Board of Directors public - 31 January 2018 - 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 31 January 2018
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** *To receive any apologies for absence: Mr Andrew Alldred*	Mrs A Schofield, Chairman	-
2.0	**Declarations of Interest and Register of Interests** *To declare any interests relevant to the agenda and to receive any changes to the register of interests*	Mrs A Schofield, Chairman	2.0
3.0	**Minutes of the Board of Directors meetings held on 29 November 2017** *To review and approve the minutes*	Mrs A Schofield, Chairman	3.0
4.0	**Review Action Log and Matters Arising** *To provide updates on progress of actions*	Mrs A Schofield, Chairman	4.0
Overview by the Chairman		Mrs A Schofield, Chairman	-
5.0	**Report by the Chief Executive Including the Integrated Board Report** *To receive the report for comment*	Dr R Tolcher, Chief Executive	5.0a 5.0b
5.1	**Well Led Review Framework Self-Assessment** *To receive the report for comment and approval*	Dr R Tolcher, Chief Executive	5.1
6.0	**Report by the Finance Director to include:** – **Financial Recovery Plan Monitoring** – **CIP Monthly Update** *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** *To receive the report for comment*	Mr R Harrison, Chief Operating Officer	7.0
7.1	**Establishment of Harrogate Healthcare Facilities Management Limited (a wholly owned subsidiary of the Trust)** *To receive the report for comment*	Mr R Harrison, Chief Operating Officer	7.1

8.0	**Report by the Director of Workforce and Organisational Development** *To receive the report for comment*	Mr P Marshall, Director of Workforce & Organisational Development	8.0
9.0	**Report from the Chief Nurse** *To receive the report for comment*	Mrs J Foster, Chief Nurse	9.0
9.1	**Patient Safety Visits Annual Report** *To receive the report for comment*	Mrs J Foster, Chief Nurse	9.1
9.2	**Infection Control Update** *To receive the report for comment*	Mrs J Foster, Chief Nurse	9.2
10.0	**Report from the Medical Director** *To receive the report for comment, including approval of the Learning from Deaths Policy*	Dr D Scullion, Medical Director	10.0
10.1	**Learning from deaths report** *To receive the report for comment*	Dr D Scullion, Medical Director	10.1
11.0	**Oral Reports from Directorates** *11.1 Planned and Surgical Care* *11.2 Children's and County Wide Community Care* *11.3 Long Term and Unscheduled Care*	Dr K Johnson Clinical Director Dr N Lyth, Clinical Director Mr A Alldred, Clinical Director	- - -
12.0	**Committee Chair Reports** *12.1 To receive the reports from the Quality Committee meetings held 6 December 2017 and 10 January 2018.* *12.2 To receive the report from the Finance Committee meeting held on 11 December 2017.* *12.3 To receive the report from the Audit Committee meeting held on 7 December 2017 and **approve** the Audit Committee Terms of Reference*	Mrs L Webster, Non-Executive Director / Quality Committee Chair Mrs M Taylor, Non-Executive Director / Finance Committee Chair Mr C Thompson, Non-Executive Director / Audit Committee Chair	12.1 12.2 12.3a 12.3b
13.0	**Other matters relating to compliance with the Trust's Licence or other exceptional items to report, including issues reported to the Regulators** *To receive an update on any matters of compliance:*	Mrs A Schofield, Chairman	-
14.0	**Any other relevant business not included on the agenda** *By permission of the Chairman*	Mrs A Schofield, Chairman	-
	Board Evaluation	Mrs A Schofield, Chairman	-
Confidential Motion – the Chairman to move: *Members of the public and representatives of the press to be excluded from the remainder of the meeting due to the confidential nature of business to be transacted, publicly on which would be prejudicial to the public interest.*			

Harrogate and District NHS Foundation Trust

BOARD OF DIRECTORS – REGISTERED DECLARED INTERESTS

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

The register is maintained by the Company Secretary and was last updated in November 2017.

Name	Position	Interests Declared
Mr Andrew Alldred	Clinical Director LTUC	None
Mr Jonathan Coulter	Deputy Chief Executive/ Finance Director	Director of Harrogate Healthcare Facilities Management Limited (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
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 2. Charity Trustee of Acomb Methodist Church, York
Dr Kat Johnson	Clinical Director PSC	None
Dr Natalie Lyth	Clinical Director CCCC	None
Mr Phillip Marshall	Director of Workforce and Organisational Development	1. Member of the Local Education and Training Board (LETB) for the North. 2. Harrogate Ambassador on behalf of Harrogate Convention Centre
Mr Neil McLean	Non-Executive Director	1. Director of: • Northern Consortium UK Limited (Chairman) • Ahead Partnership (Holdings) Limited • Ahead Partnership Limited • Swinsty Fold Management Company Limited • Acumen for Enterprise Limited
Laura Robson	Non-Executive Director	None

Mrs Angela Schofield	Chairman	1. Volunteer with Supporting Older People (charity).
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 of Harrogate Healthcare Facilities Management Limited (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust) 2. Director – Neville Holt Opera 3. Member – Council of the University of York 4. Chair – Audit Yorkshire Consortium
Dr Ros Tolcher	Chief Executive	1. Specialist Adviser to the Care Quality Commission 2. Member of NHS Employers Policy Board (Vice Chair). 3. Harrogate Ambassador on behalf of Harrogate Convention Centre
Mr Ian Ward	Non-Executive Director	1. Non-Executive Director of : • Charter Court Financial Services Limited, • Charter Court Financial Services Group Limited, • Exact Mortgage Experts Limited, • Broadlands Finance Limited • Charter Mortgages Limited. In respect of the five companies above, Mr Ward is Chairman of the Remuneration Committee and Chairman of the Nominations Committee. Also, for each of them, he is a member of the Board Risk and Audit Committees. 2. Non-Executive Director of Newcastle Building Society and a member of the Group Risk Committee. Also, he is Chairman of its subsidiary company, Newcastle Systems Management Limited and a Director of Newcastle Financial Advisers Limited. 3. Member, Leeds Kirkgate Market Management Board
Mrs Lesley Webster	Non-Executive Director	None
Deputy Directors		
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	Deputy	None

Harrison	Director of W & OD	
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
Mr Phil Sturdy	Deputy Director of Estates	Close family member is employed by the Harrogate and District NHS Foundation Trust within the estates department.

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Report Status: Open

BOARD OF DIRECTORS MEETING

Minutes of the Board of Directors' meeting held in public on
Wednesday 29 November 9.00am in the Calder Room at The Pavilions Harrogate

Present:
Mr Jonathan Coulter, Deputy Chief Executive/Finance Director
Mrs Jill Foster, Chief Nurse
Mr Robert Harrison, Chief Operating Officer
Mr Neil McLean, Non-Executive Director
Ms Laura Robson, Non-Executive Director
Mrs Angela Schofield, Chairman
Dr David Scullion, Medical Director
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 Jo Harrison, Deputy Director of Workforce and Organisational Development
Dr Kat Johnson, Clinical Director Planned and Surgical Care
Dr Natalie Lyth, Clinical Director for Children's and County Wide Community Services
Mrs Katherine Roberts, Company Secretary (minutes)

1.0 Welcome and Apologies for Absence

Mrs Schofield welcomed observers to the meeting, this included Tony Doveston (Public Governor), Carolyn Heaney (Stakeholder Governor), Daniel Scott (Staff Governor) and Mr Paul Widdowfield (Communications and Marketing Manager).

She noted that apologies had been received from Mr Phillip Marshall, Director of Workforce and Organisational Development.

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 25 October 2017

The draft minutes of the meeting held on 25 October 2017 were approved subject to three amendments. In minute 12.1 'Grey' was spelt incorrectly and should be corrected to 'Gray'. In minute 6.4 there was a typo; stroke services, not stoke services. Minute 5.7

should be clarified to explain that a decreased in SHMI was a positive result.

APPROVED:
The Board of Directors approved the minutes of the meeting held on 25 October 2017 as an accurate record of proceedings.

4.0 Review of Action Log and Matters Arising

4.1 Completed actions were noted.

4.2 Action 46; Mrs Taylor confirmed the Finance Committee would discuss the committee self-assessment on 11 December 2017.

4.3 Mr Alldred confirmed update reports regarding stroke services had been considered by the Quality Committee. These had covered the action plan developed following a recent 'hot spot' review and a deep dive into performance SNAAP data. It was noted that discussions at West Yorkshire and Harrogate level about the future configuration of stroke services had been delayed until March 2018. Mr Harrison explained that as a result the Trust was working with the Health and Social Care Partnership team to support the resilience of the Trust's stroke unit over the coming months. It was agreed this action could be closed because the matter would be considered further by the Quality Committee.

4.4 Mrs Schofield noted the Trust's catchment population had not been explored at the Board Strategy Day in November 2017. It was agreed this would be deferred until July 2018.

4.5 Mr Coulter confirmed actions 66, 67 and 68 had been completed. In addition he explained he would provide an update on action 69 during his report to the Board.

4.6 Mrs Webster confirmed the Quality Committee would consider action 73, process to monitor Cost Improvement Plans, in January 2018.

4.7 Dr Scullion provided an update on action 74; the Trust's General Office team had confirmed delays in issuing death certificates were very rare. The Board agreed this action could be closed.

4.8 There were no other matters arising.

APPROVED:
The Board of Directors noted completed actions and received an update on actions 46, 49, 53, 66, 67, 68, 69, 73 and 74.

Overview by the Chairman

Mrs Schofield acknowledged that this would be her first meeting as Chairman of Harrogate and District NHS Foundation Trust. She expressed her thanks to members of the Board and Council of Governors for making her very welcome. In addition Mrs Schofield said she had been tremendously impressed by the professionalism of the Trust's staff and the quality of care provided; the Trust's values were lived and breathed by all members of staff.

Mrs Schofield noted three governors, Dr Sally Blackburn, Mrs Jane Hedley and Mr Peter Pearson would step down from the Council of Governors in December 2017. She thanked them for their commitment and support for the Trust.

Mrs Schofield said the meeting would focus on patient experience, assurance on the Trust's financial recovery plan and understanding any implications of the plan for safety and patient experience.

5.0 Report by the Chief Executive (excluding finance matters) and Integrated Board Report

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

5.2 Dr Tolcher drew attention to the strong operational performance, all indicators were green. She noted that the overall rate of falls had continued to reduce, however there had been a slight increase in the number of falls causing fractures. Mrs Foster was scheduled to meet with senior nurses during the next week to consider any underlying themes.

5.3 Dr Tolcher explained there had been a reduction in the Friends and Family response rate compared to 2016. This had resulted in deterioration in the Trust's composite CQC Insight rating. Dr Tolcher commented that the reduction was not sufficient for her to be concerned. She was confident the Trust was appropriately capturing and responding to patient feedback.

5.4 The West Yorkshire and Harrogate Health and Social Care Partnership (WY&H HCP) continued to work towards an ambition to become an Accountable Care System from April 2018. A Memorandum of Understanding was being developed, and regulators would seek further assurance about the HCP clinical strategy and plans to close the financial gap.

5.5 Dr Tolcher confirmed that at the recent Harrogate Health Transformation Board (HHTB) the Clinical Commissioning Group (CCG) had shared draft commissioning intentions for integrated community services in the form of a 'green paper'. Mr McLean expressed concern that the commissioning intentions shared by the CCG had not demonstrated a significant pace of progress; no detail about the financial modelling had been included. Dr Tolcher explained provider organisations in Harrogate district had reaffirmed their commitment to finding ways to work collaboratively and determine the best ways to use public resources. Mrs Taylor queried whether the work undertaken by Keith Derbyshire Associates had influenced the CCG's commissioning intentions. Dr Tolcher explained the commissioning intentions had been prepared in light of the CCG's financial challenges, but detailed figures had not been shared with the Trust. Mr Coulter said the level of baseline funding for community services in Harrogate was lower than other CCG areas. Dr Tolcher highlighted the integrated commissioning strategy did not describe joint budgets between the CCG and the County Council.

5.6 Mr Thompson expressed concern that April 2018 was not far away; he queried how all parties within WY&H HCP would move to financial balance. Dr Tolcher explained a shared credible financial plan was being developed but this would not be achieved by April 2018. She noted that at overall HCP level commissioners were in financial balance.

5.7 Mrs Schofield queried why there was an ambition to move to an Accountable Care System so quickly. Dr Tolcher explained this would provide access for WY&H to funds

and some level of devolution of authority.

ACTION: provide a briefing for the Board when the final draft Memorandum of Understanding was received, clarifying any governance implications.

5.8 Mr Ward queried any impact for the Trust following the recent government budget statement. Dr Tolcher said an additional £350m had been committed to support the NHS during winter 2017/18, the mechanism to pass this funding onto providers had not been confirmed. Mr Harrison confirmed he had prepared a number of schemes which would be proposed. It was noted capital investment in a new Child and Adolescent Mental Health Unit (CAMHS) in Leeds had been approved; this would support improved access to mental health services for young people in Harrogate.

5.9 Mr Coulter clarified that the government had linked any future pay awards to negotiated changes to Agenda for Change terms and conditions. He noted the government had clarified funding for any pay uplifts would excluded doctors and dentists, this cost would need to be met by the Trust. Dr Lyth queried whether local authority funded health services would be covered by the same promise. Dr Tolcher confirmed that she had shared this issue with national bodies, but it would remain a significant risk for the Trust.

5.10 The Board considered the Integrated Board Report (IBR), which had been circulated in advance of the meeting and was taken as read.

5.11 Mr Thompson noted Trust staff working in the community were under increasing pressure, he queried whether there was a way in which this could be captured within the IBR. It was agreed this would be considered further.

ACTION: consider the inclusion of measures demonstrating the pressures faced by community services within the IBR.

5.12 Mrs Taylor noted a 1% improvement in Delayed Transfers of Care (DTOC) during October 2017. Mr Harrison said he believed this was the result of natural variation, not a substantial improvement. He detailed actions being taken by the Trust and CCG to reduce the DTOC level further.

5.13 Mrs Webster commended the achievement of 84.7% staff appraisal rate; she said she would be interested to learn about the impact on staff. Mrs Harrison said the appraisal period had ended in September 2017, it was therefore too early to comment on the impact. However the forthcoming staff survey results would be an important method to assess the impact.

5.14 Dr Lyth noted benchmark analysis on 0 – 19 services undertaken by 56 providers, in all four localities the Trust was above in all benchmarked areas.

5.15 Mr McLean queried why the capital expenditure measure was green when capital expenditure in year was being plan.

ACTION: Mr Coulter to review the capital expenditure measure in the next monthly IBR.

APPROVAL:

The Board of Directors:

- **noted the strategic and operational updates**
- **noted progress on risks recorded in the BAF and Corporate Risk Register and confirm that progress reflects the current risk appetite.**
- **received and noted the Integrated Board Report**
- **endorsed use of the Trust's seal and agreement of a licence as detailed in the report.**

6.0 Finance Report including Financial Recovery Plan and CIP update

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

6.2 Dr Tolcher noted financial performance continued to be a high risk to the Trust, with a deficit of £5.25m reported for the year to October 2017. An in month surplus of £329k had been achieved which, while positive, fell short of the risk adjusted forecast which had been for a deficit of £5.03m. If sustained, the run rate improvement would return the Trust to a positive year end position. The Senior Management Team (SMT) had reflected on the interim financial recovery controls and agreed all should be sustained until the end of the financial year. Dr Tolcher acknowledged the hard work of staff and the impact these measures had had on teams across the Trust.

6.3 Mr Coulter drew attention to the graph on page one of his report. He noted that the Trust had made a surplus in November 2017; activity levels had been higher in October 2017 than any previous month of the financial year. In addition Cost Improvement Plans had been delivered and the Trust had been successful in reducing expenditure.

6.4 The Trust had met NHS Improvement on 28 November 2017, and provided reassurance that the Board was committed to delivering the control total by the end of the financial year. NHS Improvement had been assured that the Trust's position had improved. They had agreed the main risks would be maintaining momentum and staff engagement in the financial recovery. In addition NHS Improvement had confirmed it would not be possible to negotiable a change to the 2018/19 control total. The Board noted there would be benefits for the Trust if the control total was accepted; these would need to be considered before a decision by the Board about agreeing to the 2018/19 could be reached.

6.5 Mr Coulter reported that activity during November 2017 appeared to be £250k higher than October 2017. He noted his report provided full details of the financial recovery schemes, he highlighted two material schemes; the recruitment of an additional trauma and orthopaedic locum and the addition of a new general surgery list at Wharfedale hospital from mid-December 2017.

6.6 It was noted agency spend had reduced significantly since summer 2017, and was well below the NHS Improvement ceiling; the Trust had been identified as a good practice case study by NHS Improvement.

6.7 Mrs Webster expressed concern about the level of activity which would need to be achieved in the remaining months of the financial year, she calculated that an additional 17 day case surgeries would need to be completed per day in order to catch up activity. Mr Harrison clarified that there was a new activity profile to the year end. The data included within his report related to the original plan for 2017/18, and had not been updated to reflect the plan adjusted in light of the financial recovery action plan. He

informed the Board he expected the revised activity plan to be achieved.

6.8 Mr Coulter said the expected year end position would not be the control total, but would be £900k surplus. Mr McLean noted the proposed establishment of an Alternative Service Delivery Model (ASDM) would be a large contributor to this position and without this initiative the underlying position for the year would be a deficit of £1m. Dr Tolcher confirmed a different approach to planning had been adopted for 2018/19, this included a focus on the run rate and driving down cost without exhausting the workforce.

6.9 Dr Scullion noted the significant improvement in the financial position. He highlighted the importance of feeding this back to staff and spreading the positive message of success to maintain momentum. The Board agreed communications with staff were essential to achieving the financial recovery plan.

6.10 Mr Ward welcomed progress made during recent months to recover the Trust's financial position. Looking back on past financial years, he queried why there had often been a slow-down in performance in the early months of each financial year. Mr Coulter noted the changes to tariff income, increased costs and additional efficiency targets which took effect from April each year.

6.11 Dr Tolcher said the Trust's cash position remained a concern, with 500k cash at the end of October 2017. Mr Coulter confirmed the CCG had paid the Trust a proportion of what was owed, however £4m remained outstanding. The issue had been discussed with NHS Improvement, and plans were in place to enter contractual mediation with the CCG in December 2017.

APPROVED:
The Board of Directors noted the contents of this report.

7.0 Report from the Chief Operating Officer

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

7.2 Mr McLean sought further information about the cause of the delay in the Trust providing additional sessions at Wharfedale hospital. Mr Harrison explained the additional lists would commence from 15 December 2017. A number of issues had been resolved including aligning nursing staff into a single team, difficulties with the booking system and agreeing a payment mechanism, with incentive on both sides.

7.3 Mrs Webster queried how relevant and meaningful the CQC Insight reporting was for the Board. Mr Harrison explained these measures were high level indicators which the CQC would use to drive their Key Lines of Enquiry (KLOE) during an inspection. Mrs Foster reported that she flagged areas of concern when she met with the CQC recently. Dr Tolcher noted the insight report methodology was still evolving.

7.4 Mrs Schofield queried actions being taken to increase the percentage of staff who had received the flu jab. Mrs Harrison confirmed further vaccines would be provided in the coming week, and there would be additional all staff communications. Mr Harrison noted that although the Trust was ahead of the same period in 2016/17, it was unlikely the CQUIN target would not be achieved by February 2018. Mrs Webster noted the flu jab programme had been monitored by the Quality Committee strong assurance had been received, although there would be learning to implement next year.

APPROVED:
The Board of Directors:

- **received and noted the contents of the report.**

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

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

8.2 Jo Harrison noted key areas included within the report; an update on progress with the Workforce and Organisational Development Strategy, the successful leadership innovation fund bid (£136k) and the new master vendor model to engage temporary medical staff with Medax.

8.3 Following a question from Dr Lyth it was confirmed the leadership innovation funding would be open to hospital and community staff in Harrogate. This would include a focus on training trainers so that there would be capacity to roll out the programme further in the future.

8.4 There was a discussion about the financial recovery workforce controls. Mrs Harrison noted a significant reduction in recruitment adverts, however a quality impact assessment approach had ensured the Trust had still advertised for clinically necessary and essential posts. Mr Alldred noted the lengthy discussions at the SMT meeting, it was recognised the Trust needed workforce controls.

8.5 Following a question from Mr Thompson it was agreed Mr Marshall and Mrs Foster would provide feedback about the new placement pathway for pre-registration nursing students once the programme had become established.

ACTION: Mr Marshall and Mrs Foster to provide feedback about the placement pathway in place for pre-registration nursing students.

8.6 Mr McLean queried progress on efforts to improve recruitment and staff retention. Mrs Harrison explained a pilot scheme intended to retain acute staff had not been as successful as had been hoped. The feedback received had been analysed and resulting actions had been added to the strategy action plan, for example Mrs Foster explained that the nurse preceptorship programme had been altered to include additional support with clinical skills for new starters.

8.7 Mrs Taylor queried how the advanced clinical practitioner recruitment would be monitored to demonstrate its effectiveness. Mrs Harrison explained this was monitored as part of the clinical workforce strategy. This included examining whether key posts identified within the business case had been filled by advanced clinical practitioners.

APPROVED:
The Board of Directors:

- **Noted items included within the report.**

9.0 Report from the Chief Nurse

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

9.2 Mrs Foster highlighted activity undertaken to strengthen registered nurse recruitment and retention. She noted the Trust's current vacancy rate of 15% was concerning although it benchmarked well with others in the region. Mr McLean suggested the Trust should focus on what would make the organisation an employer of choice. Mrs Harrison highlighted a number of schemes to achieve this, however she noted there were some elements related to the working environment which could be improved, for example dedicated space for staff to take breaks.

9.3 The Board expressed their congratulations to the maternity unit for achievement of Gold Standard UNICEF Baby Friendly accreditation. Mrs Foster noted that this made Harrogate the first organisation nationally to receive the gold standard for the maternity unit and also have accreditation for the special care baby unit.

9.4 Mrs Foster drew attention to the 16% decrease in the number of formal complaints compared to the same time period in 2016/17. She proposed this may be the result of increased staff appraisal rates. Following a question from Ms Robson it was reported the response rate to formal complaints had improved, but the 95% target had not been achieved. The governance arrangements for oversight of complaints were noted by the Board.

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 reporting of Director Inspections and Patient Safety Visits**
- **Confirmed they were assured of progress toward the Trust pressure ulcer target**
- **Noted the decrease in numbers of complaints received by the Trust year to date**
- **Congratulate the team working to improve standards for mothers and babies and the excellent achievement of the Maternity Unit.**

10.0 Report from the Medical Director

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

10.2 Dr Scullion reported on a visit to the Trust by Mr Tim Briggs the national programme lead for Getting it Right First Time (GIRFT). The Trust's orthopaedic department had been highlighted as an exemplar. Mr Briggs had discussed a number of follow up actions to support the Trust in attracting a higher number of trainees to the department. Mr Harrison explained the Trust had been encouraged to bid for specialty orthopaedic work within the West Yorkshire Association of Acute Trusts (WYAAT), however he noted this would require ring fenced orthopaedic beds, which would present a challenge for the organisation.

10.3 Dr Jo McCreanor had completed a retrospective case note review in elderly medicine. The review had found no cases of severe lapses in care; none of the deaths were judged to be avoidable. Work was ongoing to consider whether patient frailty had been captured by activity coding. The Board welcomed the outcome of the review by Dr McCreanor and agreed that no external review of elderly mortality was required.

10.4 Dr Scullion noted the Higher Level Responsible Officer quality review team visit to the Trust. He explained the report of the visit made a number of recommendations; an

action plan had been developed and would be taken forward.

10.5 It was reported the Research and Development Committee had been made aware of a cardiology research study in which Harrogate patients were recruited without following appropriate research governance policies and procedures. No patient had been harmed in any way. The issue had been addressed and safety net procedures were being implemented to prevent a recurrence.

ACTION: Dr Scullion to circulate to the Board a copy of the National Audit Report "Managing the costs of clinical negligence in Trusts".

APPROVED:
The Board of Directors:

- **received and noted the report.**

11.0 Oral Reports from Directorates

11.1 Planned and Surgical Care Directorate

11.1.1 Dr Johnson reported it had been a challenging period for the maternity department; there had been four closures within the past month, in one instance a patient had been diverted as a result. The closures had been caused by a rise in delivery numbers and increased complexity of patients, including multiple births. In addition there had been gaps within the department staffing due to sickness, maternity leave and recruitment vacancies. This situation had impacted negatively on morale within the department. Mr Ward noted the Trust's strategic ambition to increase the number of births; he queried whether this would be achievable in light of these recent operational pressures. Dr Johnson explained she would present a report to the Quality Committee in January 2018 which would make a number of recommendations. Mrs Schofield noted the Board would need to discuss this topic again and receive further information about the Trust's short and long term plans for maternity services.

11.1.2 Dr Johnson noted the new Surgical Assessment Unit had been operating for four weeks; initial indications were that the unit had operated successfully.

11.2 Children's and County Wide Community Services Directorate

11.2.1 Dr Lyth informed the Board that in March 2018 North Yorkshire County Council would publish a new strategy about provision of services for children with special educational needs.

11.2.2 In December 2017 an interview would be held for a second paediatric consultant with an interest in diabetes.

11.2.3 It was noted the directorate management team capacity had been challenged due to a number of commercial tenders and staff sickness. The team had coped well, but was under pressure.

11.3 Long Term and Unscheduled Care Directorate

11.3.1 Mr Alldred reported on progress to further develop the Trust's end of life service, this had involved discussions with the CCG and input from the individual who attended the

Board in October 2017 and shared their personal story.

11.3.2 The Board noted that the Trust's community services continued to face significant pressures. In order to support the service an Operational Pressures Escalation Level (OPEL) framework had been introduced. The pressures had been caused by high levels of demand and also increased levels of staff sickness in an under-resourced service. It was noted the service had operated at OPEL level three in recent weeks. Mr Harrison explained if OPEL level four was reached the Board would be informed via the Chief Operating Officer report.

11.3.3 Mr Alldred reported the directorate had robust plans for acute services during the festive period and the first week in January 2018 when demand was expected to increase.

12.0 Committee Chair Reports

Mrs Schofield welcomed reports from the Board's committees.

12.1 Report from the Quality Committee meeting held on 1 November 2017

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

12.1.2 Mrs Webster noted that as a result of the committee effectiveness survey amendments were proposed to the membership of the Quality Committee.

APPROVED:
The Board of Directors:

- **Approved the revised Terms of Reference for the Quality Committee.**

13.0 Council of Governors minutes of the meeting held 2 August 2017

13.1 The minutes of the Council of Governors meeting on 2 August were noted by the Board.

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

14.1 It was confirmed there were no items to be reported.

15.0 Any other relevant business not included on the agenda

There was no other business.

16.0 Board Evaluation

Mrs Schofield thanked members of the Board for contributing to the meeting. She reflected the current themes were workforce and financial pressures. She said well done to the Trust's staff for maintaining standards of care in such circumstances.

Mrs Taylor said the right amount of time had been spent on each report. Dr Tolcher felt there had been good triangulation of information about pressures on the Trust.

17.0 Confidential Motion

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

The Board agreed the motion unanimously.

The meeting closed at 12.29pm.

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HDFT Board of Directors Actions Schedule
Action Log
January 2018

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
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 / Katherine Roberts, Company Secretary	December 2017	Committee self-assessment will be circulated to members in early February 2018
53	July 2017	Strategic review of the gastroenterology service to be completed and considered by the Senior Management Team. Further updates would be provided to the Board through Dr Johnson's verbal update to the Board.	Dr Kat Johnson, Clinical Director Planned and Surgical Care / Dr Ros Tolcher, Chief Executive	January 2018 (date adjusted by Board in October 2017)	.
64	October 2017	Explore trends in the Trust's catchment population at a future Board strategy day.	Dr Ros Tolcher, Chief Executive / Mrs Angela Schofield, Chairman	July 2018	
66	October 2017	Within the next SKPI report provide further detail to the Board meeting about the Trust's performance on the best practice tariff at specialty level.	Mr J Coulter, Deputy Chief Executive and Finance Director	April 2018	
72	October 2017	Review presentation and interpretation of data about nurse staffing levels included within the Chief Nurse report.	Mrs J Foster, Chief Nurse / Ms Laura Robson, Non-Executive Director	January 2018	
73	October 2017	Quality Committee to review and agree a process to monitor the quality impact of Cost Improvement Plans (CIPs).	Lesley Webster, Chair Quality Committee	January 2018	
75	November 2017	Provide a briefing for the Board when the final draft Memorandum of Understanding is received from the West Yorkshire and Harrogate Health and Social Care	Katherine Roberts, Company Secretary	TBC when MOU will be published.	Draft MOU is being discussed by the WY&H Editorial Group.

