Board of Directors public - 28 June 2017 all documents


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Harrogate and District NHS Foundation Trust

**The meeting of the Board of Directors held in public will take place on Wednesday 28 June 2017 in the Boardroom, Harrogate District Hospital, HG2 7SX**

**Start: 9.00am Finish: 12.30pm**

| | AGENDA | | |
|---|---|---|---|
| **Item No.** | **Item** | **Lead** | **Paper No.** |
| **9.00am – 10.50am** | | | |
| **1.0** | **Welcome and Apologies for Absence**<br>*To receive any apologies for absence* | Mrs S Dodson, Chairman | - |
| **2.0** | **Declarations of Interest and Register of Interests**<br>*To declare any interests relevant to the agenda and to receive any changes to the register of interests* | Mrs S Dodson, Chairman | 2.0 |
| **3.0** | **Minutes of the Board of Directors meetings held on 31 May 2017**<br>*To review and approve the minutes* | Mrs S Dodson, Chairman | 3.0 |
| **4.0** | **Review Action Log and Matters Arising**<br>*To provide updates on progress of actions* | Mrs S Dodson, Chairman | 4.0 |
| **Overview by the Chairman** | | Mrs S Dodson, Chairman | - |
| **5.0** | **Report by the Chief Executive Including the Integrated Board Report**<br>*To receive the report for comment* | Dr R Tolcher, Chief Executive | 5.0 |
| **5.1** | **Nursing Establishment**<br>*To receive the report for comment* | Dr R Tolcher, Chief Executive | 5.1 |
| **6.0** | **Report by the Finance Director**<br>*To receive the report for comment* | Mr J Coulter, Deputy Chief Executive/ Finance Director | 6.0 |
| **10.50am – 11.00am – Break** | | | |
| **11.00am – 12.30pm** | | | |
| **7.0** | **Report from the Chief Operating Officer**<br>*To receive the report for comment* | Mr R Harrison, Chief Operating Officer | 7.0 |
| **8.0** | **Report by the Director of Workforce and Organisational Development**<br>*To receive the report for comment* | Mr P Marshall, Director of Workforce & Organisational Development | 8.0 |
| **9.0** | **Report from the Chief Nurse**<br>*To receive the report for comment* | Mrs J Foster, Chief Nurse | 9.0 |

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| **10.0** | **Report from the Medical Director**<br>*To receive the report for comment* | Dr D Scullion, Medical Director | 10.0 |
| **10.1** | **National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Annual Report**<br>*To receive the report for comment* | Mr David Lavalette, Consultant Trauma & Orthopaedic Surgeon | 10.1 |
| **11.0** | **Oral Reports from Directorates**<br>*11.1 Planned and Surgical Care*<br>*11.2 Children's and County Wide Community Care*<br>*11.3 Long Term and Unscheduled Care* | Dr K Johnson Clinical Director<br>Dr N Lyth, Clinical Director<br>Mr A Alldred, Clinical Director | -<br>-<br>- |
| **12.0** | **Committee Chair Reports**<br>*To receive the report from the Finance Committee meeting held 19 June 2017*<br><br>*To receive the report from the Quality Committee meeting held 7 June 2017. To review and note the Terms of Reference* | Mrs Maureen Taylor, Non-Executive Director/chair of the Finance Committee<br><br>Mrs L Webster, Non-Executive Director / Quality Committee Chair | 12.1<br><br>12.2 |
| **13.0** | **Other matters relating to compliance with the Trust's Licence or other exceptional items to report, including issues reported to the Regulators**<br>*To receive an update on any matters of compliance:* | Mrs S Dodson, Chairman | 13.0 |
| **14.0** | **Any other relevant business not included on the agenda**<br>*By permission of the Chairman* | Mrs S Dodson, Chairman | - |
| **15.0** | **Board Evaluation** | Mrs S Dodson, Chairman | - |
| **Confidential Motion – the Chairman to move:**<br>*Members of the public and representatives of the press to be excluded from the remainder of the meeting due to the confidential nature of business to be transacted, publicly on which would be prejudicial to the public interest.* | | | |

Harrogate and District NHS Foundation Trust

## BOARD OF DIRECTORS – REGISTERED DECLARED INTERESTS

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

The register is maintained by the Foundation Trust Office.

| Name | Position | Interests Declared |
|---|---|---|
| Mrs Sandra Dodson | Chairman | 1. Partner in Oakgate Consultants<br>2. Trustee of Masiphumelele Trust Ltd (a charity raising funds for a South African Township)<br>3. Trustee of Yorkshire Cancer Research<br>4. Chair of Red Kite Learning Trust – multi-academy Trust |
| Dr Ros Tolcher | Chief Executive | 1. Specialist Adviser to the Care Quality Commission<br>2. Member of NHS Employers Policy Board |
| Mr Jonathan Coulter | Deputy Chief Executive/ Finance Director | None |
| Mrs Jill Foster | Chief Nurse | None |
| Mr Robert Harrison | Chief Operating Officer | 1. Appointed Voluntary Member of the Strategy and Resources Committee of the Methodist Church<br>2. Charity Trustee of Acomb Methodist Church, York |
| Mr Phillip Marshall | Director of Workforce and Organisational Development | 1. Member of the Local Education and Training Board (LETB) for the North |
| Mr Neil McLean | Non-Executive Director | Director of:<br>- Northern Consortium UK Limited (Chairman)<br>- Ahead Partnership (Holdings) Limited<br>- Ahead Partnership Limited<br>- Swinsty Fold Management Company Limited<br>- Acumen for Enterprise Limited |
| Dr David Scullion | Medical Director | 1. Member of the Yorkshire Radiology Group |
| Mrs Maureen Taylor | Non-Executive Director | None |

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

**June 2017**

Harrogate and District
NHS Foundation Trust

**Report Status: Open**

**BOARD OF DIRECTORS MEETING**

Minutes of the Board of Directors' meeting held in public on
Wednesday 31 May 2017 9.00am in the Derwent Room, The Pavilions of Harrogate,
Great Yorkshire Showground, Harrogate, HG2 8NZ

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

**In attendance:**
Mr Andrew Alldred, Clinical Director for Long Term and Unscheduled Care
Mrs Angie Colvin, Corporate Affairs and Membership Manager (minutes support)
Dr Claire Hall, Deputy Medical Director
Ms Mikalie Lord, Programme Manager, Improvement & Transformation *(for Board briefing only)*
Dr Natalie Lyth, Clinical Director for Children's and County Wide Community Services
Mr Jordan McKie, Deputy Director of Finance *(for Board briefing only)*
Mr Paul Nicholas, Deputy Director of Performance and Informatics
Dr Chunda Sri-Chandana, Deputy Clinical Director Planned and Surgical Care
Mrs Katherine Roberts, Company Secretary (minutes)
Mr Paul Widdowfield, Communications and Marketing Manager



**Board Briefing - Clinical Transformation Programme update**

Mr McKie and Ms Lord provided an update on the Clinical Transformation Programme. Ms Lord explained that the programme had four main work streams; planned care, unplanned care, estates and technology and workforce. The Programme Management Office (PMO), established in early 2017, had helped to embed robust documentation which clearly recorded progress against planned activity. During May 2017 the PMO had supported a Rapid Process Improvement Workshop (RPIW) and the Clinical Workforce Strategy day. This demonstrated the value of the PMO, engaging with teams so that they can input to the Trust's plans.

During 2017/18 the Clinical Transformation Programme indicative target would be £3m. Mr McKie explained that £2m plans are in place, this is a little behind plan. The risk adjustment showed a number of high and medium risks, the Trust still needs to put actions in place to resolve these. For example IT/Estates and the WebV business case. Savings needed to be real and worked up. The profile of savings had shown some slippage, for example in planned care, enhanced recovery and theatre utilisation.

Mr McKie shared details of activities undertaken by the PMO since January 2017. This included work with finance business partners and work-stream leads to align project plans with CIP schemes. The focus over the next quarter would be on finalising the Stakeholder Engagement and Communications Plan. Moreover there would be further work to ensure robust documentation to support governance arrangements is in place.

Mr Coulter emphasised the importance of robust programme management documentation, in order to provide assurance about benefits which would be delivered by programmes. He noted the RPIW undertaken on theatre scheduling during week commencing 8 May 2017. This work was owned and led by two consultants. Although challenging, feedback about the event had been very positive. Key outcomes included a redesigned pre-operative assessment pathway. This would get more people on lists and reduce the number of cancellations. It would be rolled out for shoulder and urology surgery from mid-June 2017. In addition the theatres dashboard had been redesigned, this would support paired consultants and anaesthetists. It would also help to flag at an earlier date which equipment was needed for each procedure. Although this highlighted some gaps in the equipment the Trust had, this issue would be resolved as soon as possible. Dr Tolcher asked whether the dashboard could include the World Health Organisation (WHO) checklist.

Mr Thompson asked what evidence the Board would see that these changes have resulted in more productive theatres. It was agreed that Key Performance Indicators (KPIs) included in the Integrated Board Report would be reviewed.

**ACTIONS:**

- **Mr Coulter to explore option to include WHO checklist within new theatre dashboard.**
- **Mr Harrison and Mr Coulter to consider how the Integrated Board Report would capture improved efficient within theatres.**
- **Non-Executive Directors, Mr Harrison and Mr Coulter to review KPIs included within the Integrated Board Report.**

### 1.0 Welcome and Apologies for Absence

Apologies for absence were received from Mr Robert Harrison, Chief Operating Officer and Dr Kat Johnson, Clinical Director Planned and Surgical Care. Mrs Dodson noted that Mr Paul Nicholas (Deputy Director of Performance and Informatics), Dr Chunda Sri-Chandana (Deputy Clinical Director Planned and Surgical Care), and Dr Claire Hall (Deputy Medical Director) were in attendance at the meeting.

Mrs Dodson welcomed observers to the meeting, this included Mr Jules Preston (Chairman, The Mid Yorkshire Hospitals NHS Trust), Mr Paul Widdowfield (Communications and Marketing Manager), Mr Peter Pearson (Public Governor) and members of the public.

## 2.0 Declarations of Interest and Board Register of Interests

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

## 3.0 Minutes of the meetings of the Board of Directors on 26 April 2017

The draft minutes of the meetings held on 26 April 2017 were approved with no amendments.

**APPROVED:**
**The Board of Directors approved the minutes of the meeting held on 26 April 2017 as an accurate record of proceedings.**

## 4.0 Review of Action Log and Matters Arising

Completed actions were noted. In addition an update was provided regarding a number of outstanding actions:

- Item 6 – Dr Tolcher would provide an update to the Council of Governors during the planned 'Board to Board' session on 31 May.
- Item 8 – Update regarding readmissions was included within the in Chief Operating Officer report. This action was therefore complete.
- Items 11, 12, 13, 16 and 25 – would be addressed at the Board Strategy Day in July 2017.
- Item 17 – An update regarding research and development had been provided in April 2017. This action was therefore complete.
- Item 26 – Mr Thompson confirmed a small working group had been established and started the process to review the Integrated Board Report (IBR). Comments from the Non-Executives had been shared with Mr Coulter and Mr Harrison. A meeting would be held to discuss the next steps.
- Item 30 – Analysis of data relating to absconding patients was included within the Chief Nurse Report. This action was therefore complete.
- Item 32 – Update regarding stroke action plan was included within the in Chief Operating Officer report. This action was therefore complete.
- Item 33 – This item had been deferred until June 2017.
- Item 34 – Revised terms of reference were included on the agenda. This action was therefore complete.
- Item 36 – Mrs Dodson had written to domestic staff to thank them. This action was therefore complete.

**APPROVED:**
**The Board of Directors agreed actions 8, 17, 30, 32, 34 and 36 were closed.**

## 5.0 Board of Directors Terms of Reference

Mrs Dodson explained that, as discussed at the April meeting, minor amendments had been made to the Board of Directors Terms of Reference.

**APPROVED:**
**The Board of Directors reviewed and approved the Terms of Reference.**

**Overview by the Chairman**

Mrs Dodson highlighted a number of themes for the meeting. First, there was concern about the Trust's financial position; at the start of the year the Trust was off-plan. The second area of focus was delivery of quality; how can the Board drive clinical transformation to release efficiency and deliver quality.

The third area of focus was the capacity of staff to deliver transformation as well as delivering the day job. Mrs Dodson noted pockets of high level sickness and shortages of staff. It was essential that the Board was able to communicate with staff and keep them motivated.

Mrs Dodson suggested the members of the Board should use the IBR to triangulate information. This would help members of the Board identify what actions were needed.

In conclusion Mrs Dodson reflected that at the start of the year 2017/18 the Board must think about how the Trust moved forward. How the financial position would be rectified whilst not affecting the quality of delivery. Moreover this should link to the on Board Assurance Framework (BAF) and the risks the Trust faces.

**6.0 Report by the Chief Executive including the Integrated Board Report (IBR)**

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

6.2 Dr Tolcher highlighted the recent NHS cyber-attack and reported that because of existing security measures and the actions of staff the Trust was not affected, although there had been some disruption to the email system. Thanks were expressed to Mr Harrison and the IT team.

6.3 The West Yorkshire Association of Acute Trusts (WYAAT) continued to develop. Member organisations were considering their appetite for true collaboration. As programmes, such as the West Yorkshire Imaging Collaborative progressed, the principles of collaboration were being considered further. It was reported the West Yorkshire and Harrogate joint committee of CCGs had appointed a lay chair; Marie Burnham. Further information about Sustainability and Transformation Partnership (STP) governance, including NED and governor involvement, would be shared with governors at the Board to Board meeting on 31 May 2017.

6.4 It was noted CCGs in North Yorkshire were considering their future arrangements. Further information would be provided during the private section of the meeting.

6.5 Dr Tolcher reported on progress with New Models of Care, the new integrated response team was up and running it covered three GP practices. It was being referred to as a 'pop up service'. It should be recognised that community care teams remained under considerable pressure because the service must be managed back to baseline.

6.6 Janet Wagget had been appointed as the new Chief Executive for Selby District Council; she would also be the Assistant Chief Executive for North Yorkshire County Council.

6.7 A new Chair of the North Yorkshire Health and Wellbeing Board had been

appointed; Michael Harrison had assumed the role from Claire Wood.

6.8 Mrs Dodson invited members of the Board to ask questions.

6.9 Mr Thompson asked whether as care systems integrate there was an additional risk in relation to potential cyber-attacks which should be recognised in the Risk Register or the BAF. It was agreed the BAF should be reviewed and updated to reflect the ongoing and growing risk of cyber-attacks and great collaboration between Trusts.

6.10 Mr Ward asked whether there was any learning from the process; could the Trust have been fully operational any sooner. Mr Coulter explained a risk assessment process had been followed, although email systems could possibly have been switched on 24 hours earlier this would have presented a risk. It was acknowledged that there were some positives to not having access to emails, although community staff found it difficult to communicate because telephone lines were very busy. It was noted that clinical services were not impacted by the removal of emails.

6.11 Mrs Webster sought further information about the 'pop-up' integrated response service and the impact on other community teams. Dr Tolcher confirmed that in addition to the pop-up service the four locality teams continued to do work they had always done. Pro-active work was underway to identify activities which were not commissioned and would therefore need to stop being delivered. Lean methodology had been implemented to ensure the integrated response service was as productive and effective as possible. The service aimed to ensure vulnerable patients remained at home as long as possible. Mrs Taylor sought assurance that the new service would be evaluated so the Trust could consider whether it was effective. It was confirmed the service would be evaluated on daily basis and over the longer term. The service was relying on non-recurrent funding and would only be sustainable if the financial risks were managed back to establishment level.

6.12 Mr McLean asked whether the Board was sufficiently clear what "model hospital" the Trust was aiming for. Accepting the financial issues and workforce challenges, he questioned whether there was a clear vision about where the organisation should be going. Dr Tolcher accepted this very timely question at a point when WYAAT was grappling with similar issues: what was the ultimate end goal. It was noted a key strategic risk included on the BAF was the potential for the Trust's income to not be sufficient to deliver the quality of care the Board aspired to, based on the national policy. There must therefore be a continued focus on ways to drive up productivity and spend less resource. It was agreed these issues should be considered at a future Board Strategy Day.

6.13 Mrs Dodson sought further information about concerns regarding the referral management service. Dr Tolcher reported that it had come to light that there were some issues with the referral management tool commissioned by the CCG. Some referrals had been delayed by more than 72 hours. It was noted this only related to certain referrals and did not include cancer referrals. Mr Nicolas explained analysis had been undertaken of 400 referrals received by HDFT through the referral management service and only half met the agreed three day criteria. A small number of referrals were very significantly delayed. The Trust continued to work with the CCG to resolve this issue.

6.14 Mrs Dodson noted the Corporate Risk Register entry regarding do not attempt CPR (DNACPR). Dr Scullion reported further work is planned to ensure compliance with the DNACPR policy, a new resuscitation officer is in place. The REsPECT, alternative

model to DNACPR form would be implemented and subject to regular audit. The Board endorsed a 12 month implementation plan with the Executives to consider the level of resource required to support the process.

**APPROVAL:**
**The Board of Directors:**

- **noted the strategic and operational updates, and;**
- **Noted progress on risks recorded on the BAF and Corporate Risk Register and confirmed that progress reflected the current risk appetite.**

**ACTIONS:**

- **BAF to be reviewed in order to ensure the risk of cyber-attacks was appropriately reflected.**
- **Board strategy day in July 2017 to include consideration of the Board's vision for the future Trust and a focus on ways to drive up productivity within the organisation.**

**7.0 Report by the Finance Director**

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

7.2 Dr Tolcher explained that Trust had made a deficit of £1.8 million during month one 2017/18. This was the biggest variance the Trust had experienced for a very long time. Underlying issues had been explored in great detail, it was noted that there had been adverse income and spend in all directorates. As a result of this variance the Trust's rating with NHS Improvement for planned use of resources was a three. Dr Tolcher explained the finance team and directorates were considering mitigations to support forecast recovery. Although month one included some exceptional one off items, the underlying run rate was adverse.

7.3 Expanding on this Mr Coulter explained that if non-recurrent items were removed from the position there was an underlying issue with the run rate of £700k. Four areas were being focused on; elective activity, staffing in theatres, staffing on wards and cost improvement plans (CIPs). With regards to elective activity, general surgery was the biggest risk. It was noted that activity in May 2017 showed non-elective activity was up by 7% against plan, outpatients was 14% up against plan, A&E was slightly up, and elective activity was about 6-8% below plan.

7.4 Mr Coulter confirmed that a number of mitigating actions are underway; these include a review would be undertaken of productivity, in particular, how the Trust supervised junior doctors in general surgery, opportunities in trauma and orthopaedics, access to Wharfedale hospital.

7.5 Further work would be undertaken to reconcile ward staffing to budgets, roster information and requirements of safer care. This work would consider what an affordable establishment level should be in order to provide safe care. It was noted that Ripon Hospital forecast spend at a higher level than what was commissioned. Decisions to resolve this position would be considered over the next week.

7.6 Members of the Finance Committee would consider the latest situation and a summary of all potential actions when they met on 19 June. This would support follow up discussions at the Senior Management Team (SMT) and Board of Directors in late June

2017.

7.7 Mr Coulter noted other areas which would be considered. For example the rolling programme of additional deep cleaning which had been planned for 2017/18 and forecast to cost a six figure sum. This work had been agreed when clostridium difficile infections rates were high and thought to be due to high levels of environmental contamination. New cases of clostridium difficile infections had fallen very significantly following changes to antibiotic use and it was now felt that enhanced cleaning was not indicated. Views would be sought from the Director of Infection Prevention and Control. A further area to consider was moving forward agreed changes to the Trust annual leave policy which would save £500k. There would be a review of bad debt provision between government bodies, NHS Improvement had queried why these are included when payment is guaranteed, and this could save £300k. Alternative delivery models for estates and facilities staff and mechanisms to maximise value of estate would be explored.

7.8 It was noted that the NHS Improvement risk rating of HDFT for use of resources had moved from two to three. In this risk category support was offered by NHS Improvement if the Trust wished to access it. However, if the organisation's finance slipped further behind, NHS Improvement would provide mandatory support.

7.9 Mr Coulter reflected that the key issues for the Trust were known, and although this was a difficult situation the directorates were pulling together and having challenging discussions through the SMT. It was reaffirmed finance and quality of care were contingent on each other. Mr Coulter confirmed he had reviewed and was assured by controls on vacancy management.

7.10 Mr Ward reflected there were a number of actions planned to claw back the one month deficit, he queried whether the phasing in the financial forecast was correct. In response Mr Coulter explained the phasing in April related to the number of working days in month; April included Easter bank holidays and this resulted in reduced income.

7.11 Following the findings of a recent Internal Audit report it was accepted the controls on rostering must be tightened.

7.12 Mrs Taylor queried whether the reduced activity should have been identified earlier in the month of April. Would this have enabled action to be taken at an earlier date. Mr Coulter provided reassurance activity data was updated daily and reviewed on a weekly basis by the Operational Delivery Group. The deficit was flagged during month, but identifying what to do next was more difficult. It was acknowledged more should be done to resolve the ongoing issue regarding sessions available to HDFT at Wharfedale hospital. The consultant of week model appeared to have resulted in a loss of productivity. Moreover the new model of clinical supervision of trainee doctors had had more impact that was expected. Dr Scullion noted that both changes were done for good reasons, but the impact on elective activity was above the level expected.

7.13 Mr Thompson said he was very reassured by the focus of the Executives and the specific explanation provided. He expressed reluctance to release bad debt provisions at this early stage of the year. In addition he noted concerns about the Trust's cash flow position. Mr Coulter explained this was a symptom of issues in 2016/17, the Trust was £4m behind plan at end of March 2017, £2m was linked to an increased debt with the CCG.

7.14 Mr McLean sought further information about efforts to resolve difficulties accessing the agreed level of sessions at Wharfedale hospital. It was confirmed this had been raised with the senior team at Leeds Teaching Hospitals Trust.

7.15 Mrs Webster suggested a rolling forecast may provide a realistic projection of the organisations financial position. It was agreed the Finance Committee would consider this in more detail.

7.16 The importance of achieving the planned deficit of £200k at the end of quarter one was noted, this would release £600k of sustainability and transformation funding.

7.17 In conclusion Dr Tolcher reflected on how important it was that the Board understood the issues and drivers behind the financial position.

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

**ACTION:**
- **The Finance Committee would consider the Trusts financial position in further detail and consider the format of the finance report (including a rolling forecast).**
- **Views would be sought from the Director of Infection Prevention and Control about suspending the rolling programme of additional deep cleaning during 2017/18**.

**8.0 Integrated Board Report**

8.1 Mrs Webster reflected that an increasing number of quality indicators were turning red and amber; she queried how the Trust could move more measures into green performance. Mrs Foster noted plans to introduce mandatory training for care support workers regarding pressure ulcers. She noted that although the falls indicator was red, she was not unduly concerned. Although this was not where the Trust wanted to be, the rate did fluctuate and overall falls had reduced year on year.

8.2 Mr Thompson highlighted HSMR and SHMI measures were both higher this month. Dr Scullion noted both measures were still within expected levels. Mr Nicholas provided assurance that the mortality review group met regularly and reviewed the figures. It was agreed further analysis of the figures would be undertaken by the Executives and the measures would continue to be monitored.

8.3 Mr Thompson referred to overall Trust safer staffing levels and noted there had been a reduction on last month. However he reflected that the data included within the Chief Nurse's report demonstrated there was significant variance at ward level due to patient activity. In future it would be helpful for the report to better link safer staffing levels to levels of activity. It was agreed Mrs Foster could consider this further.

8.4 Mrs Webster noted children's services data included within the report was expected to alter once it had been validated. Following a discussion it was agreed future reports on these measures would only include validated data.

8.5 Mrs Taylor commented on the C-section data, the report did not make clear why the figure was high, as reported to the Board in April 2017. It was agreed that as part of the review of the Integrated Board Report this measure would be reviewed.

8.6 Mr Ward expressed frustration that there had been slow progress to improve electronic rostering. Mr Coulter explained the measure was a 12 month rolling average, it was agreed the measure should be revised to reflect current month performance.

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

**ACTIONS:**
- **Mrs Foster to review measures to ensure safer staffing levels were better linked to levels of ward activity.**
- **IBR would be amended to ensure that future reports would only include validated data for Children's services measures.**

**9.0 Report from the Chief Operating Officer**

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

9.2 Mr Nicolas confirmed CQUIN data had been submitted to commissioners, this showed good progress with the exception of the sepsis measures. This continued to be a challenge for some wards, but lots of work was being undertaken to support improvement. Sepsis continued to be monitored on a regular basis by the Operational Delivery Group.

9.3 A new approach to reporting cancer performance when patient care was transferred between providers was being proposed. The West Yorkshire cancer alliance had developed shadow reporting arrangements. When these rules were applied to the Trust, performance during April fell below the expected standard, however this was unusual and when applied to data for 2016/17 there would have been a minimal change to performance levels. Further work was underway to validate the approach and HDFT data.

9.4 It was reported that the Trust continued to work with commissioners following a change to the criteria for the podiatry service. It was estimated approximately 10% current caseload would not meet the new specification.

9.5 Mrs Webster asked whether Trust staff were aware of the potential changes to the lymphedema service. Mr Alldred confirmed staff were aware that discussions were ongoing with the CCG and the hospice. However it was not appropriate to have conversations with patients until it was clear what the CCG intended to recommission.

9.6 Mrs Webster expressed concern that gaps in medical staff rotas had resulted in consultant stepping down to cover SAS doctor posts. It was acknowledged that recruitment was difficult and there would be challenges until August 2017. Dr Lyth reported on discussions with LTHT which would enable the Trust to take on specialist register trainees; LTHT would provide the placements for specialist neonatal sections of the training programme.

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

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

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

10.2 Mr Marshall explained that following a recruitment process three candidates were interviewed for the post of chairman on 22 May 2017. The panel decided not to make an appointment.

10.3 Over 50 delegates attended a workshop to consider priorities for the first two years of the clinical workforce strategy. In considering 'tomorrow's ward' and 'tomorrow's theatre' there was an appetite to consider how the unregulated workforce could be used effectively. In particular there was a focus on Operating Department Practitioners (ODPs), Mr Marshall reported on a piece of work with the University of Huddersfield to support training ODPs.

10.4 Mr Marshall confirmed HR Directors from across the region were considering how to streamline and reduce bureaucracy between NHS organisations to facilitate easier recruitment processes.

10.5 It was reported the first candidate on the global health exchange programme had passed their English language test. Harrogate College had visited India and confirmed they are confident in the new English language test provider would be able to successfully support nurses. It was noted staff from India would be offered subsidised accommodation.

10.6 Work is underway to develop a business case to establish an internal medical and dental bank of temporary workers. If this was successful a West Yorkshire bank would also be considered.

10.7 In answer to a question about the retention rate for Spanish nurses, Mr Marshall confirmed of the 24 nurses recruited in 2014, 4 remained in the Trust's employment. A discussion followed regarding the length of time the Trust retained the Spanish workforce and any learning which can be applied to the programme with India. It was confirmed exit interviews were undertaken with staff when they leave the organisation. In addition, as soon as it was known staff were considering leaving managers discussed with the individual whether there was anything the Trust could do to retain the employee. Mrs Foster confirmed that the retention rate for this staff group was similar to that of other newly recruited nurses.

10.8 Mr Thompson said it was good to see that sickness absence levels had fallen, it was positive to see evidence of the hard work undertaken showing in the statistics.

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

**11.0 Report from the Chief Nurse**

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

11.2 Mrs Foster drew attention the outcome of recent Director Inspections, with the exception of Littondale all had been closed.

11.3 The report included information about patient absconders, over three years there had been 101 incidents recorded. The emergency department recorded a relatively high number, the Supporting Vulnerable people group would consider this issue further. It was also noted that on occasion patients with capacity issues try to leave wards, staff were appropriately trained to work through the implications of the mental capacity act and consider deprivation of liberty.

11.4 Verbal feedback had been provided following a CLAS inspection (looked after children and safeguarding). The written response was awaited, but teams were already working through actions from the verbal feedback.

11.5 A new nationally recognised category of pressure ulcers, to record unstageable pressure ulcers, had been implemented. Mrs Foster confirmed the target for the year was a reduction to zero for avoidable pressure ulcers. Support to achieve this target included continuation of awareness sessions for staff.

11.6 In conclusion Mrs Foster drew attention to implementation of new NICE guidance for the treatment of Rhesus negative women during pregnancy. HDFT was a trailblazer in this area, and resources developed by the Trust were being used as examples by NICE.

11.7 Mrs Webster sought clarification about the target for pressure ulcers, it was confirmed as zero for unavoidable pressure ulcers. Dr Tolcher explained it was hard to get valid external benchmarks because there was so much variability in measurement, however the ambition was clear; to achieve zero and avoid harm to patients. Mrs Foster noted that the route cause analysis undertaken during 2016/17 showed 55% of Pressure Ulcers were avoidable, further analysis of the causes was being completed, some may be the result of paperwork not being completed correctly, rather than actual harm to patients.

11.8 Mrs Foster informed the Board the community teams had seen an increase in requests from residential homes for district nurses to undertake risk assessments of residents, this was linked to their CQC requirements. There would be careful analysis of the situation because it might result in an increased workload for district nurses.

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

- **Confirmed they were assured by the monitoring of nurse recruitment and retention and the governance process for assuring safe staffing levels;**
- **Noted the results and changes to the reporting of Director Inspections;**
- **Noted the number of decrease in numbers of complaints received by the Trust in April;**
- **Acknowledged the excellent work to improve the care of pregnant women;**
- **Confirmed they were assured there was continual progress with the issues arising from the CLAS inspections.**

**12.0 Report from the Medical Director**

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

12.2 Dr Scullion noted the latest mortality figures, the next step was to draft a trust wide Mortality Case Review Strategy in lieu of national reporting guidance expected later in the year.

12.3 It was reiterated that there were no clinical incidents as a result of the NHS cyber-attack. Although there were some delays in radiology this was well managed and the backlog was cleared quickly. Dr Scullion expressed his thanks to Rob Harrison for his management of the incident and leadership of his expert team.

12.4 Dr Scullion and Mr Harrison had recently met with a representative from NHS Improvement to discuss progress to introduce seven day working and meet the four core national standards. During the meeting the Trust described arrangements in place with York Hospitals. There were no new developments to report from this meeting.

12.5 A 'Getting It Right First Time' meeting would be held on 22 June 2017 in London, Dr Scullion would attend on behalf of the Trust and report back to the next Board meeting.

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

**ACTION:**
- **Dr Scullion to provide feedback to the Board following the 'Getting It Right First Time' meeting on 22 June 2017.**

**13.0 Patient Experience and Incident Report Quarter 4 2016/17**

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

13.2 Mrs Foster explained this report was presented to the Board on an annual basis as part of Board schedule. The report provided a summary of patient experience and incidents. She noted it was disappointing the Trust was still not meeting target deadlines for complaint responses, this was in part due to the reorganisation of directorates in 2016/17.

13.3 Mrs Webster explained this report was reviewed by the Quality Committee on a quarterly basis. She sought views as to whether the report was appropriate for presentation at the Board, or whether the regular complaints data, part of the Chief Nurse report, was sufficient.

13.4 Mr Ward drew attention to the very positive friends and family rating; 96.6% would have recommended the Trust's services. It was important for the Board to see these results and he suggested that the marketing team should make use of this data to promote the organisation. Mr Thompson noted the NHS choices rating for both Harrogate and Ripon hospitals had improved and congratulated teams on this development. Mrs Dodson agreed these were fantastic achievements for the Trust and it was important the Board received a balanced view of services, including both positive and negative feedback from patients. Dr Tolcher agreed this market intelligence was very useful to the Communications and Marketing team for use externally and internally to the Trust.

13.5 Mrs Taylor sought further information about what the Trust did when it received feedback. Mrs Foster confirmed feedback was passed onto ward teams and the results are displayed for staff and the public to view.

13.6 High performing organisations sought complaints and responded to them quickly. Mr McLean therefore expressed concerns that the organisation was not responding to complaints within agreed timescales. He sought further details about what was being

done to resolve delays. Dr Tolcher explained 'compliance' would be one of main focus during 2017/18, this would include complaint responses. Mrs Webster noted the Quality Committee had received assurance that Directorates were making actions agreed as the result of complaints smarter and timelier. Complaints would continue to be a focus for the Quality Committee, in particular the themes from complaints and evidence of progress to address these. It was noted complaint management was a quality priority for 2017/18.

13.7 Following a discussion it was agreed the Patient Experience and Incident Report should be received by the Board on an annual basis and complaints should continue to be reported through the Chief Nurse report on a regular basis. The Quality Committee would review patient experience and incidents on a quarterly basis and would escalate issues to the Board as they are required.

