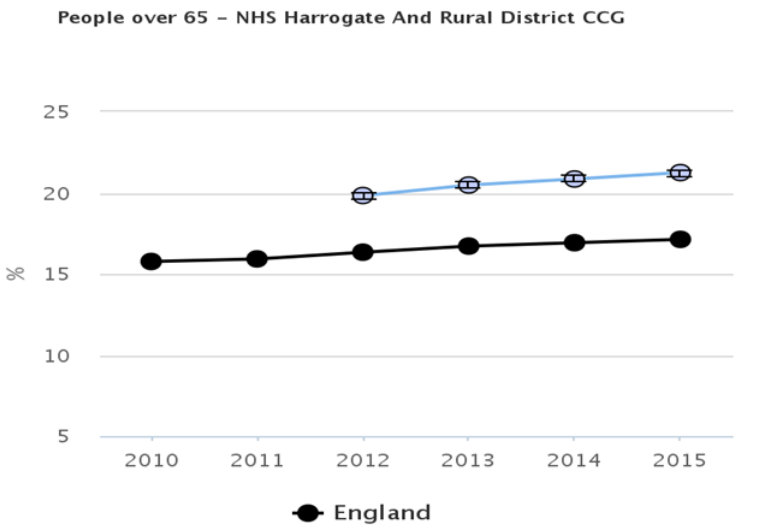
In comparison to the national average Harrogate has a lower percentage of people younger than 29 and a higher proportion aged 45 and over.
27% of the district's population is aged 60 and over (22.4% nationally).

By **2020** the district's population who are aged **65 and over** is projected to rise by around **6,000** people - a **19% rise** from current levels *(POPPI 2013)*.

The life expectancy for both men and women is higher than the national average.

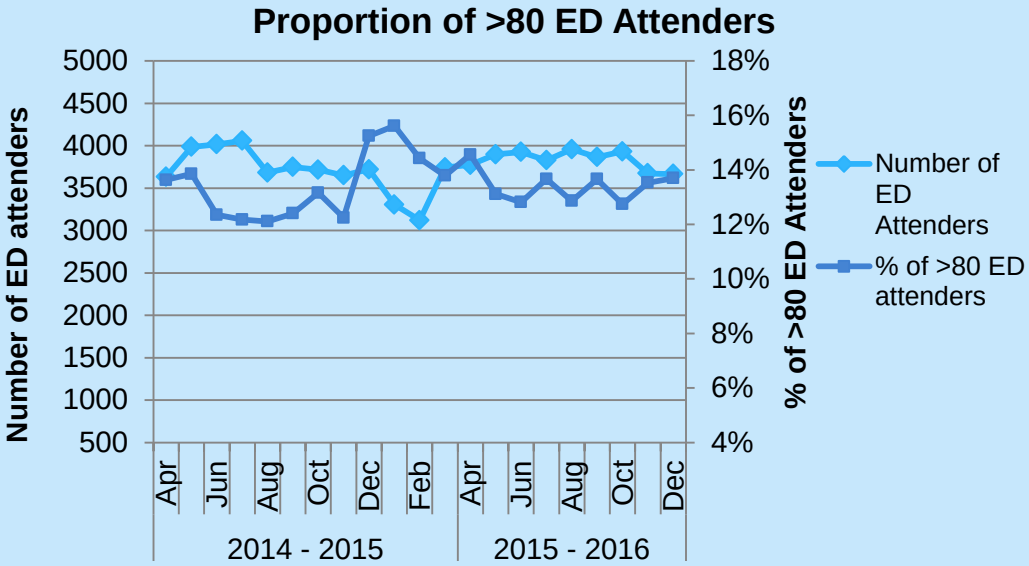
Life Expectancy (Male): 79.6 (England: 78.6) (2008-2010)
Life Expectancy (Female): 83.8 (England 82.6) (2008-2010)

Population in 2013: 159,900
Population in 2020: 165,200 *(ONS Population Projections)*



Emergency Department (ED) Attendance

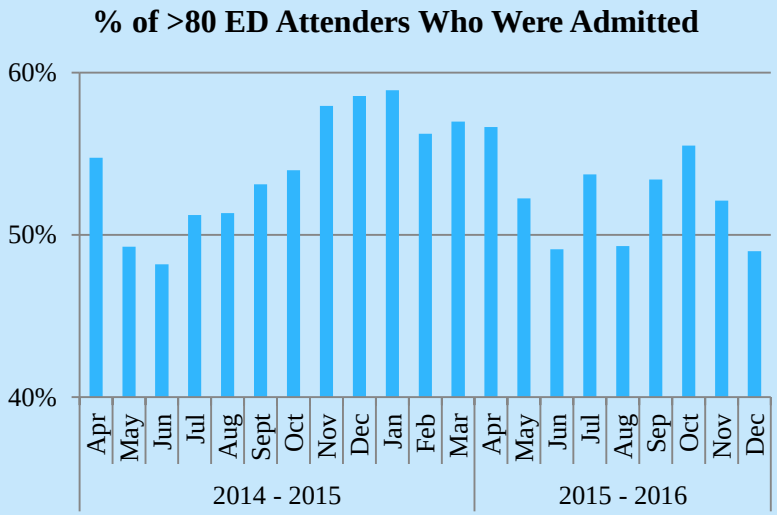
Although the frail elderly represent a relatively small number of overall presentations to the emergency department this patient group has a very high propensity to be admitted and once in hospital often decompensate, have a long length of stay and may have complex discharge needs, these issues combine to generate a large number of bed days, with the possibility of other complications (such as infection and confusion) arising while they are in hospital.



The graph demonstrates a clear seasonal trend with a winter and spring peak in 2014/15.

The proportion of people >80 years old attending increased in the winter months of 2014/15, even though the overall number of ED attenders decreased.

Due to the mild winter of 2015/16, we haven't seen the typical rise in the number of >80 ED attenders however the proportion still increased when the overall number of ED attenders decreased. We believe that our continued early frailty assessment and community work will support a reduction.

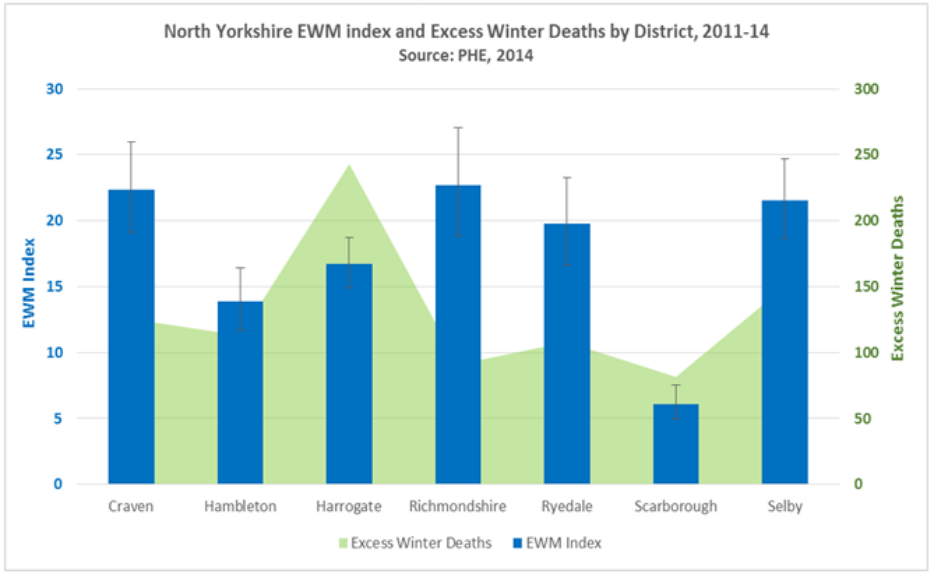


The graph demonstrates a high proportion of >80 year olds who attended ED being subsequently admitted; showing that for half of the year, more than half of >80 year olds are admitted to hospital .