		Partnership; clarifying any governance implications.			
76	November 2017	Consider the inclusion of measures demonstrating the pressures facing by community services within the IBR.	Mr Coulter, Deputy Chief Executive and Finance Director / Mr Harrison, Chief Operating Officer	January 2017	
78	November 2017	Mr Coulter to review the capital expenditure measure in the next monthly IBR.	Mr Coulter, Deputy Chief Executive and Finance Director	January 2017	
79	November 2017	Mrs Harrison and Mrs Foster to provide feedback about the placement pathway in place for pre-registration nursing students.	Mrs Foster / Mr Marshall	March 2017	
80	November 2017	Dr Scullion to circulate to the Board a copy of the National Audit Report “Managing the costs of clinical negligence in Trusts”.	Dr Scullion, Medical Director	November 2017	**Complete**

NHS
Harrogate and District
NHS Foundation Trust

Date of Meeting:	31 January 2018	**Agenda item:**	5.0a
Report to:	Board of Directors		
Title:	Report from the Chief Executive		
Sponsoring Director:	Dr Ros Tolcher, Chief Executive		
Author(s):	Dr Ros Tolcher, Chief Executive		

Report Purpose:

Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓

Executive Summary:

- The Trust is currently experiencing a surge in demand for urgent and emergency care. Attendances in the ED are up by almost 6% and occupancy levels have been extremely high
- A strong focus on sustaining safe, responsive care continues. Performance on key quality metrics remains sound
- The Trusts performance in Quarter 3 was below the required level for 2 of the 4 key national operational performance metrics - the A&E 4-hour standard and 18 weeks performance
- The Trust has benefited from non-recurrent winter funding which has been invested in additional bed capacity and additional staffing to support diverts from the York area.
- Run rate improvements and positive progress in respect of some significant transactions means we can now demonstrate achievement of our Q3 financial plan with NHS Improvement and thus qualify for additional, backdated sustainability and transformation funding of £2.45m

Related Trust Objectives

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

Key implications	
Risk Assessment:	Strategic and operational risks are noted in section 7. Risks associated with this report are reflected in the Board Assurance Framework: BAF 14: risk to deliver of integrated models of care; BAF 15: misalignment of partner strategic plans; and BAF 9; failure to deliver the operational plan.
Legal / regulatory:	There are no legal/regulatory implications highlighted within the report.
Resource:	There are no resource implications highlighted within the report.
Impact Assessment	Not applicable.
Conflicts of Interest:	None identified.
Reference documents:	None.
Assurance:	Not applicable.

Action Required by the Board of Directors:

- The Board is requested to **note** the strategic and operational updates and in particular the continued focus on care quality and staff resilience in the face of high levels of demand

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

1.0 MATTERS RELATING TO QUALITY, PATIENT EXPERIENCE AND PERFORMANCE

1.1 Operational Performance (details contained within the Integrated Board Report)

Demand from people with urgent and emergency care needs has increased in the last two months, in common with 'winter pressures' experienced by all NHS providers nationally. At HDFT this has resulted in 5.8% more ED attendances and 12.6% more admissions from ED than in the same period last year. While such surges in demand are largely foreseeable, this year has been unusual in terms of the acuity of patients admitted. Significant numbers of people with extreme frailty and complex care and discharge needs are being admitted. The situation has been compounded by rising numbers of people extremely unwell with influenza.

At times of high demand it remains more important than ever that we retain an unwavering focus on the quality of care we provide and on support for our workforce. The safety thermometer score for December remains in line with prior months (96.96%) and above the national average. Other quality indicators are largely unchanged. The general trend of fewer avoidable pressure ulcers and a reduction in falls year to date continues. The total number of hospital acquired pressure ulcers has however increased compared to last year. There has been a slight increase in short–term sickness absence this month although the overall level of sickness is stable.

The 4 hour standard (people seen in the Emergency Department and admitted or treated and discharged within 4 hours) is often seen as a barometer of whole site performance. The attainment for December overall was 92.4% which is significantly lower than the Trusts usual level of performance. This reflects both the higher than the seasonal average attendances and the relatively high acuity of patients receiving care. To date, there is not reported evidence of any patient harm as a result of longer waits. Occupancy rates at the District Hospital site were high throughout the month. Further details are provided in the Chief Operating Officer and Chief Nurse reports.

Extensive winter planning preceded this period of predictable challenge and the Trusts *Every Hour Matters Week* contributed to sustaining safe care in the first week of January. This was extended into the second week. The trust was awarded £1.3m winter funding in December (£389,000 in respect of existing costs and £950,000 for new schemes) with an expectation that this resource will enable continued attainment of the YTD 4- hour standard in Q4 (96.34%). This welcome allocation of resources was rapidly mobilised to open up additional bed capacity (acute and post-acute) including 9 additional community rehabilitation beds in Ripon and Lascelles Unit; eight spot purchased Nursing Home beds to support rehabilitation and non-weight bearing patients and 6 escalation beds. Additional resources were also deployed in the Supportive Discharge Team.

In addition to enhanced bed capacity, an element of the allocation was earmarked for additional medical staffing and other costs in the Emergency Department and Acute Medicine to enable HDFT to offer support to neighbouring Trusts. A 999 Boundary change has been enacted to enable a 24/7 border divert from York through to March 2018.

Throughout this period colleagues across the Trust have worked tirelessly to sustain care quality and offer support between teams. During this period NHSI and NHSE issued guidance to Trusts on cancelling non-urgent elective in-patient work and the redeployment of workforce in order to sustain timely access to care. While a small number of elective in-patient procedures were cancelled by the Trust, the level of disruption for patients has been kept to an absolute minimum and day case activity has been prioritised to avoid loss of productivity.

In Quarter 3, HDFT was below the required level for 2 out of the 4 key operational performance metrics in NHS Improvement's Single Oversight Framework - the A&E 4hour standard and 18 weeks, where performance at 91.6% against the 92% standard. The summary of indicators within the IBR has been updated to reflect the year to date. This reflects this deterioration in operational KPI's as above but shows an improvement in finance and efficiency KPIs and quality KPI's sustained at the same levels as Q2.

At the time of writing, levels of demand for urgent and emergency care remain high; bed occupancy rates remain high and the number of cases of 'flu being confirmed continues to rise. The impact of this level of working on those staff affected cannot be underestimated. Continued focus on staff wellbeing and resilience during this period of heightened demand is crucial. I have received a number of letters from patients and families written at this time of high demand complementing our staff on their care and compassion. Staff are to be commended for their continued hard work and sustaining high rates of and staff resilience.

1.2 GIRFT (Getting It Right First Time) Trauma and Orthopaedics

The Trust was visited on 27 November by the national GRIFT team led by Prof Tim Briggs to discuss the HDFT GIRFT Trauma and Orthopaedics report. This was a positive meeting with many areas of excellent outcomes flagged up by the visiting team. A recommendation will be made to HEE that the Trust should be offered additional training places.

1.3 Staff and Associate Specialist (SAS) doctors leadership development

I was delighted to attend a feedback event at which eight SAS Doctors who have participated in a bespoke Trust leadership training programme presented their projects. As well as developing their leadership skills have these colleagues have all undertaken improvement projects and attained the Bronze (and in one case Silver) level accreditation as Quality of Care Champions. I was impressed by their commitment and innovation. I am grateful to Dr Natalie Lyth for leading this work in her role as Lead for SAS doctors.

2.0 FINANCIAL POSITION

2.1 Financial performance and Financial Recovery Plan (FRP)

The in-month position for December was breakeven. Activity related income was behind plan in month by £200k, ward and theatres pay was overspent by £200k but these were offset by underspends elsewhere. This performance compares with a planned deficit in month of just over £200k when our recovery plan is risk adjusted.

The cumulative impact of the Financial Recovery actions at Month 9 and progress on a number of significant transactions during the month of December mean that a number of matters can now be brought forward and accounted for appropriately. The impact of these actions has materially improved the financial position so that we can now demonstrate achievement of our Q3 financial plan with NHS Improvement and thus qualify for additional, backdated sustainability and transformation funding of £2.45m. The details of these income and expenditure benefits are set out in the Finance Report.

There remains a high level of risk within the forecast position and focusing on achieving a sustainable run rate position is essential. Work also continues to prepare a comprehensive CIP plan for 2018/19 and ensure full and robust quality impact assessment of all schemes. To date 38% of 2017/18 schemes are non-recurrent which is adding to the overall savings target for 2018/19.

2.2 Meetings with NHS Improvement

Further calls with NHSI took place on 21 December and 22 January to provide assurance on progress with the FRP. The December call focused on mitigation of ongoing risk, the forecast year end position and benefits enabled by the winter money allocation. The January call reaffirmed support for the actions in hand, and the reported Month 9 position as described above.

As part of establishing our Financial Recovery Plan we chose to invite a third party view of the Trusts planning for 2017/18. This was undertaken by NHSI in December and a letter summarising the findings of that review has now been received. The letter acknowledges the strengthening arrangements already in place and offers some helpful suggestions for further consideration. Work continues to ensure that these opportunities to strengthen our arrangements are taken up.

3.0 STRATEGIC UPDATE

3.1 West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) and West Yorkshire Association of Acute Trusts (WYAAT)

Accountable Care System development

As noted at our last Board meeting, the West Yorks and Harrogate HCP is working towards endorsement as an ACS (Accountable Care System). A Memorandum of Understanding (MoU) for the partnership, a financial strategy and a place-based approach to regulation and oversight are all essential precursors to achieving this.

It is expected that the core parties will agree to be fully bound to all of the financial, contractual and accountability commitments set out in the final MoU. Becoming and ACS would re-set the relationship with NHSI and NHSE in the form of streamlined oversight arrangements. The West Yorkshire and Harrogate ACS will neither replace nor override the authority of the Boards and governing bodies of its member organisations. Each of them remains sovereign and, local Councils remain directly accountable to their electorates. The partnership is designed to provide a mechanism for joint action and joint decision making for those issues which are best tackled on a wider scale.

A new, integrated approach to performance improvement at place level is being developed. This will include operational performance, care quality, service transformation, and finance. The approach being developed is based on a single framework, covering individual places, and WY&H as a whole with an increasing focus on making judgements about a whole place, rather than individual organisations. A new WY&H system Oversight And Assurance Group will take an overview of whole system performance, enabling partners to hold one another to account. This group will be chaired by a chief executive or accountable officer and include representation from each place and each type of organisation.

The financial strategy underpinning the ACS remains work in progress it does however include an assumption that contracting models will change so that activity, quality, costs and financial risk are managed jointly by providers and commissioners (sometimes known as an “Aligned Incentive Contract”). It also assumes a single, joint and aligned savings plan and shared ownership of a system Control Total.

It is hoped that the MoU can be signed off by the STP System Leadership Executive by March 2018 for ‘go-live’ from April. A significant amount of work is yet to be done to clarify the content of this agreement and gain a shared understanding of the underpinning financial strategy. A draft

will be made available to Board members as soon as possible for review, discussion and feedback.

3.2 Pathology Networks

Members of the Board will recall that in September 2017 the WYAAT Trusts sent a joint response to NHS Improvement setting out our common position on the proposal to establish a WY&H Pathology Network. The letter confirmed WYAAT trusts agreed with the composition of the proposed WY&H (North 2) pathology network; however the future network operating model of pathology services within WY&H would require further development.

The original letter to providers from NHS Improvement required all Trusts to confirm board agreement on either a partnership or outsourced model by the end of January. Following a fruitful workshop between WYAAT and NHS Improvement colleagues, a further joint WYAAT response will be submitted. The Trust remains in dialogue with partners locally on the preferred model and benefits realisation.

4.0 WORKING IN PARTNERSHIP

4.1 Harrogate Health Transformation Board (HHTB)

The new Provider Collaborative Group met on 22 December for the first time. There is an explicit willingness to both cooperate and wherever possible collaborate in order to deliver an optimal service locally within the available resources. It is widely recognised that current levels of investment in out of hospital care do not provide for the perceived level of need and a balanced approach to risk management and prioritisation is required. Two 'keep/change' workshops are being held this month to bring partners together and agree which interventions are most valuable to our 'place' and therefore should become part of the collective community service 'offer' during 2018/19. A provider led Design and Delivery Group will coordinate the collaborative approach and oversee operational delivery.

5.0 SENIOR MANAGEMENT TEAM (SMT) MEETING

The SMT met on 12 December 2017. The following key areas are for noting:

- Financial performance was discussed. The in-month trading position was breakeven which was disappointing in the light of positive progress on income. Excess spending on ward pay and non-pay was explored and tighter controls agreed.
- Pressures in adult community services were discussed. High rates of sickness and maternity leave are adversely impacting on capacity with gaps largely being covered by existing staff working additional hours. Staff are concerned about potential risks however to date there has been no change in the number of incidents or near-miss events reported.

SMT met on 24 January. The following areas are for noting:

- Noted the executive directors decision to continue to pay Living Wage top ups to eligible employees.
- Noted that the Learning from Patient Experience group received assurance from each directorate that the Quality of Care Team meetings are taking place effectively across all directorates
- Noted the positive impact of introducing same-day 'flu testing
- Reviewed and agreed the timeline and approach to the Annual Quality Account development
- Welcomed the positive improvement in run rate and the significant transactions accounted for within the M9 financial position leading to attainment of the Q3 plan and therefore success in securing STF funding.

- Considered feedback from staff in respect of the Wholly Owned Subsidiary, and representations from Trade Unions.
- Noted that, at 91.6% compliance we have for the first time ever failed to meet the national 18 week RRT standard in December. Actions to recover this position (ophthalmology and orthopaedics) are being progressed.
- Noted that a Job Planning Consistency panel is being established.
- Discussed the feedback received from NHSDI following their invited review of planning.

6.0 COMMUNICATIONS RECEIVED AND ACTED UPON OR TO NOTE

6.1 *BREXIT right to remain*

The Home Secretary wrote to NHS Chief Executives in December 2017 following agreement at the European Council for negotiations between the UK and the EU to move to a discussion about the future relationship. The letter reaffirmed that EU citizens living lawfully here before the UK's exit from the EU will be able to stay. The deal will respect the rights that individuals are exercising and the benefits they currently have. It will not only enable families who have built their lives in the EU and UK to stay together, it also gives certainty about healthcare, pensions and other benefits.

This is good news for the EU citizens working in the NHS and for its many contractors and suppliers. We all as NHS colleagues and patients rely heavily on their knowledge, skills and compassion. They have always made, and now will continue to make, a huge positive impact on this country's healthcare services.

6.2 Winter planning- NEPP recommendation on electives

In January 2018 I received a letter from Pauline Philip (National Urgent and Emergency Care Director, NHS England) to make the Trust aware of guidance that the National Emergency Pressures Panel had issued regarding reviewing elective activity to deal with non-elective pressures ensure NHS resources are directed to the sickest patients. The Trust were asked to review elective plans to consider if it would be possible to free up further capacity to support non-elective care. The Trust has taken appropriate action to manage elective care during 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. Seven risks are currently assessed as having achieved their target risk score. During the month BAF#4; *Risk of a lack of integrated IT structure* was closed and removed from the Board Assurance Framework

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 1*	
BAF 2	Risk of a high level of frailty in the local population	*Amber 8 ↔*	*Unchanged at 1*	✓
BAF 3	Risk of a failure to learn from feedback and Incidents	*Amber 9 ↔*	*Improvement to 1*	

BAF 5	Risk of maintaining service sustainability	*Amber 9 ↔*	*Unchanged at 1*	
BAF 9	Risk of a failure to deliver the Operational Plan	*Red 12 ↓*	*Unchanged at 2*	
BAF 10	Risk of breaching the terms of the Trust's Licence to operate	*Yellow 5 ↔*	*Unchanged at 1*	✓
BAF 12	Risk of external funding constraints	*Red 12 ↔*	*Unchanged at 1*	✓
BAF 13	Risk of a reduced focus on quality	*Yellow 4 ↔*	*Unchanged at 1*	✓
BAF 14	Risk of delivery of integrated models of care	*Red 12 ↔*	*Unchanged at 1*	
BAF 15	Risk of misalignment of strategic plans	*Amber 8 ↓*	*Unchanged at 2*	✓ *(Jan 2018)*
BAF 16	Risk that the Trust's critical infrastructure is not fit for purpose	*Amber 8 ↔*	*Unchanged at 1*	✓
BAF 17	Risk to senior leadership capacity	*Yellow 6 ↓*	*Unchanged at 1*	✓ *(Jan 2018)*

7.2 Corporate Risk Register (CRR)

The CRR was reviewed at the monthly meeting of the Corporate Risk Review Group on 12 January 2018. The Corporate Risk Register contains 10 risks.

Corporate Risk Register Summary

Ref	Description	Current risk score	Risk movement	Current progress score	Notes
CR2	Risk to the quality of service delivery in Medicine due to gaps in rotas following the Deanery allocation process	12	↔	*2*	
CR5	Risk to service delivery due gaps in registered nurses establishment	16	↔	*2*	
CR12	Risk to financial sustainability from failure to deliver the Clinical Transformation Programme at pace and scale	12	↔	*1*	
CR13	Risk to urgent care system due to a lack of capacity in the out of hospital services	12	↔	*2*	
CR14	Risk of financial deficit and impact on service delivery due to failure to deliver the Trust annual plan by having excess expenditure or a shortfall in income.	16	↔	*2*	
CR17a	Risk of patient harm as a result of being lost to follow-up as a result of current processes	12	↔	*2*	
CR17b	Risk of patient harm as a result of being lost to follow up as a result of historic processes	12	↔	*3*	
CR18	Risk to provision of service and not achieving national standards in cardiology due to potential for lab equipment breaking down	12	↔	*2*	
CR24	Risk to patient safety, quality, experience, reputation, staff wellbeing and and associated effect on timely discharge from the reduction to baseline (2011) funding capacity	15	↔	*2*	*Target Risk increaed to 9 with a target date of April 2018*
CR25	Risk to quality of care due to lack of capcity in the acute and community services to meet anticipated increased demand during winter months	12	↔	*2*	*Number of mitigating actions moved to controls. New mitigating actions added*

Progress key

1 = fully on plan across all actions

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

3 = actions defined - work started but behind plan

4 = actions defined but largely behind plan

5 = actions not yet fully defined

Risks added to the corporate risk register
None

Risks removed from corporate risk register
None

Risks with amended target dates or target scores
CR24 - Risk to patient safety, quality, experience, reputation, staff wellbeing and associated effect on timely discharge from the reduction to baseline (2011) funding capacity.
Target Score: C3 x L3 = 9
Target date: April 2018.

8.0 DOCUMENTS SIGNED AND SEALED

The following documents have been signed during the month:

- Litigation funding deed between the Trust and GVA regarding mandatory business rates relief.
- Five year renewal of lease with WH Smiths.
- Revised litigation funding deed between the Trust and GVA regarding mandatory business rates relief; revised due to a change in the other NHS parties included.

Dr Ros Tolcher
Chief Executive
January 2018

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Date of Meeting:	31st January 2018	**Agenda item:**	5.0b
Report to:	Board of Directors		
Title:	Integrated Board Report		
Sponsoring Director:	Dr Ros Tolcher, Chief Executive		
Author(s):	Ms Rachel McDonald, Head of Performance & Analysis		

Report Purpose:

Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓

Executive Summary:

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

- The financial position is that the Trust is now on plan as at the end of Quarter 3. This is as a result of bringing forward a number of recovery plan schemes, in particular relating to the creation of a wholly owned subsidiary.
- The Trust experienced significant winter pressures during December. Performance against the 4 hour A&E standard was 92.4%, below the required 95%. Despite the operational pressures, the number of incidents reported and the number of inpatient falls both reduced when compared to last month.
- In Quarter 3, HDFT was below the required level for 2 out of the 4 key operational performance metrics in NHS Improvement's Single Oversight Framework - the A&E 4-hour standard and 18 weeks, where performance at 91.6% against the 92% standard.
- Elective and outpatient activity remained behind plan in December, although the position improved for elective admissions when compared to last month.
- All cancer waiting times standards were achieved for Quarter 3.

Related Trust Objectives

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

Key implications

Risk Assessment:

Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF 4: risk of a lack of interoperable systems across New Care Models partners; BAF 9: risk of a failure to deliver the operational plan; BAF 10: risk of a breach of the terms of the NHS Provider licence; BAF 16: risk to delivery of

	integrated care models.
Legal / regulatory:	None identified.
Resource:	Not applicable.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.
Reference documents:	None.
Assurance:	Report reviewed monthly at Senior Management Team in Operational Delivery Group.
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 - December 2017

Key points this month

1. The financial position is that the Trust is now on plan as at the end of Quarter 3. This is as a result of bringing forward a number of recovery plan schemes, in particular relating to the creation of a wholly owned subsidiary.

2. The Trust experienced significant winter pressures during December. Performance against the 4 hour A&E standard was 92.4%, below the required 95%. Despite the operational pressures, the number of incidents reported and the number of inpatient falls both reduced when compared to last month.

2. In Quarter 3, HDFT was below the required level for 2 out of the 4 key operational performance metrics in NHS Improvement's Single Oversight Framework - the A&E 4-hour standard and 18 weeks, where performance at 91.6% against the 92% standard.

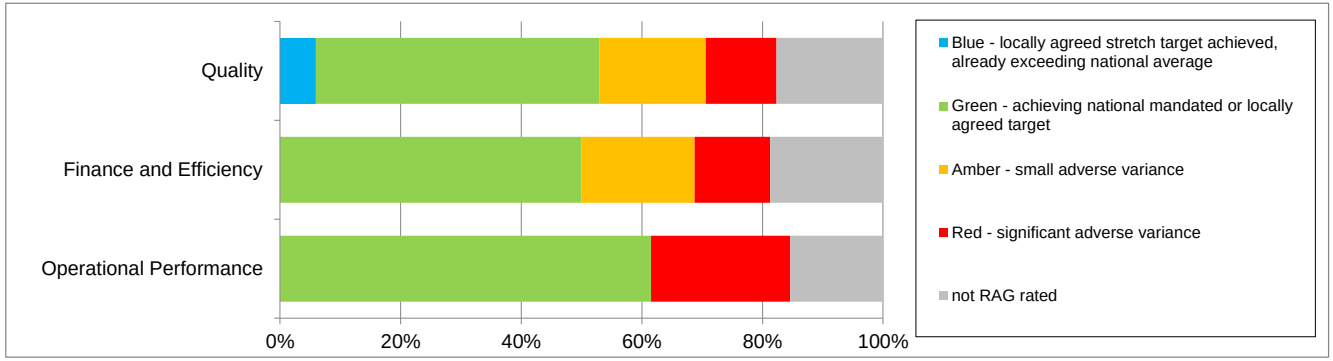
3. Elective and outpatient activity remained behind plan in December, although the position improved for elective admissions when compared to last month.

4. All cancer waiting times standards were achieved for Quarter 3.

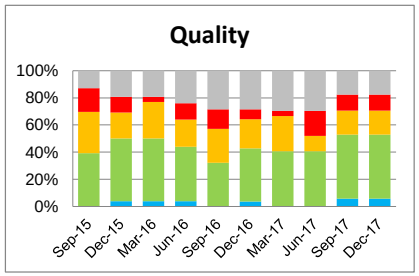
5. HDFT's average elective length of stay reduced to 2.0 days. This is a further decrease on previous months and places HDFT in the top 25% of Trusts nationally for the first time.

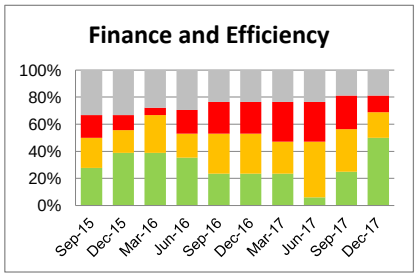
6. The new theatre utilisation dashboard was launched in December and the data presented in this report has been aligned to this.

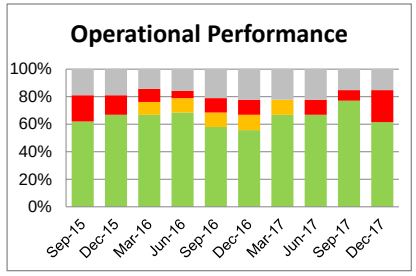
Summary of indicators - current month



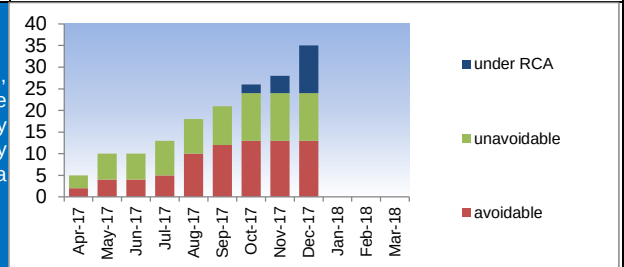
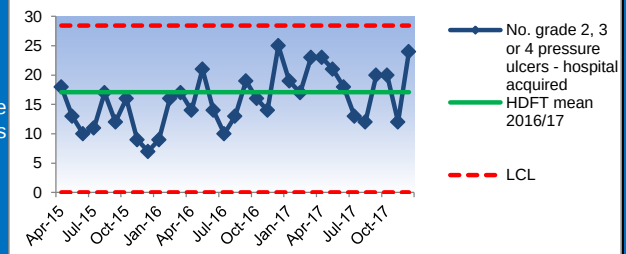
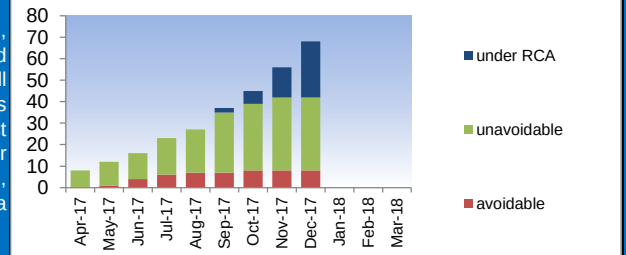
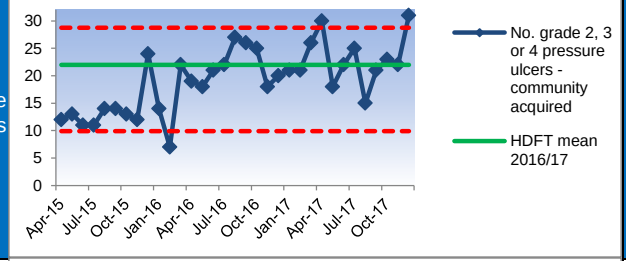
Summary of indicators - recent trends





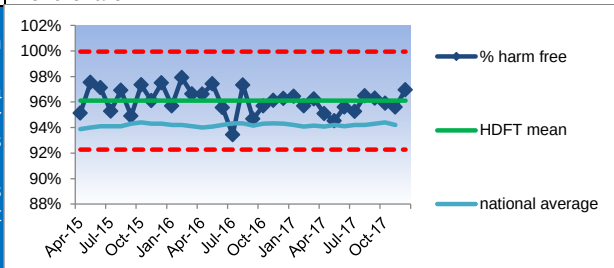
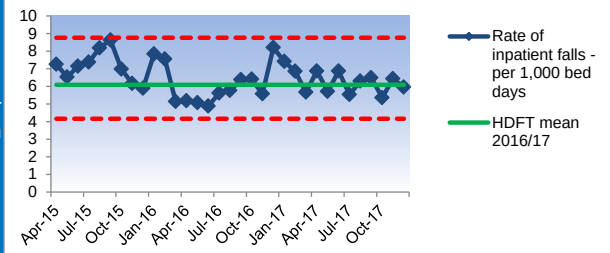
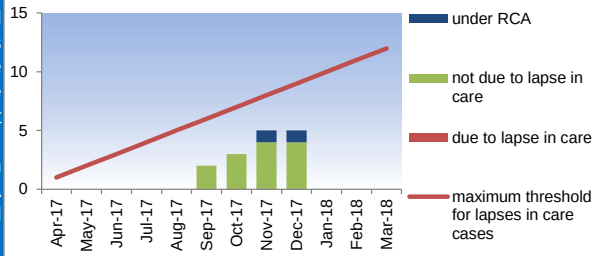
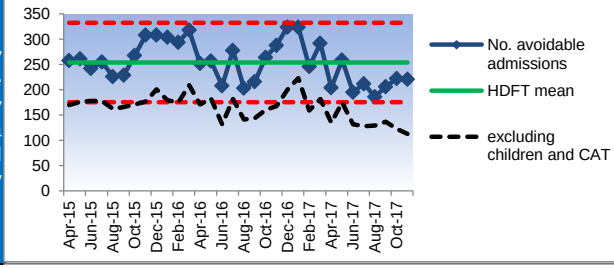


Quality - December 2017

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 7 hospital acquired unstageable or category 3 pressure ulcers reported in December, with the year to date total now at 35. Of these, 11 are still under root cause analysis (RCA), 13 have been assessed as avoidable and 11 as unavoidable. No category 4 hospital acquired pressure ulcers have been reported in 2017/18 to date. 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 December was 24, a significant increase on last month.
✓ **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 12 community acquired category 3, category 4 (or unstageable) pressure ulcers reported in December. This brings the year to date total to 68. Of these, 26 are still under root cause analysis (RCA), 8 have been assessed as avoidable and 34 as unavoidable. 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 December was 31 cases, compared to 20 last month.