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

- **Noted the Trust was participating in a number of national and local surveys.**
- **Recognised there had been a 10% increase in the number of formal complaints 2016/17. The response to agreed deadline remains poor and had fallen by 17% since last year. The number of actions completed to deadline was 38% below the target.**
- **Noted that work to improve the position regarding out of date documents on the Trust internet should start to impact positively on patient information.**

**14.0 Oral Reports from Directorates**

**14.1 Planned and Surgical Care Directorate**

14.1.1 As discussed earlier in the meeting Dr Sri-Chandana acknowledged that activity had been difficult during April 2017. It was a challenge because of the number of bank holidays and the resulting loss of clinics. He highlighted some positive developments including the Rapid Process Improvement Workshop (RPIW) to consider theatre scheduling. Where possible agreed changes were being implemented but it was acknowledged some would not have a short term benefits. There had been an increase in private practice which is a positive indication of the confidence of the consultant body have in the Trust. Dr Sri-Chandana explained the sterile service project would have impact on efficiency for the next few months but would have longer term benefits for example on the Emergency Department.

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

14.2.1 Dr Lyth reported a quality event would take place in June 2017 to showcase excellent work of the 0-19 service to commissioners.

14.2.2 Although the Trust wide sickness trend was down this was not mirrored in Children's and County Wide Community Services Directorate. Dr Lyth would continue to look at hotspots in order to reduce the sickness levels in the directorate.

14.2.3 Dr Lyth reported that children's continence services were still a challenge. 0-19 practitioners had delivered a higher level of support than the Trust was currently commissioned to deliver. North Yorkshire commissioners had allowed practitioners to continue this work while a solution was found. It was a particular focus following

a Serious Case Review in another area which included learning about the role of continence services.

14.2.4 The team had achieved the highest rate in West and North Yorkshire for immunisation of influenza; 66% which is above target.

**14.3 Long Term and Unscheduled Care Directorate**

14.3.1 Mr Alldred explained the directorate had a planned programme of bed reductions over summer 2017 which linked to the programme of ward cleaning work.

14.3.2 Linked to Clinical Workforce Strategy the Directorate had worked up a staffing plan for 'tomorrows ward', this built on the Calderdale framework and reviewed the tasks undertaken by band two, three and four roles.

14.3.3 The GP out-of-hours proof of concept continued, including integration of the GP service with the Emergency Department the Friarage Hospital. This included co-location of GPs and a plan to remove the emergency doctor overnight. The proof of concept had demonstrated that paramedics required further training and therefore the emergency doctor would not be removed overnight.

14.3.4 Mr Alldred reported pressures on the acute oncology service. Although a consultant locum was now in place they had secured a substantive post elsewhere and would therefore leave the Trust in August 2017. Mrs Dodson sought clarification that it was still the intention to appoint a substantive consultant, it was confirmed this was the plan but it was noted there are nationwide difficulties recruiting oncologists.

14.3.5 Hotspot reviews were planned for stroke, medical outliers and gastro services, once work was complete feedback would be provided to the Board. It was noted any resulting plans would be prepared in partnership with the Planned and Surgical Care Directorate.

**15.0 Committee Chair Reports**

Mrs Dodson welcomed the committee annual reports and reflected that they show the depth and robustness of the Board's committees.

**15.1 Report from the Finance Committee meeting held on 24 April 2017 and the Finance Committee's Annual Report 2016/17**

15.1.1 Mrs Taylor confirmed the Finance Committee met on the 24 April 2017. At this meeting members considered the year-end outturn report for 2016/17. In addition financial and activity variances were reviewed and reflected in projections for 2017/18, further detail about these would be presented to the Finance Committee meeting in June 2017.

15.1.2 With regards to the Finance Committee's Annual Report 2016/17, the committee had met on six occasions. Mr Taylor highlighted key sections including members of the committee, attendance, duties delegated under the terms of reference and work done throughout the year.

15.1.3 Dr Tolcher sought reassurance that the committee focused on the longer term strategic picture for the organisation, rather than the operational detail of short term financial management. It was noted the duties outlined in the terms of reference did not include oversight of the current financial position. Mrs Taylor acknowledged the committee must be forward looking, she confirmed that although some time was spent on looking at the current finance position this did not take up a great deal of the committee's time. She noted that consideration of the current position informed future strategy and linked to service line reporting and the Carter Review.

15.1.4 Mr Coulter agreed, and noted that the committee focus would vary at different times of the year, for example from September to March planning was the main topic. It was agreed this would be considered as part of the planned committee self-assessment and if necessary amendments to the terms of reference would be proposed.

**APPROVED:**
**The Board of Directors noted the Quality Committee Annual Report for 2016/17.**

**ACTION:**
- **During the planned Finance Committee self-assessment, consideration would be given to the committee's terms of reference and ensuring an appropriate balance of focus on short term financial management and longer term strategic issues.**

**15.2 Report from the Quality Committee meeting held on 3 May 2017 and the Quality Committee's Annual Report 2016/17**

15.2.1 Mrs Webster reported the committee had completed some areas of deeper dive scrutiny, this included updates from all quality of care teams. The committee was satisfied with the assurance received, all directorates had quality of care teams in place with agreed terms of reference. In addition the committee received assurance about management of pressure sores, incident management and Datix.

15.2.2 The annual report demonstrates what a busy agenda the Quality Committee had. Mrs Webster noted the committee had good attendance rates. Mrs Dodson reflected on the range of topics covered by the committee. She suggested that some topics covered by the committee may be more appropriate for consideration by the Board to manage the workload of the committee.

**APPROVED:**
**The Board of Directors:**
- **Endorsed the progression of the REsPECT methodology and expresses support for this being implemented within the Trust;**
- **Noted the Quality Committee Annual Report for 2016/17.**

**15.3 Report from the Audit Committee meetings held on 4 and 18 May 2017**

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

15.3.2 Mr Thompson thanked members and attendees because, due to the annual report

and accounts process, the committee had met on three occasions in the past month. Issues highlighted by internal audit have been picked up by the Senior Management Team, these included staff rostering and cannula care. He noted the committee's frustration that post project evaluations are not all submitted on time, in these instances individuals are invited to attend and present to the committee. Mr Coulter acknowledged this was an important process and although there was scope for further improvement, compliance was getting better.

**APPROVED:**
**The Board of Directors noted the considerations that took place at the two meetings of the Audit Committee on the 4th May and the 18th May, and also the recommendations made by the Committee.**

**16.0 Communications and Marketing Strategy**

16.1 Dr Tolcher noted how important it was that Paul Widdowfield was in attendance at every Board meeting. The Communications and Marketing Strategy was vital to achieving the Trust's future vision and objective.

16.2 Mr Coulter explained the Communications and Marketing Strategy action plan had been developed following engagement with staff. The plan presented built on the success of year one, he explained activities in year two would focus on marketing, supporting future mobilisation of the Trust's brand and values.

16.3 Where required the Communications and Marketing team would engage with the Sustainability and Transformation Partnership and engage staff and stakeholders. Mr Coulter confirmed another area of focus would be support for the Hospital Charity.

16.4 The Board thanked Mr Widdowfield and welcomed the improvement in communications and marketing they had seen over the past few years.

**APPROVED:**
**The Board of Directors noted and commented, where appropriate, on this paper.**

**17.0 Council of Governors' minutes of the meeting held 18 February 2017**

The minutes were presented for information.

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

Mrs Dodson noted the Trust's annual report and accounts were approved at an additional meeting of the Board held in private on 24 May 2017.

There were no other matters to report.

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

Mr Marshall reminded members about the Quality Conference on 14 June 2017. The event would take place in Harrogate with satellite units across the Trust's area.

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

## 20.0 Board Evaluation

In addition to consideration of implications of the Trust financial position, Mrs Dodson felt the meeting had included a wide range of discussion about quality and performance.

Mr Coulter said he found the meeting helpful in terms of what the executives should focus on. He was also reflecting on whether the team could have recognised the financial situation any earlier.

Dr Tolcher felt the meeting had a nice balance of time between agenda items. Mrs Taylor agreed, the pace of the meeting felt right. Mr Nicholas agreed the meeting was balanced and he felt discussions linked to the themes highlighted at the start of the meeting. Mrs Dodson acknowledged the pleasant environment for the meeting.

It was noted that meetings of the board often started with a patient story which can result in a delay, Mrs Webster reflected that this month the Board had been able to start on time as the patient story was scheduled to follow the meeting.

With regards to papers, Mr McLean expressed a view that reports were shorter and more focussed, meaning that it was easier to hone in on the key issues. Mrs Dodson welcomed this comment and agreed the team should further develop the quality of papers.

## 21.0 Confidential Motion

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

The Board agreed the motion unanimously.

The meeting closed at 12.30pm.

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

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

| Item Description | Director/ Manager Responsible | Date of completion/ progress update | Confirm action Complete |
|---|---|---|---|
| Submission of a Research and Development Strategy for Board comment | Dr A Layton - Associate Director for Research | January 2017 | Complete – presentation at the April 2017 Board |
| To circulate dates of Schwartz round to Board members | Mrs J Foster – Chief Nurse | February 2017 | Complete – dates circulated outside Board meeting |
| Executive Team to review the resource and investment profile for the Informatics Team and reflect the risks in the Board Assurance Framework | Dr R Tolcher, Chief Executive | February 2017 | Complete – dealt with under matters arising |
| Inclusion of KPIs on Children's Services and Community Services to be included in the IBR following a review of the new dashboard for the Directorate (4.1) | Dr N Lyth, Clinical Director | February 2017 | Complete – dealt with under matters arising |
| Junior Doctor Vacancy Rates to be added to the Corporate Risk Register<br>Dr Gray to be invited to attend the Board annually and on an ad hoc basis to address issues relating to Guardian of safe Working. | Dr D Scullion, Medical Director | February 2017 | Complete – dealt with under matters arising |
| Equality Diversity Scheme 2' summary report to be completed and circulated to the board of directors before publication on 31 January 2017 | Mrs J Foster, Chief Nurse | February 2017 | Complete - Report circulated to the Board |
| The Board of Directors to receive confirmation of dates and details of planned Patients Safety Visits for 2017 | Mrs J Foster, Chief Nurse | February 2017 | Complete – dates confirmed |
| A Non-Executive Director to be appointed to provide oversight of arrangements for learning from deaths in people with learning disabilities | Mrs S Dodson, Chairman | March 2017 | Complete – dealt with under matters arising |
| Paper to come to the Board on the possible impact and implications of IR35 | Mr P Marshall, Director of Workforce & OD | March 2017 | Complete – in Report from Director of Workforce & OD |
| Stroke action plan to be brought back to the Board | Mr R Harrison, Chief Operating Officer | March 2017 | Complete – in report from Chief Operating Officer |
| An update to be provided on the lymphoedema services and how it might be provided in the future. | Andrew Alldred, Clinical Director | March 2017 | Complete – updates to be included in Clinical Director's |

| Item Description | Director/ Manager Responsible | Date of completion/ progress update | Confirm action Complete |
|---|---|---|---|
| | | | verbal report to the Board |
| Finance Committee to review the overall financial position and the distance from target. | Mrs M Taylor and Mr Coulter, Director of Finance | April 2017 | Complete – Finance Committee conducted review |
| To include a bi-annual report on progress against the Clinical Workforce Strategy action plan to the Board on the Board Forward Plan | Dr R Tolcher, Chief Executive | February 2017 | Complete – included at Board to Board on 31 May 2017 |
| Update on the standardised readmissions | Mr R Harrison, Chief Operating Officer | February 2017 | Complete – included in Chief Operating Officer report in May 2017 |
| Submission of a Research and Development Strategy for Board comment | Dr A Layton - Associate Director for Research | January 2017 | Complete – provided in April 2017 |
| A report on absconding patients to be brought back to the Board after review by SMT. | Mrs J Foster, Chief Nurse | April 2017 | Complete – included within Chief Nurse report May 2017 |
| A report on progress against the implementation of the Stroke Improvement Plan to be received by the Board | Mr R Harrison, Chief Operating Officer | May 2017 | Complete – included in Chief Operating Officer report in May 2017 |
| Terms of Reference for the Board of Directors to be amended and brought back to the board for Approval | Mr B Courtney, Interim Company Secretary | May 2017 | Complete – approved by the Board in May 2017 |
| Chairman to issue letter to domestic staff acknowledging their outstanding work in ensuring that the Trust maintained a clean environment | Mrs S Dodson, Chairman | May 2017 | Complete – letter was sent in April 2017 |
| BAF to be reviewed in order to ensure the risk of cyber-attacks was appropriately reflected. | Mr R Harrison, Chief Operating Officer & Katherine Roberts, Company Secretary | June 2017 | Complete –BAF reviewed during June 2017, no amendments were required |
| Views would be sought from the Director of Infection Prevention and Control about suspending the rolling programme of additional deep cleaning during 2017/18 | Dr R Tolcher, Chief Executive | June 2017 | Complete – meeting held 1 June 2017 |
| Consider the Trusts financial position in further detail and consider the format of the finance report (including a rolling forecast). | Finance Committee | June 2017 | Complete – discussed at meeting on 19 June 2017 |
| Update Board on progress with EDS2 action plan (11.10) | Mrs J Foster – Chief Nurse | January 2017 | Complete – Board received an update in January 2017 |
| The Board of Directors to receive a more | Mr P Marshall, Director of | April 2017 | Complete – matters |

| Item Description | Director/ Manager Responsible | Date of completion/ progress update | Confirm action Complete |
|---|---|---|---|
| detailed overview of recruitment and retention issues April 2017 | Workforce & OD | | considered in detail at Board development day in March 2017 |

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

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

| Ref | Meeting Date | Item Description | Director/Manager Responsible | Completion date | Detail of progress |
|---|---|---|---|---|---|
| 4 | November 2016 | A recommendation paper to be submitted to Board on the Trust's substantive nursing workforce requirements. | Mrs J Foster – Chief Nurse | September 2017 | **Deferred until September** |
| 11 | June 2016<br>July 2016 | Additional information to be included in the IBR relating to readmissions of older people.<br>Update on reducing readmissions in older people to be submitted to the September Board meeting (8.9) | Mr A Alldred, Clinical Director | May 2017 | **As part of IBR review**<br><br>**To update at next Board to Board with CoG 31/05/17** |
| 12 | May 2016 | Further update on progress of the Care of Frail Older People Strategy (11.2.3) | Mr A Alldred, Clinical Director | May 2017 | **To update at next Board to Board with CoG 31/05/17** |
| 13 | June 2016 | Update on the programme of work to reduce hospital admissions (9.3) | Mr A Alldred, Clinical Director | May 2017 | **To update at next Board to Board with CoG 31/05/17** |
| 15 | September 2016 | Provide an update on progress with regard to actions associated with Corporate Risk Register CR8: risk of ophthalmology patients being lost to follow up (6.13) | Dr K Johnson, Clinical Director | April 2017 | **Final report to board June 2017** |
| 16 | October 2016 | Update on progress of internal and system wide work to improve discharge planning to *Board Strategy Day* (7.4) | Mr R Harrison, Chief Operating Officer | May 2017 | **To update at next Board to Board with CoG 31/05/17** |
| 18 | March 2016 | Additional information on learning from cases of C. Diff and associated action planning during 2015/16 to be included in the annual report (6.3) | Mrs J Foster, Chief Nurse | February 2017 | N/A |
| 24 | February 2017 | A report of the effectiveness of Quality of Care Teams to be brought to the Quality Committee in three months | Mrs J Foster, Chief Nurse | June 2017 | |
| 25 | February 2017 | • Re-admission rates to be the subject of a deep dive at the Board Strategy Day on 15 March 2017.<br>• Benchmarking data on re-admissions to be shared with the Board prior to 15 March. | Mr R Harrison, Chief Operating Officer | May 2017 | **To update at next Board to Board with CoG 31/05/17** |
| 26 | February | IBR to be reviewed by a small | Mrs S Dodson, | March 2017 | **Deferred till** |

| | | | | | |
|---|---|---|---|---|---|
| | 2017 | group post April 2017. Membership to be confirmed in March | Chairman | | **May 2017** |
| 33. | April 2017 | Research succession plan to be presented to the Board | Dr R Tolcher, Chief Executive | May 2017 | |
| 35. | April 2017 | Proposals for a revised format for the Strategic KPI Report to be brought back to the Board Strategy Day | Dr R Tolcher, Chief Executive | July 2017 | |
| 36 | May 2017 | Explore option to include WHO checklist within new theatre dashboard. | Mr Coulter, Director of Finance | July 2017 | |
| 37 | May 2017 | Consider how the Integrated Board Report would capture improved efficient within theatres | Mr Coulter, Director of Finance & Mr R Harrison, Chief Operating Officer | July 2017 | |
| 38 | May 2017 | Review KPIs included within the Integrated Board Report. | Non-Executive Directors, Mr Coulter, Director of Finance & Mr R Harrison, Chief Operating Officer | July 2017 | Linked to action 26. |
| 40 | May 2017 | Board strategy day to include consideration of the Board's vision for the future Trust and a focus on ways to drive up productivity within the organisation | Dr R Tolcher, Chief Executive | July 2017 | |
| 43 | May 2017 | Review measures to ensure safer staffing levels were better linked to levels of ward activity | Chief Nurse, Jill Foster | June 2017 | |
| 44 | May 2017 | IBR would be amended to ensure that future reports would only include validated data for Children's services measures | Mr R Harrison, Chief Operating Officer | June 2017 | |
| 45 | May 2017 | Provide feedback to the Board following the 'Getting It Right First Time' meeting on 22 June 2017. | Dr Scullion, Medical Director | June 2017 | |
| 46 | May 2017 | During the planned Finance Committee self-assessment, consideration would be given to the committee's terms of reference and ensuring an appropriate balance of focus on short term financial management and longer term strategic issues | Mrs Maureen Taylor, Chair – Finance Committee | June 2017 | |

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Harrogate and District NHS Foundation Trust

| | |
|---|---|
| **Report to the Trust Board of Directors: 28 June 2017** | **Paper No: 5.0** |
| **Title** | **Report from the 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 Board of Directors are asked to note:

- The Trust's financial performance in May continued to be adverse with the year to date deficit increasing to £2.2m against a planned small deficit. A further financial pressure relating to a high risk CIP is compounding the forecast position. Additional savings/income recovery plans have commenced with further plans to be developed.
- Publication by the Care Quality Commission (CQC) of the next phase consultation response and a follow up consultation.

**Related Trust Objectives:**

| | |
|---|---|
| 1. To deliver high quality care | Yes – the report reflects a sustained organisational focus on providing high quality care and ensuring robust controls and assurances on care quality. |
| 2. To work with partners to deliver integrated care | Yes – the report provides updates on the work of the Harrogate Health Transformation Board and West Yorkshire reflect partnership working in Harrogate and West Yorkshire areas. |
| 3. To ensure clinical and financial sustainability | Yes – the report notes from the SMT meeting demonstrate a particular focus on financial performance |
| **Risk and Assurance** | Strategic and operational risks are noted in section 6. Risks associated with this report are reflected in the Board Assurance Framework: BAF 14: risk to deliver of integrated models of care; BAF 15: misalignment of partner strategic plans; and BAF 9; failure to deliver the operational plan. |
| **Legal implications/ Regulatory Requirements** | There are no legal/regulatory implications highlighted within the report. |

**Action Required by the Board of Directors**

- The Board is requested to **note** the strategic and operational updates
- The Board is asked to **note** progress on risks recorded in the BAF and Corporate Risk Register and confirm that progress reflects the current risk appetite.

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

### 1.1 Quality Conference

The Trust hosted its inaugural Quality Conference - a key element of our Quality Charter on 15 June 2017. Three Key Note speakers and a range of presentations and breakout sessions contributed to the event which was accessed by more than 150 people. Sessions were transmitted live to three satellites each of which ran parallel breakout sessions. The Quality Charter is now in its second year and a growing number of Quality of Care Champions are contributing to our drive for continuous quality improvement.

### 1.2 Care Quality Commission (CQC) Next Phase Consultation Response

On 12 June 2017 the CQC published its response to the recent consultation on the next phase for regulating NHS Trusts. This covered all aspects of the new model including monitoring, inspecting and rating. The CQC expect to have the new approach embedded by spring 2019, aiming to inspect each trust at least once between June 2017 and Spring 2019, and approximately annually after that.

- CQC Insight: The insight model (intended to identify changes in quality markers since the last CQC inspection and rating) will focus on existing data collections which are available nationally.
- Relationship Management: Each Trust will have a relationship owner who will develop an understanding of the organisation. Relationship management meetings with Trusts will be quarterly and will inform the CQC's regulatory planning.
- Provider Information Requests (PIRs): The new PIR templates have been published by the CQC. Between June and Autumn 2018 providers will receive their first PIR, this will mark the start of the annual inspection cycle, with targeted inspections following within six months. Following this, information will be requested on an annual basis. The CQC are aiming to send PIRs to around a third of NHS trusts by the end of December 2017.
- Inspections
  - Well-led: There will be an annual announced review of well-led at trust level together with unannounced inspection of at least one core service.
  - Core service: every year the CQC will inspect all core services rated as inadequate, half of services rated as requires improvement, a third of those rated good and one fifth of core services rated as outstanding.
  - If accreditation schemes meet core standards and have sufficient uptake amongst providers the CQC may use accreditation schemes to reduce inspection activity.
- Rating: Rating will continue at provider level (as well as at service and location level), based on assessment of the well-led key question and use of aggregation principles and the professional judgement of inspection teams to rate the other four key questions. There will be a stronger role for professional judgement in agreeing trust-level ratings for providers that combine different health and social care services.

### 1.3 Care Quality Commission (CQC) Follow up Consultation

The CQC has also published a second stage of consultation which includes proposals about the way the CQC will register, monitor, inspect and rate new models of care of large or complex providers. This is relevant to the Trust's local involvement in the New Care Model (Vanguard) and also potential acute collaboration.

a) Regulating a complex changing environment.
   - Registration: The CQQ will better align registration with accountability of organisations for the care they provide. All providers will remain registered, however related organisations (eg parent companies) will also be registered and appear on the register. The CQC intends to focus on those organisations which exert significant influence over the quality and safety of services.
   - Complex Providers: A more 'intelligence-driven' approach to monitoring and inspecting complex-providers has been proposed. This is a response to providers operating across sectors and in new models of care including accountable care organisations and systems. A single CQC relationship-holder will be identified for each provider who will coordinate regulatory activity for that provider alongside named leads for each type of service. Assessment of the well-led domain will encompass leadership and governance in all services and partnership working.
   - Provider-level assessment and rating: Quality of care will be assessed at provider level; "the highest level at which CQC register any organisation that delivers more than one service. This would include the board level of an NHS trust… or the management level of a GP federation".
   - Quality of care in a place: the consultation recognises that how well services work together will influence patients' experiences of care. As such the CQC aims to develop an approach to 'quality of care in a place'.

b) Next phase of regulation for medical services and social care
   - In line with the GP Five Year Forward View and the development of GP federations, the CQC have set out the proposed direction of travel. This includes an annual online provider self-report.

c) Fit and proper persons test:
   - Proposals will change the way the CQC share information of concern from third parties about the fitness of a director. Providers will be asked to assess all information received by the CQC and provide details of the steps taken by the Trust to assure themselves of the fitness of the director. If the CQC is not satisfied with the provider's response further regulatory action will be undertaken.

## 2.0 STRATEGIC UPDATE

### 2.1 West Yorkshire and Harrogate Sustainability and Transformation Partnership (WYH STP) and West Yorkshire Association of Acute Trusts (WYAAT) update

WYAAT met on 6 June 2017. Good progress is being made on key acute collaborative work streams. Further amendments to the PID for Elective Care were agreed. A final PID will be presented to the July meeting of the Board of Directors prior to presentation to the Committee in Common for decision in August.

Funding of the WYAAT PMO was discussed and it was agreed that the programme will operate within the agreed annual budget of £984k with no further investment. More detail on return on investment is required in work stream PIDs in order to ensure the right prioritisation of work. It is important that WYAAT work is carried out by existing staff in each of the six Trusts so that it is seen as part of the 'day-job' or business as usual.

The Q1 STP transformation fund allocation in respect of cancer services is contingent on the system achieving the 62 day target by September. A local agreement on breach allocation in inter-provider transfers for cancer pathways therefore needs to be agreed by

August. This is necessary to ensure that all patients receive timely care in the most efficient way possible. Work to date suggests that the Trust will not be adversely affected by this proposal.

### 2.2 West Yorkshire and Harrogate Sustainability and Transformation Partnership (WYH STP)

Results from the WYH STP consultation on stroke services were delayed due to purdah resulting from the General Election; they are expected to be published in July 2017.

Following a review of 2017/18 CCG and Trust financial plans, work has commenced on a financial strategy for the WYH STP, once finalised further details will be shared with members of the Board.

### 2.3 Academic Health Science Network (AHSN)

The Academic Health Science Network (AHSN) seeks to align education, clinical research, informatics, innovation, training and education and healthcare delivery. Their goal is to improve patient and population health outcomes by translating research into practice, and developing and implementing integrated health care services.

2017/18 represents the final year of the initial five-year licence for all AHSNs. It has been confirmed that NHS England intends to recommission a comprehensive network of AHSNs across England for a further five year period. Configuration of the 15 AHSNs is expected to remain the same and they will have a total budget of £30m per annum over 5 years. A paper on the future of AHSNs will be taken to the NHS England public board meeting in July 2017.

Discussions between AHSNs and NHS England are focused on the licence requirements from 2018/19 onwards and the planned procurement process to be used. NHS England has identified two main functions for AHSNs; innovation and improvement, with the innovation element being highly standardised and improvement activity being localised and bespoke. Work continues to define in greater detail the objectives, priorities, assurance arrangements and metrics for the Y&H AHSN Network.

The proposed national objectives for the AHSN network are:

- Innovators, commissioners, clinicians and patients develop closer collaboration and a demonstrably clearer understanding of NHS needs and opportunities;
- Patients and the NHS have demonstrably faster and less variable access nationally to cost-effective innovations and improvements;
- Patients are demonstrably safer, and systems are demonstrably more focused on continual learning and improvement of patient care.

In addition to these national objectives, local improvement objectives will be agreed between the AHSNs and regional / STP leads.

All Trusts contribute to the funding of the AHSN and we are currently exploring with the Y&H AHSN how the Trust can derive maximum benefit from this investment.

### 2.4 General Election

During the general election on 8 June 2017 local MP Mr Andrew Jones was re-elected as the MP for Harrogate, Knaresborough and Boroughbridge and local MP Julian Smith was

re-elected as MP for Skipton and Ripon. Following a cabinet reshuffle Mr Jones has been appointed as Exchequer Secretary to the Treasury, having previously been a Parliamentary Under Secretary of State at the Department for Transport. Mr Smith has been appointed as government Deputy Chief Whip.

Mr Jeremy Hunt remains as Secretary of State for Health. At the time of writing it remains unclear what impact the election will have on the direction of health policy.

### 2.5 Queen's Speech - Draft Patient Safety Bill

The briefing document accompanying the Queens Speech on 21 June included reference to a Draft Patient Safety Bill. The document states "the draft Bill will set out a framework to help improve patient safety in the NHS and instil greater public confidence in the provision of healthcare services in England".

The draft Bill will establish the 'Health Service Safety Investigatory Body', intended to conduct independent and impartial investigations into patient safety risks in the NHS. It is understood that there will be an embargo on the disclosure of any information related to an investigation conducted by the Health Service Safety Investigatory Body.

## 3.0 WORKING IN PARTNERSHIP

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

Work continues to model the investment profile across the health and care system in Harrogate and Rural District. A further verbal update will be provided at the Board meeting.

A 30-day Report Out on Phase Two of the Vanguard in respect of the Integrated Response Service (IRS) was held on 12 June. Data so far shows a low but growing referral rate, with 30 cases accepted in the first month, and 22 cases discharged back to core services. Frailty falls and mental health issues are the main reasons for referral so far with physio and pharmacy interventions making important contributions alongside nursing care.

The Productive and Purposeful Community Services methodology has been adopted, which includes daily multi-disciplinary huddles and a leadership cell to rapidly unblock problems.

Feedback from service users, GPs and colleagues in the IRS is positive.

Pressure in the Community Teams continues however, with high levels of demand.

## 4.0 FINANCIAL POSITION

The Trust financial performance in May continued to be adverse with the year to date deficit increasing to £2.2m against a planned small deficit. No Sustainability and Transformation Funding has been assumed in this position as a result of the adverse position.

The position also results in a Use of Resource Metric of 3 which is a significant concern and requires improvement.

Issues which were reported in month 1 have continued in May, and although plans are being developed to mitigate the risk this presents, some timelines for implementation and impact are yet to be finalised. These adverse areas include –

£702k Clinical Income
£289k Ward Expenditure
£165k Theatre Expenditure
£175k CIP performance
£439k Non recurrent issues in month 1
£378k S&T funding

In addition to the adverse performance above and in the light of non-elective demand significantly above plan a major CIP scheme in LTUC needs revising. These pressures together represent a £3m risk and some immediate actions have been agreed to address this. Further measures will be required in all Directorates in order to recover this position and secure S&T funding in Q2 and beyond.

## 5.0 SENIOR MANAGEMENT TEAM (SMT) MEETING

The SMT met on 21 June. The following key areas are for noting:

- The financial position and actions required to recover the position, while sustaining care quality was the main focus of the meeting. Work completed by the Long Term Conditions and Urgent Care Directorate based on the recent acuity audit and a review of historical staff rostering suggests that an adjustment to the ward establishment is required in parallel with the planned adjustment to bed numbers. A recommendation will be made to the Board of Directors in line with SFI's and subject to further Quality Impact Assessment.
- There have been no cases of C.Difficile Infection since February.
- All actions arising from Serious Incidents (SIs) are on track and compliance with actions following Significant Events (SEs) has improved. All Directorates have reviewed arrangements and anticipate being up to date in the next two months.
- The Trust's safety thermometer score fell to 94.5% in May. The main factor driving this adverse movement appears to be the number of pressure ulcers with a possible relationship to high levels of demand in community services. The national average 94.2%.
- Compliance with the 62 day cancer pathway was been below the required 85% standard in May with breaches mainly relating to complex diagnostics and outpatient capacity. A full breach analysis will examine the impact on patients. SMT noted a new entry on the Corporate Risk Register relating to the timeliness of care and additional outpatient capacity is being planned to help mitigate this risk.
- A paper on organisational readiness for a future CQC inspection was received and recommendations agreed including self and peer assessments.

## 6.0 COMMUNICATIONS RECEIVED AND ACTED UPON

There were no significant communications to report for this period.

## 7.0 BOARD ASSURANCE AND CORPORATE RISK

### 7.1 Board Assurance Framework (BAF)

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

Links to the Corporate Risk Register have been included in the BAF.

Controls and mitigations have been reviewed and updated in the light of the recent cyber-attack which affected the NHS. No changes to risk scores were required.

Five risks are currently assessed as having achieved their target risk score. The strategic risks are as summarized as follows:

| Ref | Description | Risk score | Progress score | Target risk score reached |
|---|---|---|---|---|
| **BAF 1** | Risk of a lack of medical, nursing and clinical staff | *Red 12 ↔* | *Unchanged at 2* | |
| **BAF 2** | Risk of a high level of frailty in the local population | *Amber 8 ↔* | *Unchanged at 1* | ✓ |
| **BAF 3** | Risk of a failure to learn from feedback and Incidents | *Amber 9 ↔* | *Unchanged at 3* | |
| **BAF 4** | Risk of a lack of integrated IT structure | *Red 12 ↔* | *Unchanged at 1* | |
| **BAF 5** | Risk of maintaining service sustainability | *Yellow 6 ↔* | *Unchanged at 1* | ✓ |
| **BAF 9** | Risk of a failure to deliver the Operational Plan | *Red 12 ↑* | *Unchanged at 1* | |
| **BAF 10** | Risk of breaching the terms of the Trust's Licence to operate | *Yellow 5 ↔* | *Unchanged at 1* | ✓ |
| **BAF 12** | Risk of external funding constraints | *Red 12 ↔* | *Unchanged at 1* | ✓ |
| **BAF 13** | Risk of a reduced focus on quality | *Yellow 4 ↔* | *Unchanged at 1* | ✓ |
| **BAF 14** | Risk of delivery of integrated models of care | *Red 12 ↔* | *Unchanged at 2* | |
| **BAF 15** | Risk of misalignment of strategic plans | *Red 12 ↔* | *Unchanged at 1* | |
| **BAF 16** | Risk that the Trust's critical infrastructure is not fit for purpose | *Red 12↔* | *Unchanged at 1* | |
| **BAF 17 (formerly BAF#6)** | Risk to senior leadership capacity | *Amber 9 ↔* | *Unchanged at 1* | |

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

### 7.2 Corporate Risk Register (CRR)

The CRR was reviewed at the monthly meeting of the Corporate Risk Review Group on 9 June 2017. The Corporate Risk Register contains 12 risks.