The graph also shows a reduction 2015/16 suggesting we are getting better at turning people around without the need for admission.

Public health priority 5: Improving and maintaining health during the winter months

North Yorkshire EWM Index and Excess Winter deaths by district, 2011-2014.

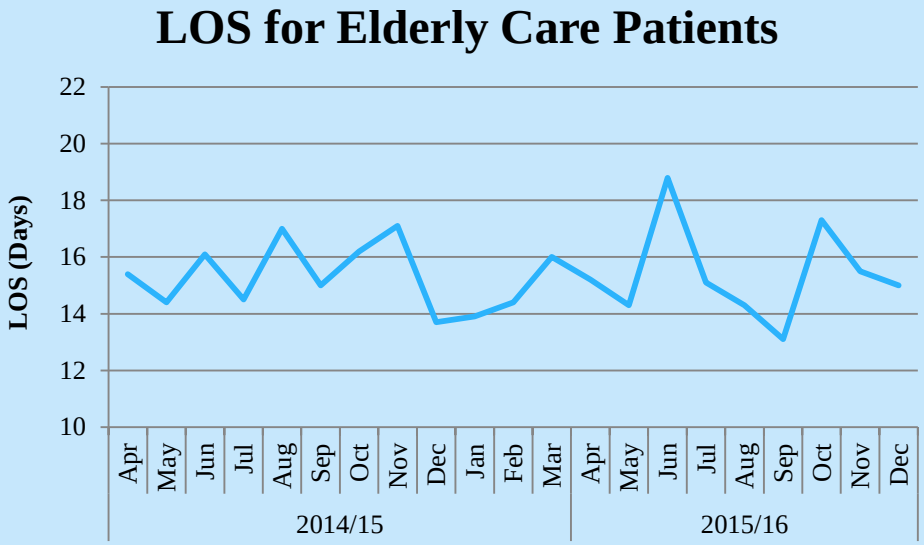


- Direct effects of weather impact on accidents, slips and trips and road safety
- Cold can increase the occurrence of heart attacks, respiratory and influenza related diseases resulting in death
- For every excess winter death it is estimated that there are an additional eight emergency admissions to hospitals
- There were a total of 90 excess winter deaths reported in Harrogate and 30 in Selby(2013-14)
- Avoidable early deaths can be positively influenced by tackling cold damp homes and fuel poverty
- There are 6,279 households in Harrogate and 2,476 households in Selby living in fuel poverty

Length of stay (LOS) for elderly patients

The successful discharge of frail older people following an emergency attendance or admission to hospital relies on effective joint working between the NHS, social care partners and the independent sector.

Evidence suggests that care planning can improve a patient's ability to self-manage and reduce emergency department attendances and emergency admissions to hospital for long-term conditions that are prone to rapid deterioration.



During July to September 2014/15; two of our elderly care consultants put concerted effort into care planning and this is demonstrated in reduced length of stay shown by the graph.

LOS hasn't increased as expected due to more and more elderly population and more and more co-morbidities .

References

The following references have been used in the development of this strategy:

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- Equity and excellence: Liberating the NHS, DOH, Jul 2010
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- Public Health Context, Harrogate and Rural District, 2015, Rachel Richards, Consultant in Public Health
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Glossary

- 4ATt – Alertness, Age, Attention and Acute change or fluctuating course
- ACP – Advanced Care Planning
- AMTS – Abbreviated Mental Test Score
- CAM – Confusion Assessment Method
- CAT – Clinical Assessment *Triage*
- CAUTI – Catheter Associated Urinary Tract Infections
- CCG – Care Commissioning Group
- CEO – Chief Executive Officer
- CG – Clinical Guidance
- CGA – Comprehensive Geriatric Assessment
- COPD – Chronic Obstructive Pulmonary Disease
- CPLD – Care Plan Last Days
- CQUIN – The Commissioning for Quality and Innovation
- CVD – Cardiovascular Disease
- DNACPR – Do Not Attempt Cardiopulmonary Resuscitation
- DOH – Department of Health
- DoLs – Deprivation Of Liberties
- ED – Emergency Department
- EOL – End Of Life
- EOLC – End Of Life Care
- EPaCCs – Electronic Palliative Care Coordination System
- EWM – Excess Winter Months
- FAIRI – Find, Assess, Investigate, Refer, Inform
- FEAT – Frail Elderly Assessment Team
- FIB – Fascia Iliaca Block
- GSF – Gold Standard Framework
- HDFT – Harrogate District Foundation Trust
- HaRD – Harrogate and Rural District
- LOS – Length of Stay
- MDT – Multi Disciplinary Team
- MFFRA – Multi Fractural Risk Assessment
- MHRA – Medicines Healthcare Regulation Authority
- NICE – The National Institute for Health and Care Excellence
- ONS – Oral Nutritional Supplements
- OT – Occupational Therapist
- OTAGO – Approved training programme
- PAINAD – Pain Assessment In Advanced Dementia
- POPPI - Projecting Older People Population Information
- PREMs – Patient Reported Experience Measure(s)
- SSKIN – Surface Skin Keep Incontinence Nutrition
- UCCC – Urgent, Community and Cancer Care

Harrogate and District NHS
NHS Foundation Trust

Paper No: 13.0

Board Committee report to the Board of Directors

Committee Name:	Quality Committee (QC)
Committee Chair:	Mrs L.A. Webster, Non-Executive Director/ Quality Committee Chair
Date of last meeting:	4 May 2016
Date of Board meeting for which this report is prepared	25 May 2016

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

Reports received:

- Paediatric Diabetes National Audit Report 2014/15 has been received into the Trust: a verbal report indicated the initial view that the results are disappointing. The committee was informed that an action plan is to be progressed and the committee will be receiving a written report in due course.
- NICE Compliance Report: the committee noted a lack of compliance information relating to at least 200 items of NICE guidance. As a result the committee discussed and agreed a more efficient methodology to review these items which would accelerate gaining assurance.
- Baseline reports for the 2016/17 Quality Priorities were received and discussed. The committee requested greater clarity around the outcomes and measurements to be used to see the progress in achieving the ambitions. Two of the reports raised concerns related to stroke and sepsis results and the quality of service provision and the committee is therefore pleased to see planned improvements in these areas as priorities for action in the year.