Quality - December 2017

Harrogate and District NHS Foundation Trust

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Safety Thermometer - harm free care	Measures the percentage of patients receiving harm free care (defined as the absence of pressure ulcers, harm from a fall, urine infection in patients with a catheter and new VTE) in the Safety Thermometer audits conducted once a month. The data includes hospital and community teams. A high score is good. Whilst there is no nationally defined target for this measure, a score of 95% or above is considered best practice.		The provisional harm free percentage for December was 96.96%, remaining above the latest national average. However one ward did not complete the audit in time for the Decemeber submission deadline. We will be able to include their data in next month's submission and will provide an update on the confirmed December position in next month's integrated board report.
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 5.95 per 1,000 bed days in December, a decrease on last month and in line with the average HDFT rate for 2016/17. There were no falls causing moderate harm in December (1 last month). In 2016/17, 697 inpatient falls were reported (including those not causing harm), a 14% reduction on the number of inpatient falls reported in the previous year.
Infection control	The chart shows the cumulative number of hospital apportioned C. difficile cases during 2017/18. HDFT's C. difficile trajectory for 2017/18 is 12 cases, no change on last year's trajectory. Cases where a lapse in care has been deemed to have occurred would count towards this. Hospital apportioned MRSA cases will be reported on an exception basis. HDFT has a trajectory of 0 MRSA cases for 2017/18. The last reported case of hospital acquired MRSA at HDFT was in Oct-12.		There were no cases of hospital apportioned C. difficile reported in December with the year to date total remaining at 5 at the end of December. 4 of the 5 cases have had root cause analysis completed and agreed with HARD CCG. The outcome on all 4 cases was that no lapse of care had occurred. 1 case has not yet had root cause analysis completed. No hospital apportioned MRSA cases have been reported in 2017/18 to date.
Avoidable admissions	The chart shows the number of avoidable emergency admissions to HDFT as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require a hospital admission. Conditions include pneumonia and urinary tract infections in adults and respiratory conditions in children.		There were 221 avoidable admissions in November, no change on last month. This metric is seasonal with less avoidable admissions in the summer compared to the winter months. This month's figure is significantly below the level reported in November last year (288). Adult admissions (excluding CAT attendances) decreased this month and remain at the lowest level since this metric was introduced in 2014.

Quality - December 2017

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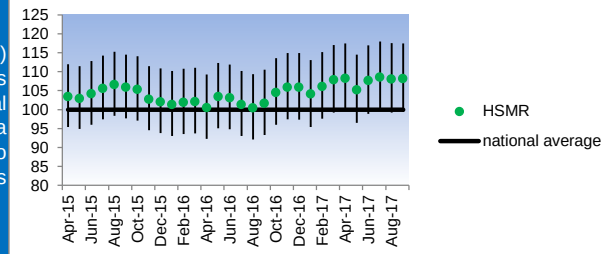
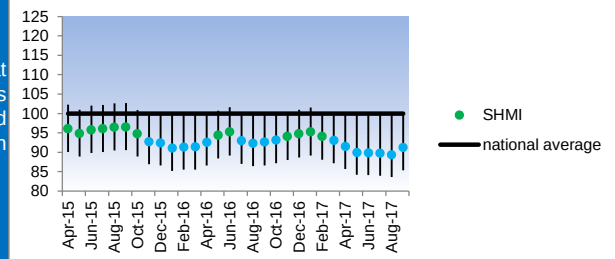
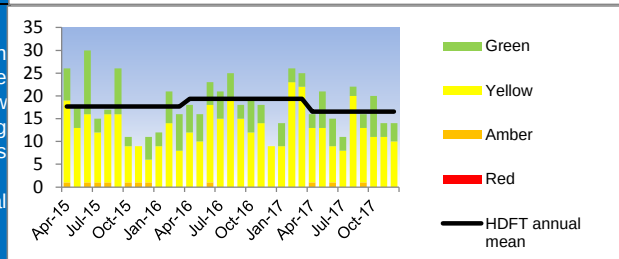
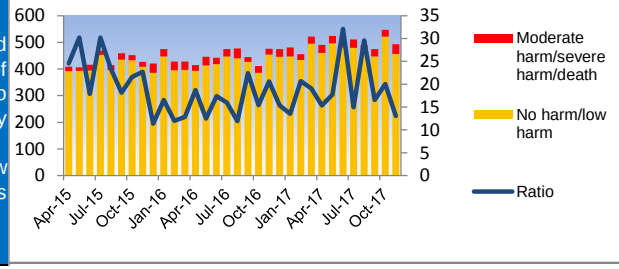
Indicator name / data quality assessment	Description	Trend chart	Interpretation
Mortality - HSMR ✓	The Hospital Standardised Mortality Ratio (HSMR) looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care. A low figure is good.		The latest HSMR data on HED includes the period to end October 2017 but reflective of the data position as at mid-November when the Trust was only partly coded for the month of October. As detailed in last month's report, we will therefore report the HSMR a month in arrears with the HED publications to ensure that it reflects a fully coded position for HDFT. HDFT's HSMR for the rolling 12 months ending September 2017 was 108.1, remaining within expected levels. At specialty level, one specialty continues to have a higher than expected standardised mortaolity rate (Geriatric Medicine)
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 increased to 91.3 for the rolling 12 months ending September 2017 but remains below expected levels. At specialty level, three specialties (Gastroenterology, Geriatric Medicine and one small volume surgical specialty) have a standardised mortality rate above expected levels. The small volume surgical specialty is flagged due to the death of a patient within 30 days of an elective admission at HDFT. This does not mean however that their death was related to their previous elective admission.
Complaints ✓	The number of complaints received by the Trust, shown by month of receipt of complaint. The criteria define the severity/grading of the complaint with green and yellow signifying less serious issues, amber signifying potentially significant issues and red for complaints related to serious adverse incidents. The data includes complaints relating to both hospital and community services.		14 complaints were received in December, no change on last month, with no complaints classified as amber or red this month. Of particular note in December 2017, there has been an increase in complaints about communication & attitude.
Incidents - all ✓	The chart shows the number of incidents reported within the Trust each month. It includes all categories of incidents, including those that were categorised as "no harm". The data includes hospital and community services. A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture		The latest published national data (for the period Oct-16 to Mar-17) shows that Acute Trusts reported an average ratio of 39 no harm/low harm incidents for each incident classified as moderate harm, severe harm or death (a high ratio is better). HDFT's ratio was 22, an improvement on the last publication but remaining in the bottom 25% of Trusts 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.

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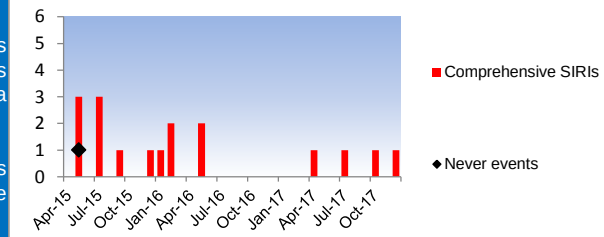
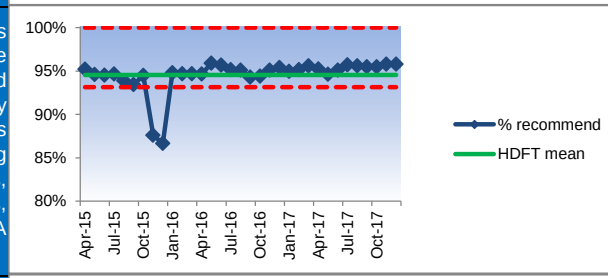
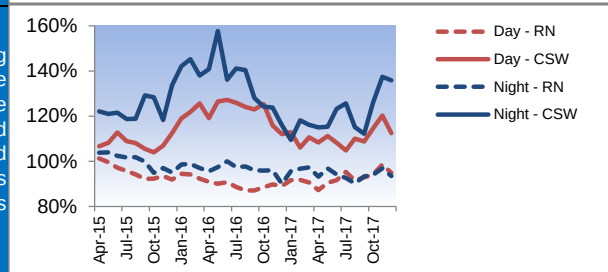
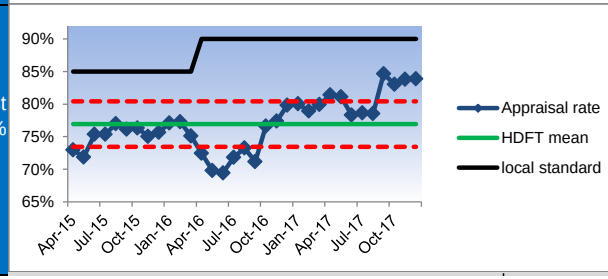
Indicator name / data quality assessment	Description	Trend chart	Interpretation
Incidents - SIRIs and never events ✓	The chart shows the number of Serious Incidents Requiring Investigation (SIRIs) and Never Events reported within the Trust each month. The data includes hospital and community services. Only comprehensive SIRIs are included in this indicator, as concise SIRIs are reported within the presure ulcer / falls indicators above.		There was 1 comprehensive SIRI and no Never Events reported in December. In 2017/18 to date, there have been 4 comprehensive SIRIs and no Never Events reported.
Friends & Family Test (FFT) - Patients ✓	The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of hospital and community services including inpatients, day cases, outpatients, maternity services, the emergency department, some therapy services, district nursing, community podiatry and GP OOH. A high percentage is good.		95.8% of patients surveyed in December would recommend our services, in line with recent months and remaining above the latest published national average (94%). Around 4,500 patients responded to the survey this month, an increase on last month. We continue to review the automated phone call survey process to maximise the number of patients being given the opportunity to participate.
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 104% in December, a decrease on last month (108%) but remaining above 100%. Care Support Worker staffing remains high compared to plan - this is reflective of the increased need for 1-1 care. Whilst safer staffing levels for registered nurses remains below 100%, the staffing level achieved still enables the delivery of safe care. Achieving safe staffing levels remains challenging and requires the increasing use of temporary staff through the nurse bank and agencies.
Staff appraisal rates ✓	The chart shows the staff appraisal rate over the most recent rolling 12 months. The Trusts aims to have 90% of staff appraised. A high percentage is good.		The Trust appraisal rates remains static at 83% compliance. The next appraisal period will start in April 2018 for 6 months as recommended by the Workforce and Organisational Development Steering group and ratified by Senior Management Team.

Quality - December 2017

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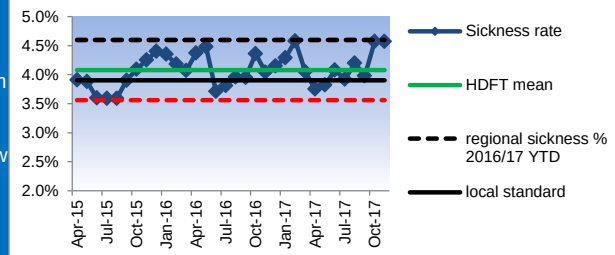
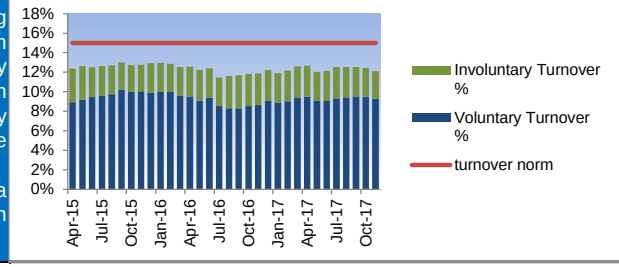
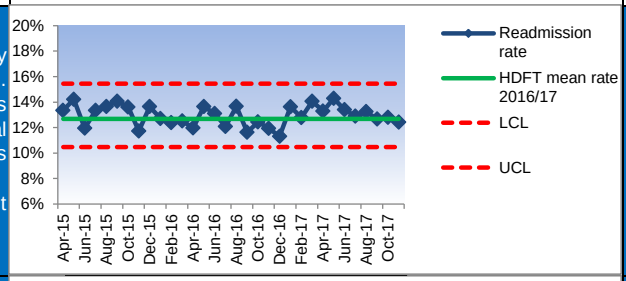
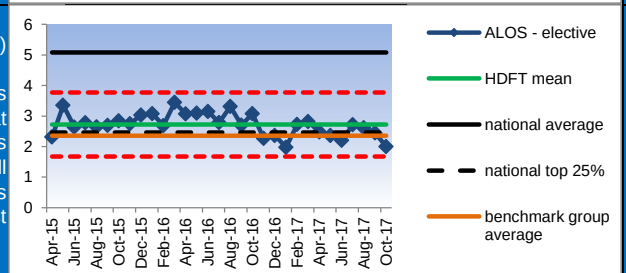
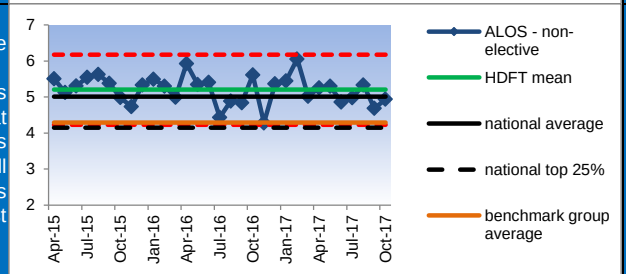
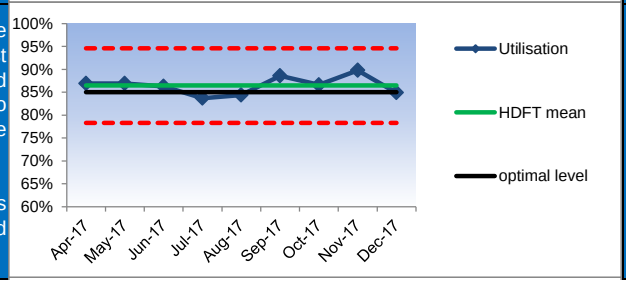
Indicator name / data quality assessment	Description	Trend chart	Interpretation
Mandatory training rates ✓	The table shows the most recent training rates for all mandatory elements for substantive staff.	See table below	The data shown is for the end of December and includes the staff who were TUPE transferred into the organisation in April 2016. The overall training rate for mandatory elements for substantive staff is 86%. 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. The Trust has set a threshold of 3.9%. A low percentage is good.		The overall sickness absence rate across the Trust for November is 4.57%. This compares to 4.04% in the same month last year. The hotspot areas continue with plans in place for all long term absences. In November, 43 long term sick cases were closed, with 40 returning to work. The Trust is currently commissioning a personal resilience programme to commence in April 2018 with the aim of addressing absences due to stress, anxiety and depression.
Staff turnover rate ✓	The chart shows the staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. The turnover figures include both voluntary and involuntary turnover. Voluntary turnover is when an employee chooses to leave the Trust and involuntary turnover is when the employee unwillingly leaves the Trust. Data from the Times Top 100 Employers indicated a turnover rate norm of 15%, i.e. the level at which organisations should be concerned.		Turnover remains static at 12%. Information is currently being gathered following the NHS Improvement retention masterclass that was attended in November. This information will then be presented to the Recruitment and Retention Group to support the development of the strategy for the year ahead.

Competence Name	% Completed
Equality, Diversity and Human Rights - Level 1	90
Fire Safety Awareness	70
Infection Prevention & Control (Including Hand Hygiene) 1	100
Infection Prevention & Control (Including Hand Hygiene) 2	77
Data Security Awareness	77
Prevent Basic Awareness (December 2015)	99
Safeguarding Adults Awareness Elearning (Dec 2015)	94
Safeguarding Children & Young People Level 1 - Introduction	93

Finance and Efficiency - December 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 November when expressed as a percentage of all emergency admissions and is now just below the HDFT average rate for 2016/17. It is critical to continue to monitor this metric during the winter period to ensure that there is no adverse impact from initiatives to reduce bed occupancy.
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.		HDFT's average elective length of stay for October (the most recent month for which we have benchmarking data) was 2.0 days. This is a further decrease on previous months and places HDFT in the top 25% of Trusts nationally for the first time.
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.		HDFT's average non-elective length of stay for October (the most recent month for which we have benchmarking data) was 5.0 days. This is an increase on last month remaining above the benchmark group average but below the national average.
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. A higher utilisation rate is good as it demonstrates effective use of resources. A utilisation rate of around 85% is often viewed as optimal.		This metric has been aligned with the new theatre utilisation dashboard this month. The new dashboard was launched in December and presents a more sophisticated analysis of theatre utilisation which takes into acount any downtime between patients, as well as looking at the start and end times of each session. Using the new metric, theatre utilisation of elective sessions was at 84.9% in December. This is a reduction on last month and just below the 85% optimal level. Further metrics from the new dashboard are being considered for inclusion in this report from April.

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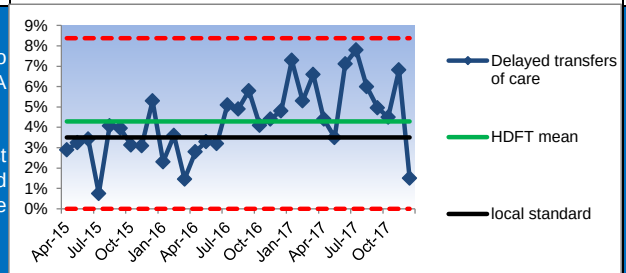
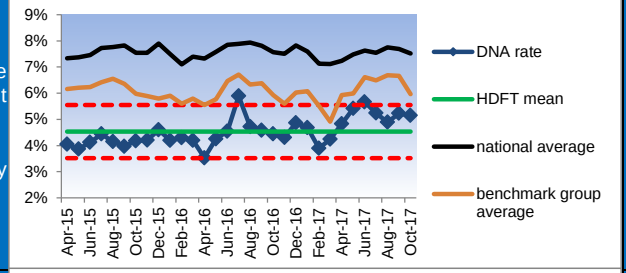
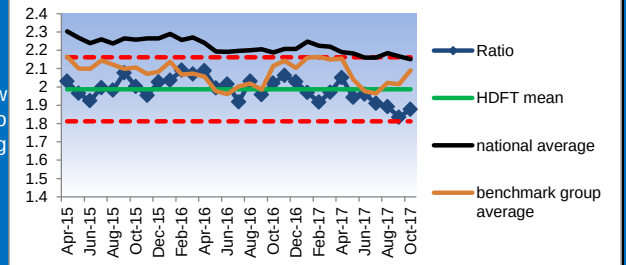
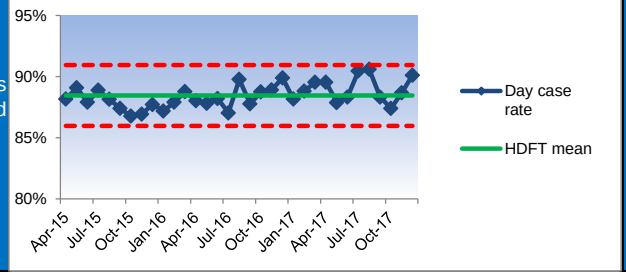
Indicator name / data quality assessment	Description	Trend chart	Interpretation
Delayed transfers of care ✓	The proportion of patients in acute hospital beds who are medically fit for discharge but are still in hospital. A low rate is preferable. A snapshot position is taken at midnight on the last Thursday of each month. The maximum threshold shown on the chart (3.5%) has been agreed with the CCG.		Delayed transfers of care reduced to 1.5% when the snapshot was taken in December. This is a significant reduction on recent months but is reflective of the snapshot being taken over the Christmas period when occupancy in the hospital was significantly reduced. The average number of delayed transfers reported per day during December was 14, which equates to around 5% of occupied beds. The number of delayed patients remains a significant concern and this figure has increased in the first half of January.
Outpatient DNA rate ✓	Percentage of new outpatient attendances where the patient does not attend their appointment, without notifying the trust in advance. A low percentage is good. Patient DNAs will usually result in an unused clinic slot.		HDFT's DNA rate decreased to 5.2% in October and remains below that of both the benchmarked group of trusts and the national average. The Clinical Directorates have been asked via Operational Delivery Group to review the application of the patient acess policy in relation to DNAs to identify what actions they can take to reduce this rate and mitigate lost clinic slots due to this issue.
Outpatient new to follow up ratio ✓	The number of follow-up appointments per new appointment. A lower ratio is preferable. A high ratio could indicate that unnecessary follow ups are taking place.		Reducing the number of follow ups is a major part of HARD CCG's financial recovery plan. HDFT's new to follow up ratio was 1.88 in October, remaining below both the historical average for HDFT and also below both the national and benchmark group average. As part of the financial recovery plan, outpatient clinic templates are being adjusted to increase the number of new slots where changes can be made to reduce the number of patients being booked for follow up. It remains essential that the Clinical Directorate teams monitor the waiting times for patients booked for follow up to ensure that they receive timely care where they do need to return.
Day case rate ✓	The proportion of elective (waiting list) procedures carried out as a day case procedure, i.e. the patient did not stay overnight. A higher day case rate is preferable.		The day case rate increased to 90.1% in December. This is in line with expectations, with reduced elective inpatients during the Christmas period and increased day case activity.

Finance and Efficiency - December 2017

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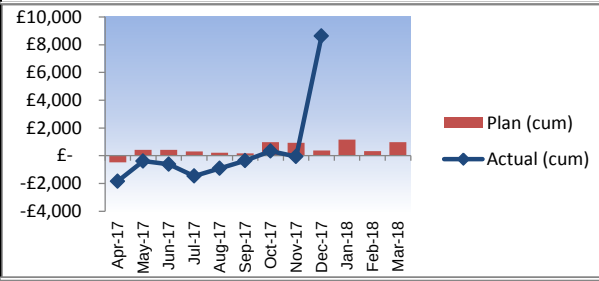
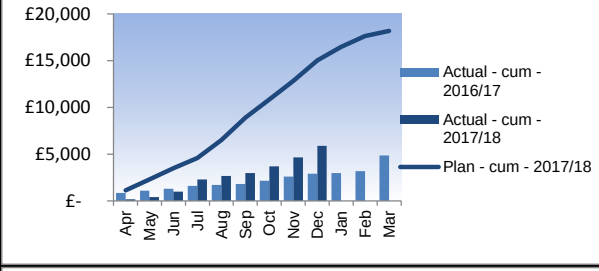
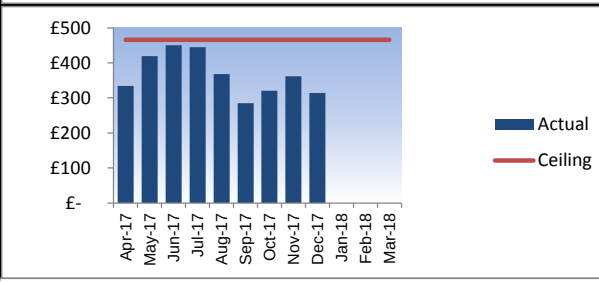
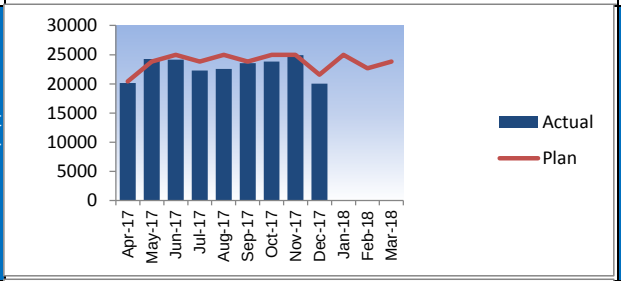
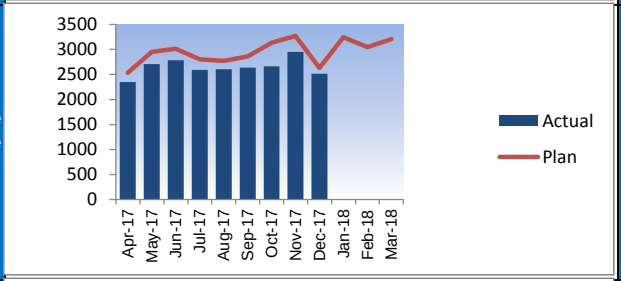
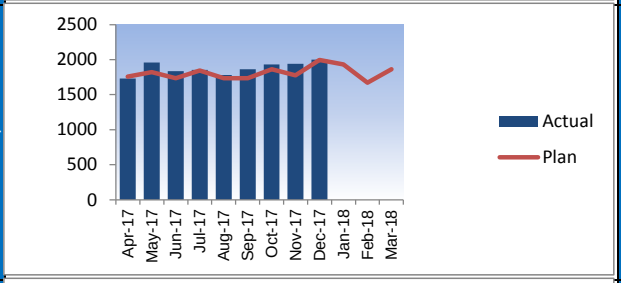
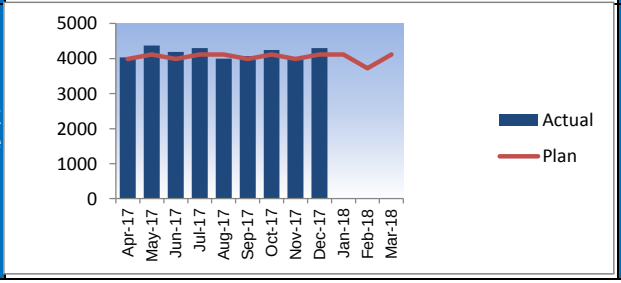
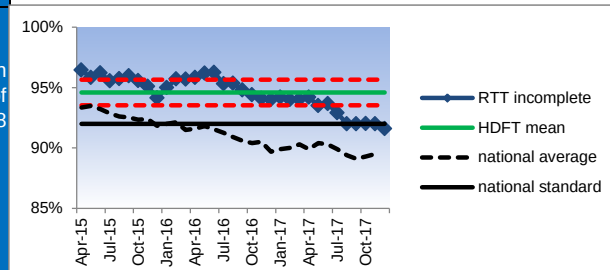
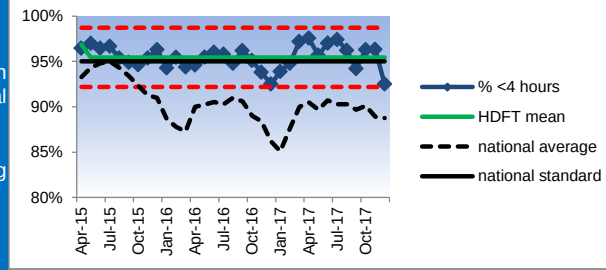
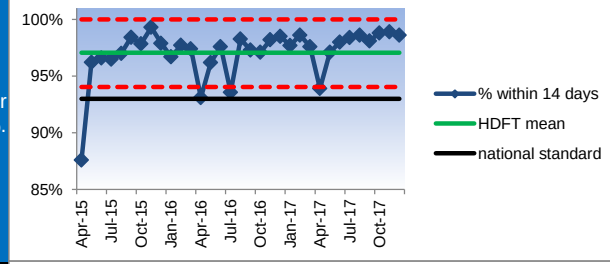
Indicator name / data quality assessment	Description	Trend chart	Interpretation
Surplus / deficit and variance to plan	Monthly Surplus/Deficit (£'000s). In some months, a deficit is planned for. This indicator reports positive or adverse variance against the planned position for the month.		The financial position is that the Trust is now on plan as at the end of Quarter 3. This is as a result of bringing forward a number of recovery plan schemes, in particular relating to the creation of a wholly owned subsidiary. We have also received some winter funding allocation. By achieving the plan, the Trust also qualifies for backdated S&T funding of £2.45m.
NHS Improvement Single Oversight Framework - Use of Resource Metric	From 1st October 2016, NHS Improvement introduced the Single Oversight Framework. As part of this this, Use of Resource Metric was introduced to replace the previous Financial Sustainability Risk Rating. This is the product of five elements which are rated between 1 (best) to 4.	**Element** / **Plan** / **Actual** Capital Service Cover: 1 / 1 Liquidity: 1 / 1 I&E Margin: 1 / 1 I&E Variance From Plan: 1 / 1 Agency: 1 / 1 **Financial Sustainability Risk Rating: 1 / 1**	The Trust will report a rating of 1 for December. This is on plan and is a result of the improvement in the I&E in month.
Capital spend	Cumulative Capital Expenditure by month (£'000s)		Capital expenditure is behind plan, however, it is anticipated that expenditure will increase to planned levels as the year progresses.
Agency spend in relation to pay spend	Expenditure in relation to Agency staff on a monthly basis as a percentage of total pay bill. The Trust aims to have less than 3% of the total pay bill on agency staff.		Year to date agency expenditure is 2.82% of total employee expenses. This is a slight improvement from November and it is anticipated that this position will further improve with the introduction of the direct engagement model for medical staffing.