**Corporate Risk Register Summary**

| Ref | Description | Risk score | Progress score* |
|---|---|---|---|
| **CR2** | Risk to the quality of service delivery in Medicine due to gaps in rotas following the Deanery allocation process | *Red 12 ↔* | *2* |
| **CR5** | Risk to service delivery due to the lack of experienced registered nurses due to national labour market shortage | *Red 16 ↔* | *2* |
| **CR12** | Risk to financial sustainability from failure to deliver the Clinical Transformation Programme at pace and scale | *Red 12 ↔* | *2* |
| **CR13** | Risk to urgent care system due to a lack of capacity in the out of hospital services | *Red 12 ↔* | *2* |
| **CR14** | Risk of financial deficit and impact on service delivery due to failure to deliver | *Red 12 ↔* | *2* |

| | | | |
|---|---|---|---|
| | the Trust annual plan by having excess expenditure or a shortfall in income. | | |
| **CR17a** | Risk of patient harm as a result of being lost to follow-up as a result of current processes | *Red 12 ↔* | *2* |
| **CR17b** | Risk of patient harm as a result of being lost to follow up as a result of historic processes | *Red 12 ↔* | *4* |
| **CR18** | Risk to provision of service and not achieving national standards in cardiology due to potential for lab equipment breaking down | *Red 12 ↔* | *2* |
| **CR19** | Risk to patient safety due to lack of provision of Acute Oncology, CUP, Breast and Urology Oncology services. | *Red 12 ↔* | *1* |
| **CR21** | Risk of temporary reduced or loss of activity as a result of disruption to services due to the major refurbishment to the Sterile Services department | *Red 12 ↔* | *2* |
| **CR22** | Risk to reputation due to non-compliance with DNACPR policy caused by failure of some clinicians to implement policy. | *Red 12 ↔* | *2* |
| **CR23** | Risk of failing cancer waiting time targets due to capacity within site specific areas for diagnostics and treatments. | *Red 12* | *To be confirmed* |

One new risk has been added: CR23, Risk of failing cancer waiting time targets due to capacity within site specific areas for diagnostics and treatments. No risks have been removed and no target scores/dates have been adjusted in the last month.

## 8.0 DOCUMENTS SIGNED AND SEALED

No documents have been signed and sealed during the month.

Dr Ros Tolcher
Chief Executive
June 2017

Harrogate and District
NHS Foundation Trust

| | |
|---|---|
| **Report to the Trust Board of Directors: 28 June 2017** | **Paper No: 5.0a** |

| | |
|---|---|
| **Title** | **Integrated Board Report** |
| **Sponsoring Director** | Dr Ros Tolcher, Chief Executive |
| **Author(s)** | Ms Rachel McDonald, Head of Performance & Analysis |
| **Report Purpose** | To provide the Board with an update on performance relating to operational performance, quality and finance and efficiency. |

**Key Issues for Board Focus:**

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

- In May, HDFT achieved 3 out of 4 key operational performance metrics in the NHS Improvement Single Oversight Framework. Performance against the cancer 62 day standard was below the required 85% in May. Quarter 1 performance for this standard is also at risk.
- The Trust reported a rating of 3 (where 1 is best) for NHS Improvement's Use of Resource Metric in May, against an expected rating of 2, and is a result of the variance from plan for income and expenditure. The Trust reported a cumulative deficit of £2,224k in month 2, £2,178k behind plan. Work continues in relation to improving activity and income, pay spend in relation to medical staffing vacancies and ward nursing, and addressing non pay issues.
- The latest published standardised mortality rates show that the HSMR has increased again but the SHMI has decreased. Both remain within expected levels.
- Staff sickness decreased to 3.75% this month.
- Delayed transfers of care decreased to 3.5% when the snapshot was taken in May, in line with maximum threshold of 3.5% set out in the contract.

| **Related Trust Objectives** | |
|---|---|
| 1. To deliver high quality care | Yes – 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 in the delivery of high quality care. |
| 2. To work with partners to deliver | Yes – key performance metrics allow the |

| | |
|---|---|
| integrated care | Board to receive assurance in terms of the delivery of high quality care, often underpinned by collaboration and partnership working, particularly when developing new care models. |
| 3. To ensure clinical and financial sustainability | Yes – the report provides the Board with assurance on progress of work across the region to ensure clinical and financial sustainability. |

| | |
|---|---|
| **Risk and Assurance** | Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF# 1: risk of a lack of medical, nursing and clinical staff; BAF# 2: risk of a high level of frailty in local population; BAF# 9: risk of failure to deliver the operational plan; and BAF# 12: external funding constraints. |
| **Legal implications/ Regulatory Requirements** | The report does not highlight any legal/regulatory implications for the period. |

**Action Required by the Board of Directors**
The Board of Directors are asked to receive and note the content of the report.

# Integrated board report - May 2017

## Key points this month

1. In May, HDFT achieved 3 out of 4 key operational performance metrics in the NHS Improvement Single Oversight Framework. Performance against the cancer 62 day standard was below the required 85% in May. Quarter 1 performance for this standard is also at risk.

2. The Trust reported a rating of 3 (where 1 is best) for NHS Improvement's Use of Resource Metric in May, against an expected rating of 2, and is a result of the variance from plan for income and expenditure. The Trust reported a cumulative deficit of £2,224k in month 2, £2,178k behind plan. Work continues in relation to improving activity and income, pay spend in relation to medical staffing vacancies and ward nursing, and addressing non pay issues.

3. The harm free percentage reported in this month's Safety Thermometer audit was 94.5%, below 95% for the first time in a number of months.

4. The latest published standardised mortality rates show that the HSMR has increased again but the SHMI has decreased. Both remain within expected levels.

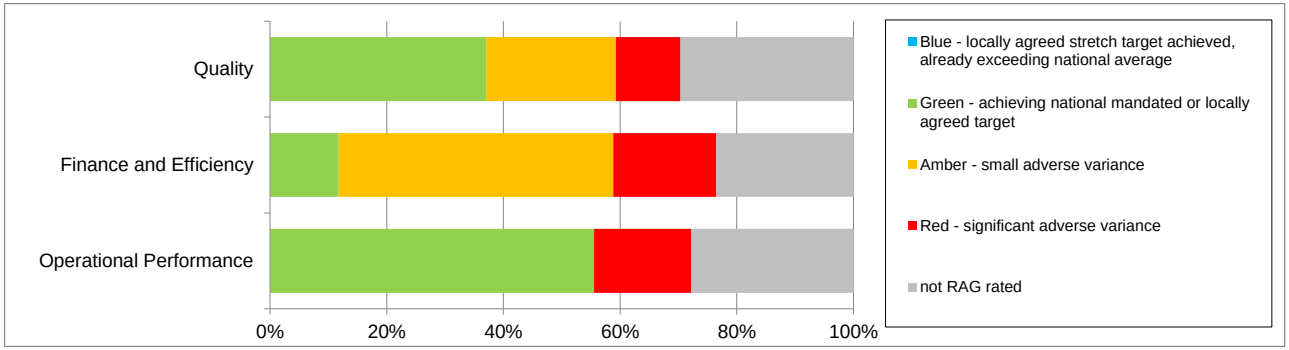
5. There have been no cases of hospital apportioned C. difficile reported in 2017/18 to date.

6. Performance against the 18 weeks standard deteriorated to 93.5% in May but remains above the 92% standard and the latest reported national average.

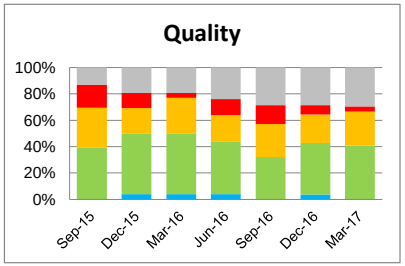
7. Staff sickness decreased to 3.75% this month.

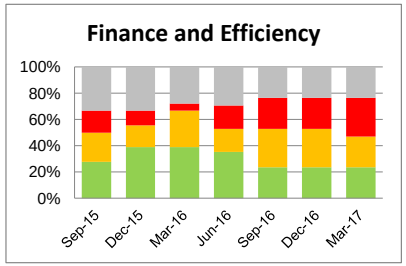
8. Delayed transfers of care decreased to 3.5% when the snapshot was taken in May, in line with maximum threshold of 3.5% set out in the contract.

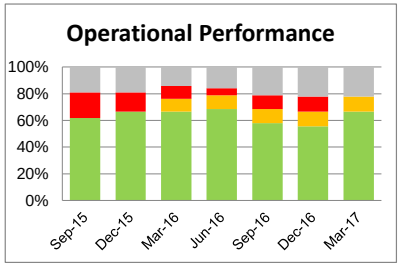
## Summary of indicators - current month



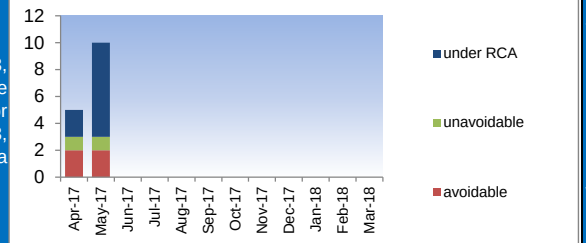
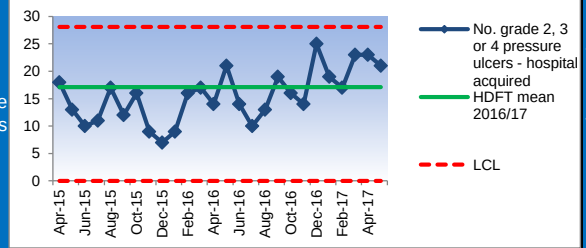
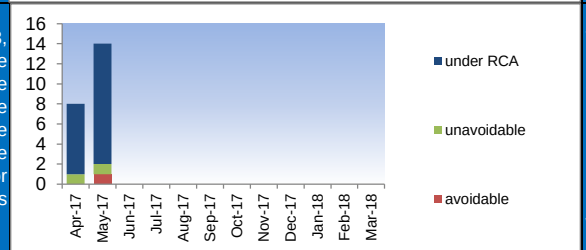
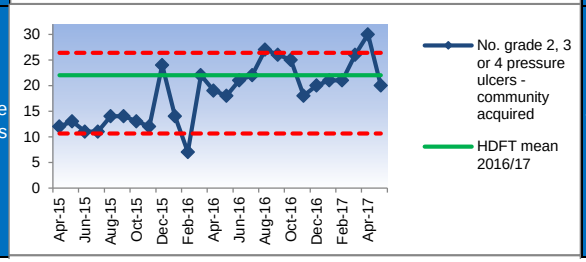

## Summary of indicators - recent trends



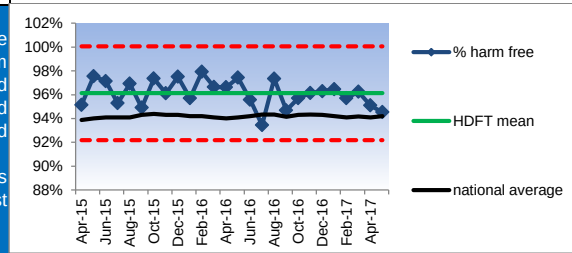
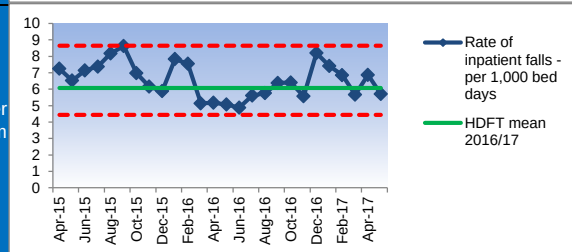
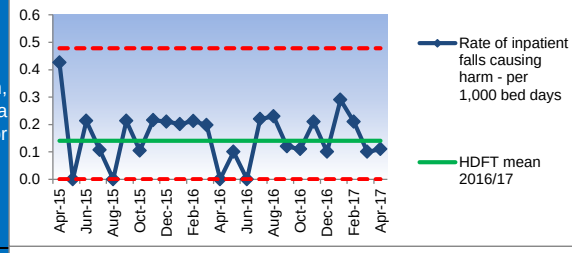
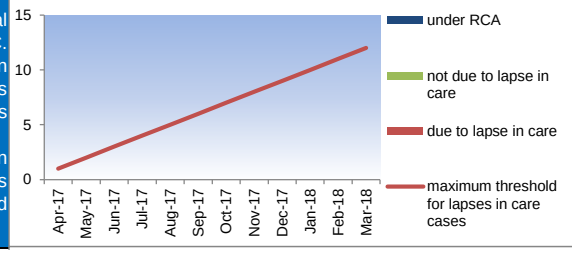



## Quality - May 2017

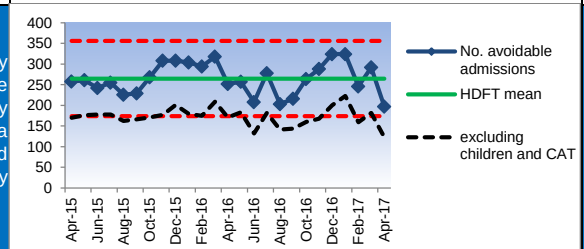
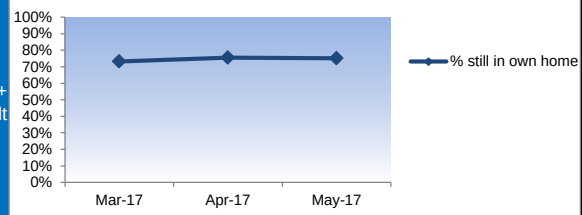
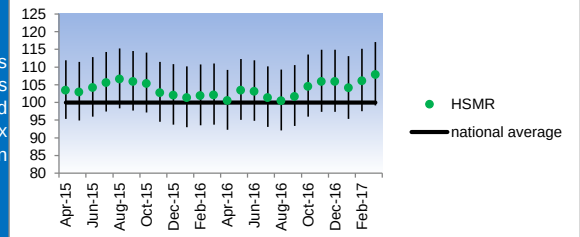
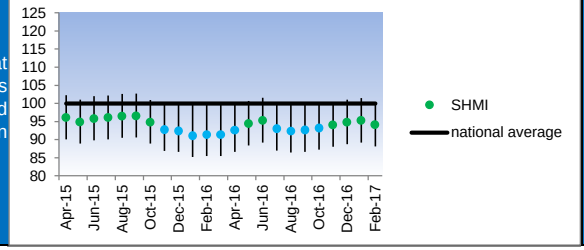
| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| ✓ **Pressure ulcers - hospital acquired** | The chart shows the cumulative number of category 3, category 4 or unstageable hospital acquired pressure ulcers in 2017/18. The Trust has set a local trajectory for 2017/18 to reduce the number of avoidable category 3, category 4 or unstageable pressure ulcers. The data includes hospital teams only. |  | There were 5 hospital acquired unstageable or categeory 3 pressure ulcers reported in May, bringing the year to date total to 10. Of these, 7 are still under root cause analysis (RCA), 2 have been assessed as avoidable and 1 as unavoidable. No category 4 hospital acquired pressure ulcers have been reported in 2017/18 to date.<br><br>In 2016/17, 33 hospital acquired category 3 or unstageable pressure ulcers were reported. Of these, 19 were deemed to be avoidable. |
| ✓ | The chart includes category 2, 3 and 4 and unstageable hospital acquired pressure ulcers. The data includes hospital teams only. |  | The number of hospital acquired category 2-4 (or unstageable) pressure ulcers reported in May was 21, compared to 23 last month.<br><br>Whilst the total number of pressure ulcers reported has increased compared with the same period last year, the number of category 3, category 4 or unstageable pressure ulcers has reduced. |
| ✓ **Pressure ulcers - community acquired** | The chart shows the cumulative number of category 3, category 4 or unstageable community acquired pressure ulcers in 2017/18. This metric includes all pressure ulcers identified by community teams including pressure ulcers already present at the first point of contact. The Trust has set a local trajectory for 2017/18 to reduce the number of avoidable category 3, category 4 or unstageable pressure ulcers. The data includes community teams only. |  | There were 6 community acquired category 3 (or unstageable) pressure ulcers reported in May, bringing the year to date total to 14. Of these, 12 are still under root cause analysis (RCA), 1 have been assessed as avoidable and 1 as unavoidable. No category 4 community acquired pressure ulcers have been reported in 2017/18 to date.<br><br>In 2016/17, 79 community acquired category 3 or 4 or unstageable pressure ulcers were reported (including 3 category 4 cases) of which, 42 were deemed to be avoidable. |
| ▲ | The chart includes category 2, 3 and 4 and unstageable community acquired pressure ulcers. The data includes community teams only. |  | The number of community acquired category 2-4 (or unstageable) pressure ulcers reported in May was 20 cases, compared to 30 last month. |

# Quality - May 2017

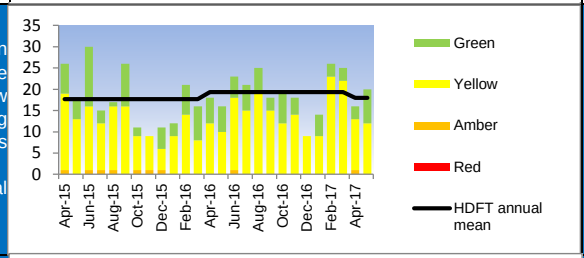
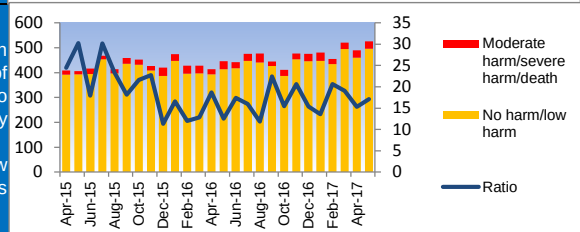
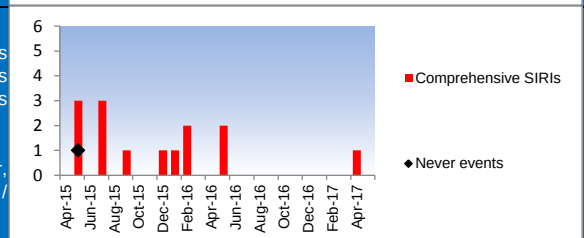
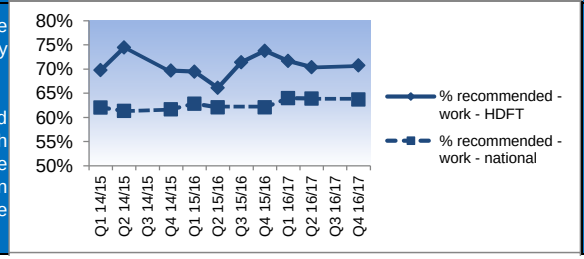
| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Safety Thermometer - harm free care** ✓ | Measures the percentage of patients receiving harm free care (defined as the absence of pressure ulcers, harm from a fall, urine infection in patients with a catheter and new VTE) in the Safety Thermometer audits conducted once a month. The data includes hospital and community teams. A high score is good.<br>Whilst there is no nationally defined target for this measure, a score of 95% or above is considered best practice. |  | The harm free percentage for May was 94.5%, a decrease on last month and below 95% for the first time in 8 months. However this remains above the latest national average and provisional data for June indicates an improved position. |
| **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 5.7 per 1,000 bed days in May, a decrease on last month and below the average HDFT rate for 2016/17.<br><br>In 2016/17, 697 inpatient falls were reported (including those not causing harm), a 14% reduction on the number of inpatient falls reported in the previous year. |
| **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 was 1 inpatient fall causing moderate harm in May. The rate per 1,000 bed days in 2017/18 to date is below the HDFT average for 2016/17. |
| **Infection control** ✓ | The chart shows the cumulative number of hospital apportioned C. difficile cases during 2017/18. HDFT's C. difficile trajectory for 2017/18 is 12 cases, no change on last year's trajectory. Cases where a lapse in care has been deemed to have occurred would count towards this.<br>Hospital apportioned MRSA cases will be reported on an exception basis. HDFT has a trajectory of 0 MRSA cases for 2017/18. The last reported case of hospital acquired MRSA at HDFT was in Oct-12. |  | There have been no cases of hospital apportioned C. difficile or hospital apportioned MRSA reported in 2017/18 to date. |

## Quality - May 2017

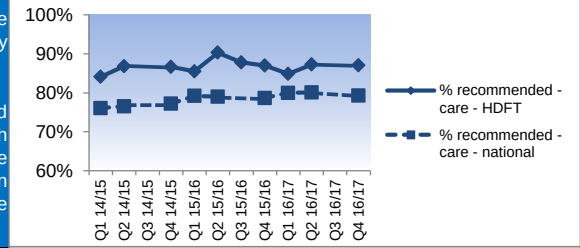
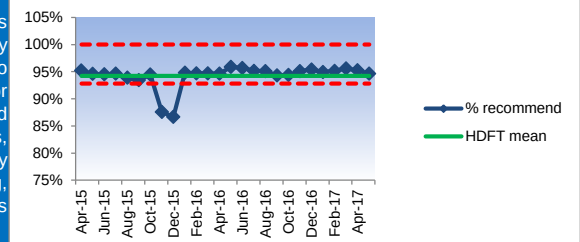
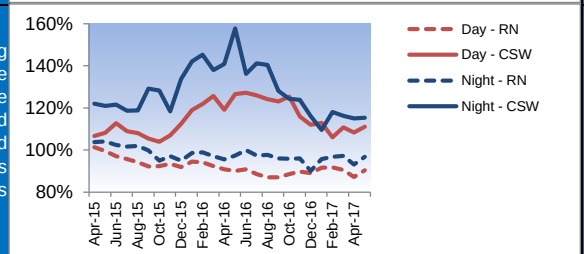
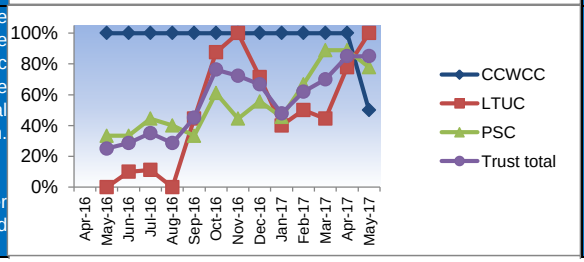
Harrogate and District NHS Foundation Trust

| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Avoidable admissions** ✓ | The chart shows the number of avoidable emergency admissions to HDFT as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require a hospital admission. Conditions include pneumonia and urinary tract infections in adults and respiratory conditions in children. |  | There were 197 avoidable admissions in April, a significant decrease on last month and below the level reported in April last year. This equates to 6.7 avoidable admissions per day, compared to 9.3 per day in March.<br><br>Adult admissions (excluding CAT attendances) also decreased this month. |
| **Reducing hospital admissions in older people** ⚠ | The chart shows the proportion of older people aged 65+ who were still at home 91 days after discharge from adult community services. A high figure is good.<br>*This indicator is in development.* |  | For patients discharged from adult community services in February, 75% were still in their own home at the end of May.<br><br>This metric now includes patients discharged from any service within the new Integrated Care Teams, as opposed to only including patients discharged from the Fast Response Team which was presented previously. Going forward, this will provide a more robust metric involving a larger group of patients but it is not be possible to present historical trend data. |
| **Mortality - HSMR** ✓ | The Hospital Standardised Mortality Ratio (HSMR) looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care. A low figure is good. |  | HDFT's HSMR increased to 107.8 for the rolling 12 months ending March 2017 but remains within expected levels. At specialty level, one specialty (Geriatric Medicine) has a standardised mortality rate above expected levels. |
| **Mortality - SHMI** ✓ | The Summary Hospital Mortality Index (SHMI) looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care. A low figure is good. |  | HDFT's SHMI decreased to 94.06, compared to 95.24 last month, remaining within expected levels. At specialty level, two specialties (Geriatric Medicine and Gastroenterology) have a standardised mortality rate above expected levels. |

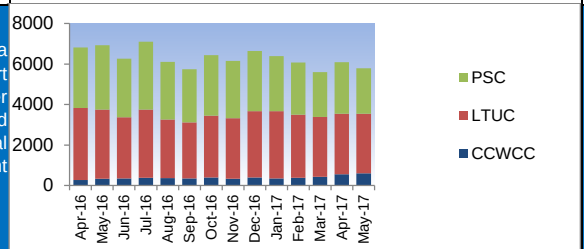
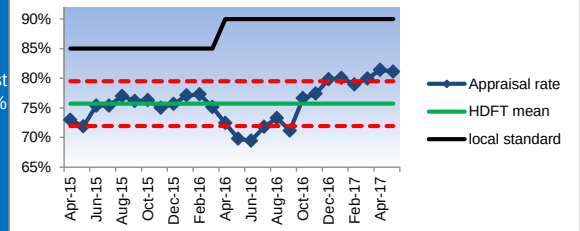
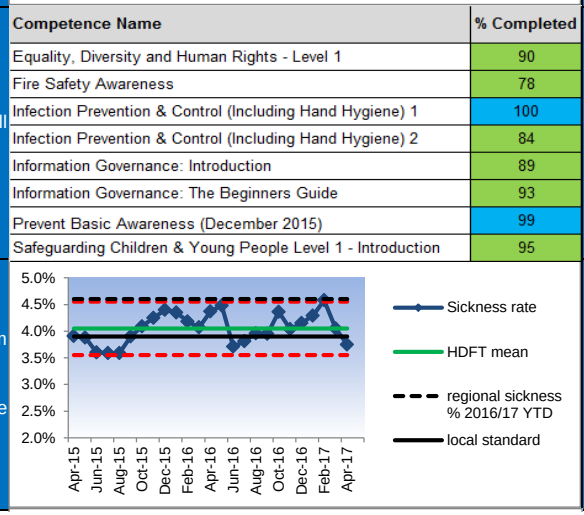
# Quality - May 2017

| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Complaints** | The number of complaints received by the Trust, shown by month of receipt of complaint. The criteria define the severity/grading of the complaint with green and yellow signifying less serious issues, amber signifying potentially significant issues and red for complaints related to serious adverse incidents.<br>The data includes complaints relating to both hospital and community services. |  | 20 complaints were received in May, compared to 16 last month. There were no complaints classified as amber or red in May. The main subjects referenced in the complaints received in May were clinical treatment and communications.<br><br>Of the complaints received in 2017/18 to date, 67% are still under investigation. Of those completed, 67% were upheld and 33% were not upheld. |
| **Incidents - all** | The chart shows the number of incidents reported within the Trust each month. It includes all categories of incidents, including those that were categorised as "no harm". The data includes hospital and community services.<br>A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture |  | The latest published national data (for the period Apr - Sep 16) shows that Acute Trusts reported an average ratio of 37 no harm/low harm incidents for each incident classified as moderate harm, severe harm or death (a high ratio is better). HDFT's local reporting ratio for the same period was 18 which places the Trust in the bottom 25% nationally. The focus going forward is to improve our incident reporting rate particularly encouraging staff to report no harm/ near miss incidents. Options to improve the Datix system to simplify the incident reporting process are being explored. |
| **Incidents - SIRIs and never events** | The chart shows the number of Serious Incidents Requiring Investigation (SIRIs) and Never Events reported within the Trust each month. The data includes hospital and community services.<br><br>Only comprehensive SIRIs are included in this indicator, as concise SIRIs are reported within the presure ulcer / falls indicators above. |  | There were no comprehensive SIRIs or never events reported in May. |
| **Friends & Family Test (FFT) - Staff - % recommend as a place to work** | The Staff Friends and Family Test (FFT) gives staff the opportunity to give feedback on the organisation they work in.<br><br>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 which would typically mean that 71% of staff would recommend the Trust as a place to work. |  | *There is no update of this data this month. The Quarter 1 HDFT results will be available in July.*<br>In Quarter 4, 70.8% of HDFT staff surveyed would recommend HDFT as a place to work, a slight increase on Quarter 2 (when the survey was last carried out) and remaining above the most recently published national average of 64%. The response rate at HDFT for Quarter 4 was 15%, compared to the most recently published national average of 12%. |

## Quality - May 2017

| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Friends & Family Test (FFT) - Staff - % recommend as a place to receive care** ✓ | The Staff Friends and Family Test (FFT) gives staff the opportunity to give feedback on the organisation they work in.<br><br>The chart shows the percentage of staff that would recommend the Trust as a place to receive care. A high percentage is good. The Trust's aim is to feature in the top 20% of Trusts nationally which would typically mean that 88% of staff would recommend the Trust as a place to work. |  | *There is no update of this data this month. The Quarter 1 HDFT results will be available in July.*<br>In Quarter 4, 87.0% of HDFT staff surveyed would recommend HDFT as a place to receive care. This is a slight decrease on Q2 (when the survey was last carried out) but remains above the most recently published national average of 79%. The response rate at HDFT for Quarter 4 was 15%, compared to the most recently published national average of 12%. |
| **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. |  | 94.6% of patients surveyed in May would recommend our services, a small reduction on last month but remaining above the latest published national average.<br><br>Around 4,100 patients responded to the survey this month, which equates to an average of 132 responses per day. |
| **Safer staffing levels** ✓ | Trusts are required to publish information about staffing levels for registered nurses/midwives (RN) and care support workers (CSW) for each inpatient ward. The chart shows the overall fill rate at HDFT for RN and CSW for day and night shifts. The fill rate is calculated by comparing planned staffing with actual levels achieved. A ward level breakdown of this data is published on the Trust website. |  | Overall staffing compared to planned was at 99.4% in May, an increase on last month. Care Support Worker staffing remains high compared to plan - this is reflective of the increased need for 1-1 care. Whilst safer staffing levels for registered nurses remiansd below 100%, the staffing level achieved still enables the delivery of safe care. Achieving safe staffing levels remains challenging and requires the increasing use of temporary staff through the nurse bank and agencies. |
| **Electronic rostering timeliness** ▲ | The chart shows the proportion of rosters that were published on time on Rosterpro (at least 4 weeks before the roster start date). It includes data for 20 specific clinical areas (mostly inpatient wards) involved in the pilot phase. The data presented is split by Clinical Directorate, as well as showing the Trust overall position. A high percentage is good.<br><br>Publishing electronic rosters in a timely manner improves staff morale, increases bank fill rates and reduces bank/agency costs. |  | This indicator has been amended to show the month on month trend, rather than a 12 month rolling position so that improvements in recent months can be more clearly seen. A Trustwide trend line has also been added which demonstrates the overall improvement on this indicator. 85% of rosters were published on time during May, compared to 25% last May.<br><br>From next month, this metric will be amended to track the number of rosters published by the new deadline of 8 weeks' notice. |

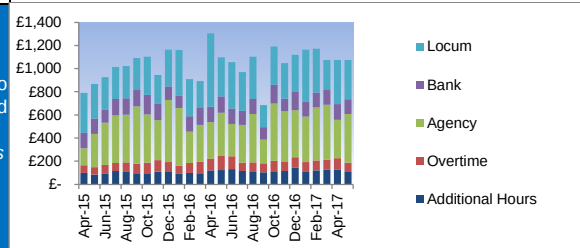
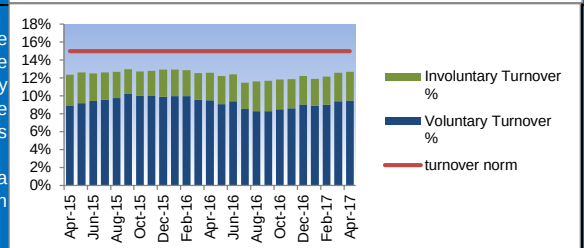
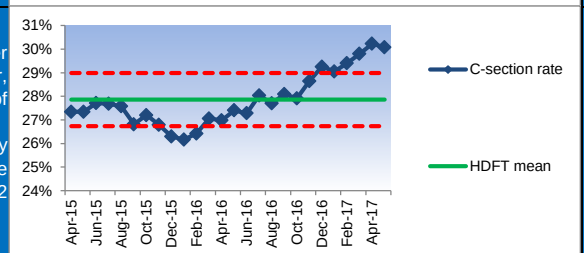
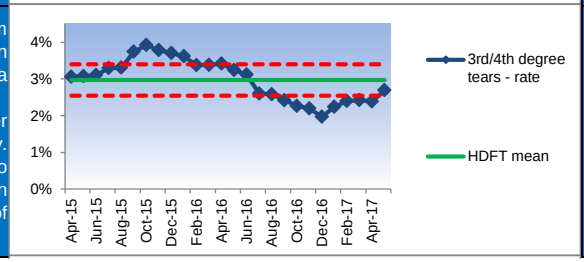
# Quality - May 2017

| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Electronic rostering hours owed** | This metric shows the sum of unused hours for staff as a running balance from the Trust's predefined audit start date. To allow for some flexibility in assigning hours over rosters (ie. for Night workers), an alert will be triggered when staff owe 15 hours or more. Data is split by Clinical Directorate for 20 specific clinical areas (mostly inpatient wards) involved in the pilot phase.<br>A low number is good. |  | The number of owed hours decreased in May.<br><br>This metric is being reviewed with a view to moving towards a month on month presentation and removing data for staff who owe less than 15 hours. |
| **Staff appraisal rates** | The chart shows the staff appraisal rate over the most recent rolling 12 months. The Trusts aims to have 90% of staff appraised. A high percentage is good. |  | The appraisal rate for 12 months to the end of May is 81%. Progress during the appraisal period is being tracked through the Directorate Board Reports which shows actual numbers of appraisals being completed as well as a target for completion rates per month. This remains a focus of the HR Business Partners |
| **Mandatory training rates** | The table shows the most recent training rates for all mandatory elements for substantive staff. |  | The data shown is for the end of May and includes the staff who were TUPE transferred into the organisation in April 2016. The overall training rate for mandatory elements for substantive staff is 90%.<br><br>The new follow up procedure is now in place for Directorates to use and we hope to see a positive impact on compliance going forward. |
| **Sickness rates** | Staff sickness rate - includes short and long term sickness.<br><br>The Trust has set a threshold of 3.9%. A low percentage is good. |  | The staff sickness rate reduced significantly in April to 3.75% which is below the trust target of 3.9%. Significant work has been undertaken in relation to long term absences and 27 cases were closed in April alone. Hot spot areas have now been identified within the Clinical Directorates: Farndale Ward, Adult Community and Woodlands Ward. Focused support, coaching and review will be undertaken in line with the requirements of our Policy. |