Safety Concerns discussed on the Day:

The unusually high activity levels in Emergency Department (ED) were noted. The committee heard that an ED summit was to take place to enable lessons to be learned from this situation.

To Note:

- Quality Account for 2015/16 draft was reviewed and the committee endorsed the breadth of activity which had been conducted in respect of quality activity carried out during the year.
- The Quality Committee Annual report and forward work-plan were agreed and submitted to the Audit Committee for review (both items provided with this report). These are included as appendices to this report.

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

No risks to be noted.

Matters for decision

The Board is asked to endorse the proposed forward work-plan for the QC for the FY16/17.

Action Required by Board of Directors:
As above.

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Annual Report of the Quality Committee

Prepared for the Audit Committee April 2016

The purpose of this annual report is to provide assurance that the Quality Committee is working effectively within its terms of reference (ToR) and achieving the required outcomes/impact.

Purpose of the Committee

The Quality Committee (QC) is an accountable Committee of the Board of Directors. The purpose of which is to oversee arrangements for quality governance and seek, and provide, assurances on the delivery of high quality care and regulatory compliance.

Background

The QC was initiated following a review of the Governance arrangements within the Trust, the first meeting being held in July 2015.

The work of this committee has evolved during the year, with the initial focus being to progress a work-plan to deliver the ToR, plus give assurance that those working groups which were de-commissioned following the review, did not result in any outstanding activity being lost.

In January 2016 following the Trust's Well-Led Review, Deloitte were invited to observe a QC meeting and provide feedback and suggestions on any areas to be included or where improvements might be required. Overall the feedback was positive, confirming that the agenda was put together well and the Committee was gaining assurance in the right areas. Two suggestions for areas for development were welcomed and are being implemented by the Committee, the first to include a specific themed report on Patient Safety, the second to develop a dashboard for the Quality Report Data received each month by the Committee.

Membership and attendance

Attendance at meetings has been very good. (Quorate being 6 core members)
One change has been made to the Core membership, following the inclusion of the activity to gain assurance in relation to Clinical Audit; Dr Clare Hall replaced Dr David Scullion as a Core Member.

Governors started to attend meetings in September to observe Non-Executive Director input.

Quality Committee

Member (by title or group representing as per ToR) / Date of Meeting	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Total Attended	No of Meetings per Year	Percentage
Non-Executive Director (Chair)	1	1	1	1	1	1	1	1	1	9	9	100%
Non-Executive Director (Neil McLean)	1	1	1	1	0	1	1	0	1	7	9	78%
Non-Executive Director (Prof Sue Proctor)	1	1	0	1	1	1	1	1	1	8	9	89%
Chief Executive	1	1	1	0	0	1	1	1	1	7	9	78%
Chief Nurse	1	1	1	1	1	1	1	1	1	9	9	100%
Medical Director/ Deputy Medical Director	1	0	1	0	1	1	0	1	1	6	9	67%
Chief Operating Officer	0	1	0	1	1	1	1	1	1	7	9	78%
Director of Workforce and OD	1	1	1	1	0	1	1	1	1	8	9	89%
Deputy Director of Governance	1	0	1	1	1	1	1	1	1	8	9	89%
Head of Risk Management	1	1	0	1	1	1	1	1	1	8	9	89%
Clinical Director - ACC	1	1	1	1	1	1	1	1	1	9	9	100%
Clinical Director - EC	1	1	1	1	1	1	1	1	1	9	9	100%
Clinical Director - IC	0	0	1	1	1	1	1	1	1	7	9	78%
Total of members per meeting	11	10	10	11	10	13	12	12	13			
*Ad hoc attendance may be by invitation of the Chair. The representative of the subgroups may also be a directorate representative.												
Sally Blackburn, Public Governor			1									
Pamela Allen, Public Governor				1		1						
Jane Hedley, Public Governor					1			1				
Joyce Purkis, Public Governor							1		1			
Michael Armitage, Public Governor												

Date on which ToR were confirmed and any changes to ToR in year
ToR were finalised in November 2015. The Committee took responsibility for gaining quality assurances around Clinical Auditing activity in December, however it was not considered necessary to alter the ToR as a result of this.

Progress on stated committee objectives or key areas of responsibility

The committee has aimed to gain assurance in relation to the four domains defined in Monitor's 'Well-led framework for governance reviews' guidance for NHS foundation trusts:

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

The work-plan has developed and evolved during the year and is now considered under 6 key headings:

1. To identify current concerns
2. Quality Reports
3. Patient Safety
4. Effective Care and Outcomes
5. Patient Experience
6. Regulatory and Compliance

1. Identify Current Concerns – The Committee uses this section to focus on specific issues that are impacting upon the ability of the Trust to deliver quality care and to gain assurances that suitable actions / activity is underway to address these. Examples of this are:
    a. regular updates received in relation to the GP Out of Hours Service action plan to improve the National Quality Requirements (NQR) results;
    b. progress to manage the cases of Clostridium difficile seen in the year;
    c. Staffing levels

2. Quality Reports – Throughout the year the Committee has heard regular updates from each Directorate on their progress to deliver the Trusts 2015/16 quality priorities which were:
    a. Communication
    b. Patient Flow
    c. Frail Elderly

    Annual Quality Account Report – The QC has oversight of this annual account

3. Patient Safety – Recent discussion at the QC has given consideration to what themes a new patient safety report should include. It is proposed that the incident section be removed from the Patient Experience and Incident report and included in the new report and incidents would be reported alongside information on claims, mortality data, Patient Safety Alerts, CAS (Central Alerting System) alerts, to provide a comprehensive picture on patient safety, on a regular basis, and highlight any issues requiring escalation. This was agreed and the first report will be received in Quarter 1 2016/17.

4. Effective Care and Outcomes – during the year the Committee took responsibility for seeking assurance in relation to the Clinical Effectiveness Audit program and has signed off the plan for 2016/17. A further important area of work has been the development of the processes for gaining assurance in relation to External Reports Received. In place now is a system for recording receipt of external reports and a log for the lead individual responsible to action these. In addition is a process to gain assurance that external reports are being acted upon and that action plans are being progressed within the

agreed timescales.

5. Patient Experience – The Committee hears the Patient Experience and Incident report each quarter, a new format report has provided assurance on this element of quality. An area the committee has focused on is dealing with complaints and closing actions within deadline.

6. Regulatory and Compliance - a list of reports received is below.

Finally the Committee has firmly endorsed the implementation of a Quality Charter.

Summary of Reports received by the Committee

Below are the reports which have been progressed, reviewed or endorsed by the Committee.

Just one item has not been dealt with as per the plan - Caldicott Report, this item was identified as an area for seeking assurance however the scope of the report has not been developed.