Finance and Efficiency - December 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Outpatient activity against plan ✓	The chart shows the position against plan for outpatient activity. The data includes all outpatient attendances - new and follow-up, consultant and non-consultant led.		Outpatient activity was 7.0% below plan in the month of December and 3.6% below plan year to date. This is a deterioration on last month's position.
Elective activity against plan ✓	The chart shows the position against plan for elective activity. The data includes inpatient and day case elective admissions.		Elective activity was 4.4% below plan in the month of December and 8.4% below plan year to date. This is an improvement on last month's position.
Non-elective activity against plan ✓	The chart shows the position against plan for non-elective activity (emergency admissions).		Non-elective activity was 0.1% above plan in the month of December and 3.8% above plan year to date.
A&E activity against plan ✓	The chart shows the position against plan for A&E attendances at Harrogate Emergency Department. The data excludes planned follow-up attendances at A&E.		A&E attendances were 4.3% above plan in the month of December and 2.6% above plan year to date.

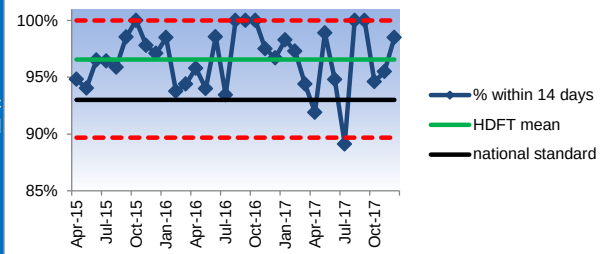
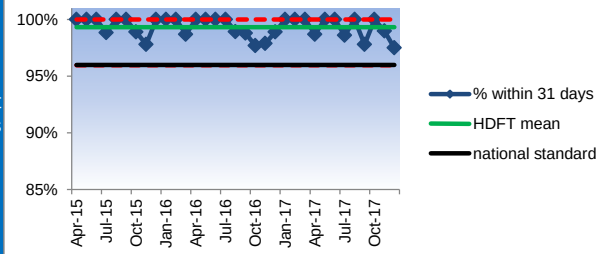
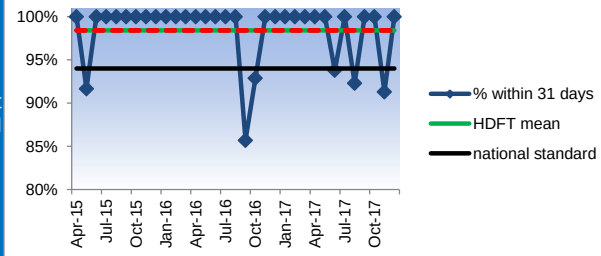
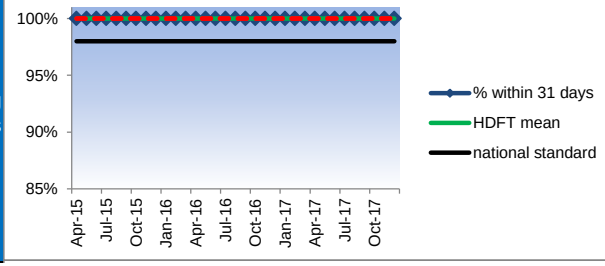
Operational Performance - December 2017

Indicator name / data quality assessment	Description	Trend chart	Interpretation
NHS Improvement Single Oversight Framework ✓	From October 2016, NHS Improvement use a variety of information to assess a Trust's governance risk rating, including CQC information, access and outcomes metrics, third party reports and quality governance metrics. The table to the right shows how the Trust is performing against the national performance standards in the "operational performance metrics" section.		In Quarter 3, HDFT's performance was below the required level for 2 of the 4 key operational performance metrics - the A&E 4-hour standard and 18 weeks performance, as detailed below.
RTT Incomplete pathways performance ✓	Percentage of incomplete pathways waiting less than 18 weeks. The national standard is that 92% of incomplete pathways should be waiting less than 18 weeks. A high percentage is good.		Performance was at 91.6% in December, below the minimum standard of 92%. At specialty level, Trauma & Orthopaedics and Ophthalmology remain below the 92% standard. Work continues around the financial recovery plans which should start to impact on the orthopaedic and ophthalmology position. Options are also being considered for additional capacity to reduce the longest waiters and directorates have been asked to focus on ensuring non-admitted pathways are reviewed.
A&E 4 hour standard ✓	Percentage of patients spending less than 4 hours in Accident & Emergency (A&E). The operational standard is 95%. The data includes all A&E Departments, including Minor Injury Units (MIUs). A high percentage is good.		HDFT's Trust level performance for December was 92.4%, a significant deterioration on last month and below the required 95% standard. This includes data for the Emergency Department at Harrogate and Ripon MIU. From this month in line with the agreed WYAAT approach, HDFT has started to report type 2 A&E attendances based on the cohorts of patients who would have previously attended A&E but now access other urgent care services directly. Performance for Harrogate ED was at 90.5%. The lowest performance reported on any one day was 82.8%. However no patients have been identified as coming to harm as a result of this.
Cancer - 14 days maximum wait from urgent GP referral for suspected cancer referrals ✓	Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%. A high percentage is good.		Delivery at expected levels.

Standard	Q1	Q2	Q3	Q4	YTD
RTT incomplete pathways	93.8%	92.3%	91.9%		92.6%
A&E 4-hour standard	96.7%	96.0%	94.9%		95.9%
Cancer - 62 days	86.1%	88.9%	90.7%		88.6%
Diagnostic waits	99.8%	99.6%	99.7%		99.7%

Operational Performance - December 2017

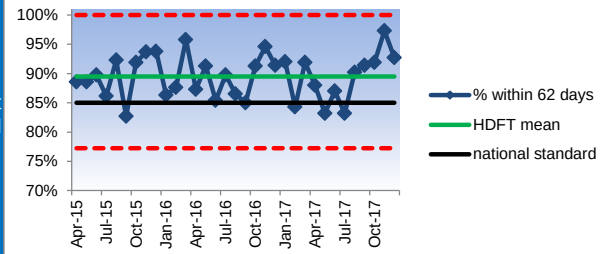
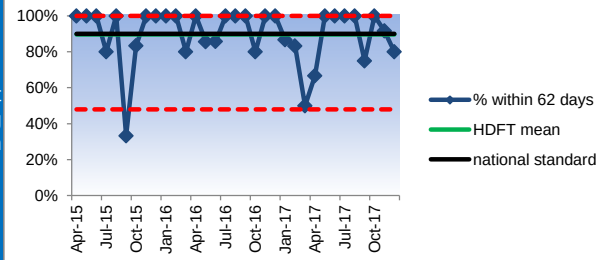
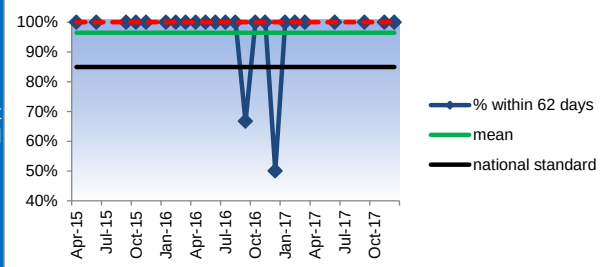
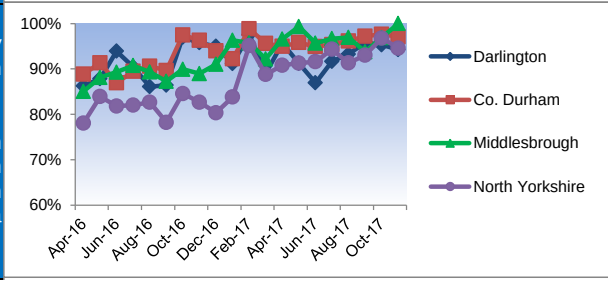
Harrogate and District NHS Foundation Trust

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.		Delivery at expected levels.
Cancer - 31 days maximum wait from diagnosis to treatment for all cancers ✓	Percentage of cancer patients starting first treatment within 31 days of diagnosis. The operational standard is 96%. A high percentage is good.		Delivery at expected levels.
Cancer - 31 day wait for second or subsequent treatment: Surgery ✓	Percentage of cancer patients starting subsequent surgical treatment within 31 days. The operational standard is 94%. A high percentage is good.		Provisional performance is at 100% for December. Confirmed performance for November was below the required 94% standard. However performance for Quarter 3 overall is above the required standard at 96.3%.
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.

You matter most

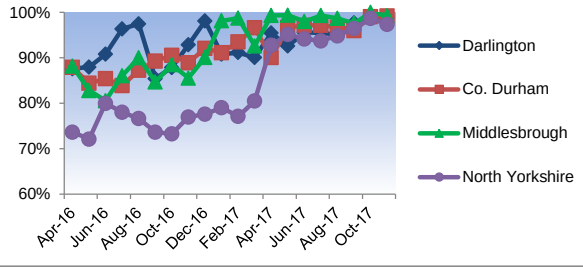
Operational Performance - December 2017

Harrogate and District NHS Foundation Trust

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 December is above the required 85% standard at 92.7% with 3.5 accountable breaches. Of the 11 tumour sites, 4 had performance below 85% in December - colorectal (2 breaches), head and neck (0.5), lung (0.5) and sarcoma (0.5). One patient waited over 104 days in December. The main reason for the delay was a complex diagnostic pathway.
Cancer - 62 day wait for first treatment from consultant screening service referral ✓	Percentage of cancer patients starting first treatment within 62 days of referral from a consultant screening service. The operational standard is 90%. A high percentage is good.		Performance was at 80% in December but with only 5 eligible pathways, this is below the de minimis level for reporting performance. Performance for Quarter 3 overall is at 90.5%, above the required 90% standard.
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.		Performance was at 100% for December but with only 2 eligible pathways, this is below the de minimis level for reporting performance. Perofrmance for Quarter 3 overall is also below the de minimis reporting level but is at 100%.
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. 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 November, the validated performance position is that 96% of babies were recorded on Systmone as having had a new birth visit within 14 days of birth. The data is reported a month in arrears so that the validated position can be shared.

Operational Performance - December 2017

Harrogate and District NHS Foundation Trust

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Children's Services - 2.5 year review	The percentage of children who had a 2.5 year review. A high percentage is good. 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 November, the validated performance position is that 99% of children were recorded on Systmone as having had a 2.5 year review. The data is reported a month in arrears so that the validated position can be shared.

Data Quality - Exception Report

Harrogate and District NHS Foundation Trust

Report section	Indicator	Data quality rating	Further information
Quality	Pressure ulcers - community acquired - grades 2, 3 or 4	**Amber** 	The observed increase in reported cases over the last two years may be partly due to improvements in incident reporting during the period.

Indicator traffic light criteria

Harrogate and District NHS Foundation Trust

Section	Indicator	Further detail	Traffic light criteria	Rationale/source of traffic light criteria
Quality	**Pressure ulcers - hospital acquired**	No. category 3 and category 4 avoidable hospital acquired pressure ulcers	tbc	tbc
Quality	**Pressure ulcers - community acquired**	No. category 3 and category 4 community acquired pressure ulcers	tbc	tbc
Quality	**Safety thermometer - harm free care**	% harm free	Blue if latest month >=97%, Green if >=95% but <97%, red if latest month <95%	National best practice guidance suggests that 95% is the standard that Trusts should achieve. In addition, HDFT have set a local stretch target of 97%.
Quality	**Falls**	IP falls per 1,000 bed days	Blue if YTD position is a reduction of >=50% of HDFT average for 2016/17, Green if YTD position is a reduction of between 20% and 50% of HDFT average for 2016/17, Amber if YTD position is a reduction of up to 20% of 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	**Infection control**	No. hospital acquired C.diff cases	Green if below trajectory YTD, Amber if above trajectory YTD, Red if above trajectory at end year or more than 10% above trajectory in year.	NHS England, NHS Improvement and contractual requirement
Quality	**Avoidable admissions**	The number of avoidable emergency admissions to HDFT as per the national definition.	tbc	tbc
Quality	**Mortality - HSMR**	Hospital Standardised Mortality Ratio (HSMR)	Blue = better than expected (95% confidence interval), Green = as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval).	Comparison with national average performance.
Quality	**Mortality - SHMI**	Summary Hospital Mortality Index (SHMI)		
Quality	**Complaints**	No. complaints, split by criteria	Blue if no. complaints in latest month is below LCL, Green if below HDFT average for 2016/17, Amber if on or above HDFT average for 2016/17, Red if above UCL. In addition, Red if a new red rated complaint received in latest month.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Quality	**Incidents - all**	Incidents split by grade (hosp and community)	Blue if latest month ratio places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%	Comparison of HDFT performance against most recently published national average ratio of low to high incidents.
Quality	**Incidents - complrehensive SIRIs and never events**	The number of comprehensive SIRIs and the number of never events reported in the year to date. The indicator includes hospital and community data.	Green if none reported in current month; Red if 1 or more never event or comprehensive reported in the current month.	
Quality	**Friends & Family Test (FFT) - Patients**	% recommend, % not recommend - combined score for all services currently doing patient FFT	Green if latest month >= latest published national average, Red if < latest published national average.	Comparison with national average performance.
Quality	**Safer staffing levels**	RN and CSW - day and night overall fill rates at trust level	Green if latest month overall staffing >=100%, amber if between 95% and 100%, red if below 95%.	The Trusts aims for 100% staffing overall.
Quality	**Staff appraisal rate**	Latest position on no. staff who had an appraisal within the last 12 months	Annual rolling total - 90% green. Amber between 70% and 90%, red<70%.	Locally agreed target level based on historic local and NHS performance
Quality	**Mandatory training rate**	Latest position on the % staff trained for each mandatory training requirement	Blue if latest month >=95%; Green if latest month 75%-95% overall, amber if between 50% and 75%, red if below 50%.	Locally agreed target level - no national comparative information available until February 2016
Quality	**Staff sickness rate**	Staff sickness rate	Green if <3.9% , amber if between 3.9% and regional average, Red if > regional average.	HDFT Employment Policy requirement. Rates compared at a regional level also
Quality	**Staff turnover**	Staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts.	Green if remaining static or decreasing, amber if increasing but below 15%, red if above 15%.	Based on evidence from Times Top 100 Employers
Finance and efficiency	**Readmissions**	No. emergency readmissions (following elective or non-elective admission) within 30 days.	Blue if latest month rate < LCL, Green if latest month rate < HDFT average for 2016/17, Amber if latest month rate > HDFT average for 2016/17 but below UCL, red if latest month rate > UCL.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Finance and efficiency	**Length of stay - elective**	Average LOS for elective patients	Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%.	Comparison with performance of other acute trusts.
Finance and efficiency	**Length of stay - non-elective**	Average LOS for non-elective patients		
Finance and efficiency	**Theatre utilisation**	% of theatre time utilised for elective operating sessions	Green = >=85%, Amber = between 75% and 85%, Red = <75%	A utilisation rate of around 85% is often viewed as optimal.

Section	Indicator	Further detail	Traffic light criteria	Rationale/source of traffic light criteria
Finance and efficiency	Delayed transfers of care	% acute beds occupied by patients whose transfer is delayed - snapshot on last Thursday of the month.	Red if latest month >3.5%, Green <=3.5%	Contractual requirement
Finance and efficiency	Outpatient DNA rate	% first OP appointments DNA'd	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	Outpatient new to follow up ratio	No. follow up appointments per new appointment.		
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	NHS Improvement Financial Performance Assessment	An overall rating is calculated ranging from 4 (no concerns) to 1 (significant concerns). This indicator monitors our position against plan.	Green if rating =4 or 3 and in line with our planned rating, amber if rating = 3, 2 or 1 and not in line with our planned rating.	as defined by NHS Improvement
Finance and efficiency	Capital spend	Cumulative capital expenditure	Green if on plan or <10% below, amber if between 10% and 25% below plan, red if >25% below plan	Locally agreed targets.
Finance and efficiency	Agency spend in relation to pay spend	Expenditure in relation to Agency staff on a monthly basis (£'s).	Green if <1% of pay bill, amber if between 1% and 3% of pay bill, red if >3% of pay bill.	Locally agreed targets.
Finance and efficiency	Outpatient activity against plan (new and follow up)	Includes all outpatient attendances - new and follow-up, consultant and non-consultant led.	Green if on or above plan in month, amber if below plan by < 3%, red if below plan by > 3%.	Locally agreed targets.
Finance and efficiency	Elective activity against plan	Includes inpatient and day case activity		Locally agreed targets.
Finance and efficiency	Non-elective activity against plan			Locally agreed targets.
Finance and efficiency	Emergency Department attendances against plan	Excludes planned followup attendances.		Locally agreed targets.
Operational Performance	NHS Improvement governance rating	Trust performance on Monitor's risk assessment framework.	As per defined governance rating	as defined by NHS Improvement
Operational Performance	RTT Incomplete pathways performance	% incomplete pathways within 18 weeks	Green if latest month >=92%, Red if latest month <92%.	NHS England
Operational Performance	A&E 4 hour standard	% patients spending 4 hours or less in A&E.	Blue if latest month >=97%, Green if >=95% but <97%, red if latest month <95%	NHS England, NHS Improvement and contractual requirement of 95% and a locally agreed stretch target of 97%.
Operational Performance	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	% urgent GP referrals for suspected cancer seen within 14 days.	Green if latest month >=93%, Red if latest month <93%.	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 14 days maximum wait from GP referral for symptomatic breast patients	% GP referrals for breast symptomatic patients seen within 14 days.	Green if latest month >=93%, Red if latest month <93%.	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 31 days maximum wait from diagnosis to treatment for all cancers	% cancer patients starting first treatment within 31 days of diagnosis	Green if latest month >=96%, Red if latest month <96%.	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 31 day wait for second or subsequent treatment: Surgery	% cancer patients starting subsequent surgical treatment within 31 days	Green if latest month >=94%, Red if latest month <94%.	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug	% cancer patients starting subsequent anti-cancer drug treatment within 31 days	Green if latest month >=96%, Red if latest month <96%.	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 62 day wait for first treatment from urgent GP referral to treatment	% cancer patients starting first treatment within 62 days of urgent GP referral	Green if latest month >=85%, Red if latest month <85%.	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 62 day wait for first treatment from consultant screening service referral	% cancer patients starting first treatment within 62 days of referral from a consultant screening service	Green if latest month >=90%, Red if latest month <90%.	NHS England, NHS Improvement and contractual requirement
Operational Performance	Cancer - 62 day wait for first treatment from consultant upgrade	% cancer patients starting first treatment within 62 days of consultant upgrade	Green if latest month >=85%, Red if latest month <85%.	NHS England, NHS Improvement and contractual requirement
Operational Performance	Children's Services - 10-14 day new birth visit	% new born visit within 14 days of birth	Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%.	Contractual requirement
Operational Performance	Children's Services - 2.5 year review	% children who had a 2 and a half year review	Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%.	Contractual requirement

Data quality assessment

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

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Date of Meeting:	31 January 2018	**Agenda item:**	5.1
Report to:	Board of Directors		
Title:	Well Led Framework Self-Assessment		
Sponsoring Director:	Dr Ros Tolcher, Chief Executive		
Author(s):	Mrs Katherine Roberts, Company Secretary		
Report Purpose:	**Decision** ✓ **Discussion/ Consultation** ✓ **Assurance** ✓ **Information**		
Executive Summary:	• The Trust completed an independent external well led assessment in late 2015. • In June 2017 NHS Improvement issued a new well led framework which aligns with the CQC's well led approach. • The self-assessment was discussed in detail by the Board in November 2017. • A small number of actions are outlined to address gaps identified during the self-assessment review.		

Related Trust Objectives

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

Key implications	
Risk Assessment:	None identified.
Legal / regulatory:	NHS Improvement has strongly encouraged providers to use the new framework to undertake developmental reviews as part of their own continuous improvement.
Resource:	None identified.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.
Reference documents:	NHS Improvement Well Led Framework: https://improvement.nhs.uk/resources/well-led-framework/
Assurance:	Not applicable, this is a matter for the Board of Directors.

Action Required by the Board of Directors:

The Board is invited to:

1) Note the robust process completed to prepare the well led framework self-assessment.
2) Agree the well led framework self-assessment at appendix A is a true and correct reflection of the Trust's position.
3) Note the gaps and actions detailed in the well led framework self-assessment.
4) Agree the well led framework self-assessment should be reviewed again in early 2019.

Harrogate and District NHS Foundation Trust: Well Led Framework Self-Assessment

1.0 Background

In December 2015 Deloitte completed an independent review of governance against the well-led framework for Harrogate and District NHS Foundation Trust. The review identified a number of areas of strength and good practice. In addition a number of follow-up actions were recommended. The resulting action plan was agreed and monitored by the Board of Directors.

In June 2017 NHS Improvement published a new well-led framework for use by NHS provider organisations; this replaced previous guidance issued in 2015.

A self-assessment against the new well led framework has been completed and is attached at Appendix A.

2.0 The Well Led Framework

The new framework maintains focus on strong integrated governance and leadership across quality, finance and operations, and increases emphasis on organisational culture, improvement and system working.

Through the framework NHS Improvement and the Care Quality Commission brought their respective well led approaches together resulting in a fully joint approach. The well led framework is structured around eight key lines of enquiry (KLOEs). The eight KLOEs are as follows:

1. Is there the leadership capacity and capability to deliver high quality, sustainable care?
2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
3. Is there a culture of high quality, sustainable care?
4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?
5. Are there clear and effective processes for managing risks, issues and performance?
6. Is appropriate and accurate information being effectively processed, challenged and acted on?
7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?
8. Are there robust systems and processes for learning, continuous improvement and innovation?

NHS Improvement have strongly encouraged providers to use the new framework to undertake developmental reviews as part of their own continuous improvement.

This guidance is issued on a ‘comply or explain’ basis. This means providers are encouraged to carry out developmental reviews approximately every three years to ensure they identify potential risks before these turn into issues.

3.0 The Self-Assessment Process

An initial assessment of the Trust's position was completed by the Chief Executive and Company Secretary. This was then considered in detail by the Board of Directors at a strategy away day on 20 November 2017.

On the basis of the self-assessment, the Board of Directors determined that at this time there was no compelling case to repeat an independent external review of the Trust against the framework.

As requested by members of the Board in November, the Children's & County Wide Community Care Directorate undertook a desk top review of the framework. This was in recognition that the directorate formed following the Deloitte independent review.

The Directorate has confirmed they have self-assessed their position and they are achieving the levels identified in the overall Trust self-assessment, subject to one variation. KLOE 8 (robust systems and processes for learning, continuous improvement and innovation) would be Amber/Green for the Directorate because they did not feel the Clinical Transformation Programme, the RPIW process and the Quality Charter work were as well embedded in Directorate as in other parts of the Trust. Agreed actions are already underway to mitigate this issue.

4.0 Next Steps

The Trust's well led self-assessment should be refreshed on a regular basis. It is therefore proposed that the well led self-assessment is reviewed again in early 2019.

5.0 Recommendations

The Board is invited to:

5) Note the robust process completed to prepare the well led framework self-assessment.
6) Agree the well led framework self-assessment at appendix A is a true and correct reflection of the Trust's position.
7) Note the gaps and actions detailed in the well led framework self-assessment.
8) Agree the well led framework self-assessment should be reviewed again in early 2019.