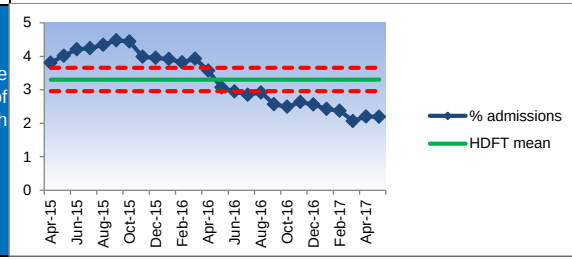
| Competence Name | % Completed |
|---|---|
| Equality, Diversity and Human Rights - Level 1 | 90 |
| Fire Safety Awareness | 78 |
| Infection Prevention & Control (Including Hand Hygiene) 1 | 100 |
| Infection Prevention & Control (Including Hand Hygiene) 2 | 84 |
| Information Governance: Introduction | 89 |
| Information Governance: The Beginners Guide | 93 |
| Prevent Basic Awareness (December 2015) | 99 |
| Safeguarding Children & Young People Level 1 - Introduction | 95 |

## Quality - May 2017

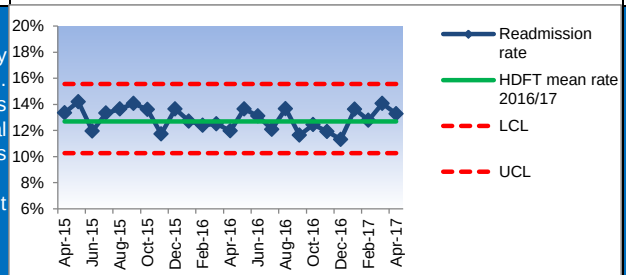
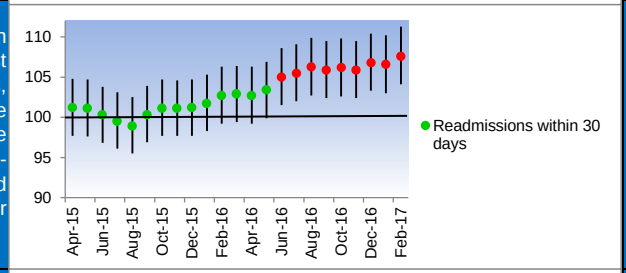
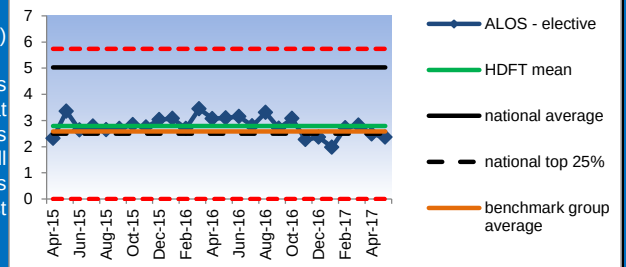
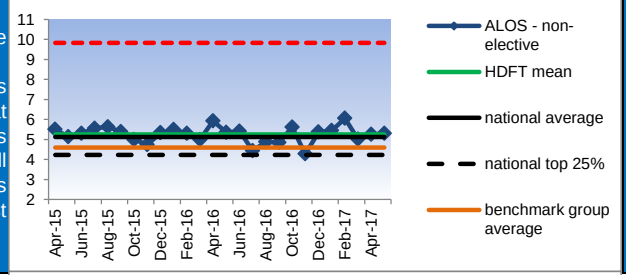
Harrogate and District NHS Foundation Trust

| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Temporary staffing expenditure - medical/nursing /other** | The chart shows staff expenditure per month, split into contracted staff, overtime and additional hours and temporary staff. Lower figures are preferable.<br>*The traffic light criteria applied to this indicator is currently under review.* |  | The Workforce Efficiency Group has now been established and meets bi-weekly. The recent discussions have been focussed on developing plans for those hard to fill specialties with the highest level of agency spend as well as reviewing the staffing models within our medical inpatient ward areas. These plans are being progressed within Directorates and will be reviewed as part of this group. |
| **Staff turnover rate** | The chart shows the staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. The turnover figures include both voluntary and involuntary turnover. Voluntary turnover is when an employee chooses to leave the Trust and involuntary turnover is when the employee unwillingly leaves the Trust.<br>Data from the Times Top 100 Employers indicated a turnover rate norm of 15%, i.e. the level at which organisations should be concerned. |  | The total staff turnover rate is 12.68% for the month of April, of which 9.48% was voluntary turnover. The pilot programme for the completion of save/exit interviews has commenced and runs until 30 September. The interviews will be arranged for all Care Support Workers and Registered Nurses in the Emergency Department, inpatient ward areas and theatres. |
| **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.<br>The rate of caesarean section can fluctuate significantly from month to month - as a result we have amended the presentation of this indicator this month to show a 12 month rolling average position. |  | HDFT's C-section rate for the 12 months ending May was 30.1% of deliveries, a decrease on last month but remaining higher than average.<br><br>The major contributing factor to the recent upward trend appears to be a significant increase in elective caesarean sections during 2016/17, with the emergency caesarean section rate remaining static and within expected parameters. |
| **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.<br>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 third or fourth degree tears was 2.6% of deliveries in the 12 month period ending May, an increase on recent months but remaining below average. |

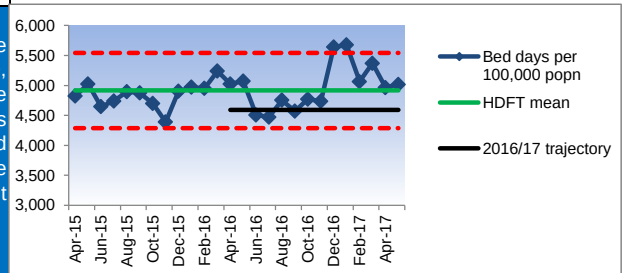
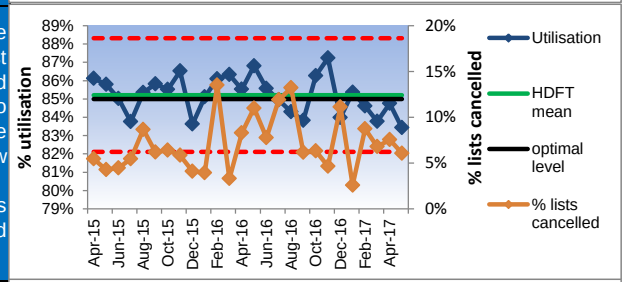
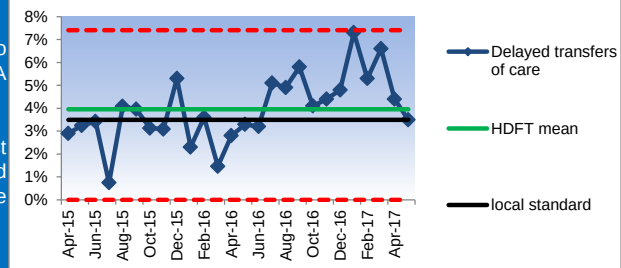
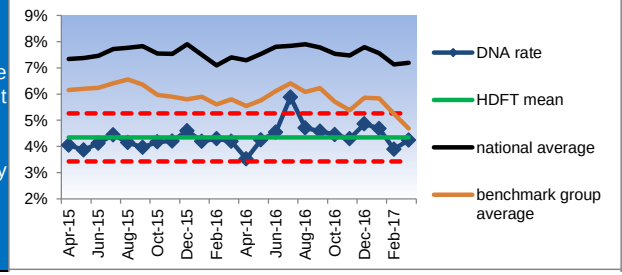
## Quality - May 2017

| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **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.<br><br>The charts shows a 12 month rolling average position. |  | The chart shows the percentage of term babies (those born at greater than 37 weeks gestation) who were admitted to the Special Care Baby Unit (SCBU).<br><br>2.2% of term babies were admitted to SCBU in the 12 months ending May, no change on last month and remaining well below the historical average for HDFT. |

## Finance and Efficiency - May 2017

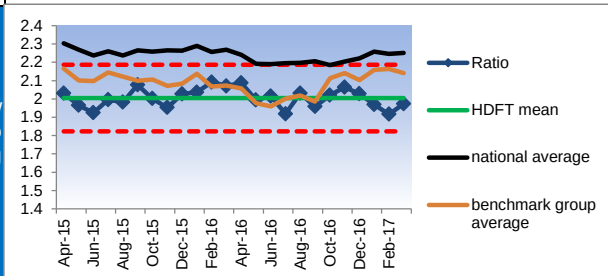
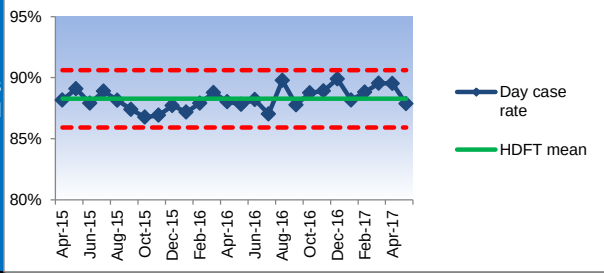
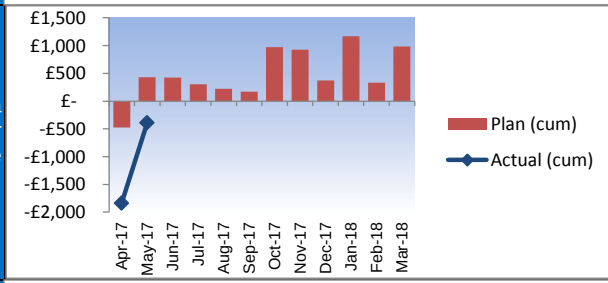
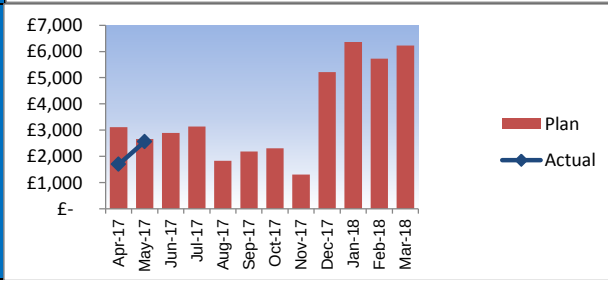
| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Readmissions** | % of patients readmitted to hospital as an emergency within 30 days of discharge (PbR exclusions applied). To ensure that we are not discharging patients inappropriately early and to assess our overall surgical success rates, we monitor the numbers of patients readmitted. A low number is good performance. This data is reported a month behind so that any recent readmissions are captured in the data. |  | The number of readmissions decreased in April, when expressed as a percentage of all emergency admissions, but remains above the HDFT average rate for 2016/17. |
| **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. |  | HDFT's standardised readmission rate increased to 107.6 in the most recently available data on HED, remaining above expected levels. At specialty level, the same 5 specialties have a standardised emergency readmission rates above expected levels (Cardiology, Clinical Haematology, Paediatrics, Medical Oncology and Well Babies). A clinical audit of a sample of paediatric and well babies readmissions was carried out by CCCC Directorate with no significant clinical concerns identified. Further work is being done to understand how this metric is constructed and whether the reasons for the higher than expected readmission rates may be explained by data issues. |
| **Length of stay - elective** | Average length of stay in days for elective (waiting list) patients. The data excludes day case patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay. |  | The average elective length of stay for May was 2.4 days, a decrease on the previous month and below the benchmark group average. |
| **Length of stay - non-elective** | Average length of stay in days for non-elective (emergency) patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay. |  | The average non-elective length of stay for May was 5.3 days, an increase on last month. HDFT's length of stay remains above the benchmark group average but in line with the national average.<br><br>The implementation of the SAFER care bundle, which supports discharge processes is now being supported by a live information dashboard, which enables ward level length of stay, morning discharges and use of planned discharge dates to be monitored at the daily bed meeting. Directorates are then progressing with targeted reductions in length of stay by ward area. |

# Finance and Efficiency - May 2017

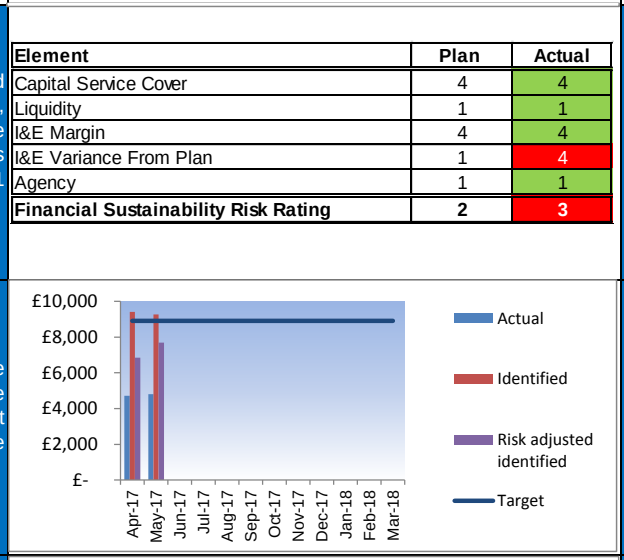
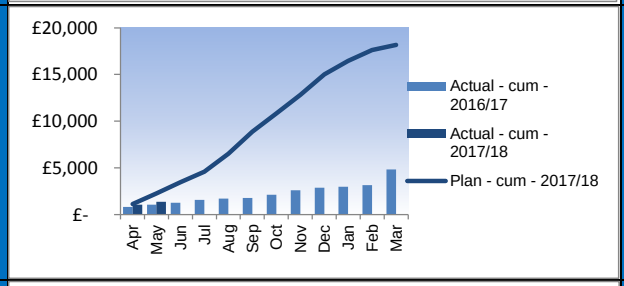
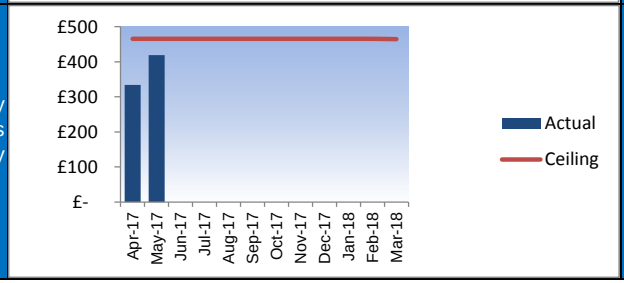
| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Non-elective bed days** ✓ | The charts shows the number of non-elective (emergency) bed days at HDFT for patients aged 18+, per 100,000 population. The chart only includes the local HARD CCG area. The 2016/17 trajectory was based on allowing for demographic growth and reducing by the non-elective reductions identified in the Value Proposition. A trajectory for 2017/18 has not yet been set.<br>A lower figure is preferable. |  | Non-elective bed days for patients aged 18+ increased in May.<br><br>The increase in non-elective admissions experienced since April has reduced the ability to meet the bed reduction programme as non-elective bed days have not reduced to the anticipated levels. The SAFER work on the wards has enabled more non-elective patients to be managed through the existing bed base; however to deliver the required bed reduction, further length of stay reductions will be required if non-elective admissions continue at this new level. |
| **Theatre utilisation** △ | The percentage of time utilised during elective theatre sessions (i.e. those planned in advance for waiting list patients). The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. An extra line has been added to the chart to allow monitoring of this.<br>A higher utilisation rate is good as it demonstrates effective use of resources. A utilisation rate of around 85% is often viewed as optimal. |  | Theatre utilisation decreased to 83.4% in May, remaining below 85%. However the number of cancelled sessions also decreased to 6.1% (compared to 7.6% last month). |
| **Delayed transfers of care** ✓ | The proportion of patients in acute hospital beds who are medically fit for discharge but are still in hospital. A low rate is preferable.<br><br>A snapshot position is taken at midnight on the last Thursday of each month. The maximum threshold shown on the chart (3.5%) has been agreed with the CCG. |  | Delayed transfers of care decreased to 3.5% when the snapshot was taken in May. This is an improvement on recent months and in line with 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.<br><br>A low percentage is good. Patient DNAs will usually result in an unused clinic slot. |  | HDFT's DNA rate increased to 4.2% in March but remains below that of both the benchmarked group of trusts and the national average. |

## Finance and Efficiency - May 2017

Harrogate and District NHS Foundation Trust

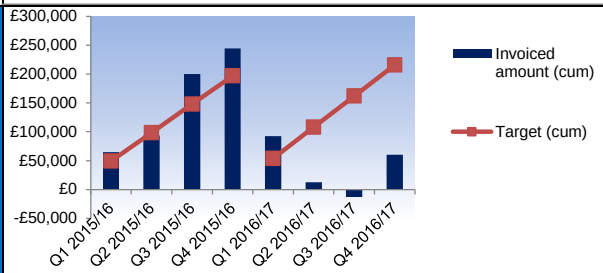
| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Outpatient new to follow up ratio** ✓ | The number of follow-up appointments per new appointment. A lower ratio is preferable. A high ratio could indicate that unnecessary follow ups are taking place. |  | Reducing the number of follow ups is a major part of HARD CCG's financial recovery plan. HDFT's new to follow up ratio increased in March to 1.97, but remains below both the national average and the benchmark group average. |
| **Day case rate** ✓ | The proportion of elective (waiting list) procedures carried out as a day case procedure, i.e. the patient did not stay overnight.<br><br>A higher day case rate is preferable. |  | The day case rate was 87.9% in May, a reduction on recent months. |
| **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 cumulative deficit of £2,224k in month 2, £2,178k behind plan. Work continues in relation to improving activity and income, pay spend in relation to medical staffing vacancies and ward nursing, and addressing non pay issues. |
| **Cash balance** ✓ | Monthly cash balance (£'000s) |  | The cash position is £96k behind plan, however, pressures in relation to the wider finances of the Trust will mean this continues to be a risk. |

# Finance and Efficiency - May 2017

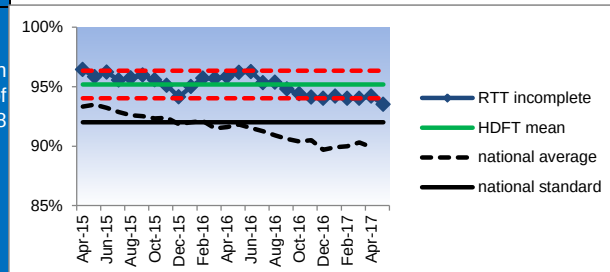
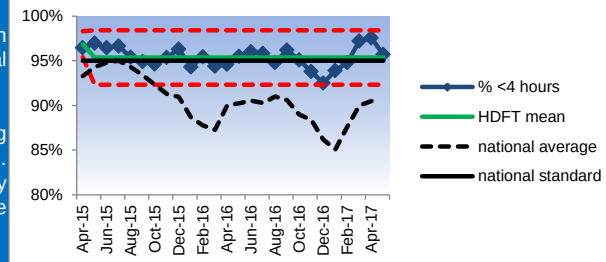
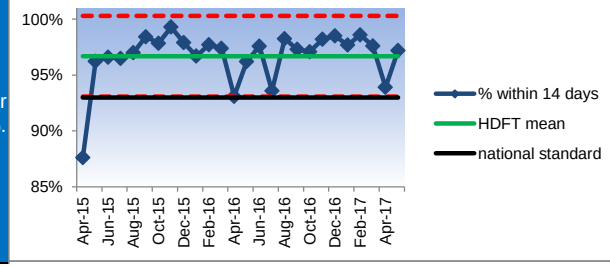
| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **NHS Improvement Single Oversight Framework - Use of Resource Metric** ✓ | From 1st October 2016, NHS Improvement introduced the Single Oversight Framework. As part of this this, Use of Resource Metric was introduced to replace the previous Financial Sustainability Risk Rating. This is the product of five elements which are rated between 1 (best) to 4. |  | The Trust will report a rating of 3 for May. This is behind the plan of 2 and is a result of the variance from plan for I&E. |
| **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. |  | Although plans are in place for over 100% of the CIP requirement for 2017/18, the risk adjusted total equates to 86%. This position is an improvement on month 1 but still includes a high level of risk. |
| **Capital spend** ✓ | Cumulative Capital Expenditure by month (£'000s) |  | Capital expenditure is in line with plan for month 2. |
| **Agency spend in relation to pay spend** ✓ | Expenditure in relation to Agency staff on a monthly basis as a percentage of total pay bill. The Trust aims to have less than 3% of the total pay bill on agency staff. |  | Agency expenditure was 3.2% of total employee expenses. Despite being below the agency ceiling set by NHSI, this remains a concern as it is above our internal target. The Workforce Efficiency Group is focused on reducing the demand and cost in this area. |

| Element | Plan | Actual |
|---|---|---|
| Capital Service Cover | 4 | 4 |
| Liquidity | 1 | 1 |
| I&E Margin | 4 | 4 |
| I&E Variance From Plan | 1 | 4 |
| Agency | 1 | 1 |
| **Financial Sustainability Risk Rating** | **2** | **3** |

## Finance and Efficiency - May 2017

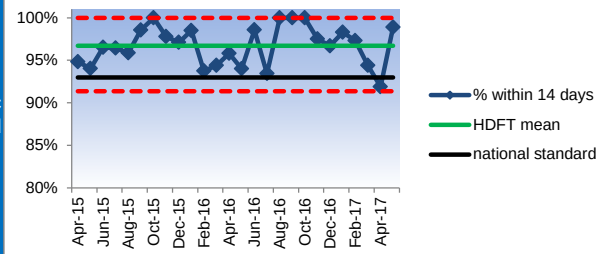
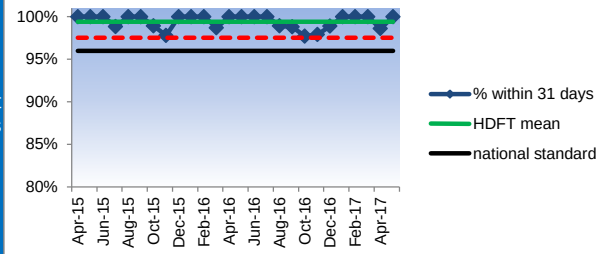
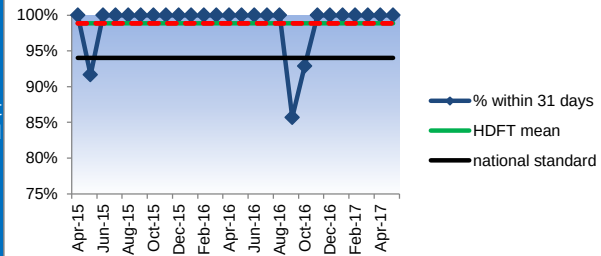
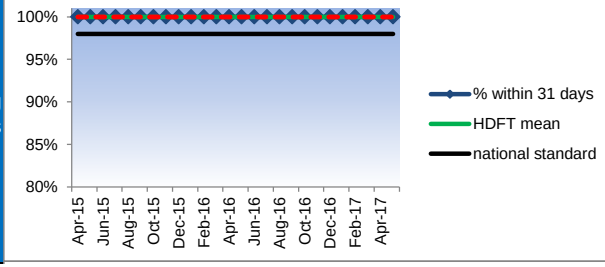
| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Research - Invoiced research activity**  | Aspects of research studies are paid for by the study sponsor or funder. |   | *There is no update on this data this month.* As set out in the Research & Development strategy, the Trust intends to maintain its current income from commercial research activity and NIHR income to support research staff to 2019. Each study is unique. Last year the Trust invoiced for a total of £223k. |

# Operational Performance - May 2017

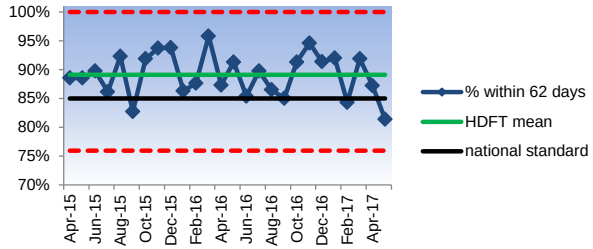
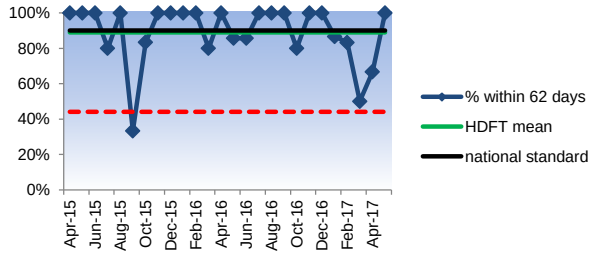
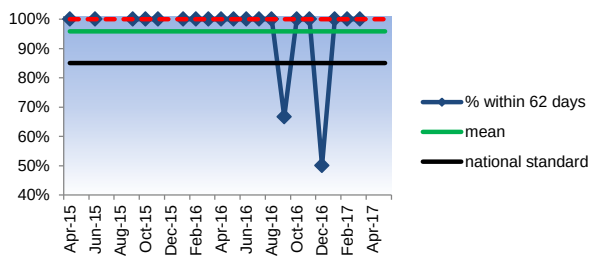
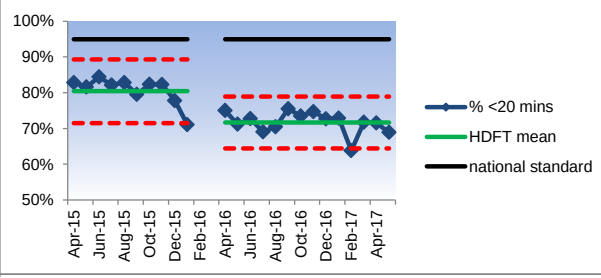
| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **NHS Improvement Single Oversight Framework** ✓ | From October 2016, NHS Improvement use a variety of information to assess a Trust's governance risk rating, including CQC information, access and outcomes metrics, third party reports and quality governance metrics. The table to the right shows how the Trust is performing against the national performance standards in the "operational performance metrics" section. | <table><tr><th>Standard</th><th>Q1 to date</th><th>Q2</th><th>Q3</th><th>Q4</th><th>YTD</th></tr><tr><td>RTT incomplete pathways</td><td>93.8%</td><td></td><td></td><td></td><td>93.8%</td></tr><tr><td>A&E 4-hour standard</td><td>96.6%</td><td></td><td></td><td></td><td>96.6%</td></tr><tr><td>Cancer - 62 days</td><td>83.8%</td><td></td><td></td><td></td><td>83.8%</td></tr><tr><td>Diagnostic waits</td><td>99.8%</td><td></td><td></td><td></td><td>99.8%</td></tr></table> | In Quarter 1 to date, HDFT's performance is above the required level for 3 of the 4 key operational performance metrics. The 62 day cancer standard is below the required 85% - further information is provided in the relevant section below and in this month's Chief Operating Officer's Report. |
| **RTT Incomplete pathways performance** ✓ | Percentage of incomplete pathways waiting less than 18 weeks. The national standard is that 92% of incomplete pathways should be waiting less than 18 weeks.<br><br>A high percentage is good. |  | 93.5% of patients were waiting 18 weeks or less at the end of May, a decrease on last month's performance but remaining above the required national standard of 92%.<br><br>At specialty level, Trauma & Orthopaedics and General Surgery remain below the 92% standard. Plastic surgery specialty is also below 92% this month but with only 20 pathways, it is likely to be below the reporting de minimis for Quarter 1. Operational Delivery Group reviews long waiting patients on a weekly basis to ensure that patients receive a date for treatment as soon as possible and the Trust maintains the national standard for RTT. |
| **A&E 4 hour standard** ✓ | Percentage of patients spending less than 4 hours in Accident & Emergency (A&E). The operational standard is 95%.<br><br>The data includes all A&E Departments, including Minor Injury Units (MIUs). A high percentage is good. Historical data for HDFT included both Ripon and Selby MIUs. In agreement with local CCGs, York NHSFT are reporting the activity for Selby MIU from 1st May 2015. |  | HDFT's Trust level performance for May was 95.4%, remaining above the required 95% standard but a reduction on last month. This includes data for the Emergency Department at Harrogate and Ripon MIU. Performance for Harrogate ED in April was 94.8%.<br><br>As can be seen on the chart, HDFT's performance remains significantly above the national average. |
| **Cancer - 14 days maximum wait from urgent GP referral for suspected cancer referrals** ✓ | Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%. A high percentage is good. |  | Provisional performance is at 97.2% for May, above the required 93% standard and an improvement on last month's position. |

# Operational Performance - May 2017

Harrogate and District NHS Foundation Trust

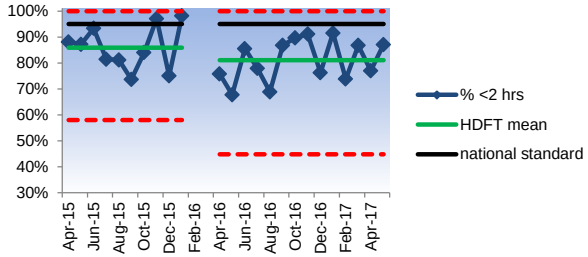
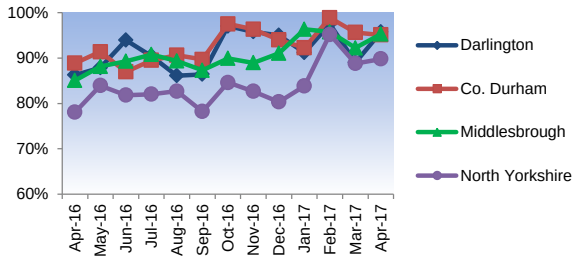
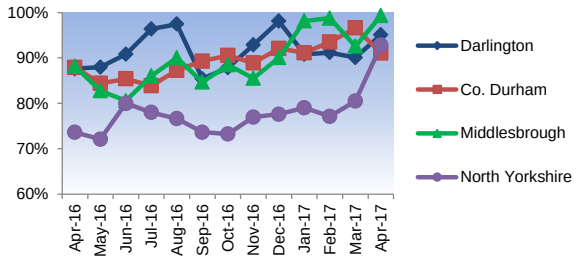
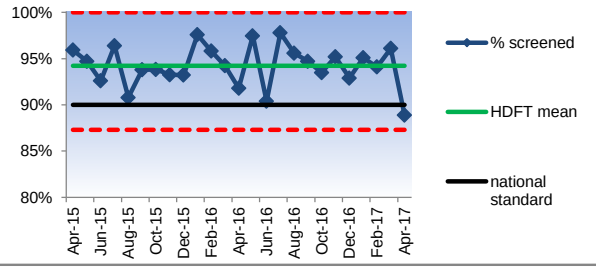
| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Cancer - 14 days maximum wait from GP referral for symptomatic breast patients** ✓ | Percentage of GP referrals for breast symptomatic patients seen within 14 days. The operational standard is 93%. A high percentage is good. |  | Provisional performance is at 98.9% for May, above the required 93% standard and an improvement on last month's position. |
| **Cancer - 31 days maximum wait from diagnosis to treatment for all cancers** ✓ | Percentage of cancer patients starting first treatment within 31 days of diagnosis. The operational standard is 96%. A high percentage is good. |  | Delivery at expected levels. |
| **Cancer - 31 day wait for second or subsequent treatment: Surgery** ✓ | Percentage of cancer patients starting subsequent surgical treatment within 31 days. The operational standard is 94%. A high percentage is good. |  | Delivery at expected levels. |
| **Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug** ✓ | Percentage of cancer patients starting subsequent drug treatment within 31 days. The operational standard is 98%. A high percentage is good. |  | Delivery at expected levels. |