Report		Item Lead
Quality Account		
Timetable for quality account preparation		S Wood
Draft report		S Wood
Final report		S Wood
Quality priority updates		
Communication		Clinical Directors
	Acute & cancer Care	
	Elective Care	
	Integrated care	
Patient flow		Clinical Directors
	Acute & cancer Care	
	Elective Care	
	Integrated care	
Frail elderly		Clinical Directors
	Acute & cancer Care	
	Elective Care	
	Integrated care	
Reports		
Infection Prevention and Control		R Hobson
Information Governance Toolkit		C Howard
Caldicott Report		D Scullion
Local Supervising Authority audit report / action plan		S Keogh
Annual Maternity screening report		S Keogh
Health and safety annual report		R Mitchell
Patient experience report - quarterly		A Leng
Annual report - Staff FFT and staff survey as it relates to the		P Marshall
Clinical audit plan / report - quarterly		H Moss / R Wixey
Well led review self assessment		S Wood
NICE compliance report		H Moss / R Wixey
Policy review		S Wood
Maternity assurance statement		K Johnson
Annual report on the management of Controlled Drugs		A Alldred
Annual report from directorates and steering groups		
Progress report on external reports from directorates and steering groups		
Clinical Effectiveness and Audit annual report		R Wixey

Proposed objectives for 2016/17

The Committee will continue to gain assurance under the 6 headings listed above.
The Committee will hear updates from the Directorates on progress to deliver the four new Quality Priorities for the year which are:

- Reduce morbidity and mortality related to sepsis
- Improve care of people with learning disabilities
- Improve the management of patients on insulin

- Provide high quality stroke care

The forward plan for reports to be received is listed below. The item Caldicot Report has been highlighted in red, the view is that we need further understanding of what information would be included in this report and to cross reference this with information already received before a decision can be made whether to retain this as an item for seeking assurance against.

Report	Item Lead	Reports due
Quality Account		
Timetable for quality account preparation	S Wood	December
Draft report	S Wood	April
Final report	S Wood	May
Quality priority updates		
Reducing morbidity and mortality from sepsis	D Earl	Baseline, Q2, Q3
Improving care of people with learning disabilities	T Campbell	Baseline, Q2, Q3
Improving the management of inpatients on insulin	A Alldred	Baseline, Q2, Q3
Improving stroke care		Baseline, Q2, Q3
Reports		
Infection Prevention and Control	R Hobson	December
Information Governance Toolkit	C Howard	October
Caldicott Report	D Scullion	
Local Supervising Authority audit report / action plan	S Keogh	October
Annual Maternity screening report	S Keogh	October
Health and safety annual report	R Mitchell	April
Patient experience report - quarterly	A Leng	Sept (Q1), Dec (Q2), March (Q3), June (Q4)
Annual report - Staff FFT and staff survey as it relates to the	P Marshall	April
Clinical audit plan / report - quarterly	H Moss / R Wixey	Sept (Q1), Dec (Q2), March (Q3), June (Q4)
Well led review action plan follow up	S Wood	
NICE compliance report	H Moss / R Wixey	Sept (Q1), Nov (Q2), Feb (Q3), May (Q4)
Policy review	S Wood	Sept, Dec, March, June
Maternity assurance statement	K Johnson	December, June
Annual report on the management of Controlled Drugs	A Alldred	January
Progress on external reports from directorates / steering groups	Leads	January and July
Clinical Effectiveness and Audit annual report	R Wixey	June
Patient safety quarterly report	S Wood	August (Q1), Nov (Q2), Feb (Q3), May (Q4)
Safeguarding children annual report	S Keogh / new post	
Adult safeguarding annual report	J Farnhill	

Conclusion

The Quality Committee considers it has delivered to the Terms of Reference as requested by the Board and has comprehensive minutes and actions log on file to further demonstrate this.
The Committee has developed a clear forward plan of activity to continue this work throughout 2016/17.

Author

Lesley A Webster, Non-Executive Director, Chair Quality Committee.
Date: 20/04/2015

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Quality Committee Forward Plan – FY 2016/17

Forward plan

Quality Committee

Report	Item Lead	Reports due
Quality Account		
Timetable for quality account preparation	S Wood	December
Draft report	S Wood	April
Final report	S Wood	May
Quality priority updates		
Reducing morbidity and mortality from sepsis	D Earl	Baseline, Q2, Q3
Improving care of people with learning disabilities	T Campbell	Baseline, Q2, Q3
Improving the management of inpatients on insulin	A Alldred	Baseline, Q2, Q3
Improving stroke care		Baseline, Q2, Q3
Reports		
Infection Prevention and Control	R Hobson	December
Information Governance Toolkit	C Howard	October
Local Supervising Authority audit report / action plan	S Keogh	October
Annual Maternity screening report	S Keogh	October
Health and safety annual report	R Mitchell	April
Patient experience report - quarterly	A Leng	Sept (Q1), Dec (Q2), March (Q3), June (Q4)
Annual report - Staff FFT and staff survey as it relates to the	P Marshall	April
Clinical audit plan / report - quarterly	H Moss / R Wixey	Sept (Q1), Dec (Q2), March (Q3), June (Q4)
Well led review action plan follow up	S Wood	
NICE compliance report	H Moss / R Wixey	Sept (Q1), Nov (Q2), Feb (Q3), May (Q4)
Policy review	S Wood	Sept, Dec, March, June
Maternity assurance statement	K Johnson	December, June
Annual report on the management of Controlled Drugs	A Alldred	January
Progress on external reports from directorates / steering groups	Leads	January and July
Clinical Effectiveness and Audit annual report	R Wixey	June
Patient safety quarterly report	S Wood	August (Q1), Nov (Q2), Feb (Q3), May (Q4)
Safeguarding children annual report	Wendy Atkinson	tbc
Adult safeguarding annual report	J Farnhill	June
Annual report Quality Committee	L Webster	April
Annual review Quality Committee TOR	L Webster	June

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Harrogate and District NHS
NHS Foundation Trust

Paper No: 13.2

Board Committee report to the Board of Directors

Committee Name:	Audit Committee
Committee Chair:	Chris Thompson, Non-Executive Director/ Audit Committee Chair
Date of last meeting:	Thursday 5th May and Thursday 19th May 2016
Date of Board meeting for which this report is prepared	Wednesday 25th May 2016

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

1. **The work of the Committee at its May meetings has been very much focused upon financial year end matters. Following the agreement of Accounting Policies and the adoption of the Going Concern concept as the basis for preparation at earlier meetings, the Committee has reviewed various iterations of the key year end reporting documentation.**

2. **At the meeting on 5th May, the following documents were considered:**

    a. **NHS Foundation Trust Code of Governance Self-Assessment and Actions**
    b. **Quality Committee Annual Report 2015/16**
    c. **Draft Audit Committee Annual Report 2015/16**
    d. **LSMS Annual Report 2015/16**
    e. **Accounts Briefing Paper**
    f. **Draft Trust Accounts 2015/16**
    g. **Draft Charity Accounts 2015/16**
    h. **Internal Audit Annual Report 2015/16**
    i. **Head Of Internal Audit Annual Opinion Statement**