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Harrogate and District NHS Foundation Trust - Draft Well Led Framework Self Assessment January 2018

Key line of enquiry	Proposed Self Assessment Rating
1. Is there the leadership capacity and capability to deliver high quality, sustainable care?	**Green**
2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?	**Green / Amber**
3. Is there a culture of high quality, sustainable care?	**Amber/Green**
4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?	**Green**
5. Are there clear and effective processes for managing risks, issues and performance?	**Green**
6. Is appropriate and accurate information being effectively processed, challenged and acted on?	**Green**
7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?	**Amber**
8. Are there robust systems and processes for learning, continuous improvement and innovation?	**Green**

Key Line of Enquiry	NHS I Ref	NHS I Characteristics of good organisations	Proposed Self Assessment Rating	Explanation of self-assessment rating	How is the Board assured; HDFT Good Practice	HDFT Gaps	Actions	Lead	Deadline
KLOE 1: Is there the leadership capacity and capability to deliver high quality, sustainable care?	1.1	Leaders have the experience, capacity, capability and integrity to ensure that the strategy can be delivered and risks to performance addressed.	Green	The Trust Board is composed of high calibre individuals from a broad spectrum of backgrounds. The Board believes that it is experienced and has the necessary experience, capacity, capability and integrity to deliver the Trust's strategy and address risks to performance. There is a full annual appraisal process of all Executive and Non-Executive Directors, which is led by the Chairman and CEO and the Deputy Chair of the Council of Governors. A robust succession plan is in place and was praised in the 2016 well-led review. The Board is stable, and where gaps have arisen recruitment was targeted at known gaps and skills required. Members of the Board approved and embody 'you matter most' and the Trust's values. There are clear executive and non executive portfolios in place. Agreed corporate strategy and annual operational plans are in place. Board development plan in place.	* Succession plan presented in September 2017 * External well-led assessment in January 2016 * Board development plan in use. * Targeted recruitment against known gaps and skills required (e.g. recruitment of Laura Robson in summer 2017) * Regular Board Strategy Days * Committees undertake annual self-assessments * Risk senior leadership capacity is insufficient to meet the needs of the complex environment (including the West Yorkshire Health and Care Partnership) is mitigation is included on the BAF	Board Code of Conduct requires review in 2018	Review Board Code of Conduct	Katherine Roberts, Company Secretary	Feb 2018
	1.2	The leadership is knowledgeable about issues and priorities for the quality and sustainability of services, understands what the challenges are and takes action to address them.	Green	The Board has quality and finance as its highest priorities. The Board includes a significant number of clinicians, both executive and non-executive. Through the quality governance structure and less formal routes, the leadership is able to identify challenges and seeks to swiftly support the delivery of solutions.	* Reports to the Board from executive directors, including the Integrated Board Report. * Consideration of matters by the Board's Committees * Board members' objectives * Quality Charter * NED involvement in all SIRIs * Examples of challenge from all members of the Board on quality and sustainability of services. * Clinical transformation programme * Hot spot review methodology * RPIW work				
	1.3	Compassionate, inclusive and effective leadership is sustained through a leadership strategy and development programme and effective selection, development, deployment and support processes and succession-planning.	Green	Compassionate, inclusive and effective leadership is sustained at the Trust through a range of leadership development programmes and processes. A robust succession plan is in place and was praised in the 2016 well-led review.	* Succession plan presented in September 2017 * Quality Charter * Shadow Board programme * Board development plan * Leadership forum * Values based recruitment * Appraisals structured around values and behaviours				
	1.4	Leaders at every level are visible and approachable	Green	The Trust's senior leaders seek to be as visible and approachable as possible across the organisation. They welcome challenge and seek to be accessible through a variety of approaches. Executive open door policy and informal walkabouts.	*Monthly team brief for staff * Monthly director visits and patient safety visits * Leadership Forum meetings * Patient safety culture work Sign Up To Safety * 'Ask the Directors' * Quality improvement training * Evidence of promotion of incident reporting				
KLOE 2: Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?	2.1	There is a clear statement of vision and values, driven by quality and sustainability. It has been translated into a robust and realistic strategy and well-defined objectives that are achievable and relevant.	Green	The Board has a credible strategy and well-defined objectives. These are reviewed annually through the annual planning process and include a focus on quality. Clear vision, mission and strategic objectives are embedded within the organisation. The Trust is a learning organisation, supported by the Quality Charter and RPIW approach. Directorate level business plans to align with Trust strategic objectives.	* Vision, mission and values embedded within the organisation * Strategic Plan 2014-2019 in place and supported by annual operating plans * Governors are involved in development of strategy and annual plans * Strategic KPIs * Quality Charter * RPIW approach * Clinical Transformation programme * Health and wellbeing programme to support trust staff * Strategy includes market analysis, threats, opportunities and financial scenarios	Patient and Public Participation Strategy is in development	(1) Finalise Patient and Public Participation Strategy	Jill Foster, Chief Nurse / Katherine Roberts, Company Secretary	Apr-18

Key Line of Enquiry	NHS I Ref	NHS I Characteristics of good organisations	Proposed Self Assessment Rating	Explanation of self-assessment rating	How is the Board assured; HDFT Good Practice	HDFT Gaps	Actions	Lead	Deadline
	2.2	The strategy is aligned to local plans in the wider health and social care economy and services are planned to meet the needs of the relevant population.	Amber	The Trust is an active participant in the West Yorkshire and Harrogate Health and Care Partnership and the Harrogate Health Transformation Board. The Trust's strategic plan links to plans to achieve clinical and financial sustainability across the wider health and care economy.	* Strategic Plan 2014-2019 in place and supported by annual operating plans * Regular updates to Board regarding HHTB, HCP/ STP and WYAAT	Trust and Commissioner plans are misaligned. Lack of trust in local demand management systems.	(1) Actions are included on the Board Assurance Framework	Jonathan Coulter, Deputy Chief Executive / Finance Director	Ongoing
	2.3	Staff in all areas know, understand and support the vision, values and strategic goals and how their role helps in achieving them	Green	The Trust's strategy, vision, values and goals were refreshed in 2015 following consultation with a broad range of stakeholders. A complimentary behaviour framework which defines the behaviours our staff must demonstrate for our Trust to perform effectively has been developed for staff by staff and patients. These have been communicated to staff through a range of mediums including values-based recruitment, induction and appraisal.	* Values-based recruitment processes now operating * Focus on vision and values at the Trust's staff induction programme * Vision and values integral to annual staff appraisal process * Values based behaviour framework * Staff Friends and Family results * Annual staff survey results				
	2.4	The vision, values and strategy have been developed through a structured planning process in collaboration with people who use the service, staff and external partners.	Green	The Trust's vision and values were refreshed in 2015 following consultation with a broad range of stakeholders. This included consultation with staff, the Board, and Council of Governors. The Trust strategy has been developed through engagement with both internal and external stakeholders. A robust process takes place each year including discussions with staff, the Board, the Council of Governors, Commissioners and the public.	* Values developed following consultation with staff, supported by a behaviours framework * Annual planning process includes participation from governors				
	2.5	Progress against delivery of the strategy and local plans is monitored and reviewed, and there is evidence of this. Quantifiable and measurable outcomes support strategic objectives, which are cascaded throughout the organisation. The challenges to achieving the strategy, including relevant local health economy factors, are understood and an action plan is in place.	Amber/Green	The Trust's strategy was written in consultation with local stakeholders and took into account both local and national drivers. The successful vanguard value proposition demonstrated common ownership of the local health economy circumstances. The risks to the strategy are captured in the BAF which is reviewed by the Executive on a monthly basis and by the Board on a quarterly basis. Annual corporate goals agreed and used as basis for objective setting.	* BAF reports * Vanguard programme * Board Strategy sessions focused on future scenarios and longer term risk management. * Strategic Key Performance Indicators in place and agreed by the Board in July and performance reviewed by the Board bi-annually. * Directorate business plans.	Strategic Key Performance Indicators have not been fully embedded within each of the Trust's directorates.	(1) Ensure Strategic Key Performance Indicators have been cascaded to directorates.	Jonathan Coulter, Deputy Chief Executive / Finance Director & Ros Tolcher, Chief Executive	Apr-18
KLOE 3 Is there a culture of high quality, sustainable care?	3.1	Leaders at every level live the vision and embody shared values, prioritise high quality, sustainable and compassionate care, and promote equality and diversity. They encourage pride and positivity in the organisation and focus attention on the needs and experiences of people who use services. Behaviour and performance inconsistent with the vision and values are acted on regardless of seniority.	Green	The Trust fosters a positive culture which is open, transparent and focused on highly quality care. This supports all leaders in being able to prioritise safe, high quality care throughout the organisation. The Directorates are clinically led and each Clinical Director attends every Board of Directors' meeting. The appraisal process is aligned with the Vision and Values and the strategic objectives of the organisation, the first of which is delivery of high quality care. Leaders in the Trust use a range of different methods to engage staff about quality and safety. The Trust established a Quality Charter in 2016 which outlines the overall methodology for quality improvement.	* Reports to the Board including the Integrated Board report and Chief Nurse report * Quality Charter * Appraisal toolkit * Staff, Board and Governor induction programmes * Staff survey * Patient surveys * Discussions at Board, Committee and Council of Governors meetings * Directorate Boards * Quality of Care teams * Leadership forum * Making a difference and team of the month awards				

Key Line of Enquiry	NHS I Ref	NHS I Characteristics of good organisations	Proposed Self Assessment Rating	Explanation of self-assessment rating	How is the Board assured; HDFT Good Practice	HDFT Gaps	Actions	Lead	Deadline
	3.2	Candour, openness, honesty, transparency and challenges to poor practice are the norm. The leadership actively promotes staff empowerment to drive improvement, and raising concerns is encouraged and valued. Staff actively raise concerns and those who do (including external whistle-blowers) are supported. Concerns are investigated sensitively and confidentially, and lessons are shared and acted on. When something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again.	Green / Amber	The Board emphasises the importance of openness, transparency and honesty. Staff from across the organisation redesigned the quality governance structure and are involved in reviewing the complaints process. The Values are part of the annual appraisal process and, where performance is not as expected, a range of HR support mechanisms are available to all staff, regardless of seniority, which can include individual coaching, facilitated workshops and team-building sessions. There is work to be done to consistently follow through with the completion of action plans identified. Both the Freedom to Speak Up Guardian and the Safe Working Guardian are in place.	* Reports to the Board including the Integrated Board report and Chief Nurse report * Quality Committee * Quality Charter * Staff, Board and Governor induction programmes * Staff survey * Patient surveys * Discussions at Board, Committee and Council of Governors meetings * Directorate Boards * Quality of Care teams * Leadership forum * Making a difference and team of the month awards	Ambition to strengthen the Trust culture of incident reporting including near misses	(1) Implementation of actions following RPIW on incident reporting which was completed in November 2017	(1) Dr David Scullion / Mrs Jill Foster	Apr-18
	3.3	There are processes for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations.	Green	The Trust's Workforce and Organisational Development Strategy outlines clear and robust processes for providing staff with development they need. Staff at all levels are supported to undertake training - mandatory, essential and learning beyond registration and enables and encourages staff to innovate new ways of working.	* Staff, Board and Governor induction programme * Appraisal process including new plan on a page * Quality Charter * Training - examples of quality / continuous improvement training *Mandatory training compliance				
	3.4	Leaders model and encourage compassionate, inclusive and supportive relationships among staff so that they feel respected, valued and supported. There are processes to support staff and promote their positive wellbeing.	Green	The Board has taken a proactive approach to seeking to promote staff wellbeing. A staff wellness programme is in place, utilising a Sheffield Hallam University programme. There are a range of HR mechanisms in place to gain feedback and provide support to staff, including Occupational Health and a staff counselling service as well as Return to Work and leavers' interviews. Executive Directors attend both the Staff Governors and Partnership Forum meetings to gain direct feedback.	* Report to the Board * Staff Wellbeing programme * Staff engagement e.g. Partnership Forum * Feedback from Staff Governors * Evidence of Board discussion re morale and wellbeing (Minutes) * Action Plans arising from staff surveys * Director of W&OD reports to Board * Staff survey results * Staff Friends and Family results * Leaver interviews * Stop smoking support * Flu vaccination campaign				
	3.5	Equality and diversity are actively promoted and the causes of any workforce inequality are identified and action taken to address these. Staff, including those with protected characteristics under the Equality Act, feel they are treated equitably	Amber/Green	The Equality and Diversity Steering Group is in place, and is supported by the Workforce Equality Group and the Stakeholder Equality Group.	* HDFT Stakeholder Equality Group (includes Patient Voice Group and Public Governor representatives) delivers an annual work plan * Equality Delivery System (EDS) report published annually * Workforce Race Equality Standard (WRES) annual report * Staff survey * Workforce Equality Group relaunched in 2017 and now meet quarterly * Youth Forum	Trust position would be strengthened by a strategy for inclusion and engagement with under-represented staff and public group (Chief Nurse report October 2017).	(1) Development of an strategy for a strategy for inclusion and engagement with under-represented groups (staff and public).	(1) Jill Foster, Chief Nurse & Phillip Marshall Director of Workforce and Organisational Development	Aug-18
	3.6	There is a culture of collective responsibility between teams and services. There are positive relationships between staff and teams, where conflicts are resolved quickly and constructively and responsibility is shared.	Amber/Green	There is generally a culture of collective responsibility which includes a flexible approach by staff to supporting acuity and dependency in other wards and departments, across both nursing and medical staff. However, there can be inconsistent behaviour across the organisation in relation to the ownership of quality, performance and financial issues.	*Quality Charter * Staff survey results * Freedom to Speak up Guardian * Reports to the Board * RPIW programme * Clinical transformation programme * Bed state demonstrates staff working together * Team Brief * Evidence of sharing performance information e.g. Consultant Forum, Staff Governor meetings *Investors in People award * Regular meetings between the Executive Team and Consultant Forum, Clinical Leads and Consultant Teams * Guardian of Safe Working	Ambition to increase theatre productivity. Concern regarding the sustainability of the gastroenterology service at Harrogate District Hospital and the experience of the trainee doctors in the service.	(1) Theatres staffing strategy developed and being implemented. (2) Implementation of actions recommended through internal deep dive review.	(1) Planned and Surgical Care Directorate (2) Planned and Surgical Care Directorate	Ongoing Ongoing

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KLOE 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?	4.1	Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective.	Green	There are clear processes for holding people to account for delivery which are widely considered by the workforce to be effective. The Trust governance framework was redesigned in 2015 to strengthen the organisation's structures, processes and accountability frameworks. Management and governance of partnerships, joint working arrangements and shared services are managed through the directorates with oversight by the Senior Management Team, a sub-Board level meeting. The director team meets regularly with peers in neighbouring Trusts to ensure effective partnership working across clinical alliances.	* Harrogate Health Transformation Board * WYAAT Memorandum of Understanding, Committee in Common * Minutes of Quality Governance groups * Annual Governance statement * Internal audit reports * Counter fraud reports * Corporate Risk Register * Governance framework * Accountability framework * Systems of internal control * Board Scheme of Delegation * Internal audit reports to SMT and Audit Committee * Clinical alliances * Audit Committee review of third party providers				
	4.2	The board and other levels of governance in the organisation function effectively and interact with each other appropriately.	Green	In 2015 the Board commissioned a significant piece of work to redesign the governance framework across the organisation. Staff from across the organisation redesigned the governance structure including quality to ensure the governance framework works effectively at all levels.	* Board, Committee and Council of Governor meetings * Director portfolios | * Scheme of delegation * Governance framework and supporting terms of reference * Accountability framework * Director functions portfolios * Decisions reserved for the Board and delegated responsibilities * Governance framework * Directorate structures - clinical and corporate * Standing Financial Instructions * Directorate business plans * Internal audit of Board to Board working				
	4.3	Staff are clear on their roles and accountabilities	Green	Trust staff understand the organisation's priorities and how their own goals and objectives contribute to the Trust's performance as a whole. And job planning processes in place. Trust operating framework sets out directorate responsibilities.	* Appraisal process including new plan on a page * Job planning process * Staff survey results - directly relevant question * Directorate and team annual plans. * Trust operating framework				
KLOE 5. Are there clear and effective processes for managing risks, issues and performance?	5.1	There is an effective and comprehensive process to identify, understand, monitor and address current and future risks.	Green	The Board has a number of strategies to identify risks both to immediate service delivery and future strategic objectives. The risks to the strategy are captured in the BAF which is reviewed by the Executive on a monthly basis and by the Board on a quarterly basis. Annual corporate goals agreed and used as basis for objective setting. BAF based on CSFs for achieving our strategic objectives. Risk can be identified at any level within the organisation and added to department, Directorate or Corporate Risk register. Risks are scored using a consistent framework and reviewed at the most appropriate level within the organisation on a monthly basis, based on the risk score. Scores of 12 and above are then reported to Board monthly with an assessment of progress against action. Progress on mitigations in BAR and Corporate Risk Review consistently scored and monitored.	*Board Assurance Framework * Risk register guidance * Corporate Risk Review Group * Board, Committee and Governor meetings * Directorate Boards * Director team * Internal audit - assurance framework * Patient safety visits * Informal walkabouts * Director inspections * Annual review of complaints * Appraisals and job planning - incorporated into personal objectives * Board strategy workshops * SKPI tracking				
	5.2	Financial pressures are managed so that they do not compromise the quality of care. Service developments and efficiency changes are developed and assessed with input from clinicians so that their impact on the quality of care is understood.	Amber/Green	The Trust has a developed approach to service improvement, this includes the Clinical Transformation Programme. A Quality Impact Assessment (QIA) process is followed before CIP or financial recovery actions are implemented.	* Quality Impact Assessment process * Board, Committee and Governor meetings * Reports to Board * RPIW *Quality Charter * Clinical Transformation Board * Post Project Evaluation process * Quality governance	(1) Service development / efficiency initiatives are not always developed with stakeholders. (2) Frequent delays on submission of Post Project Evaluations. (3) Delays in Cost Improvement Plan Quality Impact Assessments	(1) Finalise Patient and Public Participation Strategy (2) Audit Committee continue to monitor Post Project Evaluation process (3) Audit of Quality Impact Assessment compliance	(1) Jill Foster, Chief Nurse & Katherine Roberts, Company Secretary (2) Chris Thompson, Chair of Audit Committee	Feb 2018 Ongoing

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	5.3	The organisation has the processes to manage current and future performance.	Green	The Trust has a clear approach to managing performance through the Quality Governance Structure. The Trust Board receives an Integrated Performance Report on a monthly basis which covers all aspects of performance. The weekly Operational Delivery Group reviews live performance issues and seeks to ensure any adverse trends are identified and prompt actions are taken to provide resolution. Clinical Directorates are provided with an accountability framework which covers all aspects of expected performance to be achieved throughout the year; the Executive team then carries out a quarterly review with each directorate to assess performance	*Integrated Board Report * Board and Committee meetings * Internal Audit reports * Operational Delivery Group * Directorate Boards * Escalation to SMT * Accountability framework * Quality Charter * Delivery of strong performance * Executive director meetings * Meetings with NHS Improvement				
	5.4	Performance issues are escalated to the appropriate committees and the board through clear structures and processes.	Green	The Quality Governance Structure within the Trust sets out the formal reporting structure for each group / committee. This provides opportunity for rapid escalation through to the Board of Directors as necessary. The leadership also encourages concerns to be escalated through informal routes which are then acted upon through an appropriate group or committee.	* Senior Management Team * Board Reports * Action plans for performance issues * Operational Delivery Group Escalation to SMT * Escalation from CORM * Scheme of delegation				
	5.5	Clinical and internal audit processes function well and have a positive impact on quality governance, with clear evidence of action to resolve concerns.	Green	The Trust sets out a joint audit plan each year between Clinical Effectiveness and Internal Audit; this focusses on areas identified as possible weaknesses. Internal Audit Reports are shared with Senior Management team, and progress against agreed actions is managed. The Audit committee monitors compliance with completion of actions arising from Internal Audit Reports. Clinical Effectiveness audits are shared with the most appropriate group within the Quality Governance Structure at which actions are monitored. There remains inconsistent follow through and delivery of the actions agreed in audit reports. The effectiveness of actions taken following investigation of SIs / Complaints are audited.	* Joint audit plan and process * Internal audit summary report * Internal audit report to Audit Committee * Internal audit reports to SMT minutes * Examples of follow up recommendations and re-audit * Audit Committee minutes * Specialist audit meeting minutes * Clinical audit reports and presentations * Clinical audit reports - to specialist audit meetings, committees and groups in governance framework * Examples of action to resolve concerns				
KLOE 6. Is appropriate and accurate information being effectively processed, challenged and acted on?	6.1	Quality and sustainability both receive sufficient coverage in relevant meetings at all levels. Staff receive helpful data on a daily basis, which supports them to adjust and improve performance as necessary.	Green	The Board fully appreciates and regularly articulates the inter-relationship between quality and finance. Staff are encouraged to interrogate and challenge financial information across the organisation.	* Board, Committee and Council of Governors meetings * Positive feedback in recent Audit Committee self assessment about the balance between finance and quality * Integrated Board Report * Consultant information packs * Service line reporting				
	6.2	Integrated reporting supports effective decision-making. There is a holistic understanding of performance, which sufficiently covers and integrates the views of people, with quality, operational and financial information.	Green	The organisation consistently links all aspects of performance to ensure decision making is informed by a full perspective. The Clinical Directorate structure supports this approach. The Board has developed an Integrated Board Report that includes information in relation to Quality, Performance and Finance, which is RAG rated and benchmarked and which allows appropriate debate, challenge and discussion. The planning process brings together quality, performance and financial information by Directorate and the Trust to allow informed prioritisation and action where required. 'Hotspot' areas are identified and deep dive reviews rapidly undertaken, looking at the service information in an integrated manner to inform appropriate action.	* Board, committee and governor meetings * Development and regular review of dashboards * Integrated dashboard - RAG rated, up to date, benchmarked * Quality dashboard reviewed by directorate meetings * Quality dashboard available at Patient Safety Steering Group * Externally validated data e.g. national joint registry * Executive meetings with Clinical Leads * Quarterly directorate review meetings				

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	6.3	Performance information is used to hold management and staff to account.	Green	The governance structure is supported by robust, high quality information that is used to hold staff, services, directorates and the executive to account. The quality, finance and performance information is used to structure Directorate quarterly reviews as well as monthly finance and activity meetings and monthly SMT and Board meetings, and services sign off activity and financial plans at the start of each year and are accountable for delivery.	* Senior Management Team * Operational Delivery Group * Audit Committee * HR reports to SMT Examples, performance outcomes CEO 1 to 1 with CDs * Quarterly directorate review meetings				
	6.4	The information used in reporting, performance management and delivering quality care is usually accurate, valid, reliable, timely and relevant, with plans to address any weaknesses.	Green	The Trust has a robust approach to data quality, which is led by the Performance and Analysis team; systems are tested though Internal and External Audit reviews throughout each year, in addition to coding audits and comprehensive data validation processes. Information is provided as close to live as possible, through the use of electronic data collection and reporting tools. External data submissions follow a sign off process involving members of the Executive Team to ensure the validity is tested. The Integrated Performance Report includes data quality alerts on KPIs.	* Quality accounts * Quality Committee receive clinical audit report (quarterly) * Directorate Boards * Data quality audit results * Dashboard preparation for Board * Clinical audit programme driven by national audits * Electronic systems used for reliable reports e.g. iCS, Datix, etc. * Dashboard data sign off * Audit action plans - internal audit, clinical audit, re-audit * Clinical coding audit results * Clinical effectiveness audits * Case note reviews where data results questioned * Data quality processes				
	6.5	Information technology systems are used effectively to monitor and improve the quality of care.	Green	The Chief Operating Officer provides strong leadership in the deliver of high quality IT, data and analytics.	* Chief Operating Officer - executive lead * Operational Delivery Group supported by IT Steering Group * Robust business continuity planning which includes cyber-security				
	6.6	Data or notifications are consistently submitted to external organisations as required.	Green	The Board is able to demonstrate the organisation has robust data processes in place.	* Integrated Board Report * Operational Delivery Group supported by IT Steering Group * Information Governance Toolkit results and review by Internal Audit * MHR reporting of incidents				
	6.7	There are robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.	Green	An effective information governance framework is in place which supports coordinated and integrated care through appropriate information sharing.	* Integrated Board Report * Data and Information Governance Steering Group * Information Governance Toolkit results and review by Internal Audit * Included on the Board Assurance Framework				
KLOE 7 Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?	7.1	A full and diverse range of people's views and concerns is encouraged, heard and acted on to shape services and culture.	Amber	The Board seeks and reviews patient feedback in a number of ways. At a direct level, all safety visits and Director inspections include direct discussion with patients to receive feedback, and the Board hears a patient story each month, often given directly from someone who has used our services. The Board receives and reviews complaints information and all SIRI reports; the investigation team always includes a NED. The independent Patient Voice Group has access to Board members as part of its' role within the Trust, and members meetings, Governor meetings, and open events are designed to encourage members of the public to engage with the Trust on issues important to them. Whilst FFT information is also received and reviewed, we recognise that further work is required to consistently utilise the feedback received at service level to make improvements in care.	* Board meetings * Council of Governor meetings * Directorate Boards * New patient experience and incident report to Quality Committee * Clinical teams presenting at Team Brief * Patient stories at Board * Staff governor meeting * Patient FFT * Medicine for Members meetings * Complaint reports * Patient surveys * Integrated Board Report * SIRI reports to Board * Patient Voice Group reports * Director inspections * Annual members meeting * Social media coverage * Youth forum * Patient story at Board	Patient and Public Participation Strategy is in development	(1) Finalise Patient and Public Participation Strategy	Jill Foster, Chief Nurse / Katherine Roberts, Company Secretary	Apr-18

Key Line of Enquiry	NHS I Ref	NHS I Characteristics of good organisations	Proposed Self Assessment Rating	Explanation of self-assessment rating	How is the Board assured; HDFT Good Practice	HDFT Gaps	Actions	Lead	Deadline
	7.2	The service proactively engages and involves all staff (including those with protected equality characteristics) and ensures that the voices of all staff are heard and acted on to shape services and culture.	Amber/Green	Staff within the services are actively engaged by the Board and through the Clinical Directorate structure. There are a range of engagement channels ranging from informal service walkabouts to formal engagement with Trade Unions through our Partnership Forum, with accompanying communication channels such as Team Brief and Ask the Directors. Staff are keen to raise issues and these are actioned by either direct intervention or placement within the Directorate structure. Staff FFT is reviewed each month by the Board as part of the IBR. Given the geography of our service provision, there remains work to do to ensure that all parts of the service, wherever staff are based in the community, are engaged with consistently	* Staff FFT results * Staff survey reports * Patient safety visit reports to SMT and Board SMT * Board meetings * 'Ask the Directors' Team brief * Partnership Forum * Informal walkabouts * Consultant Forum * Student formal feedback sessions * Junior doctor forum * Staff governors * EDS2 *RPIW - reporting of incidents (Nov 2017)	Trust position would be strengthened by a strategy for inclusion and engagement with under-represented staff and public group (Chief Nurse report October 2017).	(1) Development of an strategy for a strategy for inclusion and engagement with under-represented groups (staff and public).	(1) Jill Foster, Chief Nurse & Phillip Marshall Director of Workforce and Organisational Development	Aug-18
	7.3	The service is transparent, collaborative and open with all relevant stakeholders about performance, to build a shared understanding of challenges to the system and the needs of the population and to design improvements to meet them.	Green	The Trust is an active member of the Harrogate health and social care system; the Chief Executive, Deputy Chief Executive and Chief Operating Officer are members of the HHTB. The Trust is engage with the local STP and provider association. Trust decisions are taken in transparent manner and where relevant the Board seeks views from stakeholders.	* Board updates regarding the Harrogate Health Transformation Board * Trust is an active participant on the Harrogate Health Transformation Board * Trust is a member of the West Yorkshire Association of Acute Trusts * Trust is an active contributor to the West Yorkshire and Harrogate Health and Care Partnership * Clinical Forum between GPs and Trust clinicians * Regular communications with local stakeholders including MPs, Councillors, Health and Wellbeing Board * Map of stakeholders				
KLOE 8: Are there robust systems and processes for learning, continuous improvement and innovation?	8.1	There is a strong focus on continuous learning and improvement at all levels of the organisation, including through appropriate use of external accreditation and participation in research.	Green	The Trust has robust processes for ensuring focus on learning and continuous improvement across the organisation, including a Trust-wide improvement strategy. This supports staff to undertake training at all levels- mandatory, essential and learning beyond registration and enables and encourages staff to innovate new ways of working.	* Thematic reviews * Staff survey * Strategy contains a number of trust- wide quality improvement goals. *Quality Charter * Training - examples of quality / continuous improvement training * Mandatory training compliance * Appraisals - link to improvement and learning * RPIW programme - quality governance example * Quality improvement newsletters * QA and all work on quality priorities	Ambition to strengthen the Trust culture of incident reporting including near misses	(1) Implementation of actions following RPIW on incident reporting which was completed in November 2017	(1) Dr David Scullion / Mrs Jill Foster	Apr-18
	8.2	There is knowledge of improvement methods and the skills to use them at all levels of the organisation.	Green	A successful service transformation approach has been embedded within the Trust. This approach includes the clinical transformation programme, delivery of the Quality Charter, and bespoke service improvement training utilising a LEAN methodology.	* Strategy contains a number of trust- wide quality improvement goals. * Quality Charter * Training - examples of quality / continuous improvement training * RPIW programme - quality governance example * Quality improvement newsletters * QA and all work on quality priorities				
	8.3	The service makes effective use of internal and external reviews, and learning is shared effectively and used to make improvements.	Green	The Trust's has process which support the use of reviews to learn and make improvements, this includes learning from deaths.	* Learning from Deaths Policy * Quality Committee receive assurance reports about the review of external report (including national audits). * Clinical audit processes * Internal audit processes * Accreditation processes within services (JAG in endoscopy, MHRA in transfusion, UKAS in pathology) *WYAAT networks * Patient Voice Group * Youth Forum * Patient information leaflet lay readers				

Key Line of Enquiry	NHS I Ref	NHS I Characteristics of good organisations	Proposed Self Assessment Rating	Explanation of self-assessment rating	How is the Board assured; HDFT Good Practice	HDFT Gaps	Actions	Lead	Deadline
	8.4	Staff are encouraged to use information and regularly take time out to review individual and team objectives, processes and performance. This is used to make improvements.	Green	The Board has agreed an appraisal approach which ensure staff have personal priorities and understand how these link to the Trust's objectives. The process enables managers to provide timely feedback and review progress against objectives.	* Staff survey * Appraisals - link to improvement and learning *Quality Charter * Training - examples of quality / continuous improvement training * Mandatory training compliance * RPIW programme - quality governance example * Quality improvement newsletters * QA and all work on quality priorities * Pathway to management programme				
	8.5	There are organisational systems to support improvement and innovation work, including staff objectives, rewards, data systems and ways of sharing improvement work.	Green	The Trust has adopted a lean methodology approach to service improvement. This is supported by the Service Transformation team and cascaded to the organisation through the Quality Charter, Clinical Transformation programme and service improvement training.	* Staff survey * Appraisals - link to improvement and learning *Quality Charter * Training - examples of quality / continuous improvement training * RPIW programme - quality governance example * Quality improvement newsletters * QA and all work on quality priorities * Improvement and transformation team in place to support the Trust * Kaizen events * Clinical transformation board programme				

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Date of Meeting:	31 January 2018	**Agenda item:**	6.0
Report to:	Board of Directors		
Title:	Finance Report		
Sponsoring Director:	Jonathan Coulter		
Author(s):	Finance Team		
Report Purpose:	**Decision**		**Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓
Executive Summary:	• Quarter 3 control total delivered with accompanying backdated S&T funding • Breakeven in-month financial performance when doing like for like comparison • Use of resources rating is 1 • Additional actions delivered • Cash remains a pressure		

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

Key implications	
Risk Assessment:	Use of Resources rating is one.
Legal / regulatory:	Part of our Board governance process.
Resource:	Not applicable.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.
Reference documents:	Not applicable.
Assurance:	Consider by Senior Management Team on 24 January 2018.

Action Required by the Board of Directors:

To note the Trust's financial performance.