# Operational Performance - May 2017

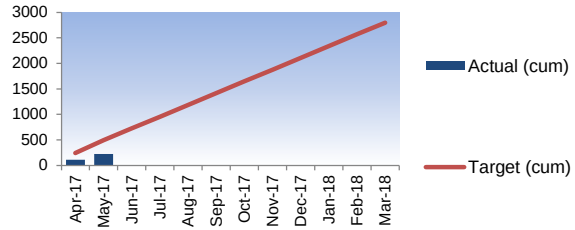
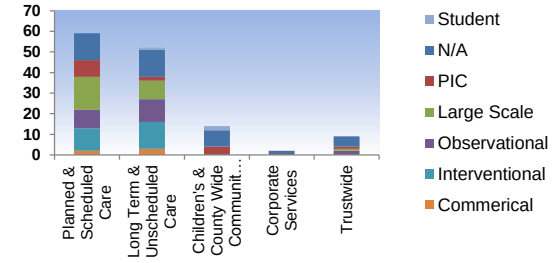
| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Cancer - 62 day wait for first treatment from urgent GP referral to treatment** ✓ | Percentage of cancer patients starting first treatment within 62 days of urgent GP referral. The operational standard is 85%. A high percentage is good. |  | Provisional performance for May is below the required 85% standard at 81.4% with 10.5 accountable breaches. Of the 11 tumour sites, 6 had performance below 85% in May - colorectal (1 breach), gynaecological (1), head and neck (1.5), lung (2), upper gastrointestinal (0.5) and urological (4.5). 3 patients waited over 104 days in May. The main reasons for the delays were complex diagnostic pathways and outpatient capacity.<br>Delivering the 85% for Quarter 1 overall remains challenging. The Clinical Directorates continue to work together to address this and proactively manage patient pathways to ensure that breach numbers are minimised. |
| **Cancer - 62 day wait for first treatment from consultant screening service referral** ✓ | Percentage of cancer patients starting first treatment within 62 days of referral from a consultant screening service. The operational standard is 90%. A high percentage is good. |  | Performance was at 100% in May. However delivery of the standard for Quarter 1 overall remains at risk with a Quarter to date performance position of 81.3%.<br><br>The final performance for Quarter 4 2016/17 was below the 90% standard at 73.2% with 5.5 accountable breaches. |
| **Cancer - 62 day wait for first treatment from consultant upgrade** ✓ | Percentage of cancer patients starting first treatment within 62 days of consultant upgrade. The operational standard is 85%. A high percentage is good. |  | There were no applicable pathways in May. |
| **GP OOH - NQR 9** ▲ | NQR 9 (National Quality Requirement 9) looks at the % of GP OOH telephone clinical assessments for urgent cases that are carried out within 20 minutes of call prioritisation.<br>A high percentage is good. |  | Performance remains below the required 95% for this metric and was at 69% in May. |

# Operational Performance - May 2017

Harrogate and District NHS Foundation Trust

| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **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. |   | Performance remains below the required 95% for this metric and was at 87% in May. |
| **Children's Services - 10-14 day new birth visit**  | The percentage of babies who had a new birth visit by the Health Visiting team within 14 days of birth. A high percentage is good.<br><br>Data shown is for the 0-5 Health Visiting Service in North Yorkshire and the Healthy Child Programme in Darlington, Co. Durham and Middlesbrough. A high percentage is good. The contract does not specify a required level. |   | In April, the validated performance position is that 93% of babies were recorded on Systmone as having had a new birth visit within 14 days of birth. The improvement in delivery across all localities should be noted, this has been a clear priority for all 0-19 services as part of the team's performance frameworks.<br><br>From this month, this data will be reported a month in arrears so that the validated position can be shared. |
| **Children's Services - 2.5 year review**  | The percentage of children who had a 2.5 year review. A high percentage is good.<br><br>Data shown is for the 0-5 Health Visiting Service in North Yorkshire and the Healthy Child Programme in Darlington, Co. Durham and Middlesbrough. A high percentage is good. The contract does not specify a required level. |   | In April, the validated performance position is that 93% of children were recorded on Systmone as having had a 2.5 year review.<br><br>From this month, this data will be reported a month in arrears so that the validated position can be shared. |
| **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. |   | Performance was at 89% in April, just below the 90% standard. This is the first time that performance has dropped below the standard for a significant period. Through Operational Delivery Group, the Clinical Directorate management teams were asked to reiterate the importance of completing and documenting the dementia screening process for eligible inpatients. A significantly improved position has been seen in the provisional May data. |

# Operational Performance - May 2017

| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Recruitment to NIHR adopted research studies** | The Trust has a recruitment target of 2,800 for 2017/18 for studies on the NIHR portfolio. This equates to 234 per month. Over recruitment is encouraged. |  | Provisional data indicates that recruitment to research studies during May was behind plan. |
| **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

Harrogate and District NHS Foundation Trust

| Report section | Indicator | Data quality rating | Further information |
|---|---|---|---|
| Quality | Pressure ulcers - community acquired - grades 2, 3 or 4 | **Amber**  | The observed increase in reported cases over the last two years may be partly due to improvements in incident reporting during the period. |
| Operational Performance | GP Out of Hours - National Quality Requirement 9 | **Amber**  | Following patient pathway changes in late 2015, reports from the Adastra system no longer calculate the correct start time for these patients and as a result, the performance reported for NQR9 was incorrect. Significant work from has been carried out by information staff at HDFT and we are now able to report performance again for this metric again, based on calculations from raw data extracts from the Adastra system. The new calculations have been shared with HARD CCG. |
| Operational Performance | GP Out of Hours - National Quality Requirement 12 | **Amber**  | |
| 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 | Children's Services - 10-14 day new birth visit | **Amber**  | Caution should be exercised as further work is required to understand the completeness and quality of this data. |
| Operational Performance | Children's Services - 2.5 year review | **Amber**  | Caution should be exercised as further work is required to understand the completeness and quality of this data. |
| Quality | Electronic rostering timeliness | **Amber**  | Caution should be exercised as further work is required to understand the completeness and quality of this data. |
| Quality | Electronic rostering hours owed | **Amber**  | Caution should be exercised as further work is required to understand the completeness and quality of this data. |

Harrogate and District NHS Foundation Trust

**Indicator traffic light criteria**

| Section | Indicator | Further detail | Traffic light criteria | Rationale/source of traffic light criteria |
|---|---|---|---|---|
| **Quality** | **Pressure ulcers - hospital acquired** | No. category 3 and category 4 avoidable hospital acquired pressure ulcers | tbc | tbc |
| **Quality** | **Pressure ulcers - community acquired** | No. category 3 and category 4 community acquired pressure ulcers | tbc | tbc |
| **Quality** | **Safety thermometer - harm free care** | % harm free | Blue if latest month >=97%, Green if >=95% but <97%, red if latest month <95% | National best practice guidance suggests that 95% is the standard that Trusts should achieve. In addition, HDFT have set a local stretch target of 97%. |
| **Quality** | **Falls** | IP falls per 1,000 bed days | Blue if YTD position is a reduction of >=50% of HDFT average for 2016/17, Green if YTD position is a reduction of between 20% and 50% of HDFT average for 2016/17, Amber if YTD position is a reduction of up to 20% of HDFT average for 2016/17, Red if YTD position is on or above HDFT average for 2016/17. | 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, NHS Improvement and contractual requirement |
| **Quality** | **Avoidable admissions** | The number of avoidable emergency admissions to HDFT as per the national definition. | tbc | tbc |
| **Quality** | **Reducing hospital admissions in older people** | The proportion of older people 65+ who were still at home 91 days after discharge from 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 2016/17, Amber if on or above HDFT average for 2016/17, Red if above UCL. In addition, Red if a new red rated complaint received in latest month. | Locally agreed improvement trajectory based on comparison with HDFT performance last year. |
| **Quality** | **Incidents - all** | Incidents split by grade (hosp and community) | Blue if latest month ratio places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25% | Comparison of HDFT performance against most recently published national average ratio of low to high incidents. |
| **Quality** | **Incidents - complrehensive SIRIs and never events** | The number of comprehensive SIRIs and the number of never events reported in the year to date. The indicator includes hospital and community data. | Green if none reported in current month; Red if 1 or more never event or comprehensive reported in the current month. | |
| **Quality** | **Friends & Family Test (FFT) - 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** | **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. | Blue if latest month rate < LCL, Green if latest month rate < HDFT average for 2015/16, Amber if latest month rate > HDFT average for 2015/16 but below UCL, red if latest month rate > UCL. | 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 | | |

| Section | Indicator | Further detail | Traffic light criteria | Rationale/source of traffic light criteria |
|---|---|---|---|---|
| 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 | Green if latest month < 2016/17 trajectory, amber if latest month below 2015/16 level plus 0.5% demographic growth but above 2016/17 trajectory, red if above 2015/16 level plus 0.5% demographic growth. | A 2016/17 trajectory has been added this month - this is based on allowing for demographic growth and reducing by the non-elective reductions identified in the Value Proposition. |
| 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 |
| Finance and efficiency | Outpatient DNA rate | % first OP appointments DNA'd | | |
| Finance and efficiency | Outpatient new to follow up ratio | No. follow up appointments per new appointment. | Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%. | Comparison with performance of other acute trusts. |
| Finance and efficiency | Day case rate | % elective admissions that are day case | | |
| Finance and efficiency | Surplus / deficit and variance to plan | Monthly Surplus/Deficit (£'000s) | Green if on plan, amber <1% behind plan, red >1% behind plan | Locally agreed targets. |
| Finance and efficiency | Cash balance | Monthly cash balance (£'000s) | Green if on plan, amber <10% behind plan, red >10% behind plan | Locally agreed targets. |
| Finance and efficiency | NHS Improvement Financial Performance Assessment | An overall rating is calculated ranging from 4 (no concerns) to 1 (significant concerns). This indicator monitors our position against plan. | Green if rating =4 or 3 and in line with our planned rating, amber if rating = 3, 2 or 1 and not in line with our planned rating. | as defined by NHS Improvement |
| Finance and efficiency | 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 - Invoiced research activity | | to be agreed | |
| Operational Performance | NHS Improvement governance rating | Trust performance on Monitor's risk assessment framework. | As per defined governance rating | as defined by NHS Improvement |
| Operational Performance | RTT Incomplete pathways performance | % incomplete pathways within 18 weeks | Green if latest month >=92%, Red if latest month <92%. | NHS England |
| Operational Performance | A&E 4 hour standard | % patients spending 4 hours or less in A&E. | Blue if latest month >=97%, Green if >=95% but <97%, red if latest month <95% | NHS England, NHS Improvement and contractual requirement of 95% and a locally agreed stretch target of 97%. |
| Operational Performance | Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals | % urgent GP referrals for suspected cancer seen within 14 days. | Green if latest month >=93%, Red if latest month <93%. | NHS England, NHS Improvement and contractual requirement |
| Operational Performance | Cancer - 14 days maximum wait from GP referral for symptomatic breast patients | % GP referrals for breast symptomatic patients seen within 14 days. | Green if latest month >=93%, Red if latest month <93%. | NHS England, NHS Improvement and contractual requirement |
| Operational Performance | Cancer - 31 days maximum wait from diagnosis to treatment for all cancers | % cancer patients starting first treatment within 31 days of diagnosis | Green if latest month >=96%, Red if latest month <96%. | NHS England, NHS Improvement and contractual requirement |
| Operational Performance | Cancer - 31 day wait for second or subsequent treatment: Surgery | % cancer patients starting subsequent surgical treatment within 31 days | Green if latest month >=94%, Red if latest month <94%. | NHS England, NHS Improvement and contractual requirement |
| Operational Performance | Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug | % cancer patients starting subsequent anti-cancer drug treatment within 31 days | Green if latest month >=96%, Red if latest month <96%. | NHS England, NHS Improvement and contractual requirement |
| Operational Performance | Cancer - 62 day wait for first treatment from urgent GP referral to treatment | % cancer patients starting first treatment within 62 days of urgent GP referral | Green if latest month >=85%, Red if latest month <85%. | NHS England, NHS Improvement and contractual requirement |
| Operational Performance | Cancer - 62 day wait for first treatment from consultant screening service referral | % cancer patients starting first treatment within 62 days of referral from a consultant screening service | Green if latest month >=90%, Red if latest month <90%. | NHS England, NHS Improvement and contractual requirement |
| Operational Performance | Cancer - 62 day wait for first treatment from consultant upgrade | % cancer patients starting first treatment within 62 days of consultant upgrade | Green if latest month >=85%, Red if latest month <85%. | NHS England, NHS Improvement and contractual requirement |
| Operational Performance | 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 | Children's Services - 10-14 day new birth visit | % new born visit within 14 days of birth | Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%. | Contractual requirement |
| Operational Performance | Children's Services - 2.5 year review | % children who had a 2 and a half year review | Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%. | Contractual requirement |
| 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 | 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 |

Harrogate and District NHS Foundation Trust

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| **Report to the Trust Board of Directors: 28 June 2017** | **Paper No: 5.1** |

| | |
|---|---|
| **Title** | Nursing Establishment Revision for Long Term and Unscheduled Care |
| **Sponsoring Director** | Dr Ros Tolcher |
| **Author(s)** | Mrs Jill Foster<br>Mr Jonathan Coulter<br>Mr Robert Harrison |
| **Report Purpose** | To recommend a recurrent change to ward nursing establishments in Long Term and Unscheduled Care |

**Key Issues for Board Focus:**
**The quality of care on the inpatient wards and the impact on the Trusts Financial Plan**

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

| | |
|---|---|
| **Risk and Assurance** | Linked to Corporate Risk Register entries CR5 and CR14. |
| **Legal implications/ Regulatory Requirements** | Compliance with the Single Oversight Framework |

**Action Required by the Board of Directors**

The Board is asked to approve option 4 subject to the completion of a satisfactory Quality Impact Assessment.

## Nursing Establishment Report

### 1. Introduction

1.1. Following detailed analysis of expenditure on Nursing Workforce across ward areas within the Long Term & Unscheduled Care (LTUC) Directorate, it has been identified that we are recurrently staffing above the budgeted establishment. The establishments were previously reviewed and formally changed in October 2015 and subsequently signed off at Directorate level as part of the annual business planning process. However based on the feedback provided by the Directorate Nursing Leadership Team and taking account of the acuity audits, local adjustments have been made to increase staffing levels on a number of wards above the budgeted establishment.

1.2. This change to local establishments has amplified the Registered Nursing recruitment challenges and has driven up the use of agency staff.

1.3. In addition to the funded establishment, the wards have been spending an increasing amount on 1:1 care, despite local initiatives.

1.4. As a result of the above this paper is presented to enable the Board to review the nursing establishments on the wards within LTUC.

### 2. Current Position

2.1. LTUC ward budgeted establishment totals £8.7m in 2017/18. In 2016/17 the wards overspent by £0.5m, partially due to agency costs and partially due to locally amended rostering patterns, based on clinical judgement at a Directorate level.

2.2. In addition to this, the Directorate spent £400k on 1:1 care, often provided by Bank or Agency Care Support Workers.

2.3. LTUC identified a Cost Improvement Programme (CIP) of £1m which was dependent upon closing beds across the year, taking into account seasonal occupancy and the programme of work in relation to patient flow.

2.4. The cost associated with the running of Trinity ward now recurrently exceeds the provision within the Community block contract.

### 3. Options

3.1. As part of the review a number of options have been developed and these are outlined below.

| Option | Description | Financial Impact (£m) |
|---|---|---|
| 1 | Reduce rosters to the recurrently funded establishment and close sufficient beds to deliver the full CIP. | 0 |
| 2 | Reduce rosters to the recurrently funded establishment, but due to changes in Clinical Assessment Team (CAT) and Community Services, reduce bed closure programme and seek alternative CIP delivery. | 0.7 |
| 3 | Increase funded establishment to the proposed rosters and deliver full CIP. | 0.3 |
| 4 | Increase funded establishment to the proposed rosters, reduce bed closure programme and seek alternative CIP delivery. | 1.0 |
| 5 | Fund establishment changes to current rosters and set aside 1:1 Specials budget of £400k and deliver bed closures to full CIP | 0.8 |
| 6 | Fund establishment changes to current rosters and set aside 1:1 Specials budget of £400k, reduce bed closure programme and seek alternative CIP delivery. | 1.5 |

## 4. Assessment of Options

4.1 Following discussions with the Directorate Team, Senior Management Team (SMT) and Director Team the assessment is as follows.

### CIP Bed Reduction

4.2 At this stage, taking account of the impact of CAT line changes and reduced Community Services it is clear that the full CIP plan is not achievable and the Directorate have brought forward revised plans to close 22 beds for 4½ months and therefore a minimum of £700k CIP will need to be identified elsewhere.

### Funded Establishment

4.3 In relation to the funded establishment, if this could be delivered with permanent staff (no Agency staff), it would have a full year impact of £0.3m. However, due to the additional spend in Months 1-3 it is estimated to be £0.4m in

2017/18. This change recognises the impact of the availability of registered nursing workforce and as such focusses investment on unregistered staff.

**Specials**

4.4 The proposed changes to the establishment enables routine Specials to be accommodated. As always in exceptional circumstances a process is in place to escalate exceptional patient need as necessary.

**Trinity Ward (Ripon)**

4.5 A review of nursing establishment, bed base and costs needs to be completed for Trinity ward. Following this, the Trust would need to engage the CCG regarding any potential changes.

## 5. Preferred Option

5.1 Following discussions the preferred option is number 4. This takes account of the acuity audits, available workforce, financial impact and bed modelling assumptions. This will require recurrent investment of £0.3m which will be applied as an additional CIP to the rest of the organisation. The £0.7m CIP which will no longer be delivered through the bed reduction programme will also need to be identified elsewhere.

5.2 This option requires a formal Quality Impact Assessment to be completed.

## 6. Recommendation

6.1 The Board is asked to approve option 4 subject to the completion of a satisfactory Quality Impact Assessment.

NHS
Harrogate and District
NHS Foundation Trust

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|---|---|
| **Report to the Trust Board of Directors: 28 June 2017** | **Paper No: 6.0** |

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

**Key Issues for Board Focus:**

1. The year to date financial performance of the Trust is a significant adverse position of £2,224k deficit.

2. Due to the financial position, no S&T funding has been included in the position. The position also results in a Use of Resource Metric of 3.

3. The current underlying run rate position would result in an adverse variance to plan of £12m. This includes the impact of not receiving sustainability and transformation funding. Plans to recover this position are outlined within the report.

| **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 2017/18 financial plan if budgetary control is not improved. Mitigation is in place through regular monthly monitoring, and discussions on improving this process are ongoing. |
| **Legal implications/ Regulatory Requirements** | |

**Action Required by the Board of Directors**

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

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# May 2017 Financial Position

**Financial Performance**

- The Trust financial performance in May continued to be adverse with the year to date deficit increasing to £2.2m against a planned small deficit. No Sustainability and Transformation Funding (STF) has been assumed in this position as a result of the adverse position. This is summarised in the table below -

| | Budget (£m) | Plan (£m) | Variance (£m) |
|---|---|---|---|
| Income | 35.200 | 34.451 | -0.750 |
| Expenditure | 35.624 | 36.675 | -1.054 |
| **Deficit before STF** | **-0.424** | **-2.224** | **-1.800** |
| | | | |
| **Deficit after STF** | **-0.046** | **-2.224** | **-2.178** |

- As a result of the above the NHS Improvement Use of Resource Metric for May is a 3. This is driven by the Trusts variance to plan and deficit position.

- A number of the issues discussed in month 1 have continued to impact on the financial position during May. These are outlined below with the year to date variance –
  - –£702k Clinical Income (see page 4)
  - –£289k Ward Expenditure (see page 5)
  - –£165k Theatre Expenditure (see page 4)
  - –£175k CIP performance (see pages 7&8)
  - –£439k Non recurrent issues in month 1
  - –£378k S&T funding

- Based on the current run rate the Trust is forecasting a deficit of approx. £6m by year end, £12m behind the Trust plan (including STF funding). This forecast does highlight the level of financial risk the Trust is experiencing and the need to urgently address the above issues, as well as develop further plans to close the gap from an operational perspective. Page 6 outlines current plans to recover this position, however, further work is required to close this gap.

- Although cash is close to planned levels, the position summarised above will have an impact and therefore it remains a concern for the Trust. Further information on cash can be found on page 9.

# Financial Position Continued

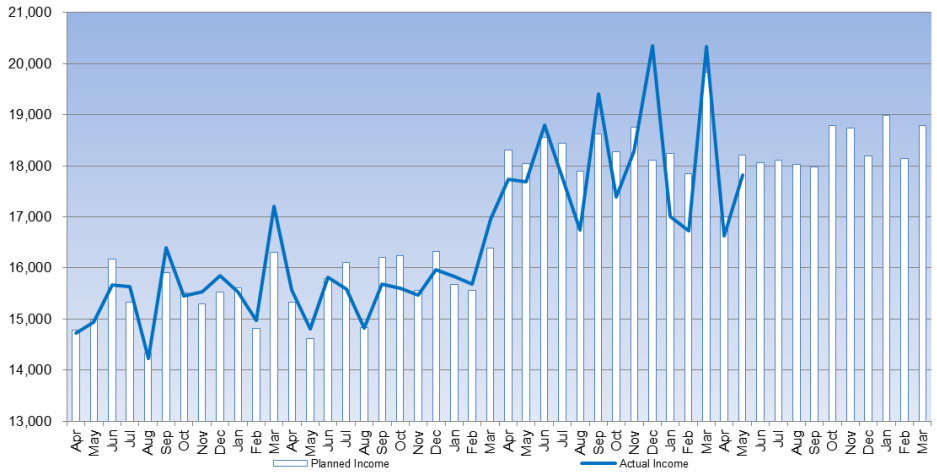
**Summary Income & Expenditure 2017/18**

**For the month ending 31st May 2017**

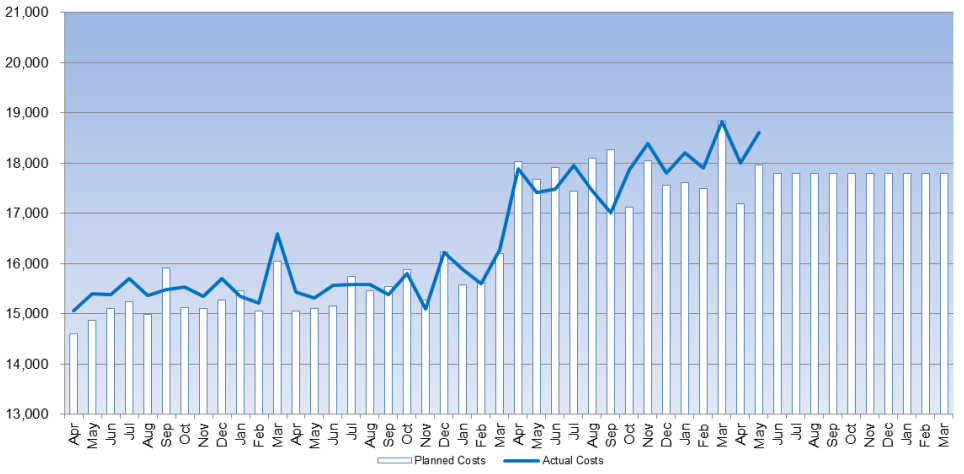
| Plan 2017/18 Budget £000 | | Budget: Annual Budget £000 | Budget: Proportion To Date £000 | Actual To Date £000 | Cumulative Variance £000 | Change in Variance £'000 |
|---|---|---|---|---|---|---|
| | INCOME | | | | | |
| | **NHS Clinical Income (Commissioners)** | | | | | |
| 146,660 | NHS Clinical Income - Acute | 147,814 | 23,744 | 23,380 | (363) | (108) |
| 51,030 | NHS Clinical Income - Community | 53,467 | 8,928 | 8,589 | (339) | (198) |
| 0 | System Resilience & Better Care Funding | 913 | 152 | 152 | 0 | 0 |
| | **Non NHS Clinical Income** | | | | | 0 |
| 1,879 | Private Patient & Amenity Bed Income | 1,472 | 245 | 270 | 25 | (18) |
| 523 | Other Non-Protected Clinical Income (RTA) | 523 | 87 | 98 | 11 | 11 |
| | **Other Income** | | | | | 0 |
| 9,787 | Non Clinical Income | 11,144 | 2,044 | 1,961 | (83) | (63) |
| 0 | Hosted Services | 0 | 0 | 0 | 0 | (5) |
| **209,878** | **TOTAL INCOME** | **215,333** | **35,200** | **34,451** | **(750)** | **(382)** |
| | EXPENSES | | | | | |
| | **Pay** | | | | | |
| (142,658) | Pay Expenditure | (149,963) | (26,030) | (26,215) | (185) | (130) |
| | **Non Pay** | | | | | 0 |
| (3,015) | Drugs | (4,415) | (2,144) | (2,101) | 44 | 35 |
| (14,378) | Clinical Services & Supplies | (14,853) | (2,703) | (2,837) | (134) | (1) |
| (12,905) | Other Costs | (16,088) | (3,476) | (3,910) | (434) | 123 |
| (9,546) | **Reserves :** Pay | (5,205) | 177 | 0 | (177) | (177) |
| | Pay savings targets | 0 | 0 | 0 | 0 | 0 |
| (11,599) | Other Reserves | (6,089) | 0 | 0 | 0 | 0 |
| (10,352) | High Cost Drugs | (8,502) | 0 | 0 | 0 | 0 |
| 4,600 | Non Pay savings targets | 0 | 0 | 0 | 0 | 0 |
| (18) | **Other Finance Costs** | (18) | (3) | (6) | (3) | 1 |
| | **Hosted Services** | (191) | (132) | (132) | (0) | 6 |
| (199,870) | TOTAL COSTS | (205,324) | (34,311) | (35,202) | (890) | (142) |
| **10,008** | **EBITDA** | **10,008** | **889** | **(751)** | **(1,640)** | **(524)** |
| | Profit / (Loss) on disposal of assets | 0 | 0 | 0 | 0 | 0 |
| (5,081) | Depreciation | (5,081) | (847) | (922) | (75) | (38) |
| (90) | Interest Payable | (90) | (15) | (40) | (25) | (12) |
| 41 | Interest Receivable | 41 | 7 | 2 | (5) | (2) |
| (2,746) | Dividend Payable | (2,746) | (458) | (513) | (55) | (28) |
| **2,132** | **Net Surplus/(Deficit) before donations and impairmen** | **2,132** | **(424)** | **(2,224)** | **(1,800)** | **(603)** |
| 0 | Donated Asset Income | 0 | 0 | 0 | 0 | 0 |
| 0 | Impairments re Donated assets | 0 | 0 | 0 | 0 | 0 |
| 0 | Impairments re PCT assets | 0 | 0 | 0 | 0 | 0 |
| **2,132** | **Net Surplus/(Deficit)** | **2,132** | **(424)** | **(2,224)** | **(1,800)** | **(603)** |
| | Consolidation of Charitable Fund Accounts | | | | | 0 |
| 3,777 | Sustainability and Transformation Fund | 3,777 | 378 | 0 | (378) | (189) |
| **5,909** | **Total and Consolidated Net Surplus/(Deficit)** | **5,909** | **(46)** | **(2,224)** | **(2,178)** | **(792)** |

# Financial Position Monthly Run Charts

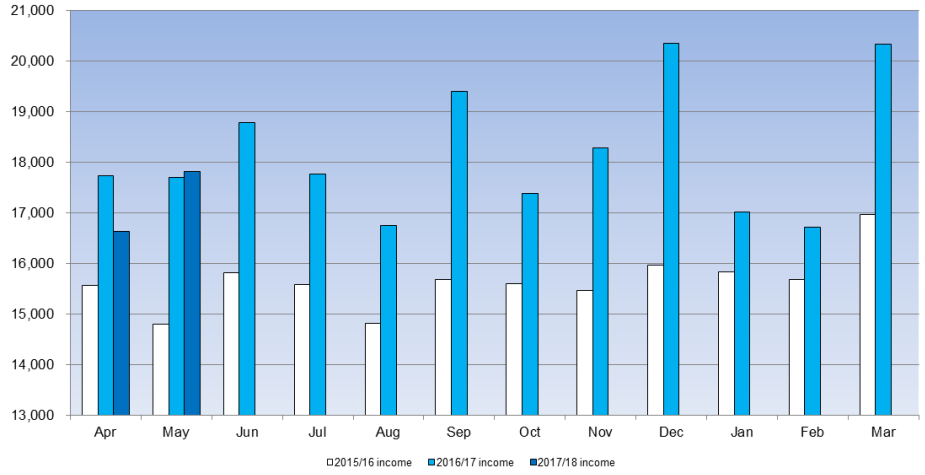
**Planned and Actual Income Apr 2014 - Mar 2018**



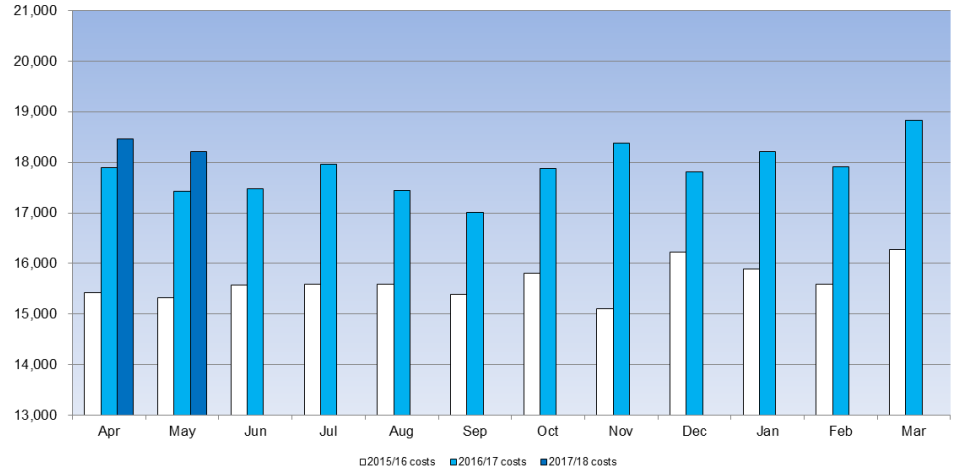

**Planned and Actual Costs Apr 2014 - Mar 2018**




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




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



# Acute Clinical Income

As outlined on page 2, NHS Clinical income is £702k behind plan. Although this is predominantly related to activity variances, an issue with casemix has also been identified. A proportion of this is accounted for in the current position.

The drivers in relation to the activity variance are highlighted in detail within the Chief Operating Officer's report.

Further work in relation to the casemix variance is being undertaken to better understand the causes of this. At this stage, it is anticipated that this relates to three possible areas –

- A genuine reduction in patient acuity;
- The actual impact of HRG 4+ being different to the planned impact;
- The translation of patient acuity being accurately reflected into the coded spell.

The Trust has communicated the issue to commissioners.

Clearly these issues add to the known challenges the Trust faces in 2017/18 relating to maintaining capacity during the sterile services development and theatre maintenance, as well as the unplanned impacts as a result of changes in relation to IR35 and disruption as a result of the power cut earlier in the year.

# Main Theatres

As previously outlined, expenditure in relation to staffing in Main Theatres is a significant cost pressure resulting from high vacancy levels and the subsequent requirement for agency staffing which is above capped rates. This is outlined in the table below.

| Main Theatres | WTE Budget | WTE Contracted | Budget £'000s | Actual £'000s | Variance £'000s |
|---|---|---|---|---|---|
| Pay | 78.61 | 61.28 | 592 | 456 | - 136 |

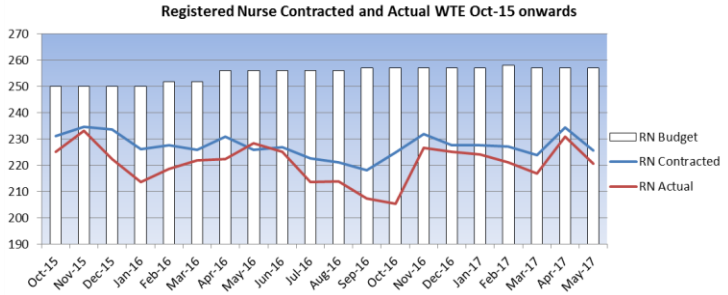
To improve the adverse pay variance in Theatres and support activity recovery plans, the Theatre Staffing strategy is in the process of being approved and implemented in the near future.

# Ward Expenditure

The tables below outlines pay expenditure and WTE across all ward areas, as well as the registered nursing position across the Trust -

| | Apr Variance (£000s) | May Variance (£000s) | YTD Variance (£000s) |
|---|---|---|---|
| All Wards (-ve = overspent) | - 109 | - 180 | - 289 |

| | Apr Budget WTE | Apr Contracted WTE | Apr WTE Variance | | May Budget WTE | May Contracted WTE | May WTE Variance |
|---|---|---|---|---|---|---|---|
| All Wards | 444 | 419 | -25.58 | | 444.24 | 411.59 | -32.65 |




As previously described, as well as the current vacancy position across the Trust work is ongoing to resolve issues in each directorate. The focus of this work is –

- LTUC – resolving the issue in relation to current worked rosters being above the funded establishment
- PSC – addressing sickness pressures in key pressure areas within the directorate which cause a reliance on bank and agency.

Options to resolve the issue in LTUC are further detailed in paper 5.1.