3. **At the meeting on 19th May, the following documents were considered:**

    a. **Draft Quality Account 2015/16**
    b. **Audit Committee Annual Report 2015/16**
    c. **Annual Corporate Governance Statement**
    d. **Draft Annual Report 2015/16**
    e. **Updated Draft Trust Accounts 2015/16**
    f. **Updated Draft Charity Accounts 2015/16**
    g. **Review of Losses and Special Payments**
    h. **Counter-Fraud Annual Report 2015/16**
    i. **External Audit ISA 260 Audit Highlights Memoranda and draft letters of representation**
    j. **Confirmation of External Audit independence**

4. **The Audit Committee has also undertaken its "normal" programme of work and review during the course of the meetings. This has included reviews of the minutes of Corporate Risk Review Group, Quality Committee, Corporate Risk Register and the Board Assurance Framework.**

5. **Considerable focus was given at the meeting on 5th May to a very comprehensive Periodic Internal Audit Report. The Committee expressed concern at the Limited Assurance outcomes reported for a number of audits and also at the delays in implementing certain Internal Audit recommendations, as highlighted in the Head of Internal Audit Opinion Statement. These concerns are the subject of a separate paper to be considered at the Board Meeting held in private.**

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

Please see separate paper

Matters for decision

- **The Committee has carefully considered a range of documents relating to the financial year end that are coming to the Board for consideration and approval. These include:**
    - **Accounts Briefing paper**
    - **Draft financial statements for the Trust and for the Charity**
    - **Draft representation letters for the Trust and for the Charity**
    - **ISA 260 Audit Highlights Memoranda**
- **The Committee also submits its Annual Report for consideration by the Board;**
- **The Audit Committee can confirm that it does recommend that the Board approves the signing of the year end accounts for the Trust and for the Charity and also the letters of representation for the Trust and the Charity for submission to the external auditors, KPMG.**

Action Required by Board of Directors:

The Board is asked to note the considerations that took place at the two meetings of the Audit Committee on the 5th May and the 19th May, and also the recommendations made by the Committee.

Harrogate and District NHS
NHS Foundation Trust

Council of Governors

Minutes of the public Council of Governors' meeting held on 6 February 2016 at 10:45 hrs at St. Aidan's Church of England High School, Oatlands Drive, Harrogate.

Present:

Mrs Sandra Dodson, Chairman
Ms Pamela Allen, Public Governor/ Deputy Chair of Council of Governors
Mr Michael Armitage, Public Governor
Dr Sally Blackburn, Public Governor
Mrs Yvonne Campbell, Staff Governor
Mrs Cath Clelland, Public Governor
Mrs Angie Colvin, Corporate Affairs and Membership Manager
Mr Jonathan Coulter, Director of Finance/Deputy Chief Executive
Dr Sarah Crawshaw, Stakeholder Governor
Mr Tony Doveston, Public Governor
Mrs Emma Edgar, Staff Governor
Cllr John Ennis, Stakeholder Governor
Mrs Beth Finch, Stakeholder Governor
Mr Andrew Forsyth, Interim Head of Corporate Affairs
Mr Robert Harrison, Chief Operating Officer
Mrs Jane Hedley, Public Governor
Mrs Pat Jones, Public Governor
Mrs Sally Margerison, Staff Governor
Mr Phillip Marshall, Director of Workforce and Organisational Development
Mr Peter Pearson, Public Governor
Mrs Joyce Purkis, 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
Mrs Lesley Webster, Non-Executive Director

In attendance: 4 members of the public

1. Welcome to the newly elected and appointed Governors, the public and setting the context of the meeting, including apologies for absence

Apologies were received from Cllr. Bernard Bateman, Stakeholder Governor, Ms Clare Cressey, Staff Governor, Mrs Liz Dean, Public Governor, Mrs Jill Foster, Chief Nurse, Mr Neil McLean, Non-Executive Director, Mrs Zoe Metcalfe, Public Governor, Mrs Joanna Parker, Stakeholder Governor, Prof. Sue Proctor, Non-Executive Director, Mr Andy Robertson, Public Governor, Mr Ian Ward, Non-Executive Director, Mr Paul Widdowfield, Communications and Marketing Manager and Dr Jim Woods, Stakeholder Governor.

Mrs Dodson offered a warm welcome to the members of the public and to the newly elected and appointed Governors in attendance: Mrs Campbell, Staff Governor for Non-

Clinical, Mr Doveston, Public Governor for Harrogate and surrounding villages and Mrs Finch, Stakeholder Governor representing the Voluntary Sector. New Governors Ms Cressey, Staff Governor for Other Clinical and Mrs Metcalfe, Public Governor for Knaresborough and east district, were unable to attend the meeting due to other commitments. Mrs Dodson also congratulated Dr Scott, Staff Governor for Medical Practitioners on being re-elected for a second term of office.

Mrs Dodson commented that some members of staff would be using BoardPad during the meeting; an electronic meeting and document system as opposed to hard copy papers. She welcomed questions for item 9 on the agenda and asked for these to be submitted during the break.

2. Minutes of the last meeting, 4 November 2015

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

3. Matters arising and review of actions schedule

3.1 Appointment of Company Secretary

Mrs Dodson was pleased to report that the Trust had appointed Miss Debbie Henderson as the Trust's Company Secretary; this role was a professional and qualified position to develop further the Deputy Director of Corporate Affairs role. Miss Henderson was already established in this role at University Hospitals Bristol.

Mrs Dodson took this opportunity to thank Mr Forsyth who had covered the role of Deputy Director of Corporate Affairs brilliantly in the interim measure and he would continue to work for the Trust as Revalidation and Compliance Manager. Mr Forsyth had been recently acknowledged by the Care Quality Commission (CQC) for his input into the organisation of their recent visit to the Trust.

3.2 Effectiveness of Quality of Care Teams update

In Mrs Foster's absence, Mrs Dodson provided a brief explanation of the role of the Quality of Care Teams for those members of the public present.

There had been some areas of concern expressed by Governors regarding both the consistency and medical representation across the different teams. Mrs Foster was leading a review into the effectiveness of the Quality of Care Teams including a review of standards which would form the basis of the overall Terms of Reference. There would be reference to the Trust's objectives and quality improvement priorities in the standards going forward.

Mrs Dodson confirmed that Mrs Colvin would continue to assign Governors to a variety of Quality of Care Teams across the Trust and she highlighted how their attendance at these meetings would provide Governors with an additional level of assurance into quality of care.

Good quality care is at the heart of the Trust's vision and mission and Dr Tolcher stated that the Quality of Care Teams would assist in the delivery of our Quality Charter.

Matters arising not on the agenda:

Mr Pearson asked for an update on the Ripon development.

Dr Tolcher confirmed that work was progressing, albeit slowly. No final decisions had been made as scoping work was still underway, but hopefully there would be a further update available at the next meeting in May.