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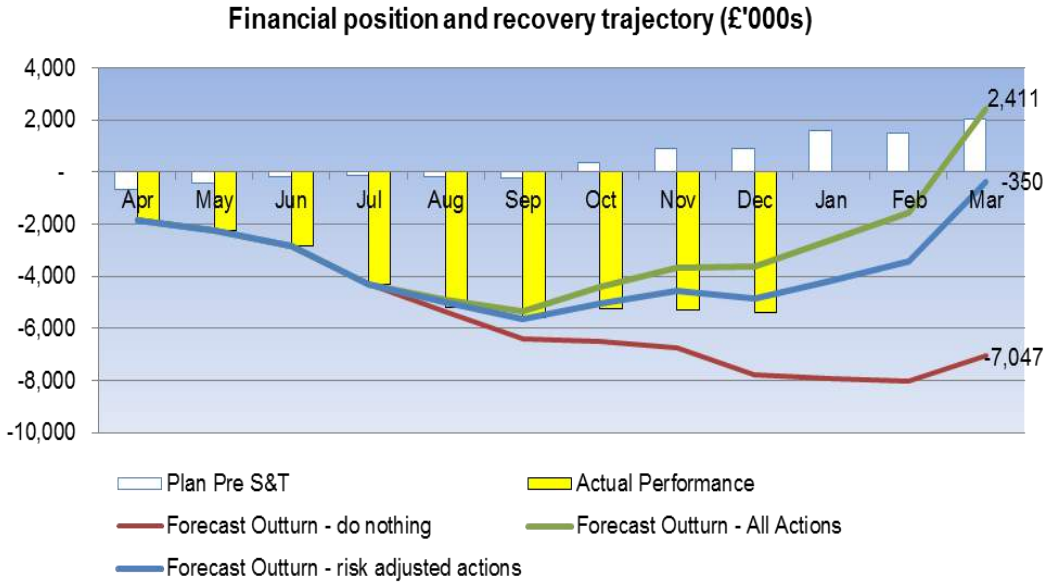
December 2017 Financial Position

Financial Performance (1)

- . The financial performance for Month 9 is more complex to report due to a number of significant transactions that we have made during the month of December. The report will therefore be broken down into two parts – firstly, the usual analysis of our financial position in line with how we have performed through the year so far, and secondly an explanation of the additional actions brought forward and accounted for appropriately which have improved the financial position further.

- Our comparable financial position is that we effectively achieved breakeven in December. Activity related income was behind plan in month by £200k, ward and theatres pay was overspent by £200k and these were offset by underspends elsewhere. This performance compares with a planned deficit in month of just over £200k when our recovery plan is risk adjusted.
- The graph below illustrates the financial performance so far this year:



- In the light of current performance, existing controls around training, discretionary spend and recruitment remain in place.
- Activity recovery plans that we have in place, in particular in relation to elective care services, need to remain a priority, alongside the cost controls in place.
- A significant long term solution to our financial and operational issues will be related to recruiting to or creating an alternative workforce for our wards and medical staffing, but in the meantime, we need to be as efficient as possible in relation to the demand for (and cost of) temporary and bank staff.

- It is important to maintain and improve our financial control as our recovery plan requires surpluses to be delivered across the remaining months of the year.

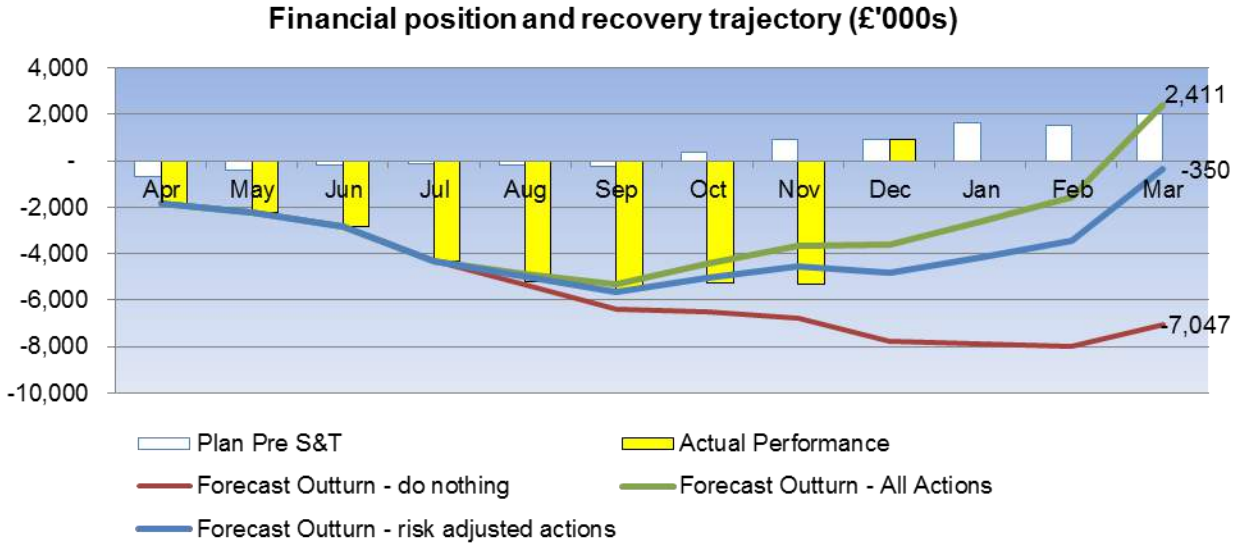
December 2017 Financial Position continued

Financial Performance (2)

- As part of assessing our position for the end of December, we have, in addition to our normal income and expenditure transactions, accounted for a number of material benefits. These benefits are:

1. Creation of our wholly owned subsidiary – benefit in year of £3.1m, which can be accounted for now that the decision has been taken to proceed
2. Winter funding allocation of £1.34m
3. Assessment of a rate rebate – backdated benefit of £1.9m, with papers lodged with the High Court for decision later this year
4. Mobilisation of new contract in Stockton – funding of £0.11m allocated in addition to the baseline contract to offset mobilisation costs

- The impact of these transactions is that it means that we can demonstrate achievement of our Q3 financial plan with NHS Improvement and thus qualify for additional, backdated sustainability and transformation funding of £2.45m.
- The graph below illustrates the current reported position:



- This achievement of S&T funding will be a significant help to our current cash balance, which has reduced due to our financial performance.
- It should be emphasised that these actions – particularly the wholly owned subsidiary benefits – have been brought forward in our recovery plan to maximise the benefit to the Trust. We need to continue to focus on our runrate improvements needed both this year and going into next year.
- Our use of resources rating is 1.

Income and expenditure

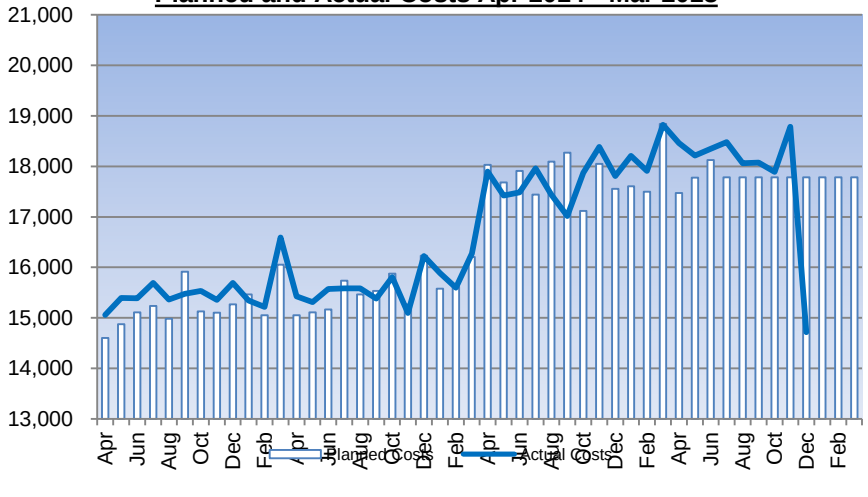
Harrogate and District NHS
NHS Foundation Trust

Summary Income & Expenditure 2017/18
For the month ending 31st December 2017

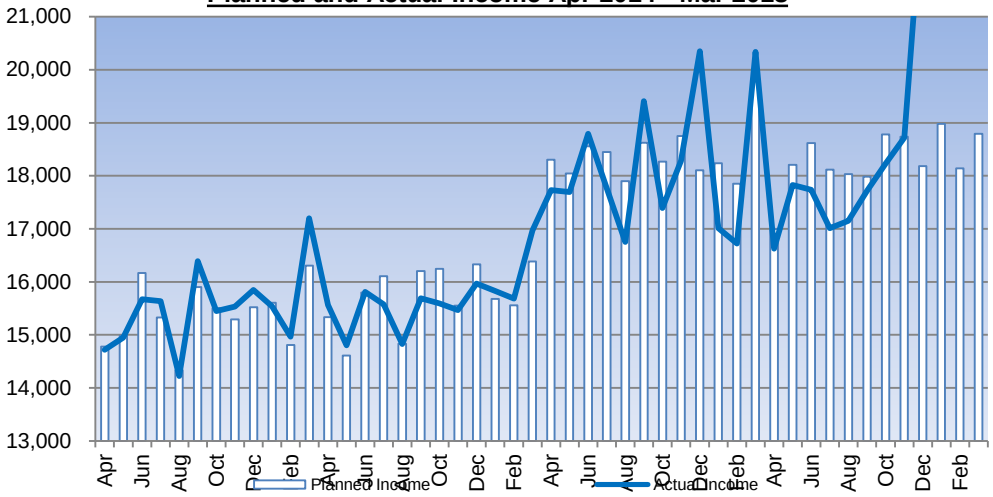
	Budget		Actual	Cumulative
	Annual Budget £000	Proportion To Date £000	To Date £000	Variance £000
INCOME				
NHS Clinical Income (Commissioners)				
NHS Clinical Income - Acute	147,985	110,391	109,545	(845)
NHS Clinical Income - Community	52,012	39,084	38,243	(840)
System Resilience & Better Care Funding	913	685	685	0
Non NHS Clinical Income				
Private Patient & Amenity Bed Income	1,509	1,123	1,164	41
Other Non-Protected Clinical Income (RTA)	523	392	297	(95)
Other Income				
Non Clinical Income	12,732	9,801	10,518	716
Hosted Services	887	887	1,431	544
TOTAL INCOME	**216,561**	**162,362**	**161,883**	**(479)**
EXPENSES				
Pay				
Pay Expenditure	(154,106)	(116,660)	(116,890)	(230)
Non Pay				
Drugs	(11,289)	(10,668)	(10,455)	212
Clinical Services & Supplies	(15,801)	(12,169)	(12,109)	60
Other Costs	(18,667)	(16,126)	(15,456)	669
Reserves : Pay	(2,709)	(0)	0	0
Pay savings targets	0	0	0	0
Other Reserves	(2,447)	578	0	(578)
High Cost Drugs	(986)	0	0	0
Non Pay savings targets	0	0	0	0
Other Finance Costs	(18)	(13)	(6)	7
Hosted Services	(531)	(513)	(696)	(183)
TOTAL COSTS	(206,553)	(155,570)	(155,613)	(43)
EBITDA	**10,008**	**6,792**	**6,271**	**(522)**
Profit / (Loss) on disposal of assets	0	0	0	0
Depreciation	(5,081)	(3,811)	(3,533)	278
Interest Payable	(90)	(68)	(188)	(120)
Interest Receivable	41	31	13	(17)
Dividend Payable	(2,746)	(2,059)	(1,733)	326
Net Surplus/(Deficit) before donations and impairments	**2,132**	**885**	**830**	**(55)**
Donated Asset Income	0	0	23	23
Impairments re Donated assets	0	0	0	0
Impairments re PCT assets	0	0	0	0
Net Surplus/(Deficit)	**2,132**	**885**	**854**	**(31)**
impact of capital grants / donations		72	132	60
consoidation of charitable funds				
Total and Consolidated Net Surplus/(Deficit)	**2,132**	**957**	**986**	**29**
Sustainability and Transformation Fund	3,777	2,455	2,455	0
Operational Budgetary Position	**5,909**	**3,412**	**3,441**	**29**

Financial Position Monthly Run Charts

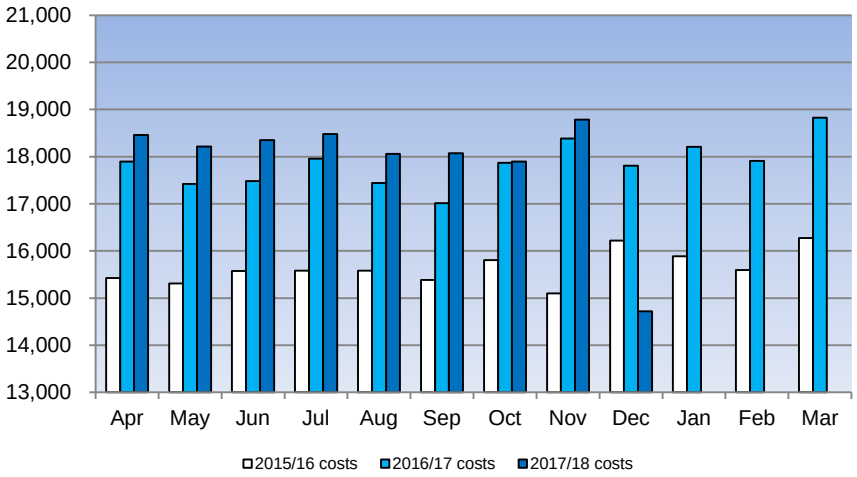
Planned and Actual Costs Apr 2014 - Mar 2018



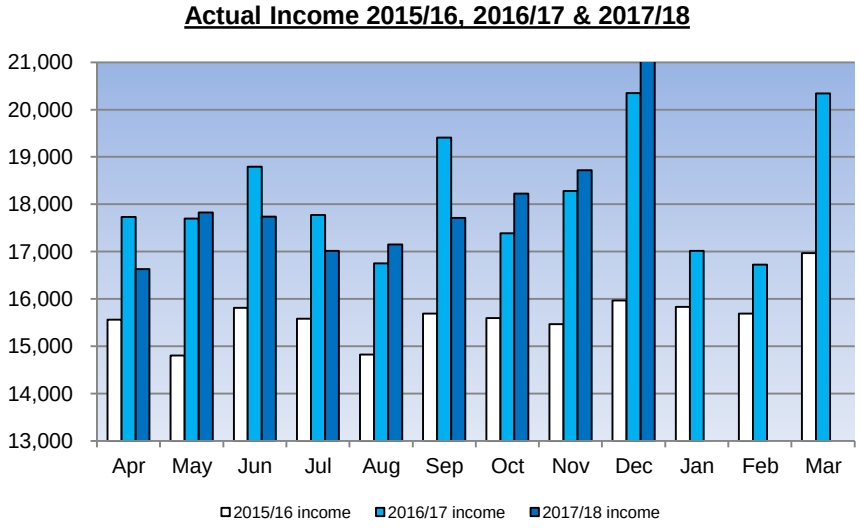
Planned and Actual Income Apr 2014 - Mar 2018



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



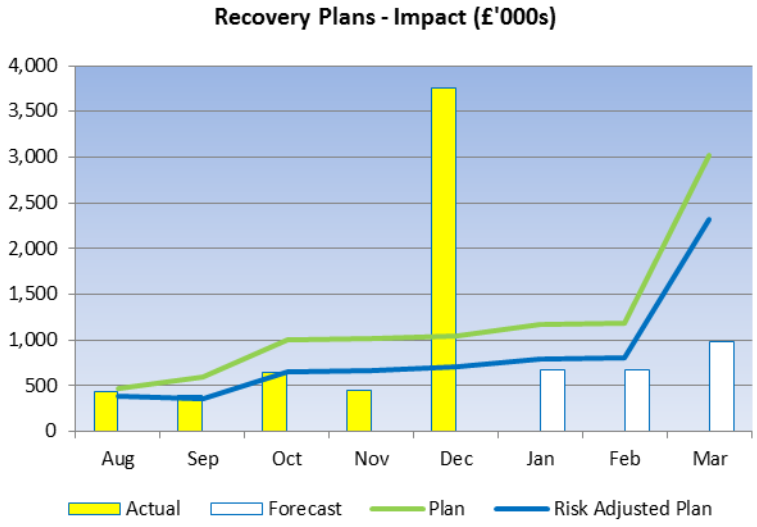
Actual Income 2015/16, 2016/17 & 2017/18

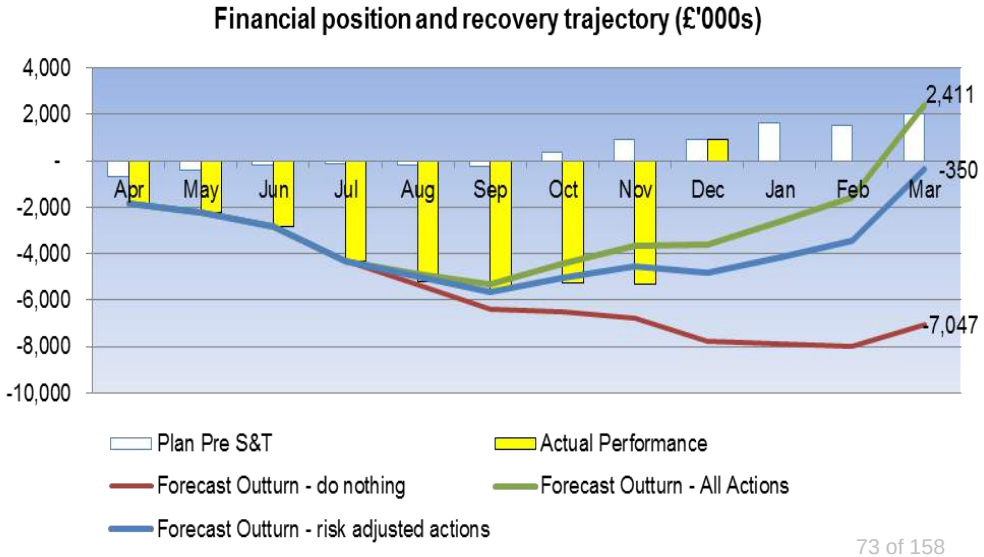


Financial Recovery Plans - Summary

The impact of recovery plans are summarised in the table and graph below. These are clearly a key subset of the current financial performance and should be viewed in summary alongside the overall financial position against our plan in Slides 1 and 2. This is repeated below for ease of comparison.
The impact of the wholly owned subsidiary contribution is £3.1m, with the balance in month being therefore £660k.

Category	Plan/Actual	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Total	Plan	**466**	**603**	**1,007**	**1,015**	**1,043**	**1,175**	**1,178**	**3,020**	**9,506**
	Risk Adjusted Plan	**383**	**352**	**650**	**660**	**702**	**796**	**809**	**2,321**	**6,673**
	Actual	**436**	**392**	**645**	**443**	**3,760**	**0**	**0**	**0**	**5,675**
	Risk Adjusted Var	**53**	**40**	**-5**	**-217**	**3,057**	**0**	**0**	**0**	**2,927**
	Forecast					**0**	**673**	**679**	**979**	**2,330**





Financial recovery plans - income

Category	Plan/Actual	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Income										
Casemix	Plan	145	35	35	35	35	35	35	35	**390**
	Risk Adjusted Plan	129	29	29	29	29	29	29	29	**330**
	Actual	145	25	47	12	12	0	0	0	**241**
	Forecast	0	0	0	0	0	35	35	35	**105**
locum T&O consultant	Plan	0	0	93	93	93	93	93	93	**558**
	Risk Adjusted Plan	0	0	74	74	74	74	74	74	**446**
	Actual	0	0	0	0	56	0	0	0	**56**
	Forecast	0	0	0	0	0	0	0	0	**0**
GS / Gastro incl Wharfedale	Plan	10	48	48	48	48	48	48	48	**345**
	Risk Adjusted Plan	9	23	23	23	23	23	23	23	**168**
	Actual	0	0	0	0	6	0	0	0	**6**
	Forecast	0	0	0	0	0	41	41	41	**123**
Ophthalmology	Plan	0	20	20	38	38	38	38	38	**231**
	Risk Adjusted Plan	0	5	5	18	18	18	18	18	**98**
	Actual	0	1	1	1	1	0	0	0	**4**
	Forecast	0	0	0	0	0	29	29	29	**87**
Professional leave	Plan	0	0	65	65	57	65	60	63	**375**
	Risk Adjusted Plan	0	0	13	13	11	13	12	13	**75**
	Actual	2	0	5	0	0	0	0	0	**7**
	Forecast	0	0	0	0	0	0	0	0	**0**
Activity recovery general	Plan	0	173	181	181	157	181	165	173	**1,211**
	Risk Adjusted Plan	0	35	36	36	31	36	33	35	**242**
	Actual	0	53	38	38	30	0	0	0	**159**
	Forecast	0	0	0	0	0	38	38	38	**114**
sub-total	Plan	**155**	**276**	**442**	**461**	**427**	**461**	**439**	**450**	**3,110**
	Risk Adjusted Plan	**137**	**91**	**180**	**193**	**186**	**193**	**188**	**191**	**1,359**
	Actual	**147**	**79**	**91**	**51**	**104**	**0**	**0**	**0**	**472**
	Forecast	**0**	**0**	**0**	**0**	**0**	**143**	**143**	**143**	**429**

Financial recovery plans - spend

Category	Plan/Actual	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Spend										
Ward Pay	Plan	75	75	104	85	89	92	92	92	**704**
	Risk Adjusted Plan	46	46	69	66	67	69	69	69	**502**
	Actual	73	51	82	86	43	0	0	0	**335**
	Forecast	0	0	0	0	0	112	112	112	**335**
Theatre Pay	Plan	0	-6	-9	3	15	53	53	53	**162**
	Risk Adjusted Plan	0	-6	-9	3	14	50	50	50	**154**
	Actual	0	-6	13	-9	0	0	0	0	**-2**
	Forecast	0	0	0	0	0	53	53	53	**159**
Agency	Plan	0	0	0	0	16	16	16	16	**65**
	Risk Adjusted Plan	0	0	0	0	15	15	15	15	**62**
	Actual	0	0	3	6	23	0	0	0	**32**
	Forecast	0	0	0	0	0	16	16	16	**49**
Community	Plan	0	0	23	23	23	23	23	23	**139**
	Risk Adjusted Plan	0	0	22	22	22	22	22	22	**132**
	Actual	6	9	10	17	10	0	0	0	**52**
	Forecast	0	0	0	0	0	23	29	29	**81**
Additional Procurement Opportunities	Plan	0	0	0	0	10	10	10	10	**40**
	Risk Adjusted Plan	0	0	0	0	10	10	10	10	**38**
	Actual	0	0	0	0	10	0	0	0	**10**
	Forecast	0	0	0	0	0	10	10	10	**30**
Additional CIP Requirement	Plan	52	52	132	82	82	82	82	82	**646**
	Risk Adjusted Plan	24	24	101	53	53	53	53	53	**416**
	Actual	52	52	52	61	82	0	0	0	**299**
	Forecast	0	0	0	0	0	82	82	82	**247**
sub total	Plan	**127**	**121**	**250**	**194**	**236**	**276**	**276**	**276**	**1,756**
	Risk Adjusted Plan	**70**	**65**	**183**	**144**	**182**	**220**	**220**	**220**	**1,303**
	Actual	**131**	**106**	**160**	**161**	**167**	**0**	**0**	**0**	**725**
	Forecast	**0**	**0**	**0**	**0**	**0**	**296**	**302**	**302**	**901**

Financial recovery plans - other

Category	Plan/Actual	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Other										
Board contingency	Plan	83	83	83	83	83	83	83	83	**667**
	Risk Adjusted Plan	79	79	79	79	79	79	79	79	**633**
	Actual	83	83	83	83	83	0	0	0	**416**
	Forecast	0	0	0	0	0	83	83	83	**250**
capitalisation	Plan	22	22	22	22	22	22	22	22	**178**
	Risk Adjusted Plan	21	21	21	21	21	21	21	21	**169**
	Actual	22	22	22	22	22	0	0	0	**111**
	Forecast	0	0	0	0	0	22	22	22	**67**
ASDM	Plan	0	0	0	0	0	0	0	1,486	**1,486**
	Risk Adjusted Plan	0	0	0	0	0	0	0	1,189	**1,189**
	Actual	0	0	0	0	3,100	0	0	0	**3,100**
	Forecast	0	0	0	0	0	0	0	0	**0**
Provisions	Plan	0	0	0	0	0	0	0	300	**300**
	Risk Adjusted Plan	0	0	0	0	0	0	0	285	**285**
	Actual	0	0	0	0	0	0	0	0	**0**
	Forecast	0	0	0	0	0	0	0	300	**300**
sub total	Plan	**106**	**106**	**106**	**106**	**106**	**106**	**106**	**1,892**	**2,630**
	Risk Adjusted Plan	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**1,574**	**2,276**
	Actual	**106**	**106**	**106**	**105**	**3,205**	**0**	**0**	**0**	**3,627**
	Forecast	**0**	**0**	**0**	**0**	**0**	**106**	**106**	**406**	**617**

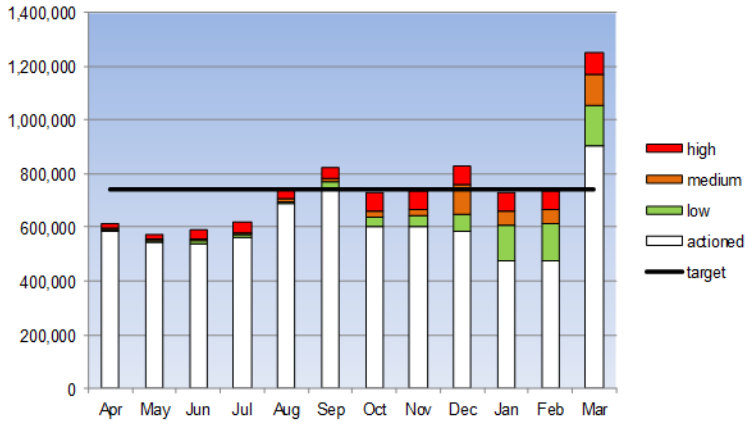
Financial recovery plans – further controls

Category	Plan/Actual	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Further Controls										
Holding Vacancies	Plan	0	0	45	90	135	180	225	270	**945**
	Risk Adjusted Plan	0	0	36	72	108	144	180	216	**756**
	Actual	0	0	27	61	70	0	0	0	**158**
	Forecast	0	0	0	0	0	60	60	60	**180**
Corporate Services Actions	Plan	80	42	70	70	70	84	64	64	**545**
	Risk Adjusted Plan	76	40	67	67	67	80	61	61	**518**
	Actual	35	42	41	33	33	0	0	0	**184**
	Forecast	0	0	0	0	0	0	0	0	**0**
Non Pay Control	Plan	0	0	35	35	35	35	35	35	**210**
	Risk Adjusted Plan	0	0	28	28	28	28	28	28	**168**
	Actual	0	0	152	-13	151	0	0	0	**290**
	Forecast	0	0	0	0	0	35	35	35	**105**
Reduce overtime/additional hours	Plan	0	20	20	20	20	20	20	20	**140**
	Risk Adjusted Plan	0	19	19	19	19	19	19	19	**133**
	Actual	17	24	27	32	22	0	0	0	**122**
	Forecast	0	0	0	0	0	20	20	20	**60**
Training	Plan	0	39	39	39	13	13	13	13	**169**
	Risk Adjusted Plan	0	37	37	37	12	12	12	12	**161**
	Actual	0	35	21	13	28	0	0	0	**97**
	Forecast	0	0	0	0	0	13	13	13	**39**
sub total	Plan	**80**	**101**	**209**	**254**	**273**	**332**	**357**	**402**	**2,009**
	Risk Adjusted Plan	**76**	**96**	**187**	**223**	**234**	**283**	**300**	**336**	**1,735**
	Actual	**52**	**101**	**269**	**126**	**304**	**0**	**0**	**0**	**851**
	Forecast	**0**	**0**	**0**	**0**	**0**	**128**	**128**	**128**	**384**
										0

Efficiency Update

The CIP target was increased to £9.4m in June with new targets issued to each of the directorates. Current performance shows that plans are in place for 94% of this target, however the risk adjusted total outlines potential delivery of 89%. 77% has been actioned up to the end of Quarter 3.