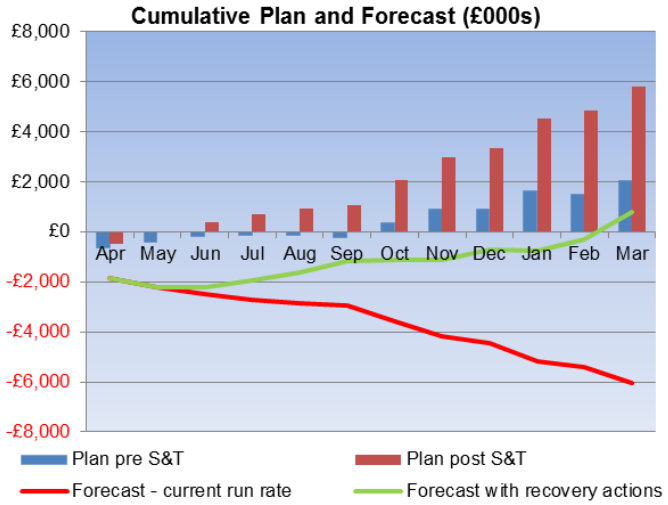
# Recovery Planning

As outlined on page one, the forecast variance as a result of current performance is £12m behind plan. This is a result of the underlying run rate and subsequent impact on STF income. Details of this and plans to recover the position are outlined below -

| Current high level forecast position | Plan £'000s | Forecast £'000s | Variance £'000s |
|---|---|---|---|
| Forecast Run Rate | £5,909 | -£5,959 | -£11,868 |
| Forecast less STF | £2,132 | -£5,959 | -£8,091 |

| Forecast as a result of the above improvements | Plan £'000s | Forecast £'000s | Variance £'000s |
|---|---|---|---|
| Pre STF | £2,132 | £896 | -£1,236 |
| **Forecast with improvements including STF** | **£5,909** | **£896** | **-£5,013** |

**Remaining Operational Gap** **-£1,236**



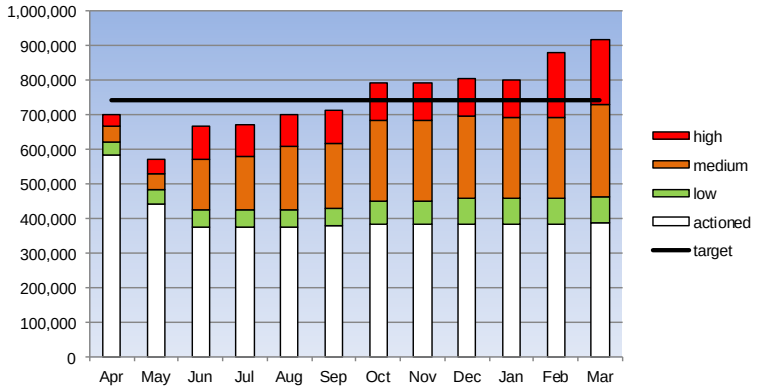

| Recovery Plan Actions | Improvement to run rate £'000s | Subtotal £'000s | Start Date |
|---|---|---|---|
| **Non Recurrent Issues effecting forecast variance** | | | |
| Such as power failure, maintenance charge from 16/17 | £695 | | **Ongoing** |
| **Total Non Recurrent Issues** | | **£695** | |
| | | | |
| **Activity/Income** | | | |
| - Casemix Review (Elective and Non Elective) | £850 | | Jun-17 |
| - Orthopaedic Locum | £250 | | Sep-17 |
| - General Surgery model | £150 | | Sep-17 |
| - Theatre Productivity | £500 | | Jul-17 |
| - Professional leave management | £500 | | Sep-17 |
| - Wharfedale Activity | £250 | | Aug-17 |
| **Total Activity/Income Improvements** | | **£2,500** | |
| | | | |
| **Expenditure** | | | |
| - Nurse Staffing (inc. 1 to 1 care) | £800 | | Jul-17 |
| - Theatre Staffing Strategy | £160 | | Jan-18 |
| - Agency premium reduction (Medical bank for example) | £100 | | Oct-17 |
| - Management of Community Services to contracted values | £100 | | Oct-17 |
| - Further Procurement Opportunities from WYAAT collaborative work | £40 | | Sep-17 |
| **Total Expenditure Improvements** | | **£1,200** | |
| | | | |
| **Other Items** | | | |
| - Release Board Contingency | £750 | | Jun-17 |
| - Capitalisation | £200 | | Jun-17 |
| - ASDM Opportunity | £750 | | Mar-18 |
| - Annual Leave Accrual | £460 | | Jun-17 |
| - Provisions | £300 | | Mar-18 |
| - Rates | TBC | | TBC |
| **Total Other Improvements** | | **£2,460** | |
| | | | |
| **Total Improvements** | | **£6,855** | |

Although there are a number of initiatives which are being moved forward, there is still work to do to ensure that these plans are implemented, the full benefit achieved and further plans identified.

# Efficiency Update

Although plans are in place for over 100% of the CIP requirement for 2017/18, the risk adjusted total equates to 86%. This highlights the level of risk in current planning to achievement.

## Trustwide Cost Improvement Programme 2017/18

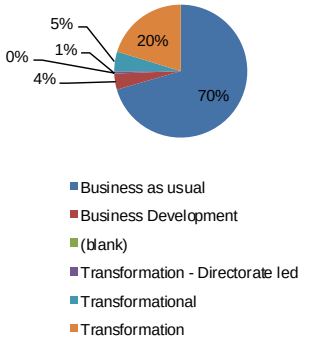



| Summary | Target | Actioned | Low | Medium | High | Total | Total %age | Risk Adjust | Risk Adj %age |
|---|---|---|---|---|---|---|---|---|---|
| Trustwide | 8,900,000 | 4,807,700 | 782,203 | 2,331,880 | 1,342,276 | 9,264,059 | 104% | 7,684,752 | 86% |
| | % age of target | | 9% | 26% | 15% | | | | |

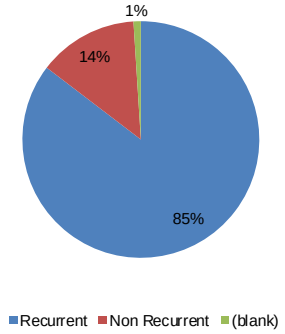
**Top 10 unactioned schemes** Top 10 as % of schemes - 23%

| No. | Scheme | Directorate | Value | Risk |
|---|---|---|---|---|
| 1 | Inpatient Workstream 1 | LTUC | 250,000 | Medium |
| 2 | Inpatient Workstream 2 | LTUC | 250,000 | Medium |
| 3 | Inpatient Workstream 3 | LTUC | 250,000 | Medium |
| 4 | Inpatient Workstream 4 | LTUC | 250,000 | Medium |
| 5 | Review of Recruitment Process | LTUC | 240,000 | Medium |
| 6 | Theatre Utilisation | Planned Care | 208,333 | high |
| 7 | Enhanced Recovery | Planned Care | 208,333 | high |
| 8 | Pathology Review | LTUC | 200,000 | high |
| 9 | Endoscopy Developments | Planned Care | 159,143 | high |
| 10 | Job Planning Review | LTUC | 150,000 | Medium |

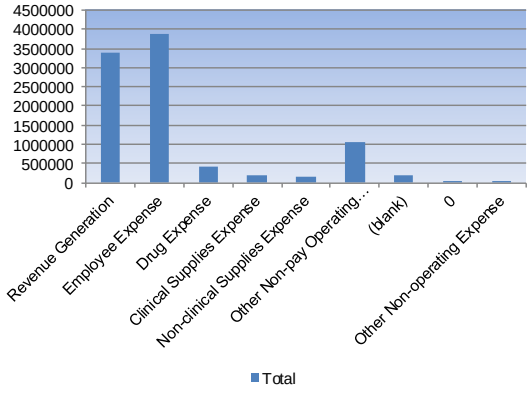
**CIP schemes by internal category**



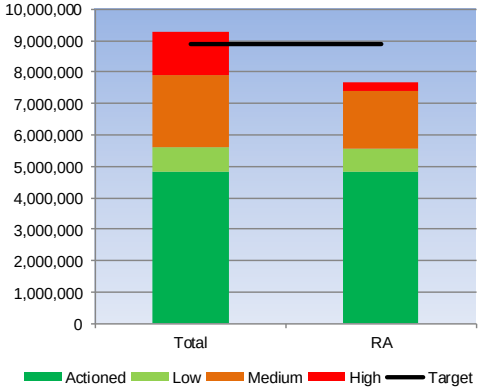

**Recurrent V Non Recurrent Plans**




**Efficiency Category**



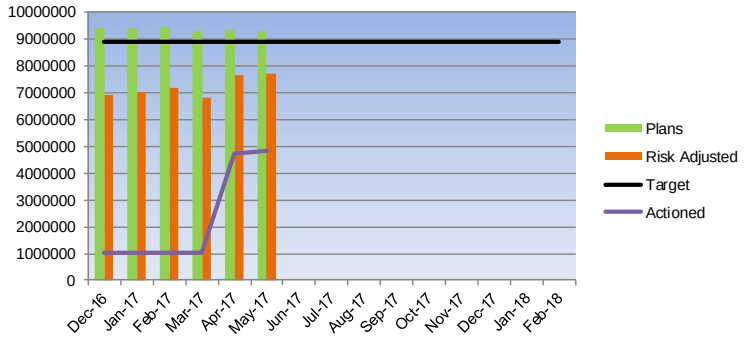

**Risk Profile**



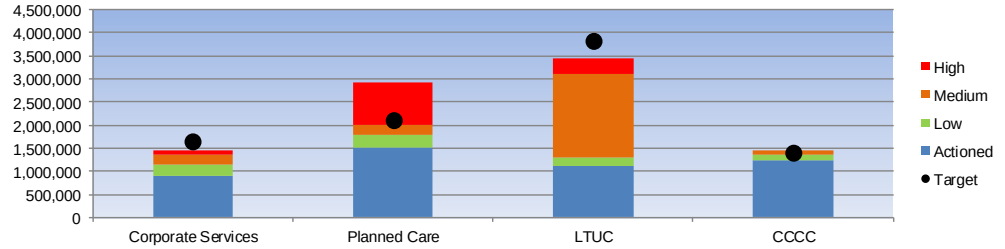

Further work is being done to review the inpatient workstream efficiency savings in light of the changes to ward staffing.

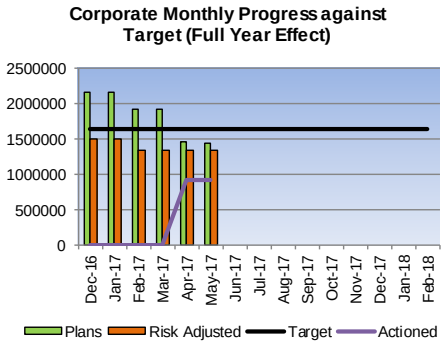
# Efficiency Update Continued

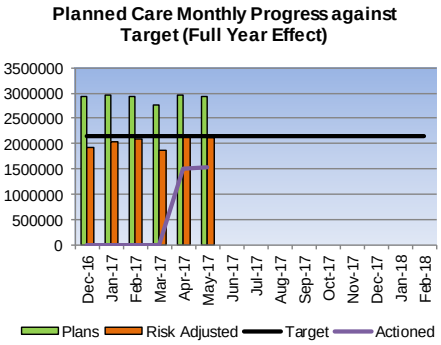
## Trustwide Cost Improvement Programme 2017/18

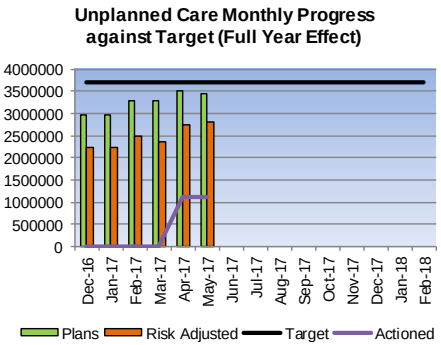


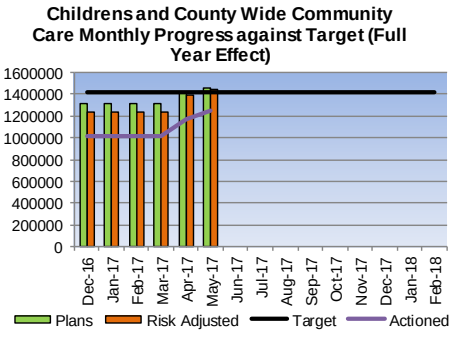

| Summary | Target | Actioned | Low | Medium | High | Total | Total %age | Risk Adjust | Risk Adj %age |
|---|---|---|---|---|---|---|---|---|---|
| Corporate Services | 1,640,000 | 911,600 | 227,200 | 233,700 | 71,000 | 1,443,500 | 88% | 1,328,600 | 81% |
| Planned Care | 2,123,000 | 1,530,100 | 257,983 | 205,900 | 923,276 | 2,917,260 | 137% | 2,124,559 | 100% |
| LTUC | 3,832,700 | 1,132,200 | 156,600 | 1,806,400 | 348,000 | 3,443,200 | 90% | 2,795,690 | 73% |
| CCCC | 1,414,200 | 1,245,700 | 132,620 | 85,880 | 0 | 1,464,200 | 104% | 1,440,393 | 102% |

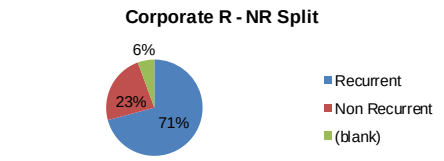


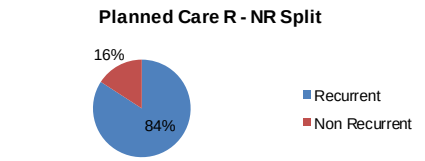



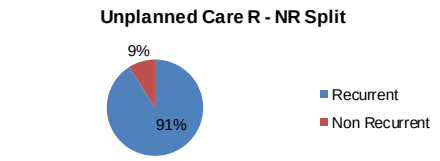



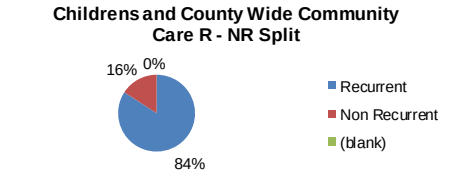



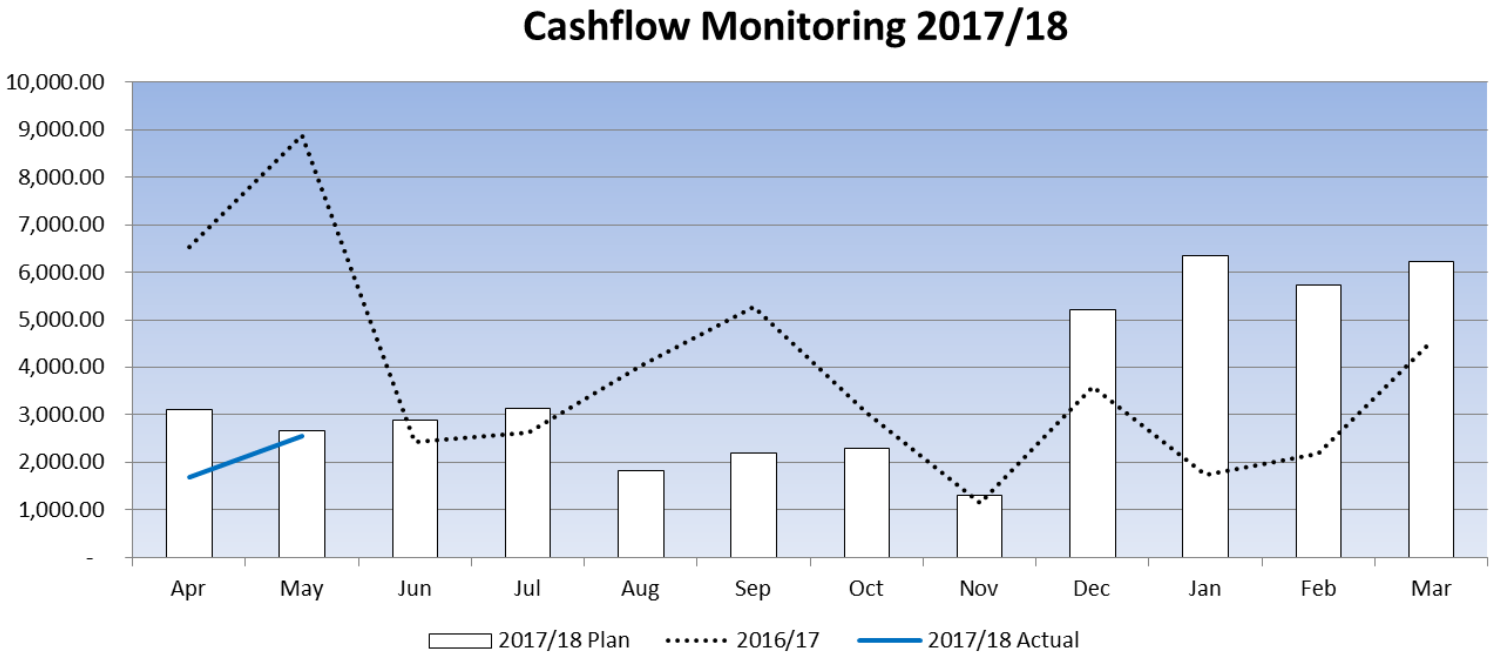



# Cashflow

Although the cash position is only £96k behind plan, the value is still relatively low. Given the pressure in relation to income and expenditure this continues to be a concern for the Trust.




Despite having improved contract terms in 2017/18 for the main Acute contract with HaRD CCG, a number of debts remain outstanding. The most significant area to be moved forward is the difference in outturn for 2016/17 between the Trust and HaRD CCG. This is being addressed through Contract Management Board meetings.

The Trust will also be reviewing to Capital Programme to ensure actions are in place to mitigate pressures as a result of the current deficit position.

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Harrogate and District
NHS Foundation Trust

| Report to the Trust Board of Directors: 28 June 2017 | Paper No: 7.0 |
|---|---|

| Title | Chief Operating Officer's Report |
|---|---|
| **Sponsoring Director** | Mr Robert Harrison, Chief Operating Officer |
| **Author(s)** | Ms Rachel McDonald, Head of Performance & Analysis<br>Mr Jonathan Green, Information Analyst Specialist |
| **Report Purpose** | To provide the Board with an update on operational issues during the period for information |

**Key Issues for Board Focus:**
The Board of Directors are asked to note:

- Service activity remains below plan, analysis of the issues and actions to mitigate the risk are in development.
- A preliminary report from Picker has ranked HDFT's Emergency Department (ED) as the best performing Trust in the country in relation to the 2016 ED survey results.
- Provisional data indicates that delivery of the 62 day standard for quarter 1 (Q1) will be challenging. Shadow reporting of the 62 day standard shows an improvement in performance for May when re-allocation rules are applied.

| **Related Trust Objectives** | |
|---|---|
| 1. To deliver high quality care | Yes – the report provides updates to the Board on progress with regard to work to improve the efficiency and effectiveness of high quality care deliver within the Trust. The report provides detail on operational issues and delivery against national performance standards. |
| 2. To work with partners to deliver integrated care | Yes – the report provides updates on the collaborative work with partners across the region and our commissioners to improve delivery of care and treatment to patients. |
| 3. To ensure clinical and financial sustainability | Yes – the report provides the Board with assurance on progress of work across the region to ensure sustainable delivery of clinical models across the system. |
| **Risk and Assurance** | Risks associated with the content of the report are reflected in the Board Assurance Framework (BAF) via: BAF 4: risk of a lack of interoperable systems across New Care Models partners; BAF 9: risk of a failure to deliver the operational plan; BAF 10: risk of a breach of the terms of the NHS Provider licence; BAF 16: risk to delivery of integrated care models. |
| **Legal implications/ Regulatory Requirements** | The report does not highlight any legal/regulatory implications for the period. |
| **Action Required by the Board of Directors**<br>The Board of Directors are asked to receive and note the content of the report. | |

## 1.0 NATIONAL INPATIENT SURVEY 2016

The Care Quality Commission (CQC) has recently published the results for the national inpatient survey 2016. This allows us to benchmark HDFT's performance with other Trusts.

This survey looked at the experiences of 77,850 people who received care at an NHS hospital in July 2016. Between August 2016 and January 2017, a questionnaire was sent to 1,250 recent inpatients at each Trust. Responses were received from 608 patients at Harrogate and District NHS Foundation Trust.

For each question in the survey, the individual (standardised) responses are converted into scores on a scale from 0 to 10. A score of 10 represents the best possible response and a score of zero the worst. The higher the score for each question, the better the trust is performing.

HDFT scored:

- 'About the same' on 55/65 questions
- 'Better' on 9/65 questions
- 'Worse' on 1/65 questions

Using the weighted results, in nine out of the 65 questions HDFT was deemed to have performed significantly better than average:

- Quality of food.
- Help with eating.
- Explanation of anaesthetic.
- Care after discharge.
- Advice after discharge.
- Medication side effects.
- Information about medicines.
- Home and family situation.
- Equipment and adaptions in the home.

For one of the 65 questions, HDFT was scored as worse than the average, and this related to patients being asked to give their views on the quality of their care during their stay.

There were nine areas where there was a 'significant change' when compared to last year's results. Of these, five questions had a higher score than last year:

- How would you rate the hospital food?
- Were you offered a choice of food?
- Before the operation or procedure, did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain in a way you could understand?
- Were you told how to take your medication in a way you could understand?
- Were you given clear written or printed information about your medicines?

For four questions, the 2016 score was lower than last year:

- How do you feel about the length of time you were on the waiting list before your admission to hospital?
- Did you ever use the same bathroom or shower area as patients of the opposite sex?
- How clean were the toilets and bathrooms that you used in hospital?
- During your hospital stay, were you ever asked to give your views on the quality of your care?

## 2.0 NATIONAL EMERGENCY DEPARTMENT SURVEY 2016

Picker has published a national ranking report relating to the 2016 Emergency Department survey, and of 75 NHS organisations who used Picker, HDFT has been ranked as the best performing Trust.

The report also contains information on the percentage of patients who reported a problem in any given question. Of the 75 trusts that worked with Picker in both 2014 and 2016, HDFT is the 16th most improved with 4.58% fewer patients on average reporting a problem.

Please note the CQC results have not yet been published for the ED Survey and are expected late this summer.

## 3.0 EMERGENCY DEPARTMENT STREAMING AND WEST YORKSHIRE ACCELERATION ZONE

Following the recent bids for capital funding to embed Primary Care Streaming in Emergency Departments (EDs) in England, the district hospital site has been awarded £340k to provide facilities at the front of ED to enable front door streaming of patients presenting to ED who can be managed within the GP Out of Hours service. Delivery of this will require changes to the Paediatric waiting area in ED and the two small offices in the main foyer, it is anticipated this will be completed at the in December / January.

Following the success of the West Yorkshire Acceleration Zone (QYAZ) work in Quarter 4 of 2016/17 a further funding allocation has been awarded for 2017/18. HDFT will receive £380k to support extending ambulatory care and improving patient flow. The Trust is working with YAS and the Red Cross on discharge support as part of this programme. Teams from across West Yorkshire are presenting the work of WYAZ at a regional event on 30 June.

## 4.0 CANCER SERVICES

<u>62 day cancer performance</u>

In May the Trust had a high number of 62 day cancer breaches resulting in a projected performance for the month of 81.4% (85% target). This position will be validated at the monthly Breach Analysis meeting in June, after which we will have the confirmed May position. This meeting will also identify the key issues that need to be addressed in order to improve patient pathways and performance. The performance for May has meant that delivery of the Q1 2017/18 will be extremely challenging. The Cancer Team are working with the relevant tumour sites to ensure that, where possible, patients are offered treatment prior to their target date and that patients are referred to the treating Trust promptly as soon

as the decision to refer is made.

Inter-Provider Transfer (IPT) performance

As stated above, projected performance for May with the current allocation rules is at 81.4%. A total of 22 patients were treated at tertiary centres in May following a 2WW referral to Harrogate. Of these, 13 were transferred by day 38 (59.1%).

Shadow reporting of the 62 day standard shows that when the national guidance re-allocation rules are applied, performance in May would be below the expected standard at 84.8% (3.4% higher than reported performance). When the re-allocation rules developed by Leeds Teaching Hospitals are applied, shadow performance would be above the expected standard at 85.3% (3.9% higher than reported performance).

## 5.0 SENTINAL STROKE NATIONAL AUDIT PROGRAMME (SSNAP)

The latest SSNAP (Sentinel Stroke National Audit Programme) results were published at the end of May. The national SSNAP team now only publish reports every 4 months, instead of quarterly, so the latest figures relate to the December 2016 to March 2017 period.

HDFT has been rated D overall, which is no change on the last publication. Our overall score is 55, compared to 57 last time. Our score has been slightly impacted by the data quality adjustment; however our score prior to the data quality adjustment (58) would still have placed us in band D.

Of the 10 domains in the SSNAP data set, one has seen an improvement since the last report:

- Thrombolysis – (D to C) – 100% of eligible patients (6 out of 6 ) were thrombolysed but only 21% were thrombolysed within 1 hour.

Two domains have seen a deterioration:

- Physiotherapy (B to C)
- Speech & Language (C to D)

The other seven domains stayed at the same score.

Other points to note about the latest data:

- We saw improvements in the “time to scan” but still remained in Band D overall for this domain;
- The proportion of patients arriving on the stroke unit within 4 hours and the proportion spending 90% of their stay on the stroke unit both deteriorated;
- The proportion of patients seeing a stroke consultant within 24 hours significantly dropped in January – to 54% (we normally average 80-90%) but performance improved back to usual levels in February and March;
- The proportion of patients having a swallow screen within 4 hours was low in December to February (around 55%) but improved to 88% in March.

The Hot Spot review commissioned by the Executive team has now reached a draft report stage and once it is finalised and the action plan completed this will be shared with the Board of Directors.

## 6.0 CARBON AND ENERGY FUND

On 6 June 2017 EDF Energy Services, a joint venture between EDF Energy and Dalkia Europe, agreed to acquire Imtech UK and Ireland from Endless LLP. Completion of the deal is subject to merger control clearance from the European Commission. Comment has been sought from CEF on this acquisition and their comments are;

*"At the moment the contract between HDFT and Imtech is not affected because that was with Imtech, and the Parent company guarantee is unaffected because that is with ESSCI which merely has been sold.*

*The part of EDF that has bought ESSCI is itself a new venture with little trading history, so CEF are working with EDF and Imtech to ensure that the position for CEF members is truly improved."*

## 7.0 SERVICE ACTIVITY

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

| | Apr-17 | | | May-17 | | | May-17 YTD | | |
|---|---|---|---|---|---|---|---|---|---|
| **Activity type** | **Actual** | **Plan** | **Variance** | **Actual** | **Plan** | **Variance** | **Actual** | **Plan** | **Variance** |
| **New outpatients** | 6831 | 7000 | -2.4% | 8496 | 8167 | 4.0% | 15327 | 15167 | 1.1% |
| **Follow-up outpatients** | 14020 | 14039 | -0.1% | 16529 | 16379 | 0.9% | 30549 | 30418 | 0.4% |
| **Elective inpatients** | 246 | 273 | -9.9% | 328 | 344 | -4.7% | 574 | 617 | -7.0% |
| **Elective day cases** | 2104 | 2263 | -7.0% | 2377 | 2609 | -8.9% | 4481 | 4872 | -8.0% |
| **Non-electives** | 1731 | 1757 | -1.5% | 1939 | 1822 | 6.4% | 3670 | 3579 | 2.5% |

Despite remaining behind plan, May has seen an improvement on the April position. The specialties with the largest adverse variance to plan on elective activity YTD are: General Surgery, Orthopaedics, ENT, Ophthalmology and Urology.

However there are a number of factors impacting on our ability to deliver the elective activity plan. These are primarily:

- Medical staffing vacancies;
- Theatre productivity;
- General Surgery Consultant of the Week;
- General Surgery resident Middle Grade requirements;
- Access to the planned Wharfedale sessions.

The following actions are being taken to improve the adverse position:

- A full review of the Consultant of the Week model is close to completion in General Surgery, which includes a specific aim to revising the model to improve the activity position in this specialty. With immediate effect, SMT requested that the Clinical Directorate now plan a level of elective activity to be included each week within the model;
- The theatre productivity dashboard which enables timely analysis of productivity will be completed in July. This will be utilised to improve the current productivity position and enable teams to identify further efficiency opportunities;
- A review of gastroenterology medical staffing deployment which is anticipated to

improve delivery of the activity plan;

- ENT relates to the disproportionate level of annual leave taken at the beginning of the year by the Consultant team. Therefore it is anticipated that this activity will be recovered through the year;
- Urology has experienced a number of Consultant and Middle Grade vacancies. These are now filled and it is anticipated that the specialty should return to plan;
- Options are being explored for reducing the cost of elective activity currently delivered at a loss;
- The appointment of a locum Consultant Orthopaedic surgeon from September.
- Agreement now in place to increase the number of endoscopy sessions utilised on the Wharfedale Hospital site;
- An immediate review of medical staffing professional leave has commenced. This is currently managed separately to the study leave allocation and results in a further reduction in clinical activity.

In addition to the activity variances outlined above, a case-mix issue has been identified which is further affecting income. At this stage, it is anticipated that this relates to three possible areas:

- A genuine reduction in patient acuity;
- The actual impact of HRG 4+ being different to the planned impact;
- The translation of patient acuity being accurately reflected into the coded spell.

Further work is being undertaken to better understand each of these three possibilities and in the interim, a letter has been issued to all affected commissioners.

Harrogate and District NHS Foundation Trust

| | |
|---|---|
| **Report to the Trust Board of Directors: 28 June 2017** | **Paper No: 8.0** |

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

**Key Issues for Board Focus:**

1. **The recruitment process to appoint to the position of Chair of the Trust has commenced.**
2. **The inaugural Trust Quality Conference was held on 14 June 2017.**
3. **The sickness absence rate has reduced significantly for a second consecutive month from 4.05% to 3.75%.**

| **Related Trust Objectives** | |
|---|---|
| 1. To deliver high quality care | Through the proactive management and development of the workforce, including recruitment, retention and staff engagement. |
| 2. To work with partners to deliver integrated care | Working with external organisations, including NYCC, Health Education England, Higher Education Institutions and NHS Employers, to provide a qualified and professional workforce fit to deliver services. |
| 3. To ensure clinical and financial sustainability | By seeking to recruit and retain our workforce to full establishment and minimise the 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.*

### a) Recruitment of Chair of the Trust

The final interviews for the shortlisted candidates were held on 22 May 2017 and a number of colleagues participated in what was a thorough process. The Trust has always sought to include as many staff as possible in the selection of candidates for the most senior roles, including attendance at presentations by each of the candidates.

The position of Chair is a key element of the governance of the Trust and it is essential for the Trust's future development that the right candidate is selected. On this occasion it was the view of the Interview Panel, taking into account all the different elements of the recruitment process, that there was no candidate suitable for the position amongst those who were shortlisted. While this is disappointing, the Interview Panel considered that it was the right decision in the circumstances.

The Council of Governors has now reviewed the position and a new process commenced with the advertising of the role from 19 June 2017, with a view to interviewing shortlisted candidates on 13 September 2017.

### b) Sickness Absence

Sickness across the organisation has seen a further significant reduction during April from 4.05% to 3.75% and is now below the Trust threshold of 3.9%. This shows significant improvement on the absence levels seen at the beginning of the year, from January to March. This decrease has been the result of reductions in absence levels across all four Directorates.

The largest decreases in absence levels were seen in Corporate Services and Children's and County Wide Community Care where absence levels were reported at 2.87% and 3.42% respectively. Long Term and Unscheduled Care has also seen a reduction in absence to 3.87%, although there remains work to do on completion of return to work interviews, with only 49% of interviews being recorded in Rosterpro. Planned and Surgical Care absence has also seen a decrease in absence levels; they currently sit at 4.57% which is above the Trust's target of 3.9%. There are targeted action plans being put in place for the inpatient areas within the Directorate and a significant focus on Farndale Ward has already seen a number of long term sickness cases concluded.

The Health & Wellbeing team has been working to raise further awareness of the importance of emotional wellbeing through activities during the national Mental Health Awareness week. The Trust is also looking at further ways in which to address the completion of return to work interviews to ensure further compliance across the Trust.

### c) Nurse Recruitment

The Trust recruited nurses from the European Union (EU) in 2014 and 2016. From a total of 24 nurses recruited in 2014, two remain with the Trust and two remain from the 2016 intake.

Across the NHS EU nurses tend not to stay with a Trust for any longer than 18 months. This is due to a number of factors including the freedom of movement within the EU and to other employing Trusts (no visa issues when transferring employer), no requirement for IELTS if they were recruited before April 2017 and the draw of London which has attracted a high number of our recruits.

Other EU countries, notably Ireland, do not have the same requirements as England for those who are also trained midwives. Some of the nurses the Trust has recruited have moved to Ireland as their degree is accepted and they can practise as a midwife. Four of the nurses recruited by the Trust from the EU left due to their personal circumstances.

International recruits stay with an employer statistically longer than those from the EU. This is due to a number of reasons including:

- Three-year visa with the employer. Whilst it can be moved, it is uncommon for international nurses, for example, to move between NHS employers;
- The process of UK registration is complex and the nurse has a higher sense of loyalty due to the time and cost invested in them by the Trust
- The nurses tend to be older and have families at home which in some cases they look to bring to the UK at a later date.

The only realistic way of recruiting significant cohorts of nurses is via undergraduate students and international recruitment. The Trust is always improving our local student offer but it is unlikely that the Trust will recruit any more than 30 students per year, partly due to the local competition from other Trusts that are within more affordable areas to live.

Consideration may need to be given to establishing a local School of Nursing in conjunction with a Higher Education institution. The Trust has already taken steps to recruit students to a dedicated Harrogate undergraduate nurse training programme, which will offer all students a placement in the Trust and a guarantee of employment on graduation, supported by a tie-in clause.