Mrs Clelland enquired about the contract to deliver children's services in Middlesbrough; further information would be available in the Chief Executive's update under item 8 on the agenda.

Mrs Jones raised an issue regarding patients being treated at York Hospital or via a private appointment as there were no appointments for some specialities through Choose and Book at Harrogate for the foreseeable future. Mrs Dodson commented that a similar question regarding Choose and Book had been raised by a Governor at a previous meeting.

In response, Mr Harrison confirmed that the Trust continued to work hard to predict the demand for the range of services using the NHS e-Referral Service, a national programme which had replaced Choose and Book in 2015. The system worked well where capacity matched demand however, when demand was high, some specialities ran out of slots available to book online. Mr Harrison was unable to discuss individual cases, but agreed to follow this up with Mrs Jones outside of the meeting.

Action: Mr Harrison/Mrs Jones

Mrs Dodson clarified that individual cases could not be discussed in the meeting, but thanked Governors for raising subjects which were in the interests of the members and the general public, and of a generic matter.

Mr Pearson asked for an update regarding District Nursing in the Ripon area following the question he raised at the last meeting in November.

Dr Tolcher confirmed that the first New Care Model pilot site in Knaresborough, Boroughbridge and Green Hammerton commenced on 1 February. District Nurses were now working together to deliver a joined up service; recruitment had been successful and the situation had improved. Staff were able to choose their own shift pattern and the view was that caseloads were appropriate.

There were no other outstanding actions on the schedule at Paper 3.0.

4. Declaration of interests

There were no declarations of interests received.

4.1 Council of Governors' Declaration of Interests

Mrs Dodson reminded Governors that they would be asked to sign a Declaration of Interest form on an annual basis and 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

Mrs Dodson was pleased that Ms Allen was now at the meeting in her role as Deputy Chair of Governors and Lead Governor. She was looking forward to working with Ms Allen who had already shown her enthusiasm and commitment to the role.

Mrs Dodson referred briefly to the CQC inspection which took place between 2 and 5 February; a further update would be included in the Chief Executive's update later in the meeting.

6. Governor sub-committees

Mrs Dodson clarified the role of the two formal sub committees and the Patient and Public Involvement, Learning from Patient Experience Group 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 Jane Hedley, had been circulated prior to the meeting and was taken as read.

Mrs Hedley highlighted the ongoing activities of committed volunteers including success at the 2015 Harrogate and District Volunteering Oscars. She was also delighted to provide an update regarding the Work Experience Programme, which was being run in-house by the Corporate Secretarial team. Contact had been made with 16 local schools and there was an increase in the total number of placements being offered. Mrs Hedley thanked the team for their hard work in raising the profile of such a valuable programme.

There were no questions for Mrs Hedley.

Mrs Dodson added how proud the Trust was of all the volunteers who were dedicated to giving their time to improve the patient experience.

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 Foundation News magazine in her report and was looking forward to the next edition which would be sent to members shortly. She asked for fellow Governors to volunteer in the production of the magazine by proof reading articles; anyone interested in helping should contact Mrs Colvin following the meeting.

There were no questions for Ms Allen.

6.3 Patient and Public Involvement

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

Mrs Purkis explained that the Group met every month and the meeting was chaired by the Chief Nurse, Mrs Foster. She highlighted the National Inpatient Survey in her report and confirmed that, at their last meeting, the Group had agreed to select five questions from the survey for review at Directorate level.

Mrs Dodson reiterated the importance of the Group and how their role was to understand, monitor and challenge live issues and to seek to improve the quality of experience for people using Trust services.

There were no questions for Mrs Purkis.

6.4 Patient Safety Visits – update on last year and plans for this year

The report from the Deputy Director of Governance had been circulated prior to the meeting and taken as read.

Mrs Dodson provided a brief explanation of Patient Safety Visits and referred to the report which included a detailed summary of visits made in the last year, issues raised, and plans for the year ahead. Mrs Dodson was pleased that Governors had also taken part in a significant number of visits alongside Executive and Non-Executive Directors.

Cllr. Ennis commented that it was good to see a summary of the visits undertaken however, following a visit to Ripon Fast Response Team, he would have liked to have seen the visit report. Dr Tolcher apologised for this oversight and provided reassurance that following each visit a written report and action log was produced. She also confirmed that Senior Management Team received a progress report on Patient Safety Visits. It was agreed to circulate the Ripon Fast Response Team visit report to Cllr Ennis and circulate the appendices referred to in the paper.

Action: Deputy Director of Governance

7. HDFT Constitution and ratification of the minutes of the HDFT Constitution Review Working Group, 07.12.15

Paper 7.0 had been circulated prior to the meeting and taken as read. The Council of Governors was asked to discuss and approve the proposed amendments to the Constitution and ratify the minutes of the Constitution Review Working Group, 7 December 2015.

Mrs Dodson asked for any questions and explained that the following the meeting, the proposed amendments would be submitted for discussion and approval to the Trust's Board of Directors at its meeting on 24 February. If approved, the amended Constitution would then be submitted to Monitor and the vacancy for a Public Governor for the Rest of England would be included in the scheduled election in the spring.

In line with the proposed amendments:

1. Following the recent appointment of a 'Company Secretary' the term 'Secretary' and 'Deputy Director of Corporate Affairs' would be replaced with 'Company Secretary' throughout the document – **all Governors present at the meeting agreed.**

2. To increase the number of public constituencies to six and increase the Council of Governors by one additional public Governor to represent the interests of a membership covering 'The Rest of England' – Mrs Dodson summarised the detailed discussion regarding these proposals by the Constitution Review Working Group and welcomed any Governors present at the Working Group to answer any questions.

   Mrs Crawshaw commented that the Trust could have interest in 'The Rest of England' vacancy from someone residing in the South of England; although this would probably be unlikely.

   Mrs Clelland asked for some assurance that the Trust would not go to disproportionate effort to obtain high numbers of members in 'The Rest of England'. Mrs Dodson confirmed that the Group had discussed this and agreed that a minimum of 50 members would be required.

   Mrs Colvin explained that we had approximately 455 Affiliates on our database at the current time; people who had chosen to engage with the Trust but were unable to become members as they were either under the age of 16 or lived outside of the Trust's membership catchment area. The people 16 years or over residing in England would therefore automatically become members and would be the target audience for the new 'Rest of England' Governor.

   In view of the addition of nearly 500 new staff members with the new contracts for Children's Services in Middlesbrough, Durham and Darlington, Mrs Margerison asked about the addition of another Staff Governor.

   In response, Mrs Dodson confirmed that as the majority of additional staff would fall within the Nursing and Midwifery Staff Class and, as there were currently two Staff Governors to represent the interests of these members, the numbers across the four classes remained proportionate and the Working Group agreed there was not a requirement at this stage to review further.

   Dr Scott also added that this extra constituency would impact positively on future recruitment of Non-Executive Directors as applicants were required to be a member of the Trust.