Trustwide Cost Improvement Programme 2017/18

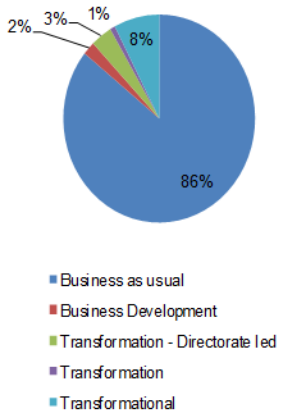


Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Trustwide	9,409,800	7,231,350	714,393	396,567	528,703	8,871,013	94%	8,333,018	89%
	% age of target		8%	4%	6%				

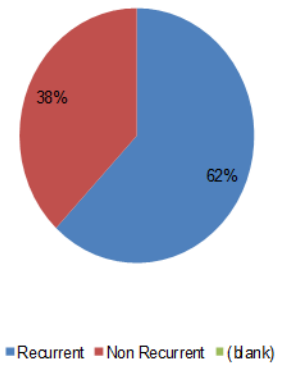
Top 10 unactioned schemes Top 10 as % of schemes - 12%

No.	Scheme	Directorate	Value	Risk
1	Recruitment controls in LTUC	Planned Care	227,570	High
2	Endoscopy Scheme	LTUC	216,500	Low
3	Outpatient Productivity	Planned Care	125,000	High
4	Bed Savings	LTUC	112,000	Medium
5	Theatre Utilisation	Corporate	77,000	Low
6	Non Recurrent Vacancy Control in LTUC	LTUC	68,500	Medium
7	Repatriation of Orthopaedics	LTUC	61,500	Low
8	Agency Savings	CCCC	59,656	Medium
9	Endoscopy Scheme	Planned Care	51,360	Low
10	Pathology review	Planned Care	50,000	High

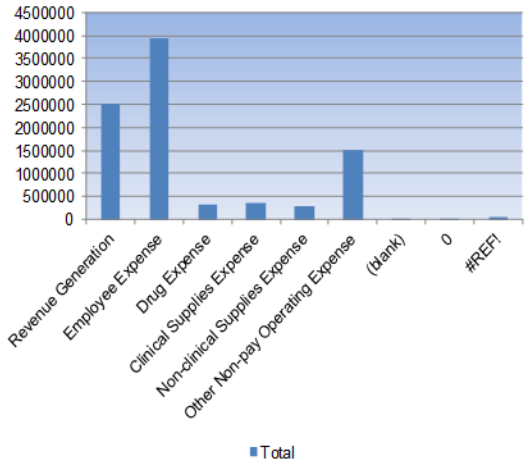
CIP schemes by internal category



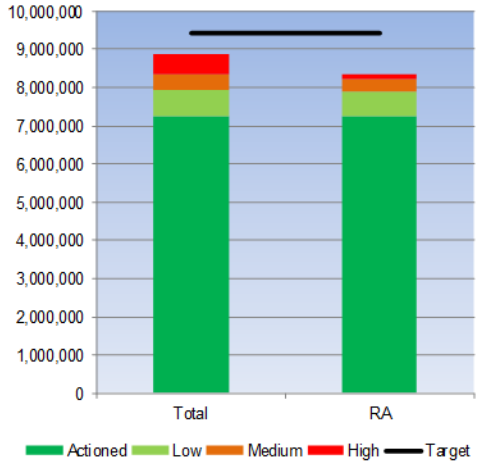
Recurrent V Non Recurrent Plans



Efficiency Category



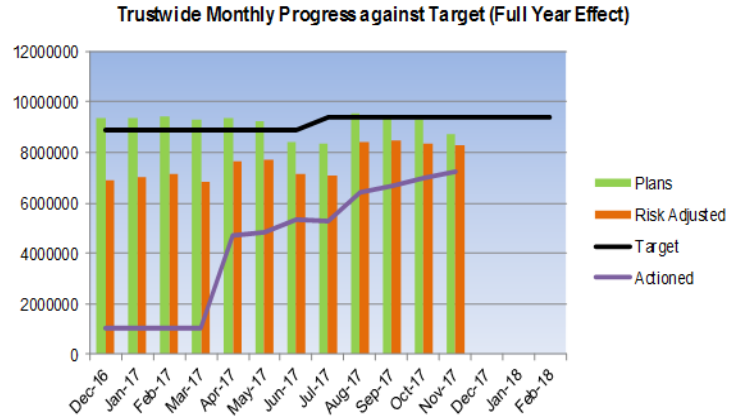
Risk Profile

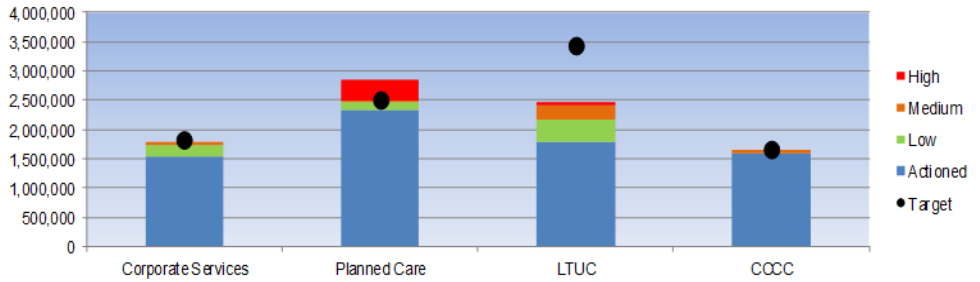


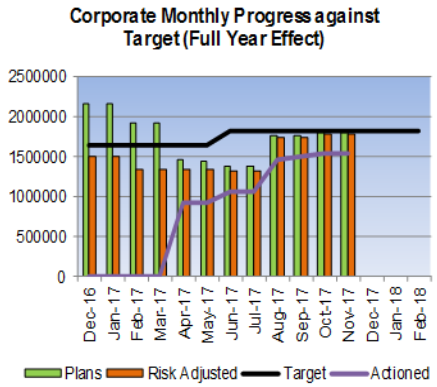
Efficiency Update Continued

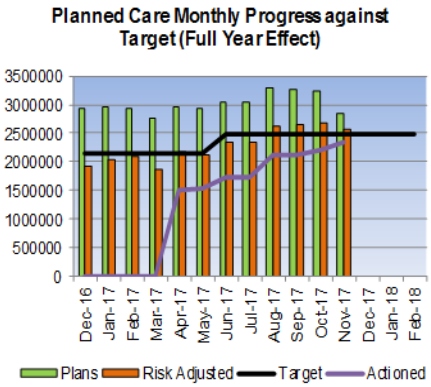
Trustwide Cost Improvement Programme 2017/18

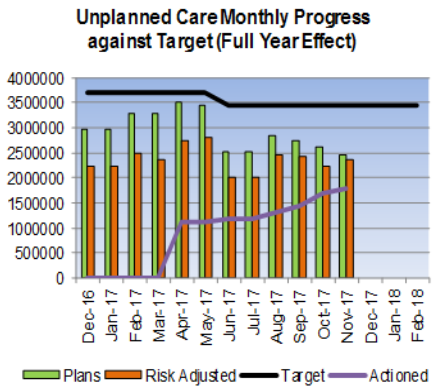
Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Corporate Services	1,818,900	1,539,550	202,900	49,300	0	1,791,750	99%	1,771,745	97%
Planned Care	2,497,000	2,334,200	118,193	48,667	347,103	2,848,163	114%	2,554,838	102%
LTUC	3,446,000	1,776,500	393,300	235,800	46,500	2,452,100	71%	2,348,100	68%
CCCC	1,647,900	1,581,100	0	62,800	0	1,643,900	100%	1,631,300	99%

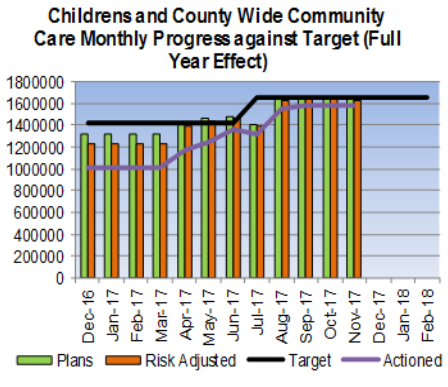


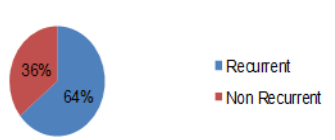


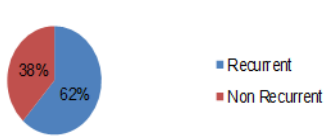


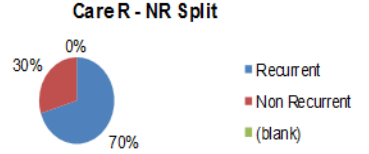




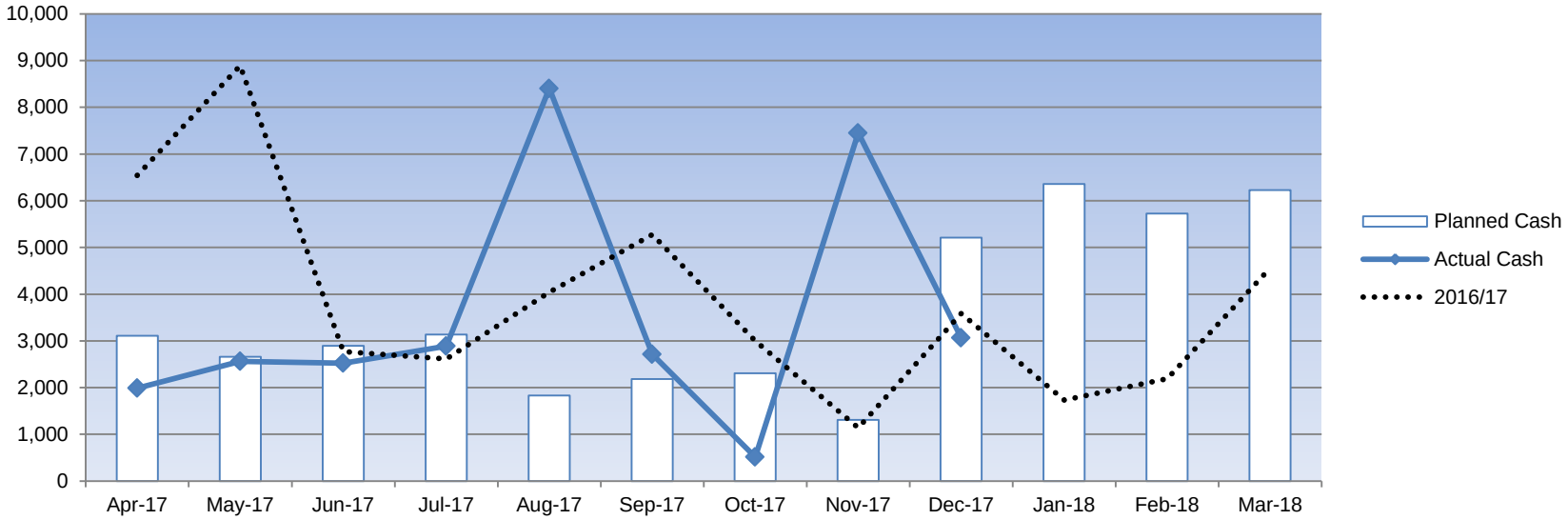








Cash



The cash balance at the end of December was £3.0m. There remains a significant balance outstanding with HaRD CCG. Since the contractual agreement was made At the beginning of January, around £500k of cash has been paid. Further payments are due but this cannot take Place until February due to CCG drawdown timescales. The risk in relation to contractual payments in March has receded and an update will be given at the Board.

Dec-17	£
NHS HARROGATE AND RURAL DISTRICT CCG	5,058,922.98
NORTH YORKSHIRE COUNTY COUNCIL	807,596.83
YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	796,959.85
NHS VALE OF YORK CCG	748,632.33
NHS SCARBOROUGH AND RYEDALE CCG	747,927.07
	8,160,039.06

Note: The NYCC balance is due to advanced invoicing that is beneficial to HDFT.

Date of Meeting:	31st January 2018	**Agenda item:**	7.0
Report to:	Board of Directors		
Title:	Chief Operating Officer's Report		
Sponsoring Director:	Mr Robert Harrison, Chief Operating Officer		
Author(s):	Ms Rachel McDonald, Head of Performance and Analysis Mr Jonathan Green, Information Analyst Specialist		
Report Purpose:	**Decision** ✓ **Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓		
Executive Summary:	• Elective and outpatient activity remains below plan in December. • The Trust experienced significant operational pressures in December. • The Healthy Children's pathway team have secured a further two contracts for Gateshead and Stockton which are currently being mobilised.		

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

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

Action Required by the Board of Directors:

It is recommended that the Board:

- *Notes items included in the report.*

CHIEF OPERATING OFFICER'S REPORT
Board of Directors' meeting 31st January 2018

1.0 SERVICE ACTIVITY

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

	Nov-17				Dec-17				Dec-17 YTD			
Activity type	Actual	Original plan	Recovery plan	Variance against recovery plan	Actual	Original plan	Recovery plan	Variance against recovery plan	Actual	Original plan	Recovery plan	Variance against recovery plan
New outpatients	8648	8555	8753	-1.2%	6918	7389	7602	-9.0%	72483	73111	73815	-1.8%
Follow-up outpatients	17065	17159	16339	4.4%	13807	14398	14065	-1.8%	140318	146633	142927	-1.8%
Elective inpatients	334	369	342	-2.3%	249	304	283	-12.0%	2617	2916	2778	-5.8%
Elective day cases	2618	2904	2834	-7.6%	2268	2329	2303	-1.5%	21187	23069	22761	-6.9%
Non-electives	1942	1779			1997	1996			16897	16268		
A&E attendances	3999	3987			4297	4120			37500	36546		

December saw a reduction in activity, particularly in inpatient work which was largely linked to the high volume of leave taken over this period.

In relation to day cases, additional Endoscopy lists at Wharfedale Hospital started in December and are scheduled in to the job plan. HDFT continues to work with Leeds to maximise the number of patients on these lists. This along with a number of other actions has improved the day case position in relation to the recovery plan.

Actions which continue to be undertaken to improve the activity position include:

- Continued alteration of outpatient clinic templates to increase the number of new patients seen per clinic;
- Replacing other specialty theatre lists with orthopaedic lists. Primarily this is happening with the use of the Trauma and Orthopaedic locum, but also where other consultants can pick up additional lists. In addition, starting hand and wrist local anaesthetic procedures is being planned within the Cath lab by the end of February, with the aim that this work is regular and in addition to the current run rate;
- Ensuring outpatient clinics are filled at short notice when patient cancellations free up slots;
- The continued increase in Saturday day surgery lists to additional specialties and utilising the skills of SAS doctors more and where possible, running lists without anaesthetists (local anaesthetic lists only) for appropriate cases, to therefore reduce costs and increase margin;
- Progression of the theatre staffing strategy to ensure recruitment. Band 6 posts have been recruited (including an agency staff member joining substantively). The 'Just are' campaign has started in January with the focus on filling the ongoing vacant band 5 posts. These continue to be filled by agency staff and therefore remain less efficient;
- Work continues with regards to theatre productivity. The Theatre dashboard was launched at the end of December;

- The altered pre-assessment process is being rolled out which is aimed at reducing cancellations and increasing utilisation. All general surgery clinics are now rolled out and orthopaedics plan a full roll-out by the end of February;

- As a result of using CIA and the Cath lab there are now 2 additional endoscopy lists at Harrogate, and from January the number of endoscopy lists at Wharfedale has been increased from 6 to 8.

2.0 IMPLEMENTATION OF WINTER PLANS

The Trust has experienced significant pressures in December, and these continue into January. Colleagues are to be congratulated on retaining a clear focus on high quality patient care. Every Hour Matters week contributed to an initial reduction on bed occupancy following the significant pressures experienced between Boxing Day and New Year's Day. This played a major part in improving the Trust's position in relation to the 4 hour standard. However, performance continues to be below 95% at present in January.

The confirmed December and Q3 position for the 4 hour standard was at 92.4% and 94.9% respectively. However, year-to-date the Trust continues to meet this standard.

HDFT has also seen increasing numbers of patients with the flu. This increase is consistent with the rise in the number of flu cases seen throughout the country this winter. In order to improve turnaround times for confirmation of flu testing which enables better patient management, use of side rooms, and reduces the need for rapid deep cleans, the Trust has recently implemented testing on site, reducing the requirement to send samples to Leeds Teaching Hospitals.

Throughout this challenging period, the Trust has provided support to pressure points elsewhere in the regional health system - in particular, the York/Scarborough Health economy, by taking ambulance diverts from them in a planned way. Supported by the winter funding from NHS England, a formal divert arrangement is now in place which seeks to balance pressures across hospitals in North Yorkshire. Changes to ambulance boundaries have been agreed for a 3 month period, and this means that patients from Tadcaster and villages west of York ring road will come to Harrogate Emergency Department. This equates to about 3-5 extra ambulances per day. The map below illustrates the areas covered by these changes.

It is anticipated that winter pressures will continue and the teams across the Trust continue to focus on providing the best possible care during this challenging period.

Actions we are deploying to support the current position are:

- 9 Additional Community Rehabilitation beds opened at Trinity Ward in Ripon & Lascelles Unit Harrogate (phased opening started 18th December with 3 additional and full 9 opened on 2nd January).

- 8 Spot purchase Nursing Home beds to support rehabilitation and non-weight baring patients (phased opening from the 2nd January 2018. Currently 6 beds occupied).

- Funding for Agency nursing to support escalation beds on the HDH site.

- Enhancing Supportive Discharge Team to support rehabilitation and management of patients moved to community beds. This will also provide more home assessment capacity as an alternative to escalation beds, initially with bank and agency Therapy staffing. The size of the team will expand as more capacity is sourced.

- Additional ED Consultant shift - Monday to Sunday 3pm to 11pm.

- Additional ED Nursing Support – Monday to Sunday 3pm to 11pm. Additional ENP cover Monday to Friday.

- Enhancing Discharge Team to support pathway coordination (additional nurse, discharge coordinator, ward admin roles).

- Additional Acute Physician Monday to Friday to support increase in ambulatory capacity.

- Additional Acute Physician to support Bank Holidays.

- Additional Medical Registrar to support Outlier patients in January.

- Roles to enhance acute discharge – SALT capacity/Pharmacy Prescribers.

- Discharge transport capacity and home follow-up service from Red Cross.

3.0 CANCER SERVICES

Performance

All applicable Cancer Waiting Times standards were achieved for December and Quarter 3. Trust performance for the 62 day standard was above 85% for December and Quarter 3 with 92.9% and 90.6% of patients treated within 62 days respectively.

Inter-Provider Transfer (IPT) performance

As stated above, performance for December with the current allocation rules is at 92.9%. A total of 33 patients were treated at tertiary centres in the quarter following a 2WW referral to Harrogate. Of these, 24 were transferred by day 38 (72.7%) which is an improvement on the previous 2 quarters (Q1 48% and Q2 60%).

Shadow reporting of the 62 day standard shows that when re-allocation rules are applied, performance would be slightly higher for December and Q3. The chart and table below illustrate HDFT's performance when re-allocation rules are applied.

ACTUAL performance	Apr-17	May-17	Jun-17	Q1	Jul-17	Aug-17	Sep-17	Q2	Oct-17	Nov-17	Dec-17	Q3
Total	**50.0**	**57.5**	**58.0**	**165.5**	**47.5**	**62.5**	**70.0**	**180.0**	**67.5**	**59.0**	**49.0**	**175.5**
Within 62 days	44.0	48.0	50.5	**142.5**	39.5	56.5	64.0	**160.0**	62.0	51.5	45.5	**159.0**
Outside 62 days	6.0	9.5	7.5	**23.0**	8.0	6.0	6.0	**20.0**	5.5	7.5	3.5	**16.5**
Performance	88.0%	83.5%	87.1%	**86.1%**	83.2%	90.4%	91.4%	**88.9%**	91.9%	87.3%	92.9%	**90.6%**

Re-allocation (NATIONAL)	Apr-17	May-17	Jun-17	Q1	Jul-17	Aug-17	Sep-17	Q2	Oct-17	Nov-17	Dec-17	Q3
Total	**48.5**	**57.5**	**57.5**	**163.5**	**47.0**	**61.5**	**69.5**	**178.0**	**67.0**	**59.0**	**48.5**	**174.5**
Within 62 days	40.5	50.0	47.0	**137.5**	39.5	55.5	62.5	**157.5**	61.0	51.5	46.0	158.5
Outside 62 days	8.0	7.5	10.5	**26.0**	7.5	6.0	7.0	**20.5**	6.0	7.5	2.5	16.0
Performance	83.5%	87.0%	81.7%	**84.1%**	84.0%	90.2%	89.9%	**88.5%**	91.0%	87.3%	94.8%	**90.8%**

Difference (National/Actual)	Apr-17	May-17	Jun-17	Q1	Jul-17	Aug-17	Sep-17	Q2	Oct-17	Nov-17	Dec-17	Q3
Total	**-1.5**	**0.0**	**-0.5**	**-2.0**	**-0.5**	**-1.0**	**-0.5**	**-2.0**	**-0.5**	**0.0**	**-0.5**	**-1.0**
Within 62 days	-3.5	2.0	-3.5	**-5.0**	0.0	-1.0	-1.5	-2.5	**-1.0**	0.0	0.5	**-0.5**
Outside 62 days	2.0	-2.0	3.0	**3.0**	-0.5	0.0	1.0	0.5	**0.5**	0.0	-1.0	**-0.5**
% difference	-4.5%	3.5%	-5.3%	**-2.0%**	0.9%	-0.2%	-1.5%	**-0.4%**	-0.8%	0.0%	2.0%	**0.2%**

Re-allocation (WYH policy)	Apr-17	May-17	Jun-17	Q1	Jul-17	Aug-17	Sep-17	Q2	Oct-17	Nov-17	Dec-17	Q3
Total	**46.5**	**59.5**	**54.5**	**160.5**	**47.5**	**61.5**	**68.5**	**177.5**	**66.5**	**59.0**	**49.5**	**175.0**
Within 62 days	38.5	52.0	44.0	**134.5**	40.0	55.5	61.5	**157.0**	60.5	51.5	47.0	**159.0**
Outside 62 days	8.0	7.5	10.5	**26.0**	7.5	6.0	7.0	**20.5**	6.0	7.5	2.5	**16.0**
Performance	82.8%	87.4%	80.7%	**83.8%**	84.2%	90.2%	89.8%	**88.5%**	91.0%	87.3%	94.9%	**90.9%**

Difference (WYH policy/Actual)	Apr-17	May-17	Jun-17	Q1	Jul-17	Aug-17	Sep-17	Q2	Oct-17	Nov-17	Dec-17	Q3
Total	**-3.5**	**2.0**	**-3.5**	**-5.0**	**0.0**	**-1.0**	**-1.5**	**-2.5**	**-1.0**	**0.0**	**0.5**	**-0.5**
Within 62 days	-5.5	4.0	-6.5	**-8.0**	0.5	-1.0	-2.5	**-3.0**	-1.5	0.0	1.5	
Outside 62 days	2.0	-2.0	3.0	**3.0**	-0.5	0.0	1.0	**0.5**	0.5	0.0	-1.0	**-0.5**
% difference	-5.2%	3.9%	-6.3%	**-2.3%**	1.1%	-0.2%	-1.6%	**-0.4%**	-0.9%	0.0%	2.1%	**0.3%**

IPTs SENT (actual patients treated at Tertiary centres)	Apr-17	May-17	Jun-17	Q1	Jul-17	Aug-17	Sep-17	Q2	Oct-17	Nov-17	Dec-17	Q3
Total	**10**	**22**	**18**	**50**	**15**	**19**	**16**	**50**	**12**	**13**	**8**	**33**
Within 38 days	3	14	7	**24**	8	13	9	**30**	6	12	6	**24**
Outside 38 days	7	8	11	**26**	7	6	7	**20**	6	1	2	**9**
Performance	30.0%	63.6%	38.9%	**48.0%**	53.3%	68.4%	56.3%	**60.0%**	50.0%	92.3%	75.0%	**72.7%**

4.0 DEVELOPMENT PLANS TO SUPPORT EARLIER DIAGNOSIS PROJECT

The Trust has secured in excess of £700,000 of investment in 2018/19 to deliver a number of projects which will provide significant improvements in the earlier diagnosis of Cancer. This has been secured through the West Yorkshire and Harrogate Cancer Alliance and will focus on the following projects:

Wave 1

Increased capacity delivered through enhanced workforce capabilities:

- Training additional reporting radiographers
- Training an additional sonographer to carry out TRUS and neck scanning

Development of a new model of diagnostics including Vague symptom pathways, Timed pathways and One stop diagnostic clinics.

Wave 2

- Roll out and implementation of Faecal Immunochemical Testing (FiT)
- Advance practitioners in Cellular Pathology
- Workforce Role redesign in Endoscopy to increase capacity

This investment is planned to deliver:

- CWT standards consistently

- Better patient experience through earlier diagnosis
- Better patient experience through earlier MDT decision making and earlier start of treatment
- Better patient experience through reduction in unnecessary tests
- Best use of existing capacity through best test first time
- Ability to manage increasing demand over at least the next five years through maximised efficiency

5.0 CHILDREN'S SERVICES

The school age immunisation team have just completed the school age flu vaccinations. This year they have had an additional year group to vaccinate (Year 4) and have once again achieved outstanding results with regards to the numbers of children vaccinated. Feedback from commissioners has confirmed that the team achieve the highest % of vaccinations in the region. In North Yorkshire and York the team have embraced new ways of working through an online consent process, and this has improved the uptake and reduced workload for schools. This is a new innovation that has been driven by the team and has been welcomed by parents. We are one of the only organisations in the country to adopt this innovative approach. In addition, the team have taken on the vaccination of community based staff for HDFT. Again this has been taken on with no additional resource.

6.0 CHILDREN'S AND YOUNG PEOPLE'S SURVEY 2016

The Children & Young Peoples survey 2016 results were published in November 2017. The survey involved 132 acute and specialist NHS trusts and in total, responses were received from 34,700 children and young people under the age of 16. Responses to the survey were received from 181 HDFT patients which equates to a HDFT response rate of 31%, compared to 26% nationally.

Questionnaires sent to those aged 8-11 and 12-15 had a short section for the child or young person to complete, followed by a separate section for their parent or carer to complete. Where a child was aged 0-7, the questionnaire was completed entirely by the parent or carer. The results of the survey have been standardised by age group, route of admission, and length of stay to ensure no Trust will appear better or worse than another because of its respondent profile. For each question in the survey, the individual (standardised) responses are converted into scores from 0 to 10. A score of 10 represents the best possible response and a score of zero the worst.

Based on overall score, HDFT scored of 8.1 with 52 of 59 scored questions reported as being within the expected range, and for all 132 Trusts the scores ranged from 7.7 to 9.2.

The following questions were highlighted by the CQC report as being better than the expected range for HDFT:

- Did you like the hospital food (children/young people aged 8-15)?
- Did the hospital staff answer your questions (children/young people aged 8-15)?
- Before operations or procedures, did hospital staff explain to you what would be done (children/young people aged 8-15 and parents/carers of 0-15 year olds)?

HDFT scored worse in comparison to other Trusts for the following questions:

- Did members of staff treating your child communicate with them in a way that your child could understand (parents/carers of 0-7 year olds)?

- When you left the hospital, did you know what was going to happen next with your care (children/young people aged 8-15 and parents/carers of 0-15 year olds)?

The directorate board have reviewed the report and an action plan has been developed in order to address the key areas for improvement identified in the report.

7.0 HDFT CQC INSIGHT FOR ACUTE NHS TRUSTS

CQC have published the latest Insight packs for acute and specialist NHS trusts, mental health services, GP practices and adult social care services. There are over 300 indicators used to monitor the quality of care of acute trusts. Updates are due to be published monthly going forward, although not all indicators are updated each month.

The packs incorporate data indicators that align to key lines of enquiry for that sector and bring together information from people who use services, knowledge from inspections and data from partners and will be updated monthly. The packs indicate where the risk to the quality of care provided is greatest, allows Trusts to monitor change over time and points to services where the quality may be improving.

HDFT's headline composite indicator score has improved this month and is now in the top 25% of acute trusts.