**d) Global Health Exchange update**

The one successful candidate nurse from the first cohort has submitted his NMC application and expects to hear back from it by the end of July. Once he has the result of his application, he will then be able to apply for his visa. As long as everything runs to the expected timeframe, the Trust can expect him to start work in mid to late September.

A new provider, based in the UK, has been engaging with Health Education England (HEE), which is working with the Trust and the Apollo Group on the Global Health Exchange programme. The new spoke provider works with partners in a number of countries and has already supplied HEE with six CVs. HEE is completing the pre-screening elements and all potential applicants have been told about HDFT and are keen to work here.

Of the six nurses whose CVs have been supplied, one nurse has passed IELTs and Computer Based Testing and two have passed IELTs. Three other nurses have narrowly failed IELTs, although scoring over 6 for all elements. The CVs have been made available to the Trust, interviews have taken place and five offers of employment have been made. This is in addition to a further eleven offers of employment following the Trust's Open Evening on 20 June made to existing registered nurses or students, eight of these will commence between now and September 2017.

### e) Recruitment of new Non-Executive Director

A total of 27 applications were received by the closing date of 22 May 2017 and a longlisting process took take place which reduced these to eight potential candidates. Each of these was invited to an informal discussion with the Chairman, the Deputy Chair of the Council of Governors and a Non-Executive Director on 15 June. Final interviews will take place on 29 June 2017, including a discussion with a Focus Group. Three candidates were shortlisted to attend for these interviews. The final selection will be ratified at a subsequent Extraordinary Council of Governors' meeting.

### f) Job Planning

The latest job planning figures for Consultants and Specialty Doctor and Associate Specialist grades as at 31 May 2017 are shown in the table below. Overall progress in completed Job Plans month on month is shown as a RAG rating. The Job Planning Group met on 13 June 2017 and discussed the progress of the Action Plans which were endorsed by Senior Management Team (SMT) at the May meeting. It was noted that all Directorates have committed to achieving the deadlines in their Action Plans and a significant number of Job Plans are in the final stages of completion. The meeting also had an updated discussion on tracking and recording professional leave and heard that plans for allocating leave by programmed activities rather than by days or hours was in the final stage of development.

| JUNE 2017 JOB PLANNING CENTRAL REPORT - CONSULTANTS | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Directorate | Number of Consultants | Job Plans within 12 months | % | Job Plans older than 12 months | % | Number of Consultant with no Job Plans recorded | % | In progress | Notes | RAG |
| C & CWCC | 12 | 11 | 91.67% | 1 | 8.33% | 0 | 0.00% | 0 | Ex Mat Lve (1) | |
| LT & UC | 52 | 30 | 57.69% | 22 | 42.31% | 0 | 0.00% | 0 | | |
| P & SC | 66 | 48 | 72.73% | 17 | 45.90% | 1 | 1.52% | 0 | | |
| **Total** | **130** | **89** | **68.46%** | **40** | **30.77%** | **1** | **0.77%** | 0 | | |

| JUNE 2017 JOB PLANNING CENTRAL REPORT - SAS GRADES | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Directorate | Number of SAS Doctors | Job Plans within 12 months | % | Job Plans older than 12 months | % | Number of SAS Doctors with no Job Plans recorded | % | In progress | Notes | RAG |
| C & CWCC | 5 | 5 | 100.00% | 0 | 0.00% | 0 | 0.00% | 0 | | |
| LT & UC | 12 | 10 | 83.33% | 1 | 8.33% | 1 | 8.33% | 0 | | |
| P & SC | 35 | 6 | 35.30% | 10 | 28.57% | 19 | 54.29% | 0 | | |
| **Total** | **52** | **21** | **40.38%** | **11** | **21.15%** | **20** | **38.46%** | 0 | | |
| **Change from previous month (in-date JPs)** | | **Improved** | | **No change** | | **Worse** | | | | |

### g) Quality Conference

The Trust held the first multi-disciplinary Quality Conference on 14 June with a total of around 150 attendees across the main site, in Harrogate, and three satellite sites at Ferryhill, Scarborough and Northallerton. A mix of external and NHS speakers delivered a series of workshops and plenary sessions and there were 20 entries for the poster competition. Our own Health and Wellbeing team facilitated three breakout sessions for staff to share the health and wellbeing offer and seek input in shaping our future offer. Evaluation of the day is underway and a full report on the Conference and the outcomes will be available for the July SMT report.

Chaired by Chief Executive, Dr Ros Tolcher, the conference provided an opportunity to become immersed in quality improvement for a day. In an effort to make best use of delegate's time the day was fast-paced and the agenda jam-packed. There was a wide

range of presentations and workshop sessions hosted by a mix of external and NHS speakers.

Some of the feedback from delegates included:

*"Superb conference. Great evidence of engagement at all levels and some great ideas. Very well organised. Thoroughly enjoyed it."*

*"The most useful part of the conference was listening to people from outside the NHS for inspiration and ideas. It was easy to be able to draw parallels to [NHS} practice."*

The Quality Conference Delivery Group will meet soon to formally evaluate the event and implement learning. I would like to offer my personal thanks and those of the Board to David Plews and his team for their planning and preparation of what truly was an inspirational conference.

### h) Save/Exit Interview Trial

Further to a discussion at the Workforce and OD steering group it has been agreed to undertake a short term programme to support the Trust in reducing staff turnover within two large staff groups by adopting a save/exit interview process. This will support the Trust to obtain valuable information on the drivers and key reasons for staff turnover within the Trust and support the development of an action plan for implementation. The next four months are critical to our retention plan as these are the months that we see the highest levels of turnover across the Trust.

From 12 June to 30 September 2017, at the point at which a Band 2 Care Support Worker or a Band 5/6/7 Registered Nurse/ODP (within an inpatient ward, Emergency Department, Theatres or Day Surgery) tenders their resignation or cites their intention to leave, the Trust will:

1. Identify a suitable member of the management team to carry out a save/exit interview with the member of staff at the earliest opportunity (ideally) within the next 7 days (this will be held with either an Operational Director, Head of Nursing, Deputy Chief Nurse and/or Deputy Director of Workforce and OD)
2. If suitable action can be identified to retain the staff member in employment at the Trust then this will be taken forward within the appropriate Directorate in a timely way
3. If no steps can be taken to retain the individual in employment then the exit interview information should be submitted to workforce information for recording on the Trust's Electronic Staff Record system.

By undertaking a detailed review over this period the Trust may be able to take steps to reduce the turnover within these job roles by taking action to support individuals to stay in Trust employment. If individuals decide to leave then detailed information will be obtained through the exit interview process. A detailed report will be provided to the Nursing Recruitment and Retention group at the end of the pilot detailing the drivers of staff turnover and identifying any key themes so that an action plan can be established.

### i) Health Education England visit in May

Health Education England (HEE) visited the Trust on 23rd May 2017 to discuss the quality of training provided to Doctors in Training at the Trust in Gastroenterology. HEE

measure the Trust's performance as a training provider using the General Medical Council's standards for training.

The HEE panel, led by Dr David Eadington, Deputy Postgraduate Dean, met with trainees in Gastroenterology and separately with relevant Consultants involved in clinical and educational supervision. At the end of the visit they provided feedback to the Director of Medical Education.

A final report from this visit has been issued to the Trust which details three conditions for training.

Actions are being taken forward within the Planned and Surgical Care Directorate to address these conditions, including; A named Consultant of the week to provide day time support, training for Medical Training Initiative doctors to update their skills and clarification of their roles and responsibilities in order to provide the necessary support to trainees, as well as consideration of the introduction of new roles in Gastroenterology such as Physician's Associates and Advanced Nurse Practitioners.

### j) NHS Employers Health and Wellbeing Network Event

The Trust have been asked to present at the NHS Employers Health & Wellbeing Network event in Leeds on 22 June 2017 to share our health & wellbeing journey and in particular our approach to facilitating the Schwartz Rounds within the Trust. Representatives from NHS organisations within the north of England will be attending to hear our story and share learning from their own organisations.

### k) Apprenticeship Levy

On 21 June I accepted the terms of the legally binding agreement on behalf of this Trust with the Education and Skills Funding Agency. This will now enable the Trust to release the levy monies to support the education and development of a variety of apprentices across the Trust. In excess of £600k will be available each year and the Trust will be expected to meet its public sector duty to recruit an agreed number of apprentices. This duty will be monitored via the Trust's Integrated Board Report from September 2017 onwards.

### l) GMC Junior Doctor in Training Annual Survey

The above survey has now closed and the results expected imminently.

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

June 2017

| Report to the Trust Board of Directors: 28 June 2017 | Paper No: 9.0 |
|---|---|
| **Title** | Chief Nurse Report |
| **Sponsoring Director** | Chief Nurse |
| **Author(s)** | Jill Foster, Chief Nurse |
| **Report Purpose** | To receive, note and approve the contents of the report. |

**Key Issues for Board Focus:**

- Monitoring of nurse recruitment and retention continues to show a challenging but improving position
- One Director Inspection visit and one re-inspection visit have resulted in 'green' ratings.
- Complaints in May have been higher than the last two months.

| **Related Trust Objectives** | |
|---|---|
| 1. To deliver high quality care | Yes – the report provides assurance that staffing levels are maintained throughout the Trust and the actions taken for areas where staffing levels have not been maintained |
| 2. To work with partners to deliver integrated care | No |
| 3. To ensure clinical and financial sustainability | Yes – the report supports Trust's quality objective to ensure quality of care is not compromised to insufficient clinical staff |

| | |
|---|---|
| **Risk and Assurance** | Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF 1 : risk of a lack of medical, nursing and clinical staff; BAF 3: risk of failure to learn from feedback and incidents and BAF 13: risk of insufficient focus on quality in the Trust. |
| **Legal implications/ Regulatory Requirements** | No additional legal/regulatory implications for the period, |

**Action Required by the Board of Directors**

- Be **assured** by the monitoring of nurse recruitment and retention and the governance process for assuring safe staffing levels
- **Note** the results and changes to the reporting of Director Inspections
- **Note** the increase in numbers of complaints received by the Trust in May.

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

## 1. Nurse Recruitment

1.1 The Trust's recruitment and retention working group continue to work toward zero vacancies. A recruitment event was held on the evening of 20 June 2017, 16 people attended and 14 were interviewed. Offers were made to 12 Registered Nurses and one Care Support Worker (CSW). This breaks down as:

- Long Term and Unscheduled Care (LTUC) – six Registered Nurses - two with experience and two qualifying in September, one Return to Practice finishing in August and one qualifying in March 2018 and one CSW (Byland).

- Planned and Surgical Care (PSC) – five Registered Nurses - two with experience and three qualifying in March 2018.

1.2 The next event is planned for 20 June 2017.

1.3 The next 'keeping in touch event is planned for 5 July 2017.

1.4 The numbers of Registered Nurse vacancies in LTUC in-patient wards and departments remain about the same as last month. In PSC the numbers of Registered Nurse vacancies have increased to approximately 11 and sickness levels on Farndale remains high.

1.5 In Main Theatres there is full recruitment in Band 7 and 6 registered roles and in the Band 2 – four roles. At Band 2 to 4 levels there are two additional employees in post to support training from Band 3 to 4. The number of vacancies at Band 5 level, either Registered Nurses (RN) or Operating Department Assistants (ODP) is 15 WTE out of 43WTE. Three ODP's and two RN's have been recruited and are expected to start by August 2017. Day Surgery is fully established at all levels.

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

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

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

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

1.9 A recommendation for increasing nursing budgets in the LTUC Directorate is included in the Chief Executive's report at item 5.1.

## 2. Unannounced Directors' Inspections 2017-2018

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

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

| Date of inspection | Ward/Dept. visited | Risk Rating |
|---|---|---|
| 21/04/17 | Trinity | Green |
| 12/05/17 | Granby | Green |

2.3 Services which are rated amber or red at the time of inspection are reviewed at a later date, until a green rating is achieved. The table below summarises services which are yet to achieve a green rating and the key issues to be addressed:

| Date of initial inspection | Ward/Dept. | Risk Rating at initial inspection | Critical Issues identified | Review Date | Outcome of re-inspection | Critical issues at re-inspection |
|---|---|---|---|---|---|---|
| 21/02/17 | Littondale | Red | Controlled Drug Book had gaps in daily checks | 19/04/17 | Red* | Controlled Drug Book had gaps in daily checks |
| | Littondale | | | 16/06/17 | Green | |
| 03/04/17 | Wensleydale | Red | Height adjusters to raise toilet seats soiled | 18/05/17 | Green | Height adjusters clean and process in place |

* Littondale - failed inspections in Dec 2016 and Feb 2017 due to gaps in daily checking of controlled drug book and lack of evidencing IV Cannula care. Failed on both counts in April 2017. Issues being addressed with Ward Manager and Matron. Re-inspection took place 16 June 2017 and was passed as green.

## 3 Patient Safety Visits

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

| Date | Area | Key Findings |
|---|---|---|
| 25/04/17 | Littondale | • Pressure of work due to staffing levels for both medical and nursing staff, good feedback regarding the contribution of the ACP<br>• Showers leaking and concern about increased falls risk – estates aware<br>• Ward is paperless for rostering<br>• Still some delays for ward attenders |
| 23/03/17 | Granby | • Nurse staffing levels concern as staff often work through break and stay late<br>• There is limited space on ward but potential to convert unused rooms<br>• Alternative methodology for cannula care audit was discussed<br>• Staff believe patients would benefit from therapy provision at weekends<br>• Staff could use OT room when not in patient use for breaks<br>• Staff would like to push forward 'End of PJ Paralysis' campaign |

**Patient Outcomes**

## 4 Pressure Ulcer Target 2017/18

4.1 As I discussed last month, the pressure ulcer reduction target this year, in both the hospital and the community, is to reduce the number of avoidable category 3 and 4 pressure ulcers. This target has been identified from the root cause analysis of category 3 and 4 pressure ulcers in 2016/17 which determined, in both the hospital and community, 66% of category 3 and 4 pressure ulcers analysed were deemed avoidable. There is one pressure ulcer still under investigation. The table below provides further detail.

### 4.2 Concise SIRI Pressure Ulcer Investigations 2016/17

| 2016/17 | Total Concise PU SIRI | Avoidable | | | Unavoidable | | | Under RCA Investigation |
|---|---|---|---|---|---|---|---|---|
| | | Community | Hospital | Total | Community | Hospital | Total | |
| April | 9 | 3 | 1 | 4 | 3 | 2 | 5 | 0 |
| May | 14 | 5 | 4 | 9 | 2 | 3 | 5 | 0 |
| June | 8 | 2 | 1 | 3 | 5 | 0 | 5 | 0 |
| July | 13 | 10 | 1 | 11 | 1 | 1 | 2 | 0 |
| August | 6 | 3 | 0 | 3 | 3 | 0 | 3 | 0 |
| September | 11 | 5 | 3 | 8 | 3 | 0 | 3 | 0 |
| October | 11 | 6 | 2 | 8 | 3 | 0 | 3 | 0 |
| November | 5 | 1 | 1 | 2 | 3 | 0 | 3 | 0 |
| December | 11 | 2 | 1 | 3 | 5 | 3 | 8 | 0 |
| January | 5 | 0 | 2 | 2 | 2 | 1 | 3 | 0 |
| February | 3 | 0 | 0 | 0 | 2 | 1 | 3 | 0 |
| March | 12 | 5 | 3 | 8 | 1 | 3 | 4 | 1 |
| **Total** | **108** | **42** | **19** | **61** | **33** | **14** | **47** | **1** |

*Data as at 20/06/17*

**Patient Experience**

## 5 Complaints

5.1 In May the Trust received 20 complaints. Of the 20 complaints received, 12 have been graded Yellow, and eight green.

5.2 The number of complaints received by month and compared with 2016/17 and 2015/16 is shown below:

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

**Appendix One**

**Actual versus planned nurse staffing - Inpatient areas**

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

In addition we are required to submit information on the total number of patients that were on each ward throughout the month – this is then used to calculate the "Care Hours Per Patient Day" (CHPPD) metric. Our overall CHPPD for May was **8.00** care hours per patient per day.

| | **May 2017** | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Day** | | **Night** | | **Care hours per patient day (CHPPD)** | | |
| **Ward name** | **Average fill rate - registered nurses / midwives** | **Average fill rate - care staff** | **Average fill rate - registered nurses / midwives** | **Average fill rate - care staff** | **Registered nurses / midwives** | **Care Support Workers** | **Overall** |
| AMU | 90.2% | 96.8% | 96.8% | 104.3% | 4.30 | 2.30 | 6.60 |
| Byland | 90.2% | 130.9% | 95.7% | 109.1% | 3.30 | 3.30 | 6.60 |
| CATT | 97.8% | 126.5% | 104.8% | 146.2% | 5.30 | 3.10 | 8.40 |
| Farndale | 62.4% | 94.1% | 100.0% | 93.5% | 3.60 | 4.40 | 8.00 |
| Granby | 87.6% | 111.6% | 103.2% | 122.2% | 3.20 | 3.20 | 6.40 |
| Harlow | 106.5% | 90.3% | 100.0% | - | 7.60 | 2.10 | 9.70 |
| ITU/HDU | 99.2% | - | 96.8% | - | 23.30 | 1.50 | 24.80 |
| Jervaulx | 76.5% | 145.2% | 85.2% | 107.0% | 2.80 | 3.50 | 6.30 |
| Lascelles | 93.7% | 100.0% | 100.0% | 122.6% | 4.60 | 4.40 | 9.00 |
| Littondale | 91.7% | 114.8% | 88.2% | 109.7% | 3.50 | 2.20 | 5.80 |
| Maternity Wards | 90.2% | 88.7% | 97.6% | 90.3% | 12.70 | 3.50 | 16.20 |
| Nidderdale | 97.9% | 99.1% | 98.9% | 141.9% | 3.70 | 2.60 | 6.30 |
| Oakdale | 89.9% | 117.7% | 95.2% | 174.2% | 4.30 | 3.50 | 7.80 |
| Special Care Baby Unit | 96.2% | 85.7% | 90.3% | - | 13.60 | 1.40 | 15.00 |
| Trinity | 103.8% | 95.5% | 100.0% | 103.2% | 3.60 | 3.90 | 7.50 |
| Wensleydale | 89.4% | 119.4% | 100.0% | 103.2% | 3.70 | 2.80 | 6.40 |
| Woodlands | 81.9% | 91.9% | 95.7% | 90.3% | 10.90 | 3.30 | 14.30 |
| **Trust total** | **90.4%** | **111.1%** | **96.8%** | **115.3%** | **4.90** | **3.10** | **8.00** |

| | | | | |
|---|---|---|---|---|
| ED staffing | 94% | 237% | 87% | 139% |

**Further information to support the May data**

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

On Farndale ward the daytime RN hours in May were less than planned due to vacancies and sickness, however beds were reduced in response to this and activity levels.

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

On Littondale the day and night time RN hours were less than planned due to staff sickness and vacancies.

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 Registered Midwife and care staff gaps were due to sickness and vacancies; however a professional assessment was made on a shift by shift basis to ensure that nurse staffing numbers matched the activity.

In some wards the actual care staff hours show additional hours used for 1:1 care for those patients who require intensive support. In May this is reflected on the wards; CATT, Byland, Granby, Jervaulx, Lascelles, Nidderdale and Oakdale.

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

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

In the Emergency Department the elevated daytime care staff hours reflects new starters having supervised practice.

Harrogate and District
NHS Foundation Trust

| | |
|---|---|
| **Report to the Trust Board of Directors: 28 June 2017** | **Paper No: 10.0** |

| | |
|---|---|
| **Title** | Medical Director's report |
| **Sponsoring Director** | Dr David Scullion |
| **Author(s)** | Dr D Scullion, Medical Director |
| **Report Purpose** | To receive an update on clinical issues |

**Key Issues for Board Focus:**

- To note mortality indices and for discussion as necessary.
- To note progress on national mortality reporting.

| **Related Trust Objectives** | |
|---|---|
| 1. To deliver high quality care | Yes – the report provides an update on clinical issues which may impact on the delivery of high quality care |
| 2. To work with partners to deliver integrated care | Yes – the report provides assurance that the Trust continues to work with partners and colleagues at a national and local level, in preparation for forthcoming changes to guidance of a clinical nature. |
| 3. To ensure clinical and financial sustainability | Yes – the report provides assurance that the Trust continues to deliver clinically sustainable services. |

| | |
|---|---|
| **Risk and Assurance** | Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF 1: risk of a lack of medical, nursing and clinical staff; BAF 13: risk of insufficient focus on quality. |
| **Legal implications/ Regulatory Requirements** | The report does not highlight any legal/regulatory implications for the period. |

**Action Required by the Board of Directors**

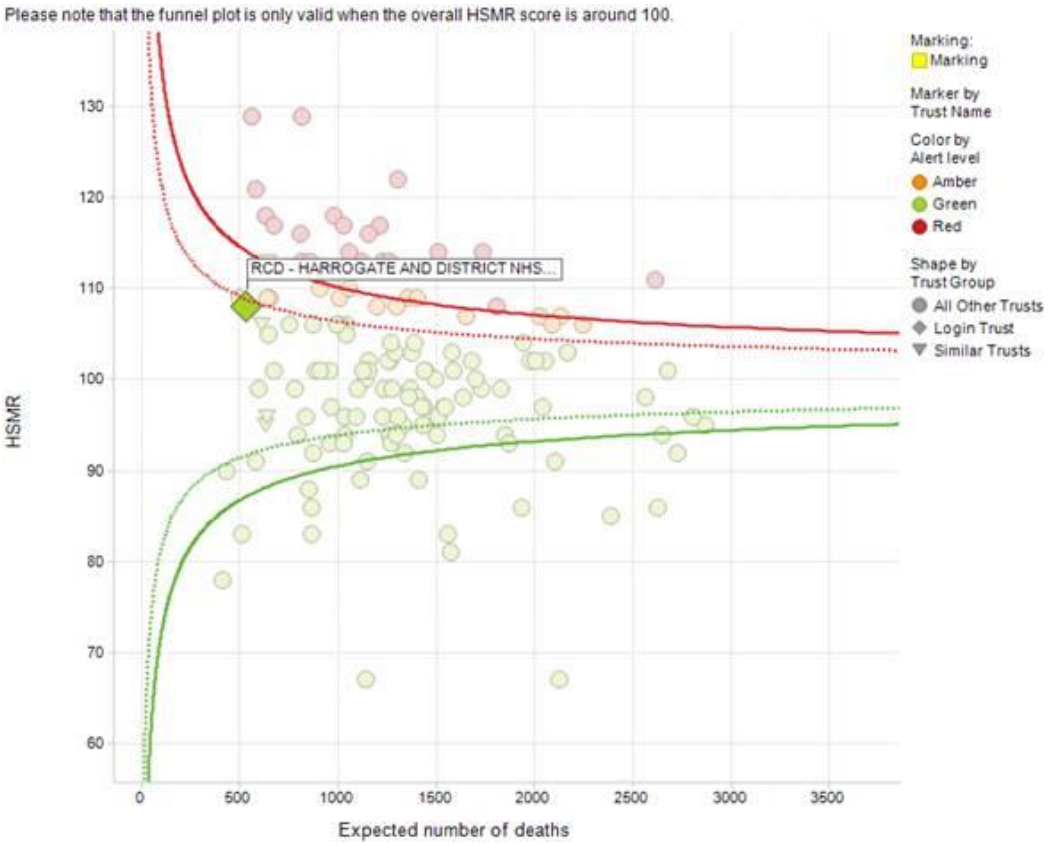
To note content of report and for discussion as deemed necessary.

**Medical Director Board Report June 2017**

## 1. Mortality update

No CUSUM, Hospital Standardised Mortality Ratio (HSMR) or Summary Hospital –level Mortality Index (SHMI) alerts were generated for the period March 2016 to March 2017.

The latest HED monthly update has shown a fall in SHMI from 95.24 to 94.06. However there has been a further rise in SHMR from 106.1 to 107.8. The latest funnel plot for HSMR is depicted below.




The overall Trust level HSMR remains within expected levels, however the plot confirms it is extremely close to the two standard deviation mark, where the metric would tip from green to amber on the Integrated Board Report. For HSMR, Geriatric Medicine has a higher than expected HSMR.

For interest, mortality indices for a few selected comparator Trusts are given below:

| Trust | HSMR | SHMI |
|---|---|---|
| HDFT | 108 | 94 |
| Airedale | 95 | 97 |
| George Eliot | 96 | 109 |
| Northern Devon | 106 | 106 |
| Yeovil | 113 | 100 |

The reasons for the slowly rising HSMR are as yet unclear and are likely to be multifactorial. Whilst it is important to consider all of these factors, it remains of prime importance to establish that there are no underlying lapses of clinical care and that outlying indices in one area of clinical practice mask good practice in others.

The usual method for more intensive scrutiny is case note review. I have discussed this with Directorate colleagues and will be discussing practical options for reviews with clinical colleagues. I am mindful of the additional work pressures that this exercise poses on an already stretched clinical service. Alongside this we will be examining other possible factors that might adversely affect mortality indices such as coding completeness and specialist palliative care input.

I will also be contacting colleagues in other Trusts in order to share experience and explore solutions.

Alongside this process, a local structure for the national reporting of deaths in hospital and local case note reviews is beginning to emerge. A small task force has formed to bring this process to fruition. It is important to emphasise that this is an iterative rather than binary process. Guidelines exist, but local flexibility is allowed and over time a picture will emerge of what works and does not work locally. Some categories of deaths in hospital will be subject to mandatory structured review. Examples in include:

1. Patients with Learning Disabilities (in conjunction with the national LeDeR programme)
2. Patients with mental health Disorders (in conjunction with TEWV where appropriate)
3. Deaths in children
4. Stillbirths
5. Maternal deaths
6. Death following any elective admission
7. Deaths from sepsis
8. Deaths referred to the Coroner
9. Deaths where concerns raised by staff, family or other advocates
10. Any patient groups where a national mortality alert is received

In practice these form a small proportion of in-hospital deaths. What is also important is that we have a system for identification of concerns in other patient death groups in order that a thorough case note review can be carried out. I am in the process of developing a triage system for this group of deaths that will capture information and learning on all deaths in hospital whilst identifying the small number that require a second stage more intensive review. I will be discussing this in greater depth with the Board NED oversight lead for mortality and with local CQC representatives. I am also in contact with the Trust mortality lead in YDH who are developing a similar process locally in order to share ideas and best practice.

I am currently working with colleagues to write the new Trust policy on mortality reviews and national reporting. This is a national requirement by September 2017.

There are a number of obstacles in this process that will need to be overcome. These include but are not limited to:

1. Accurate data capture
2. Current training needs for greater numbers of structured judgment reviewers
3. Administrative support for the process
4. Timely dissemination and return of review data
5. Perceived bias in triage judgement reviews
6. Capture of collective learning and themes
7. Dissemination of learning and themes
8. Inequality of workload in already pressurised specialties
9. Clinical engagement with review process

I will update Board on progress as necessary.

## 2. Stroke mortality review update

The Board will recall an earlier alert from Dr Foster, via the CQC, regarding outlier mortality in stroke and cerebrovascular disease. This resulted in an extensive case note review of deaths, the results of which were submitted to the CQC in March 2017 in addition to data from the national stroke audit and an action plan addressing improvements in a number of areas of stroke care. I have received a written response to this information and audit data on 23/05/2017. A copy of this letter is in the reading room.

The letter was refreshingly brief. Acknowledgement was made of the data received, but no in depth response offered. No criticism of care was made. The case has now been passed on to our local inspection team who will assess progress against the action plan. Once they are satisfied that sufficient action has been taken, the matter will be closed.

## 3. Implementing the Carter Report: an update for Medical Directors

I attended a meeting in London on 20 June with a very large number of Medical Directors from across the NHS. This was a follow up meeting to report on progress over the last 12 months.

A number of key themes emerged:

1. Initial scepticism around the GIFT service reviews is fading and clinical engagement increasing.
2. There are still major variations in care and outcomes across the NHS. These must be addressed
3. The GIRFT reviews are expanding and selected regional reviews are planned (WYAAT, October 2017)
4. The evidence for large financial efficiencies is strong
5. The Carter process is one of “gradualism “rather than a silver bullet. Small changes matter and attention to detail is key
6. Data is king. The model hospital is going to be big!
7. Robust e-rostering is vital for workforce planning
8. Explore efficiencies in networking (pathology and radiology)
9. Both Board and senior clinical leadership are vital drivers for change.

The must do’s for the coming year are ED 4hr target, 62 day cancer target, “shoring up” of primary care and equity of mental health services (Stevens).

## 4. GMC trainer approval an links to revalidation

The GMC regulations regarding approval of Named Educational and Clinical Supervisors, required to support postgraduate medical trainees, came into force nearly a year ago, on 31 July 2016.

As part of the process HEE developed e-learning and face to face training, and with the support of our Director of Medical Education, this has been delivered to Named Supervisors in our organisation prior to submission of their names to GMC.

Subsequently, all Organisations have been submitting quarterly updates of Named Supervisors.

The training remains in place, and indeed is being updated currently to meet the needs of the evolving supervisor role.

All new Named Supervisors need to complete this or equivalent training. The GMC will be including Named Supervisor status on the public facing medical register entries from July 2017.

Re-approval of such roles is currently via a 5 yearly cycle of e-learning. An alternative to this approach is that all Named Supervisors within the Trust are considered to have an educational role as part of their scope of practice and that the re-approval process is assured locally through the appraisal and revalidation route.

A cynical view might be that a core HEE function is being devolved locally in a climate of significant financial pressures. However, I am assured by our Director of Medical Education that a local solution is achievable and our Deputy DME is currently working on a framework to ensure supervisors keep up to date with requirements and appraisers (especially those who are not supervisors) feel supported in receiving such assurance through the appraisal process.

**5. Dr Umesh Sharan**

I am deeply saddened to report the death of Dr Umesh Sharan who worked initially as a Staff Grade, and subsequently as a substantive Consultant in Geriatric Medicine in the Trust for over 25 years. He was known for his very caring attitude to patients and passed away after a short illness. Dr Sharan retired from practice in 2013. I am sure the Board would join me in sending condolences to his family.

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NHS
Harrogate and District
NHS Foundation Trust

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| **Report to the Trust Board of Directors: 28 June 2017** | **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 T&O |
| **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 comment on the content of this report.

## 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 2016 – April 2017. 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 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 | Current status at HDFT | Notes |
|---|---|---|---|---|---|---|---|---|---|
| Emergency & Elective Surgery in the Elderly Report: An age old problem | Sep-10 | | AHL & RH | Nov-10 | B Barron | Cross directorate | EC Board | Actions ongoing. | Received for IPSSG Feb 2017. March – April 2017 - some work undertaken to update progress and current position |
| Subarachnoid haemorrhage: Managing the flow | Mar-13 | Mar-13 | AHL & RH | Nov-13 | Dr J Smith | Cross directorate | | Actions ongoing. | Received for IPSSG Feb 2017 |
| Gastrointestinal Haemorrhage: Time to get control? | Feb-14 | May-14 | RH & SW | Jun-15 | Dr G Davies | IC | IC Board | Actions ongoing. | Action plan received IPSSG Jan 2017. |
| Sepsis: Just say Sepsis! | Feb-14 | Nov-14 | RH & SW | Nov-15 | Dr D Earl | Cross directorate | IPSSG | Actions ongoing. | Action plan received at IPSSG Dec 2016 and March 2017. |
| Acute Pancreatitis: Treat the cause | Dec-14 | Sep-15 | RH & SW | July 2016 | Mr J Simpson | PSC | | Action plan drafted. | Action plan to IPSSG April 2017. |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Mental Health in General Hospitals: Treat as one | Jun-15 | May-16 | RH & SW | 26-Jan-17 | Dr D Scullion | Cross directorate | IPSSG | Report published | Gap analysis started Directorates to identify leads to work with the Medical Director to agree and progress action plan |
| Young Person's Mental Health* | Dec-15 | Sep-16 | RH | | | | | Prospective and Retrospective data collection exercises completed. Organisational Questionnaires completed and submitted - 20/09/16. | Clinical questionnaires outstanding |
| Chronic Neurodisability* | Dec-15 | Jun-16 | N/A | | | | | Retrospective data collection exercised completed- 27/04/16 10 Organisational service surveys completed by appropriate service leads. | Clinical admission questionnaires and ongoing care questionnaire outstanding |
| Non Invasive Ventilation Study | Jan-16 | Nov-16 | RH/SW | | | | | Organisational Questionnaire completed and submitted- 28/11/17. One of four clinical questionnaires completed and returned | Study now closed to submissions. Only one of four clinical questionnaires returned |
| Cancer in Children and Young People Study | Nov-16 | | | | | | | Retrospective data collection - blank return 11/11/16 | Organisational questionnaire received |
| Acute Heart Failure Study | Mar-17 | | | | | | | Retrospective data collection submitted - 05/04/17 | |
| Perioperative Diabetes | Jun-17 | | | | | | | Retrospective data collection due for submission- 27/06/17 | |

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

### 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 continues to be long delays with progressing some of the recommendations, some of 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 was approved and advertised for interview in June 2016 but there were no applicants. There are plans to re-advertise with the aim of recruiting summer 2017. 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 latest action plan is at appendix 1.