   Mrs Dodson thanked Dr Scott for highlighting this and confirmed that we would want to consider recruiting Non-Executive Directors who resided in areas where we were offering services.

   In relation to the proposed amendments listed in Paper 7.0, items 2 – 4, all Governors present at the meeting agreed.

   Finally, Mrs Dodson confirmed that item 5 did not require a vote, but for clarity, the Working Group agreed with the proposal to retain a Vice Chairman on the Board as

the Council of Governors had a Deputy Chairman; the Constitution at section 16.5 would therefore not be amended.

The proposed amendments would now be submitted for discussion and approval to the Trust's Board of Directors on 24 February.

Action: Mr Forsyth

8. Update from the Chief Executive, including the Integrated Board Report

Dr Tolcher's paper summarised the key strategic matters impacting on the Trust at present and an update on operational and quality performance was circulated with the Integrated Board Report prior to the meeting and taken as read.

Operational performance and quality

Dr Tolcher was pleased to report that the Trust continued to perform well against all the national performance standards including access and waiting times, referral to treatment time targets and emergency department access targets.

Moving on to an overview of the financial position, the Trust had reported a small loss in December 2015 however the forecast was to deliver a small surplus at the end of the financial year. Key drivers of overspend continued to be ward nursing and medical staffing but the Trust continued to work hard and monitor staffing levels carefully to ensure quality and safe patient care.

Dr Tolcher was thrilled to report that the Trust had spread its footprint and would provide children's services in Durham, Darlington and Middlesbrough from 1 April. Approximately 500 new staff would join the Trust and there were a variety of plans in place to engage and communicate with our new colleagues.

Strategic matters

Dr Tolcher confirmed the Trust had been busy with the Operational Plan covering the next 12 months; the first draft was to be submitted to Monitor the following week. In addition to this document, the Trust was also working with partners to submit a five year Sustainability and Transformation Plan (STP) by the end of June.

Dr Tolcher described 'transformation footprints' or 'place'; an agreement between health and social care to work together. Conversations were underway as the Trust would be part of a number of 'places' due to overlap of service provision across Leeds, York, North Yorkshire and now Durham, Darlington and Middlesbrough.

Dr Tolcher went on to explain the government's Sustainability and Transformation funding allocated to individual acute providers. The NHS was heading for a deficit of around £2.8 - £3 billion and the aim of the government funding was to ensure that the provider sector returned to financial balance over the next 12 months.

The Trust had been allocated £4.6 million for 2016/17, but there would be rules attached, for example: agreeing to deliver a surplus of £6.8 million (an additional £2.2 million savings in addition to the £4.6 million cash allocated), continuing to deliver access standards in relation to referral to treatment 18 week target, A&E target, ambulance waits and compliance with Agency Cap rules. Dr Tolcher explained this was similar to having savings in the bank that could not be touched for 12 months. Further

information was awaited on when the controls would be relaxed and when the Trust could re-invest the £4.6 million.

At this stage in the meeting Dr Tolcher invited Governors to ask questions about any of the items discussed.

Mrs Clelland commented that there was no certainty at this stage that the funding controls would be relaxed after 12 months.

Dr Tolcher confirmed this had not been clarified and the finer detail was still unknown at this stage. Mr Coulter added that it was a 'no lose' situation as the Trust would plan to deliver a surplus of £2.2 million, and if this was achieved the £4.6 million would be in the bank. He added that other Trusts had been asked to save more in order to receive the additional funding.

Mrs Edgar asked how we envisaged achieving the required surplus when we were behind plan.

Mr Coulter agreed this was a challenge however the Agency Cap, collaborative working and robust cost improvement plans would all have an impact and as yet there was still uncertainty about the exact rules on receiving the funding.

Mr Armitage asked for clarity on the government funding and Mr Coulter confirmed that the Trust would need to have a £2.2 million surplus at the end of the financial year 2017 in order to get the £4.6 million for future investment; this would be for us to decide how to spend it, but the final rules were awaited.

Mr Armitage added that if the Trust was behind plan in December he assumed it was also behind plan in January and asked if we were hopeful of a break-even position at the end of the financial year. Mr Coulter was pleased to report that historically there was always an increase in the activity level in the last quarter of the financial year and this would have a positive impact on the financial balance.

Mrs Clelland raised the question about a number of community service contracts being due for re-negotiation and asked if the Trust was confident these services would remain with the Trust.

Mr Coulter confirmed that in 2016/17 there were a number of community service contracts up for renewal, eg Podiatry and Wheelchair Services and the Trust was currently undergoing a review to assess services and a re-tendering process. He added that most contract renewals would be due in 2017/18.

Dr Tolcher continued with her update at this stage.

<u>Governance and assurance</u>

The Trust was required to submit a quarterly Governance Statement to Monitor and the Board of Directors had approved a 'Green' rating for Quarter 3.

Dr Tolcher highlighted that Foundation Trusts were required to undertake an external assessment of the competency and skills of the Board in the form of a Well Led Review every three years, within the terms of their licence. The Trust commissioned Deloitte to undertake this robust review which included observations and interviews to understand

the governance of the organisation, its systems and processes. The final report had been received at the end of December which provided assurance that the Trust was well led and offered key findings for areas of development (these could be found in Paper 8.0 in more detail). Dr Tolcher was delighted to report feedback from Deloitte that suggestions for further development was the smallest they had ever provided across the Trusts they had worked for.

Mrs Webster added that the Quality Committee would look at the findings from the Well Led Review and she would be happy to provide feedback at the next meeting.

Action: Mrs Webster

Finally, Dr Tolcher provided a verbal update on the CQC inspection. She confirmed that in the previous week a total of 61 inspectors had visited our sites far and wide meeting with staff and patients and their families. Feedback from the Chair and Lead Manager from the CQC was that they were very impressed with the staff who were positive, welcoming and open and honest in their conversations. They were also pleased with the number of comments received from service users and stated that they had received over 600 comment cards, most of which were overwhelmingly positive, and this was in fact the most ever received by the CQC. Dr Tolcher confirmed that the CQC would now look at key areas and triangulate their data which would involve a huge amount of information gathering. It was hoped that the Trust would receive a final rating within the next 6-8 weeks.

On behalf of the Board, Mrs Dodson wished to formally thank colleagues and pay tribute to the professionalism of all staff involved. She also thanked the Executive Team who had led the organisation of the CQC visit.

Mrs Edgar talked about the staff experience during the CQC inspection and for some this had brought about a level of anxiety. She had attended two discussion sessions with inspectors; one in her role as a Staff Governor with fellow Governors and the other as a Specialist Nurse along with Senior Nurses, Ward Managers and Matrons. She confirmed good attendance by staff during a busy working day and reported that colleagues enjoyed the opportunity to talk to inspectors about high quality care, feeling well led with accessible leaders and working for a friendly organisation. She expressed the feeling that everyone spoke as 'one' and this was a positive and emotional experience.

Mrs Dodson thanked Mrs Edgar for sharing this with her fellow Governors and added that the Chair of Inspectors had commented that the Trust 'felt like a family'.

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

Mr Elliot, member of the public, complimented Dr Tolcher on her report and asked if the external review carried out by Deloitte was value for money.

Mrs Dodson clarified that Foundation Trusts were required to seek third party assurance in the form of a Well Led Review every three years within the terms of their licence.

Dr Tolcher summarised the selection process which included inviting bids from various companies to undertake the work. The Trust interviewed three companies and their overall costs were similar. The Trust felt that Deloitte had the most appropriate expertise and experience and were able to provide a wealth of evidence from work undertaken with other Trusts. The cost of the review was approximately £35-40k which

included the initial review and then some follow up work afterwards for example supporting the Quality Committee. Dr Tolcher confirmed that the Trust received value for money as Deloitte were able to provide additional information to the Trust.

The external assessment process complimented the role of the Council of Governors as a third party gaining assurance and confidence in the processes and systems in place. Governors could take assurance from the review findings as well as the Executive Team.

Ms Allen added that she was interviewed by Deloitte and she was impressed with the level of questioning; she could evidence how Governors' opinions were valued and how the Council was integrated into the governance of the organisation.

Mrs Dodson confirmed that Rev Dr Willshaw was also interviewed by Deloitte as he was the Deputy Chair of Governors and Lead Governor up to the end of December 2015. She endorsed Dr Tolcher's comment that the work was value for money however going forward it was hoped that a pool of expertise from peer Trusts could be developed to undertake the exercise.

Dr Scullion reiterated the reputational benefits of an organisation that was well led.

Ms Paulak, member of the public, wished to comment that she had received the finest treatment in the organisation, but asked whose responsibility it was to check a patient's GP details.

Mr Harrison confirmed he could not discuss individual matters in the meeting, but confirmed there were several ways in which a patient's GP details could be checked against what was held on Trust patient records. He confirmed that both the receptionist and the medical staff would usually ask the patient to clarify their GP details when they arrived at clinic or for treatment. He also confirmed that where IT systems were connected, GP details should match. Mr Harrison agreed to communicate a reminder to all staff of the importance of asking for GP details as part of the patient pathway.

Action: Mr Harrison

Mrs Clelland, Public Governor, asked for an update on Junior Doctors and whether any local issues had emerged.

Mr Marshall confirmed that the junior doctors' industrial action was a national issue around their new contract of employment. A second period of industrial action was due to take place on 10 February. Essentially, Junior Doctor cover would be similar to Christmas Day, providing emergency care only between 8 am 10 February until 8 am the following day. Mr Marshall confirmed a significant amount of work had gone into preparations for the industrial action to ensure that the Trust continued to be well prepared and that high quality patient care remained the primary focus. The Trust hoped to keep disruption to patients to an absolute minimum and remained committed to working with and supporting Junior Doctors during this difficult time.

Mr Marshall also informed Governors about a recent visit from Health Education England following some concerns raised about education and training for Junior Doctors. An action plan had been received from the visiting team and the Deanery was working with us on the intensity of work for the Junior Doctors.

10. Non-Executive Directors update including time for discussion

10.1 Update on involvement in the Annual Plan for 2016/17 and views on the progress of Non-Executive Director 360 degree feedback

Mrs Taylor, Chair of the Finance Committee, confirmed the Committee had met to consider the draft Operational Plan prior to submission to Monitor. She confirmed that Governors met periodically and received regular updates on the Operational Plan. She provided a brief explanation of the format of both the Operational Plan and the new five year Sustainability and Transformation Plan and explained the role of the Committee was to scrutinise and have oversight of the development and delivery of the financial plan. To conclude, Mrs Taylor assured Governors that the Finance Committee was happy with the draft Operational Plan.

Mr Thompson highlighted the work of the Business Development Team to develop innovative ideas and bring new business to the Trust. He was happy to confirm that Non-Executive Directors were confident in the Trust's process to bid for new business.

On behalf of the Council of Governors, Dr Scott was pleased with the Governor involvement in the Operational Planning process. He asked for an update on plans in the coming year for seven day working.

Dr Scullion confirmed that Emergency Department Consultants routinely worked weekends as well as Radiologists and Physicians; other medical services were also provided on weekends such as MRI scans. He confirmed the Trust was close to appointing another Consultant Surgeon and there was lots happening to focus on a seven day emergency service.

Mr Doveston added that the Yorkshire Air Ambulance accessed four trauma areas with 24 hour per day service.

Mrs Dodson provided an update on the progress of the Non-Executive Director 360 degree feedback; a pilot commissioned by Health Education Yorkshire and the Humber to develop an innovative 360 degree feedback approach to support leadership development for Non-Executive Directors. Mrs Dodson commented that the framework methodology provided a valuable way to look at both individual and collective performance and all Non-Executive Directors were currently undergoing conversations with Executive Directors, Clinical Directors and Governors regarding their role and responsibilities. Mrs Dodson thanked Governors for their involvement in the pilot.

Mr Thompson reflected on the timing of the pilot and stated it was well timed with the Well Led Review and assisted in the preparation for the CQC. He welcomed honest feedback from colleagues and believed that the process was already having a positive impact on the Board. He highlighted the professionalism of the coaches and expressed his delight in the way in which the local NHS was leading the way with such an innovative approach.

Mrs Taylor echoed Mr Thompson's comments and confirmed this process was better than a predominantly paper-based one she had been involved with before.

She explained how discussions were based around a scenario and focussed on feedback around contribution and actions for improvement. She agreed that the input from the coaches had formed a positive part of the process.

Mrs Edgar said she found her one to one with Mrs Webster a valuable exercise and it gave them the opportunity to get to know each other better.

Mrs Dodson hoped that the pilot would be rolled out nationally as Non-Executive Directors welcomed personal development similarly to any other members of staff in the organisation. Further analysis and evaluation was required to determine how often this feedback was required.

Mrs Dodson asked if there were any further questions for Non-Executive Directors before she moved to the final item on the agenda.

Mrs Margerison asked about Non-Executive Director involvement in the Harrogate Health Transformation Board.

Mrs Dodson confirmed that Non-Executive Directors were kept well informed via Dr Tolcher's updates and minutes following Board meetings.

Mrs Webster confirmed it was important to be kept appraised and described how the information was fed into both the Finance and Quality Committees.

There were no more questions for Non-Executive Directors and Mrs Dodson moved on to any other business.

11. Any other business

Mrs Colvin confirmed the next Governor meeting to discuss the Operational Plan would take place on 22 February and details would be circulated.

Mrs Dodson raised awareness of the Trust's staff pantomime, 'Dr Al Addin and the Missing Medicines', taking place at the Frazer Theatre, Knaresborough from 24 – 27 February. All proceeds would go to the Harrogate Hospital and Community Charity.

12. Date and time of next meeting

Mrs Dodson thanked everyone for attending and confirmed the next meeting would take place on Wednesday, 18 May 2016 at 5.45 pm at St. Aidan's High School in Harrogate.