3.1.2. 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 first discussed at Standards Group in December 2013. Dr John Smith was appointed as clinical lead and a gap analysis was received in April 2014. Since the last report to the Board this action plan has been received at the Improving Patient Safety Steering Group once in February 2017.

The majority of actions are now complete. Outstanding actions relate to agreement from Radiology on availability of cross sectional imaging both in and out of hours, and the development of standard protocols for the care of aneurysmal subarachnoid haemorrhage patients in secondary care across the Yorkshire Regional Subarachnoid Haemorrhage Network. Dr Smith has completed the secondary care bundle but the other care pathways were to be developed by others in the network. The plan is to include transfer in the secondary bundle as this has not developed by network, complete internal ratification and implement.

The latest action plan is at appendix 2.

3.1.3. 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 gastrointestinal (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 action plan has been reviewed twice by the Improving Patient Safety Steering Group since last reported to Board, in December 2016 and January 2017.

The majority of actions have been completed. The outstanding actions are:

- To establish an agreement or SLA for interventional radiology with York. Whilst there are effective working arrangements in place to support our most critically ill GI bleed patients a formal arrangement needs to be established. This is being added to the endoscopy risk register in the interim.

- Dr Davies has drafted a GI bleed management protocol which will close most of the outstanding NCEPOD issues. Whilst the principles are agreed and in place we are awaiting confirmation of implementation.
- The recommendation to have a lead clinician responsible for local integrated care pathways for both upper and lower GI bleeding and their clinical governance has not been completed. There is agreement from all gastroenterologists that they will look after all significant upper GI bleeds. Regarding lower GI bleeds, gastroenterologists and GI surgeons do not think it would be useful at this time to combine upper and lower GI bleeds under one team. Awaiting confirmation that this has been added to the endoscopy risk register for ongoing escalation and management before closing on this action plan.

The action plan can be found at appendix 3

3.1.4. 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. An updated action plan was provided to the group in December 2016 and March 2017.

The remaining actions are to undertake a more focused audit after Patientrack sepsis screening has been embedded into use, and this is planned for Spring 2017.

The action plan can be found at appendix 4.

3.1.5. Acute Pancreatitis: Treat the cause

This NCEPOD report highlights the process of care for patients aged 16 years or older with acute pancreatitis. 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 July 2016. Mr John Simpson was appointed as the clinical lead to review the report and produce a gap analysis against the report's recommendations. This was received by the Improving Patient Safety Steering Group in October 2016. An action plan is due to be received by the group in April 2017.

The action plan can be found at appendix 5.

3.1.6. Mental Health in General Hospitals: Treat as one

This NCEPOD report highlights the quality of mental health and physical health care for patients aged 18 years or older with a significant mental disorder who are admitted to a general hospital. 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 January 2017 and was circulated in order to agree a clinical lead to review the report and undertake a gap analysis against its recommendations. A gap analysis has been undertaken and shared at Quality Committee in April 2017 and the lead

for the action plan will be discussed at Improving Patient Safety Steering Group in April 2017.

### 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)
- Alcohol Related Liver Disease: Measuring the Units (2013)
- 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 Alison Pedlingham, 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 |
|---|---|---|
| Confidential Enquiry into Maternal Death 2016-Saving Lives, Improving Mothers Care | Dec 2016 | Action plan in place, progress monitored by Maternity Risk Management Group |
| Perinatal Mortality Surveillance Report Jan - Dec 2014 | May 2016 | All recommendations in place to support clinical care. |

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 Centre for Maternal and Child Enquiries (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. Successes noted in this report include a reduction in deaths due to influenza and sepsis, and a continued reduction in deaths from hypertensive disorders of pregnancy.

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, an action plan has been completed and progress is monitored through the Maternity Risk Management Group. The key findings and recommendations relevant to HDFT are:

- Cardiovascular disease is the largest single cause of maternal death in the UK and the key focus on the 2016 report is lessons about cardiovascular disease, caring for women with hypertensive disorders of pregnancy, and messages for early pregnancy and critical care. The importance of multi-disciplinary care for women across medical specialities in addition to obstetrics, midwifery, anaesthetics and critical care is key. An important message being that the need to consult an expert in a different medical area should not be seen as a failing.

- The report supports the 3Ps in a Pod' initiative, which emphasises recognition of the significance of persistent breathlessness and orthopnoea, new or increasing fits in pregnancy, signs and symptoms of sepsis and maternal estrangement from her baby as a 'red flag' for concern over mental health problems. An informatics poster and 5 minute video have been produced to raise awareness amongst all health professionals who may encounter pregnant or post-partum women in any aspect of their work. These resources have been shared with the HDFT Emergency Department team, and local GP's.

The Perinatal mortality Surveillance report is the second UK perinatal surveillance report produced under the auspices of the Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI-CORP). The programme is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. The scope of the MNI-CORP programme has four main elements. This report focuses on: Surveillance of all late fetal losses ($22^{+0}$ to $23^{+6}$ weeks gestational age), stillbirths, and neonatal deaths. The main findings of the report are represented in a combination of maps and tables showing both the crude and the stabilised & adjusted mortality rates for stillbirths, neonatal deaths, and extended perinatal deaths (stillbirth and neonatal deaths combined).

There has never been a safer time to have a baby in England. The stillbirth and neonatal mortality rate has fallen by a fifth in the last decade. However we can certainty do better and the NHS recently set out a national ambition to halve the rates of stillbirths by 2030, with a 20% reduction by 2020. The Saving Babies Lives Care Bundle is a bold step towards introducing many evidence-based and policy recommendations in maternity care towards the goal of reducing stillbirth in the UK. Saving Babies' Lives is designed to tackle stillbirth and early neonatal death. It brings together four elements of care that are recognised as evidence-based and/or best practice:

1. Reducing smoking in pregnancy – at HDFT we now perform carbon monoxide (CO) monitoring of all women at the booking appointment followed by more frequent surveillance for women who smoke or live in households of people who smoke. We have good referral pathways for the smoking cessation service and we plan to train additional staff to provide support to women during their pregnancy.

2. Risk assessment and surveillance for fetal growth restriction – we continue to use customised growth charts to monitor fetal growth during pregnancy and there have been definite improvements with the identification of compromised babies and implementation of appropriate management plans resulting in positive outcomes. This continues the work of the SaBiNe (Saving Babies Lives in the North of England) project. This has however meant an additional strain on the ultrasound department when extra scans have been required. Ensuring that staff remain competent in the use of the customised growth charts and accurate measurements required we have a session on the mandatory training day for both midwives and medical staff.

3. Raising awareness of reduced fetal movements – The confidential enquiries into stillbirth have consistently described a relationship between episodes of reduced fetal movement and stillbirth incidences. We have highlighted to women the need to monitor the movements of their babies during pregnancy and all women are given the RCOG leaflet on "Your baby's movements in pregnancy" between 20-22 weeks gestation (normally given after the anatomy scan at approximately 20 weeks gestation). We have a clear clinical guideline on the management of reduced fetal movements and women are asked about their baby's movements at each antenatal appointment, this is clearly documented in the hand held antenatal notes.

4. Effective fetal monitoring during labour - To improve staff skill and maintain staff competence we have individual training available using the updated electronic K2 fetal monitoring programme and this includes the new recommended practice by

NICE 2014. Compliance with this is electronic package is monitored by the professional development midwife. We have introduced group teaching on mandatory training days (for both midwifery and medical staff) and ad hoc sessions take place whenever possible. There is ongoing multi-disciplinary review/teaching of clinical cases at daily case reviews and discussion at the Professional Advisory Panel.

In response to national recommendations the substantive Bereavement Midwife continues to work 1 day per week to support bereaved parents in the postnatal period. She has developed support and effective relationships for women returning to our service with a subsequent pregnancy after pregnancy loss. She leads on education and training in bereavement issues for staff, and is the lead on national and regional projects including the launch of the national stillbirth care bundle.

We continue to participate in all of the regional work streams including perinatal mental health, stillbirths, and most recently maternal critical care. We have very recently recruited a Band 7 Perinatal mental health and substance misuse midwife who will have responsibility for ensuring we have a clear clinical pathway for women who have mental health issues and to provide training for the multi-disciplinary team on mental health.

## 5. NCISH REPORTS

The latest NCISH annual report and 20-year review was published in October 2016 and presents findings from 2004 to 2014 and reviews 20 years of data collection. It provides the latest figures on suicide, homicide and sudden unexplained deaths and highlights the priorities for safer services. There is an infographic available, illustrating the key messages which include:

- There are now around 3 times as many suicides by CHRT patients as in in-patients. The crisis team is now the main setting for suicide prevention in mental health
- Many people who died by suicide had a history of drug or alcohol misuse, but few were in contact with specialist substance misuse services. Access to these specialist services should be more widely available, and they should work closely with mental health services
- More patients who died by suicide were reported as having economic problems, including homelessness, unemployment and debt
- There has been a rise in the number of suicides by recent UK residents: those who had been in the UK for less than 5 years, including those who were seeking permission to stay
- There are a number of ways in which mental health care is safer for patients, and we now know what services can do to reduce suicide risk:
    - Safer wards
    - Early follow-up on discharge
    - No out-of-area admissions
    - 24 hour crisis teams
    - Outreach teams
    - Dual diagnosis service
    - Family involvement in ‘learning lessons’
    - Guidance on depression
    - Personalised risk management
    - Low staff turnover
- In England the number of homicides by people with schizophrenia appears to have risen since 2009, though the numbers are small
- Most patients who committed homicide had a history of alcohol and drug misuse. This was found in all UK countries but was more common in Scotland and Northern Ireland

These reports are discussed at the regular meetings with Tees, Esk & Wear Valley NHS Trust (TEWV).

## 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.

The Improving Patient Safety Steering Group continues to monitor progress with all NCEPOD action plans, and presents an update to the Quality Committee every 6 months. There remain delays in getting progress updates from the leads of some action plans.

After reporting last year that that the engagement of colleagues around data collection and submission of clinical and organisational questionnaires and clinical records has improved, over the past year the responsibility for completing a number of clinical questionnaires for multiple studies has fallen on a few individuals who have reported limited capacity in order to contribute to these studies. As a result, we were unable to meet the initial submission deadline set by NCEPOD in most cases and only returned 1 of 4 clinical questionnaires for the non-invasive ventilation (NIV) study.

The Deputy Director of Governance, NCEPOD Ambassador and NCEPOD Local Reporter have since met with the Medical Director to discuss the ongoing challenges faced with the engagement of colleagues around providing updates for report action plans and participation in the studies.

As an organisation the Trust recognises the importance of contributing to these studies and understands that under the National Clinical Audit and Patient Outcome Programme (NCAPOP) participation in the Clinical Outcome Review Programme into Medical and Surgical Care, and Child Health Review is mandated.

It has been agreed that for future studies on receipt of clinical questionnaires the NCEPOD ambassador and/or local reporter will make contact with the relevant directorate governance groups in order that the directorate are able to identify the appropriate clinical team to complete the questionnaires and support the Trusts contribution to the study.

## 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**

**Action plan progress April 2017**

| 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | 1 | High | Business case written. Approval for the appointment of a second specialist medicine for the care of the elderly consultant to support the orthogeriatric consultant within Elective Care.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.<br><br>Advertised for interview June 16. Did not recruit to the post as no applicants. To be re-advertised in April 2017. Individuals identified who are interested, discussions taking place. See business case with integral timeframes for development of service to meet this recommendation.<br><br>C:\Users\m.england\Desktop\BC001 1C3983D6.pdf | Appointment to be made<br><br>Ensure cross cover at times of annual leave between surgery and orthopaedic geriatrician<br><br>. | Rebecca Leigh /Jonny Hammond | Beth Barron | Sep-20 |
| 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 | 2a | Complete | Dec 2011MCA and best interest forms in use on all wards.<br>MCA Policy in place and supported by capacity assessment forms, best interests forms and consent form 4. Capacity assessment is based on each specific decision and at a point in time and this is outlined in the policy and forms. | Ensure all medical and nursing teams undertake relevant training - new action added | | | Complete |
| | | | | | | | 2b | Closed | 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. To be closed on this action plan. | | MCA task and finish group | J Foster | Closed |
| 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 | 3a | High | See progress regarding surgical geriatrician in 1.<br><br>Currently patients will be referred via blue referral to the geriatrician service via surgical consultants if further assessment is required.<br><br>Discussion with C Arditto re: pre-admission assessment of frail elderly in PAAU with input from therapy - aim to identify actions prior to admission. | Develop protocol / processes to ensure early involvement of Medicine for the Care of Older People for all relevant elderly surgical patients<br><br>Data analysis required to understand which patients require early involvement of Medicine for the Care of Older People<br><br>Explore with D Earl and D Carter potential to develop the pre-assessment service | Rebecca Leigh /Jonny Hammond | Beth Barron | tbc |
| 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 | | Complete | Trust implementation of e-Prescribing will prompt daily medicines review. On going audits to be undertaken in surgery around the med chart access.<br><br>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.<br><br>April 2013 - complete | | | | Complete |

| 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | | Low | National Laparotomy audit data is being reviewed to understand length of time to theatre and outcome - John Simpson<br><br>Jon Conroy/Rebecca Leigh have re-established the Hip Fracture group which is meeting bi-monthly. Delays are recorded as part of BPT and reviewed at this group.<br><br>Gynae - not relevant as very small numbers of emergency gynae procedures in older women.<br>Acute and trauma audit undertaken 2016<br>Trauma delays to theatre at weekends audit 2015<br>Mortality case note reviews. | 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 |
| 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 | | 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.<br><br>Elderly Care surgical steering group to be initatied to review guidelines - want to ensure new geriatirican appointment is embeded withint the anaesthetic and surgeon teams, therefore need to understand how this role will work. See progress regarding surgical geriatrician in 1. | | Chris Mahon<br>Anne-Marie Davies<br>Tracy Jackson<br>Jeremy Childs<br>Mark Farndon | Kat Johnson | Jul-17 |
| 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 | | Closed | 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 Patientrack.<br><br>March 2017: The referral process has changed taking out some of the inappropriate referrals and so there is not the same pressure on the service.<br><br>Lack of additional resource to strengthen the APS is on the risk register. | | | | Closed |
| 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 | | Complete | 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. All AKI guidelines implemented - see action plan for Patient SAfety Alert NHS/PSA/RE/2016/007. Audit of AKI completed 2017 and actions will be followed up. | | | | Complete |
| 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 | | 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.<br>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 | | Medium | Review of the hip fracture handbook to see if it can be updated to become an acute abdo handbook.<br><br>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: Subarachnoid Haemorrhage: Managing the flow (2014)

| NCEPOD SAH April 2014 | | | | | Action Plan Progress Monitoring - Update February 2017 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 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) | Responsible 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 regional 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 presentation 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.<br><br>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.<br><br>To discuss with new clinical lead for Radiology | | | tbc |
| 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 completed by J Smith in HDFT. | Agreed by network. To include transfer as not developed by network, complete internal ratification and implement | | | tbc |
| | | | | | S3b | Low | Others in the network are developing the other care pathways | Network to ratify the entire set of protocols / pathways | SAH network group | | tbc |
| 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 easily available now for routine use | | | |
| 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 | | | | |

## 7.3. Appendix 3: Gastrointestinal Haemorrhage: Time to get control? (2015)

**NCEPOD Gastroenterology Haemorrhage – time to get control**

**Reviewed April 2017**

| *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<br>There are effective working arrangements in place to support our most critically ill GI bleed patients. To add to alliance documentation.<br><br>On agenda to discuss at next York / HDFT Alliance meeting June 2017.<br><br>To add to endoscopy risk register whilst work continues | 01 September 2017 |
| 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<br>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 | | |

| *Ref No* | *Issue* | *Action* | *Responsible Lead* | *Operational Lead* | *Target date* | *Progress* | Progress on actions | New target date if original passed |
|---|---|---|---|---|---|---|---|---|
| 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<br><br>*Agreement from all gastroenterology colleagues that they will look after all significant upper GI bleeds.*<br><br>*Regarding lower GI bleeds - gastroenterologists and GI surgeons do not think useful at this time to combine upper and lower GI bleeds under 1 team. Feeling that there would need to be major movement from specialist societies and retraining of a generation of doctors before the NCEPOD recommendation can be rolled out. Harrogate not alone in this.*<br><br>Recommend adding to endoscopy risk register and escalate / manage appropriately. | 01 September 2017 |
| 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 | Progressing | Advice included in GI bleed management protocol. Principles agreed and in place. Paperwork need fine tuning<br><br>*Different processes depending on whether OOH endoscopist is physician or surgeon.* | 01 June 2017 |
| 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 | Achieved | *Resolved as ongoing management rests with the gastroenterologists.* | |
| 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 | Achieved | This is part of the new GI bleed management protocol paperwork, *has been circulated to colleagues and so can be considered done. When the care pathway is agreed and in situ the compliance will improve. To be audited.* | |

## 7.4. Appendix 4: 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 | ID no. | Risk at review (H/M/L or comple | Progress made | Further action/s to ensure completion | New target date if original passed |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | **Action plan progress February 2017** | | | |
| 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).<br><br>Establish an annual audit of compliance | CCOT | CCDG | Oct-16 | 1 | Low | CQIN screening audit looks at compliance. | More focussed audit planned for Spring 2017 after Patientrack screening bedded into use | Jul-17 |
| 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 | | | | | 2 | Complete | | | |
| 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 | | | | | 3 | Complete | | | |
| 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 | 4 | Complete | Due for launch 12th December 2016 | | |
| 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 | | | | | 5 | Complete | | | |
| 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 | | | | | 6 | Complete | | | |
| 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 | 7 | Complete | Part of mandatory training | | |
| 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.<br>To add to the next update of annual elearning requirement | | D Earl | Nov-16 | 8 | Complete | Now part of mandatory e-learning for all doctors with fluid-prescribing duities. Continuing education will be necessary for the forseeable future until the topic is firmly part of the healthcare community | | |

| 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 | ID no. | Risk at review (H/M/L or comple | Progress made | Further action/s to ensure completion | New target date if original passed |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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:<br>a. All acutely ill patients to be reviewed by a consultant within the recommended national timeframes (max of 14 hours after admission)<br>b. Formal arrangements for handover<br>c. Access to critical care facilities if escalation is required; and<br>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)<br><br>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 | 9 | Complete | Provision of CCOT 24/7 is on risk register but no plans to achieve 24/7 coverage | | |
| 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. | | | | 10 | Medium | Audited as part of the CQIN screening data collection | In depth audit planned for spring 2017 | Jul-17 |
| 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. | | | | 11 | Complete | | | |
| 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 | | | | 12 | Complete | | | |
| 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 | | | | | 13 | Complete | | | |
| 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 | Not yet in place | Medium | Not yet established. To discuss at next Critical Care Consultants' Meeting | D Earl | R Tuffin | Apr-16 | 14 | Complete | In place but compliance unclear. | | |
| 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 | | | | | 15 | Complete | | | |
| 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)<br><br>Include in audit - see section 1 | | | | 16 | Low | | This will be part of the Spring 17 audit into confirmed sepsis cases | Jul-17 |

| 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 | ID no. | Risk at review (H/M/L or comple | Progress made | Further action/s to ensure completion | New target date if original passed |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | | | | | 17 | Complete | | | |
| 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<br><br>To discuss with DoME for inclusion in teaching on death certification | D Earl | | | 18 | Complete | Part of the induction training for all juniors. | | |
| 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 | | | | | 19 | Complete | | | |

## 7.5. Appendix 5: Acute Pancreatitis: Treat the Cause! (2016)

**Action plan:** *NCEPOD: Treat the Cause. A review of the quality of care provided to patients treated for acute pancreatitis*
**Date:** *March 2017*
**Action plan owner:** *Mr John Simpson*
**Monitoring group / committee:** *Improving Patient Safety Steering Group*

**Action plan progress: March 2017**

| ID no. | Issue / Audit Finding / Theme | Initial risk (H/M/L) | Action/s | Operational Lead | Responsible Lead | Target Date | ID no. | Risk at review (H/M/L or complete) | Progress made | Further action/s to ensure completion | Operational Lead (if changed) | Responsible Lead (if changed) | New target date if original passed |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Ensure that all patients admitted to HDFT with a diagnosis of pancreatitis are assessed for their overall risk of malnutrition. | Medium | All ward admissions are screened for nutritional risk and referred to the dietitians based on their nutrition risk score - but the current screening tool may not pick up this particular group.<br><br>To undertake an audit over 6 months to determine if these patients are at nutritional risk and to determine if they will benefit from nutritional advice. All patients admitted with acute pancreatitis to be referred to the dietitians for assessment of their nutritional screening tool score and dietetic intervention required. If the audit demonstrates these patients are at risk - to add acute pancreatitis to automatic dietetic referral criteria. | Jeanie Ferguson Macmillan Specialist Dietitian | Jill Gale Senior Specialist Dietitian/Team Leader | Sep-17 | | | | | | | |
| 2 | Increase the number of patients with acute gallstone pancreatitis having surgery to remove their gall bladder within 2 weeks on their index admission. | Medium | Implementation of the Consultant of the week model will enable progress towards this target.<br><br>HDFT has a good and supportive relationship with the pancreatic unit in Leeds which facilitates the management of the more complex cases. | John Simpson Consultant Surgeon | John Simpson Consultant Surgeon | Sep-17 | | | To monitor data at surgical audit meetings | | | | |

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Harrogate and District NHS Foundation Trust

# Board Committee report to the Board of Directors

| | |
|---|---|
| **Committee Name:** | Finance Committee |
| **Committee Chair:** | Maureen Taylor |
| **Date of last meeting:** | 19 June 2017 |
| **Date of Board meeting for which this report is prepared** | 28 June 2017 |

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

1. The Committee received information on how activity levels in 2016/17 are embedded in the 2017/18 projections. For elective work the 2017/18 plan is for the same level of activity as in 2016/17 and there is confidence that this will be achieved.
2. Expenditure in 2016/17 on high cost drugs was examined and it was noted that the £1.8m overspend is fully met by income.
3. Month 2 figures were reported which show the Trust is £2.1m behind plan due to a combination of expenditure and income variances. This is an unprecedented level of deficit for the Trust. The letter to NHS Improvement setting out a number of actions was discussed.
4. The Trust is unlikely to achieve the required financial position to secure Quarter 1 S&T funding. The current deficit will need to be brought back on track for any future S&T money to be achieved.
5. Cash at the end of May was £2.6m. There are still some significant debtors outstanding from 2016/17.
6. The Committee considered outline options for the Nurse Staffing Establishment. These options will be considered by SMT prior to a recommendation being made to Board.
7. The committee received a presentation on the data available within the model hospital which now includes more speciality detail including efficiency. This information can be used to benchmark the performance of the Trust against other organisations. A discussion is to take place with Clinical Leads as to how to identify priority areas and progress them. The Committee agreed that this benchmarking information should be included within the Trust's reporting arrangements.
8. The Committee looked at BAF15 – Misalignment of Financial Plans and agreed that the risk remains high.

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

- Receipt of S&T money is dependent on getting back on track financially and achieving our budgeted surplus. Failure to do this will impact on our capital programme.
- Outstanding debts from 2016/17 are impacting on our cash position.

**Matters for decision**

None

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

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Harrogate and District NHS Foundation Trust

# Board Committee report to the Board of Directors

| | |
|---|---|
| **Committee Name:** | Quality Committee (QC) |
| **Committee Chair:** | LA Webster |
| **Date of last meeting:** | 7 June 2017 |
| **Date of Board meeting for which this report is prepared** | 28 June 2017 |

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

**Board request for QC to seek assurance:**

- **Falls** – A look back and forward plan report was received from Carmel Lister, Falls Prevention Coordinator. This report provided good assurance to the QC that we are providing a quality service to patients at risk of falling. 3 areas to note:
    1. The spike of falls seen in the IBR over December and January which prompted the additional scrutiny was explained and the reason addressed.
    2. Going forwards there are capacity issues for this service area which the Directorates are encouraged to resolve where possible.
    3. Support in addressing the technical issues with the falls equipment would add value.

  In conclusion the QC considers that the Trust is performing well in this area given the older demographic of our users and the current financial constraints. *Action closed.*

**Hot Spots Discussed:**

- A focus on improved communications between MDT in Chester–le-Street;
- New patient meal trolleys are incompatible with the 'Red Tray' service for patients with compromised food intake, solutions being considered.

**Reports heard:**

- **2017/18 Quality Priority Baseline reports received and discussed**
    1. Reduce morbidity and mortality related to sepsis
    2. Provide high quality stroke care
    3. Improve learning from incidents, complaints and good practice
    4. Improve the patient experience of discharge processes
    5. Strengthen the voice of children, young people and families by seeking patient reported experience and using this in the development of a number of services.

- **Children's and County Wide Community Care Governance Group Annual Report** – Comprehensive report. Of note - 18% of incidents reported were Estates related issues, the QC considered this to be an area where some Corporate focus might be applied to reduce this unnecessary distraction from patient care.
- **Patient Safety Quarter 4 Report**

- **Adult Safeguarding Annual report** – good report providing assurance. Some challenges to deliver training to the required number of staff was noted.
- **Patient Experience Quarter 4 Report**
- **NICE Compliance Report Quarter 4** – QC discussed how the Trust might record non-compliance risks in a more visible way and Directorates asked to consider how this could be done.

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

No

**Matters for decision**

None

**Action Required by Board of Directors:**

- **QC Terms of Reference –** The TOR were reviewed, two minor membership changes to note and a reference to the Information Governance Toolkit was removed. The Board is requested to approve the TOR for next 12 months.

Harrogate and District
NHS Foundation Trust

# Terms of Reference

# Quality Committee

## 1. Accountable to Board of Directors

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

## 2. Purpose of the Committee

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

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

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

## 3. Responsibilities

The key responsibilities of the group are to:

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

- Organisational learning and improvement as a result of patient and staff feedback from national and local surveys including FFT, and patient safety visits;
- Organisational learning and improvement in compliance with best practice and quality standards as a result of audit, NICE publications, national inquiries and reviews relating to quality by DH arms length bodies, regulators and professional bodies, inspections and peer reviews etc.
- Research and development, quality improvement and innovation, including rapid process improvement workshops and delivery of CQUIN.

- Receive key reports for example:
  - Infection prevention and control annual report;
  - ~~Information governance toolkit annual report;~~
  - Local Supervising Authority audit report;
  - Maternity screening report;
  - Health and Safety annual report;
  - Patient experience including complaints, concerns and compliments annual report;
  - Staff survey as it relates to the quality of care.

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

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

## 4. Membership

The core membership comprises:

| **Title**<br>*List members by title and indicate Chair and Deputy Chair* | **Deputy**<br>*Deputies are welcome to attend any meetings* | **Attendance:**<br>*Indicate if required for part meetings* |
|---|---|---|
| Lesley Webster (NED) – Chair | | |
| ~~Sue Proctor~~Maureen Taylor (NED) – interim until new NED is appointed | | |
| Neil McLean (NED) | | |
| ~~Chief Executive~~ | ~~Deputy Chief Executive~~ | |
| Chief Nurse | Deputy Chief Nurse | |
| Deputy Medical Director – Clinical Audit | Medical Director | |
| Chief Operating Officer | Deputy Director of Performance and Information | |
| Director of Workforce and Organisational Development | Deputy Director of Workforce and Organisational Development | |
| Deputy Director of Governance | | |

| | | |
|---|---|---|
| Head of Risk Management | Clinical Effectiveness and NICE Manager / Risk and Complaints Manager | |
| Clinical Director Children's and County Wide Community Care directorate | Head of Children's Public Health Nursing (North Yorkshire, Darlington and Middleborough) ~~Operational Director Children's and County Wide Community Care directorate~~ | |
| Clinical Director Long Term and Unscheduled Care directorate | Deputy Clinical Director Long Term and Unscheduled Care directorate | |
| Clinical Director Planned and Surgical Care directorate | Deputy Clinical Director Planned and Surgical Care directorate | |

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

At least one member of the Audit Committee will also be a member of the Quality committee to ensure appropriate triangulation.

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

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

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

**7. Frequency of meetings**
The meeting will be timetabled to take place monthly.

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

**9. Reporting**
The Quality Committee will present an annual report to the Board of Directors outlining its work against its duties set out in the terms of reference. The Quality Committee will make recommendations to the Board of Directors on any area within its remit where action or

improvement is required. Member's attendance at Quality Committee meetings will be disclosed in the Trusts Annual Report.

**10. Review**
The terms of reference will be reviewed annually.

**11. Date**
June 2017

| | |
|---|---|
| **Report to the Trust Board of Directors: 28 June 2017** | **Paper No: 13.0** |

| | |
|---|---|
| **Title** | Self-certification of FT 4 |
| **Sponsoring Director** | Chairman |
| **Author(s)** | Company Secretary |
| **Report Purpose** | Self-Certification – FT4 |

**Key Issues for Board Focus:**

NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence.

Condition FT4(8) obliges that providers should review whether their governance systems achieve the objectives set out in the licence condition.

There is no set approach to these standards and objectives but NHS Improvement expect a compliant approach will involve effective board and committee structures, reporting lines and performance and risk management systems. A key source of assurance is the annual governance statement 2016/17 which was approved by the Board on 24 May 2017.

The self-certification template is presented to the Board for comment and approval.

| **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 risk of the Trust breaching the provider license is included on the BAF #10, the target risk score of 5 has been reached. |
| **Legal implications/ Regulatory Requirements** | The attached self-certification is a regulatory requirement for submission in June 2017. |

**Action Required by the Board of Directors**

The Board of Directors is asked confirm the statements within the attached paper for submission to NHS Improvement.

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# Self-Certification Template - Condition FT4

## Harrogate and District NHS Foundation Trust

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

*Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)*
*Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)*

These Declarations are set out in this template.

**How to use this template**

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

**Worksheet "FT4 declaration"**

## Corporate Governance Statement (FTs and NHS trusts)

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

| 1 | Corporate Governance Statement | Response | Risks and Mitigating actions | |
|---|---|---|---|---|
| 1 | The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. | Confirmed | Trust Board has regard for good governance principles. Systems and processes receive regular attention via the Board & committee structure and are subject to internal and external audit. Further details about systems of corporate goverance are set out in the Trust's annual governance statement. | Please complete Risks and Mitigating actions |
| 2 | The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time | Confirmed | Corporate governance processes and systems are revised to reflect guidance, this addressed through Board meetings and development sessions. | Please complete Risks and Mitigating actions |
| 3 | The Board is satisfied that the Licensee has established and implements:<br>(a) Effective board and committee structures;<br>(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and<br>(c) Clear reporting lines and accountabilities throughout its organisation. | Confirmed | A well-established committee structure is in place to support the Board with agreed terms of reference and regular reporting process from committees to the Board. Standing Orders and SFIs are in place which detail delegation and accountability. An established senior management team is in place which reports to the Board. | Please complete Risks and Mitigating actions |
| 4 | The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:<br><br>(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;<br>(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;<br>(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;<br>(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);<br>(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;<br>(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;<br>(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and<br>(h) To ensure compliance with all applicable legal requirements. | Confirmed | Well-led review (2015) provided assurance that systems and process were in place to ensure that the Board and Senior Leadership Team had good oversight of quality of care, operations and finances. The Trust has established Standing Orders, Standing Financial Instructions and a Scheme of Reservation and Delegation in place. There is clarity about decisions reserved for the Board and powers delegated to a committee of Directors or to an Executive Director. The Trust has sufficient skills and capacity at Board level to undertake financial-decision making, management and control. The Trust met its statutory financial requirements in 2016/17 and has provided a transparent view on areas of performance. | Please complete Risks and Mitigating actions |
| 5 | The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:<br><br>(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;<br>(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;<br>(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;<br>(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;<br>(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and<br>(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate. | Confirmed | Quality of care is identified as a strategic and an operational objective. The Trust Board has substantial oversight of the quality and safety of care within the organisation receiving detailed reports from management, which is supported by oversight and scrutiny by a the Quality Committee. Further detail about systems and processes is included within the Trust's Quality Accounts. Assurance about quality of care has been provided by the Friends and Family Tests (patients and staff) and by internal audit. | Please complete Risks and Mitigating actions |

| | | | | |
|---|---|---|---|---|
| 6 | The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence. | Confirmed | Plans for succession to Board and senior positions are in place across the organisation. The Trust Board receives data on staffing figures regularly and the impact of staffing issues. Clinical workforce strategy has been agreed and is being delivered. | Please complete Risks and Mitigating actions |

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

| Signature | Signature |
|---|---|
| | |
| **Name** Dr Ros Tolcher | **Name** Sandra Dodson |

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

| | | |
|---|---|---|
| A | | Please Respond |

## Worksheet "Training of governors"

# Certification on training of governors (FTs only)

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

### 2 Training of Governors

| | | | |
|---|---|---|---|
| 1 | The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role. | Confirmed | OK |

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

| | | | |
|---|---|---|---|
| **Signature** | | **Signature** | |
| **Name** | Dr Ros Tolcher | **Name** | Sandra Dodson |
| **Capacity** | Chief Executive | **Capacity** | Chairman |
| **Date** | | **Date** | |

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A