Of the 77 trust wide indicators, there is no change in HDFT's headline performance:

- Much better compared nationally - 1 (1%)
    - Sick days for medical and dental staff

- Better compared nationally – 2 (3%):
    - Ratio of occupied beds to other clinical staff
    - Help with eating

- Worse compared nationally – 1 (1%):
    - Flu vaccination uptake - national average 67.3%, HDFT (Sept 16 – Feb 17) 42.1%)

- Much worse compared nationally – 0 (0%)

- Improved - 2 (5%)
    - Deaths in low-risk diagnosis groups (Dr Foster intelligence Oct 2017)
    - Help with eating (CQC inpatient survey May 2017)

- Declined - 3 (8%)
    - Flu vaccination uptake
    - Inpatient response rate for FFT – 32.6% (Sept 15 – Aug 16) to 25.7% (Sept 16 – Aug 17)
    - Patient-led assessment of environment for dementia care - national average 76.1%, HDFT 69.8% (Feb 16 – Jun 16) and 64.1% (Mar 17 – Jun 17)

8.0 PRIVATE HEALTHCARE INFORMATION NETWORK (PHIN)

In line with the CMA Final Order for the submission of Private Healthcare Data, the Trust made its first submission to the Private Healthcare Information Network by the required date. The datasets included:

- Admitted Patient care data set,
- Adverse events,
- Patient feedback and experience.

As of the end of December the Trust also initiated the collection of Private Healthcare PROMs (Patient Reported Outcomes Measures) data in preparation for the submission date of 31st March 2018.

Date of Meeting:	31 January 2018	**Agenda item:**	7.1
Report to:	Board of Directors		
Title:	Update on establishment of Harrogate Healthcare Facilities Management Limited		
Sponsoring Director:	Mr Roberts Harrison, Chief Operating Officer Mr Jonathan Coulter, Deputy Chief Executive / Finance Director		
Author(s):	Mrs Katherine Roberts, Company Secretary		

Report Purpose:

Decision		Discussion/ Consultation		Assurance	✓	Information	✓

Executive Summary:

In November 2017 the Board agreed to establish a new wholly owned subsidiary company to provide estates and facilities services to the Trust. This decision was made in private due to the commercially sensitive nature of the topic.

The Board considered and agreed a business case, which provided options and recommendations for establishment of the company. The business case included a number of benefits to the Trust.

Creation of HHFM will affect circa 350 staff and present a sizable TUPE transfer arrangement.

Robust governance arrangements have been established to support the company. A number of important decisions will be reserved to the Trust's Board, these are referred to as reserved powers.

Related Trust Objectives

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

Key implications

Risk Assessment:	The project team supporting establishment of HHFM maintain a detailed risk register.
Legal / regulatory:	The Trust engaged professional legal and financial advice from Hempsons Solicitors and Ernst and Young.
Resource:	A number of financial benefits were identified during preparation of the business case. Details are included within the report.
Impact Assessment:	An Equality Impact Assessment was completed during preparation of the business case.
Conflicts of Interest:	As directors of Harrogate Healthcare Facilities Management, Mr Coulter and Mr Thompson have a conflict of interest in this agenda item.

Reference documents:	Not applicable
Assurance:	The matter was considered full by the Board of Directors in November 2017.

Action Required by the Board of Directors:

The Board of Directors is invited to:

- Note in public the decision made in private in November 2017 to establish a new wholly owned subsidiary company called Harrogate Healthcare Facilities Management Limited.
- Note the powers which will be reserved to the Board of Directors of Harrogate and District NHS Foundation Trust, as sole shareholder in the company.

Establishment of Harrogate Healthcare Facilities Management Limited

Background

In November 2017 the Harrogate and District NHS Foundation Trust Board of Directors decided to establish a new wholly owned subsidiary company (called Harrogate Healthcare Facilities Management Limited) to provide estates and facilities services to the Trust. This decision was made in private due to the commercially sensitive nature of the topic.

The Business Case

In reaching their decision members of the Board of Directors considered a business case which provided options and recommendations for the establishment, service transfer and management of a new wholly owned company to deliver estates and facilities services; Harrogate Healthcare Facilities Management Limited (HHFM).

It was determined that the establishment of HHFM would create a more connected and efficient service delivery arrangement for estates and facilities services. The business identified some a number of specific benefits:

- Modernising pay, terms and conditions for new staff to recognise market rates, this will ensure that HHFM is competitive in the employment market, thereby driving the performance of service delivery.
- Providing the potential to generate return to the Trust through establishing revenue contracts with external clients.
- An ability to generate greater operational efficiencies through delivery of estates and facilities services in an agile and commercially astute manner.
- Changes in the operating model would enable more cost effective delivery of the Trust's capital programme.
- Developing a distinct entity, subject to competitive forces, which is focused wholly on the provision of high quality service to meet the needs of the Trust.

It was recognised that the creation of HHFM will affect circa 350 staff and present a sizable TUPE transfer arrangement. Staff consultation closed in December 2017. A significant element in this was the transfer of NHS pension arrangements for those who transfer and engagement with the Pensions Agency has commenced.

It should be noted that the business case identified a number of financial benefits to the Trust of establishing HHFM. These will result in a benefit of £3.1m in 2017/18, and recurrent a benefit of £1.2m in future years. These financial benefits will be achieved through:

- Recurrent revenue savings
- Cash benefit through the funding for any future capital programme to be more efficient;
- Non-recurrent savings through a re-assessment under the Capital Goods Scheme of recent capital expenditure;
- Commercial income through the expansion of third party income; and
- Flow of funds and working capital arrangements.

Legal advice and guidance from NHS Improvement confirmed this would not be a significant or material transaction (as defined in the Trust's constitution and in NHS Improvement guidance). The Board did not therefore require approval from the

Council of Governors to establish HHFM, nor was there a legal requirement to consult Governors. However, in line with recommended practice, Governors were consulted about the proposed establishment of an HHFM in the private meeting of the Council of Governors held on 1 November 2017.

Governance of the company

Day to day management of HHFM will be delegated to a Board of Directors. The Board of the ASDM will be comprised of no more than five directors; two Trust directors and three non-Trust directors. However, as sole shareholder the Trust Board will retain the power to remove any director.

Jonathan Coulter (Deputy Chief Executive / Finance Director) and Chris Thompson (Non-Executive Director) have been appointed as the initial Trust directors on the HHFM Board. Recruitment for the Chair of the HHFM is ongoing, and the recruitment process for the remaining two directors will commence in late spring 2018.

A number of important decisions will be reserved to the Trust's Board; these will be referred to as reserved matters. The reserved powers were prepared following consideration of advice from the Trust's legal advisors to ensure the proportionate balance is delivered between independence and control as the shareholder.

Full details of the reserved powers are included below:

- Approving and signing off plans for the strategic direction of the Company.
- Approving the Company's annual business plan.
- Deciding whether the Company should incur expenditure outside the annual business plan which exceeds 1% of the projected budget.
- Deciding whether the Company should join, leave, establish or wind-up any pension scheme or materially alter participation in or, where relevant, the terms of any existing pension scheme.
- Deciding whether the Company should take out any borrowings, except for normal trade credit in the ordinary course of business, except as contemplated in the annual business plan.
- Deciding whether the Company should make any significant change in the nature of the business of the Company, except as contemplated in the annual business plan.
- Deciding whether the Company should enter into, vary, renew or terminate any contract or other arrangement which exceeds the term of the Operated Healthcare Facilities Agreement with the Trust.
- Deciding whether the Company should enter into any partnership or joint venture arrangement or vary or terminate any existing arrangement, or establish any subsidiary except as contemplated in the annual business plan or a separately approved business case.
- Deciding whether the Company should acquire or dispose of any patent, trademark, registered design or other know-how or any intellectual property rights.
- Deciding whether the Company should give or create any guarantee, indemnity, mortgage, or charge over its business, assets or undertakings or sell, discount or otherwise dispose of any of its book or other debts owing to it from time to time, except early payment discounts given in the ordinary course of business, except as contemplated in the annual business plan or any separately approved business case.

- Deciding whether to pass any resolution or take any other corporate action for the winding up of the Company.
- Following a decision by the ASDM's board of directors as to the level of a dividend, deciding whether the Company should pay any dividend or make any other distribution.
- Deciding whether to change the Company's accounting reference period.
- Setting the Company's accounting policies and deciding whether to change them.
- Deciding whether the Company should acquire or agree to acquire any freehold or leasehold interest in or licence over land.
- Deciding whether the Company should sell, lease, license, transfer or otherwise dispose of any of its assets at a total price per transaction exceeding £20,000.
- Approving any outsourcing arrangement or agreement (including by way of subcontract) in respect of the Company, where such arrangement or agreement will, or may, result in the TUPE transfer of staff employed by the Company to a third party

Recommendations

The Board of Directors is invited to:

- Note in public the decision made in private in November 2017 to establish a new wholly owned subsidiary company called Harrogate Healthcare Facilities Management Limited.
- Note the powers which will be reserved to the Board of Directors of Harrogate and District NHS Foundation Trust, as sole shareholder in the company.

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Date of Meeting:	31 January 2018	**Agenda item:**	8.0
Report to:	**Board of Directors**		
Title:	Report by the Director of Workforce and Organisational Development		
Sponsoring Director:	Mr Phillip Marshall, Director of Workforce and Organisational Development		
Author(s):	Mr Phillip Marshall, Director of Workforce and Organisational Development		
Report Purpose:	**Decision**		**Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓
Executive Summary:	• NHS Workforce Strategy consultation • Harrogate Healthcare Facilities Management - update • Living Wage and Agenda for Change Pay Review		

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

Key implications	
Risk Assessment:	Any identified risks are included in the Directorate and Corporate Risk Registers and the Board Assurance Framework.
Legal / regulatory:	Health Education England and the Local Education and Training Board have access to the Trust's workforce data via the Electronic Staff Records system. Providing access to this data for these organisations is a mandatory requirement for the Trust
Resource:	None identified
Impact Assessment:	Not applicable
Conflicts of Interest:	None identified.
Reference documents:	None appropriate
Assurance:	Not applicable.

Action Required by the Board of Directors:

The Board of Directors is requested to:

- **Note** the content of the report and comment as required

a) The NHS Workforce Strategy

With over 1.3 million staff performing over 300 different types of jobs across more than 1,000 different employers, the NHS needs a robust workforce planning process to ensure that we have staff in the right numbers, with the right skills and the right values and behaviours to deliver high-quality care.

Part of the core role of Health Education England (HEE) is to provide system-wide leadership and oversight of the workforce's education and training; HEE will work to ensure that healthcare staff are recruited in the right numbers and with the right values and behaviours to support the delivery of excellent healthcare and to continue to drive improvement. It is also a partner in delivering the NHS Five Year Forward View and is supporting the Government to deliver on its priority areas, including mental health.

HEE acknowledges that the NHS and the wider health and care system face many immediate and significant workforce challenges.

The NHS Workforce Report *Facing the Facts, Shaping the Future – a draft health and care workforce strategy for England to 2027* was published in September 2017 and describes the nature and scale of these challenges and sets out proposals for the management of workforce issues at both local and national level.

Professor Ian Cumming OBE, Chief Executive, Health Education England said:

"This is our first opportunity for a quarter of a century to ensure we have a comprehensive system-wide understanding of our workforce needs for the future; be that next year, five years away, or a decade away. This document outlines five years of action, taking on challenges as they arose, and finding solutions, but the future needs more than fixing as we go along. Agreeing what we need is the first step to planning the capacity and capability measures to deliver what we need. This document takes the first step – together we need to take the next one."

HEE's role in supporting effective delivery of healthcare

HEE is responsible for planning and delivering a healthcare workforce in the right numbers and with the right skills, values and behaviours to meet the current and future needs and expectations of patients.

Every year, NHS Trusts produce workforce plans to ensure that they are employing the right workforce to meet the needs of current patients. But because it takes at least three years to train a nurse - and even longer for other professionals like GPs and hospital doctors - Trusts also forecast how the needs of their patients could change in future, to inform our decisions about what the shape of the future workforce should be.

As such, every employer has a duty to ensure that they are recruiting the right numbers of staff with the right skills and behaviours to meet the needs of their patients, and the boards of provider organisations are responsible for assuring themselves that current staffing levels are safe and appropriate.

As HEE is driven by both national priorities and local needs, this unique governance model ensures that healthcare providers, informed by clinicians and professional leaders who have day-to-day contact with their patients, can inform and shape the decisions about education, training and workforce planning, whilst taking into account the long-term constraints of the academic cycle.

The consultation started 13 December 2017 and finishes at 5pm on Friday 23 March 2018. It can be accessed at: https://consultation.hee.nhs.uk and staff have been encouraged to contribute to the consultation on what will become the workforce of *their* future.

It is the Trust's intention to respond to the consultation from a service rather than an individual perspective and any relevant comments should be forwarded to me **no later than Friday 2 March 2018.**

b) Workforce Planning

Following the annual planning review meeting with NHS Improvement (NHSI) in December, the Trust has been provided with feedback on their reflections on the annual planning process undertaken within the Trust. One of the key areas of focus, unsurprisingly, was workforce; particularly in relation to productivity and resilience as well as capacity and demand within the context of our operating environment i.e. limited future workforce pipeline, Deanery allocations of Doctors in Training, inability to recruit registered nurses and the resulting agency spend.

NHSI did recognise the improvements made by the Trust in relation to workforce plans that mitigate future risks within the organisation, and external STP collective consideration of workforce and engagement in projects to secure future workforce pipelines. Our work with Health Education England on the Global Health Exchange and local university placements with tie-in clauses also drew particular mention.

We are continuing to develop our approach to annual planning for 2018-2019 by developing a workforce plan which sits as part of the activity planning. HR Business Partners are working with Directorates to identify areas of priority based on existing and future predictions of gaps in the workforce. This will then be developed into a specialty workforce plan that will focus on the key actions and interventions that will be implemented to close the gaps. This work should be concluded by the end of February and an overarching Trust level plan will be considered by the Workforce Efficiency Group.

c) Formation of Harrogate Healthcare Facilities Management

The Trust Board considered and approved the full business case for the creation of a wholly-owned subsidiary. Consultation with the affected staff groups (totalling around 340 staff in the Trust's Estates and Facilities departments) commenced in November 2017 and was extended until 18 December 2017. During this time a number of open meetings were held with staff to introduce the consultation and staff were able to request a one to one meeting with their manager and a member of the HR team.

The staff have now received the outcome paper regarding the transfer of their employment to Harrogate Healthcare Facilities Management (HHFM) which will occur on the 1 March 2018.

During this time there have been continuing discussions with Trade Union colleagues regarding the consultation and consideration of alternative models and issues raised have been addressed. Staff and Trade Union colleagues were concerned regarding a number of issues including the annual cost of living rise, pension provision, payment of the Living Wage, increments, promotion opportunities and new terms and conditions.

The Board of HHFM has met and has made some immediate decisions to support staff by confirming that the cost of living rise, when awarded, will be implemented, that HHFM are not seeking to harmonise existing terms and conditions of service and staff can continue on Agenda for Change terms for the life of the contract. It has also been agreed to continue payment of the Living Wage (as calculated by the living wage foundation) with an annual review in line with the process undertaken currently by the Trust. The Trust and HHFM have also agreed to undertake a number of internal recruitments prior to the transfer, to ensure that staff are able to be promoted and retain their current Agenda for Change terms at point of transfer. HHFM is yet to finalise and negotiate the terms for new staff who join the company after 1 March 2018 but this will be part of the Partnership Forum discussions that are to commence with Trade Union colleagues in February.

Further Trustwide open events have been organised for any staff members, both affected or not, who wishes to discuss the changes. In addition there have been a further six events organised specifically for affected staff to raise any questions to Directors of the Trust and HHFM, alongside HR colleagues.

Trade Union colleagues have lodged a formal collective grievance in relation to Harrogate and District NHS Foundation Trust's proposals to create a wholly owned subsidiary called Harrogate Healthcare Facilities Management (HHFM). There is the potential for some form of industrial action in the future, unless agreement can be reached on the matters that are in dispute.

d) Appraisal

A review was undertaken of the implementation of a dedicated appraisal period between April and September 2017. The results demonstrated clearly that there was a positive impact on the uptake of appraisals for Agenda for Change staff and that overall this had increased the Trust's compliance with appraisal completion to 84.67% for the 12 months at the end September 2017. This is the highest level of compliance across the Trust for three years.

A detailed paper was reviewed and approved for escalation to the Senior Management Team by the Workforce and Organisational Steering Group. The core recommendation was that in 2018 the appraisal window commences in April for a period of six months.

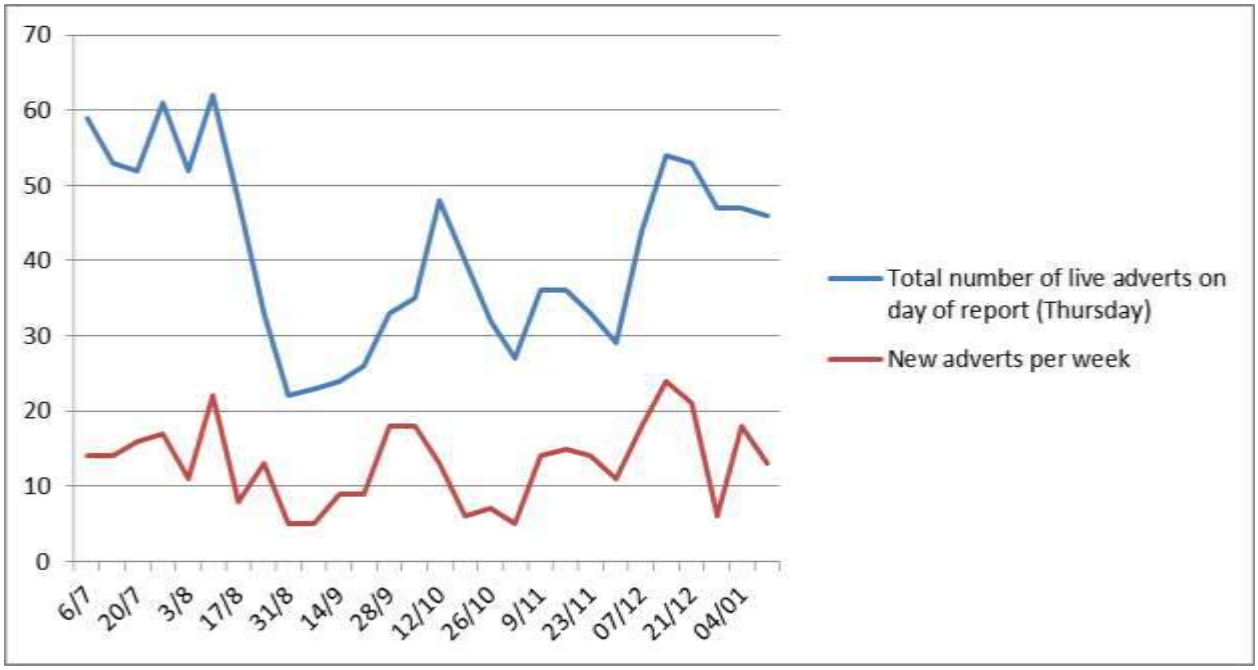
Staff are now experienced in the ethos and underlying rationale for the window and the reduced 'appraisal on a page' has been introduced and is embedded. The Operational HR Team will provide further training on undertaking group appraisals as this was an area which, although welcomed, was only taken up in a few areas.

For statistical comparison purposes, in future all areas of the Trust will be included in the denominator except for standard exclusions (new starters within 12 months, new to post within 12 months, absence covering 6 of the previous 12 months, open ended sickness over 28 days and all Medical and Dental staff).

A communication programme and training for areas who request it will commence during February and March. The Senior Management Team accepted this approach following g a recommendation made to the meeting on 24 January.

e) Financial Constraints

The Workforce and Organisational Development team continues to monitor the measures which have been put in place to improve the financial position of the Trust. Enhanced recruitment controls remain in place and vacancies which are deemed essential are reviewed weekly at the Vacancy Control group meeting. The graph below shows the changes in recruitment activity since the recruitment controls were put in place:



	JUL	AUG	SEP	OCT	NOV	DEC
Headcount incl Bank	4509	4511	4481	4507	4523	4503
Headcount excl Bank	4213	4209	4189	4207	4209	4191
Whole Time Equivalent	3433.16	3431.36	3418.30	3415.02	3429.32	3423

f) Sickness Absence

The overall sickness absence rate across the trust for November has remained at 4.57%, which is the same figure as October and is 0.69% above the overall Trust target of 3.9%. The comparable figure reported to SMT in January 2017 was 4.11%.

Looking at overall sickness and the split between short and long-term, short-term absence is 2.56% and long-term is 2.01%; therefore, although we have a similar split, it demonstrates that short- term absence is higher at this current time, which is likely to be a combination of the time of year and being in the winter months.

We have seen an overall decrease in two of the Directorate sickness rates. Long Term and Unscheduled Care has reduced from 4.92% to 4.76% which is a reduction across the Directorate of 0.16%, and Planned and Surgical Care has reduced from 5.45% to 5.34% which is a reduction of 0.11%. The other Directorates have seen an increase in

sickness rates, Children's and Countywide Community Care has moved from 4.27% up to 4.53% and Corporate Services have seen a slight increase moving from 3.10% to 3.16% which is an increase of 0.06%.

In September hot-spot areas for the Planned and Surgical Care Directorate were identified as theatres and the day surgery unit; following this meetings have taken place with management across each of these areas to review absence overall and put clear plans in place for all live long term sickness cases, to help facilitate a return back into work. New hot spots were identified in October's data for Children's and Countywide Community Care, which include Children Services 0-5 Whitby, Children Services 0-5 Ripon & Boroughbridge and Speech Therapy. Meetings are being scheduled in order to review each of these areas, to further review absence overall and discuss how the Trust's absence management lead can work with each of these teams to support them in helping to reduce sickness absence. Within Long Term and Unscheduled Care, adult and community care remains the identified hot spot. We have met with the Directorate to put in place a plan specifically for the live long-term sickness cases, and to address short-term sickness and the reporting procedures for this. We will continue to meet regularly to review absence data to support the reduction of sickness in this area.

Monthly sickness summits in Long Term and Unscheduled Care and Planned and Surgical Care continue to be held to focus on both long-term and short-term sickness absence in these Directorates; these meetings are with the management team to ensure more engagement from senior nursing staff to develop a plan for each employee, to become more active in the management of long term sickness, to see how we can impact on the short-term absence and to understand the impact sickness is having on wards. There has been a welcome decrease in each of these two Directorates which is a great start; these meetings will continue to be proactive in supporting the further reduction of sickness absence rates.

Overall across the Trust 43 long-term sickness cases were concluded in November 2017.

g) Flu update

The 2017-2018 flu vaccination programme continues to progress, with uptake for front-line healthcare workers as at 24th January 2018 is 59%. The national NHS target for front-line healthcare workers' flu vaccination uptake is 70%, and this is linked to the staff health & wellbeing CQUIN. The Trust has already met the first stage of the CQUIN target, having achieved a 50% vaccination rate, the second stage of the CQUIN target is 60% compliance.

Linked to the CQUIN requirements, Occupational Health has reviewed the individual flu vaccination uptake data and issued reminders to frontline staff in December who had not been recorded as being vaccinated during this campaign. Staff who have already been vaccinated elsewhere or who decline the vaccination have been asked to inform Occupational Health.

As in the rest of the country, the Trust is seeing an increase in admissions with respiratory illnesses, many of which will be viral. Four different viruses have been identified as circulating in the Trust:

- Seasonal flu A,
- Swine flu (a different sort of flu A)
- Flu B
- RSV- not flu but gives similar symptoms

Staff who have not had a flu vaccination yet have been urged to do so as soon as possible, to protect themselves, their patients and their visitors. Trained Flu Champions (peer vaccinators) will be continuing to visit wards, departments and community services over the coming weeks to vaccinate staff in their work area. At the same time recruitment of additional peer vaccinators is continuing.

h) Flu Vaccine 2018-2019

In 2018 the Trust has used a trivalent vaccine, in common with many other healthcare worker programmes. This year there were 14 different flu vaccines available. Twelve of these were for use in adults; the children's vaccine programme uses quadrivalent vaccines, of which there were three available for adult use.

Experience to date shows that there has been a mixture of Flu A H3, Swine Flu H1N1, undifferentiated Flu A and Flu B (much more prevalent than in 2016-2017). There have been several cases of hospital-acquired flu in patients, and also matching staff/patients cases. The trivalent vaccine procured this year does not protect against Flu B. The trivalent vaccine was procured by the Pharmacy team, as in previous years, and has been the vaccine of choice for some time. However, the Infection Prevention team has strongly recommended that the quadrivalent vaccine be ordered for 2018-2019. In addition, the trivalent vaccine ordered for this year did not have the low egg protein (ovalbumin) levels which would make it more suitable for those with an egg allergy. This restricts its use and provides a reason for a small number of staff refusing to be vaccinated.

Vaccine orders for the following flu 'season' need to be placed in March and the decision will not only include the clinical considerations outlined above but also whether or not to order the entire requirement from one supplier, which could achieve the largest discount on costs, or split the requirement to reduce the risk of delays or failure in manufacture (vaccine production is an annual process involving viral culturing and so carries a risk of failure). The decision will be made by a multidisciplinary team including representatives of Occupational Health, Microbiology and the Director of Pharmacy, which will look at the evidence and the associated costs of the trivalent and quadrivalent options.

Consideration is being given to ordering the vaccine for the 2018/19 campaign along with other Trusts in our STP area as one order, which may deliver financial savings.

i) Supervisor's Mandatory Training Record

I am pleased to highlight that the report on the compliance of Workforce and Organisational Development supervisors with Mandatory and Essential Skills training shows that all have achieved at least the minimum 95% compliance as at 1 January 2018, with the overall figure standing at 98% and 20 of the 25 achieving 100% compliance.

j) NHS National Staff Survey

The survey went out to over one million staff across England for the first time ever this year.

Draft benchmark reports will be sent out in the week commencing 19 February 2017 and will be subject to an embargo. Primary and secondary contacts in the Trust will receive a full benchmark report, a summary benchmark report, and a copy of the 'Making sense of your Staff Survey data' document.

Results must not be shared with anyone outside of the Trust prior to the lifting of the embargo**.** The Trust is free to use results for operational purposes (e.g. action planning) prior to the publication date. The Trust is also free to share results it receives before this date within the organisation, but none of the results are to be made available publicly prior to this.

The embargo on open discussion of the results will be lifted on Tuesday 6 March 2018 at 9:30am, when the full results will be published to the public.

k) Apprenticeship Register

The Workforce and Organisational Development Steering Group recently approved a paper relating to the employment of Apprentices. It will establish a redeployment register for those nearing the end of their apprenticeship who have yet to obtain employment, in order to try and secure them a role at HDFT if possible.

l) The Living Wage

The Trust made the decision in 2015 to support the implementation of the Living Wage. This was in line with the baseline salary and hourly rate as recommended by the Living Wage Foundation. This is reviewed annually and a paper was submitted to Director Team in early January 2018 recommending that the Trust continues to pay the Living Wage to all eligible staff.

The Trust recognised and wished to support lower paid workers within the NHS by implementing the Living Wage in 2015 and this has been renewed in 2016 and 2017. The Living Wage will be reviewed again nationally in November 2018.

The hourly rate announced by the Living Wage Foundation on 6 November 2017 for immediate implementation is £8.75 per hour which equates to a salary of £17,062 (an increase on the rate for 2016 at £8.45); this affects staff up to spine point 6 (whole of band 1, part of band 2 and the entry point of band 3) This sees a significant increase in eligible staff in 2017/2018 to 637 staff as the eligible staff group has increased into more administrative and clerical roles.

The Trust is very pleased to be able to continue paying the Living Wage supplement to its staff.

m) Agenda for Change Pay Process 2018

NHS Employers has submitted evidence to the Pay Review bodies for 2018. It made clear the scale of the workforce challenge facing the NHS, the need for an end to pay restraint to be fully funded, and the importance of the consultation on the draft health and care workforce strategy being an opportunity for the Department of Health and

Social Care and its arm's length bodies to adopt a credible and coherent approach to workforce strategy, planning, and policy. Representatives will be attending oral evidence sessions with the review bodies during February and March.

The Pay Review bodies' processes have been delayed this year due to changes in Government public sector pay policy announced in the November budget. It is therefore expected that they will report to Government sometime after April rather than by March as is usually the case.

In the November budget the Government announced that it would fund an end to pay restraint for Agenda for Change staff subject to successful talks between NHS Employers and trade unions on reform of Agenda for Change to boost productivity. These talks are continuing and the Government has said it expects the outcome to inform the NHS Pay Review bodies' report and recommendations.

Phillip Marshall
Director of Workforce and Organisational Development

January 2018

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Harrogate and District NHS Foundation Trust

Date of Meeting:	31st January 2018	**Agenda item:**	9.0
Report to:	Trust Board		
Title:	Chief Nurse Report		
Sponsoring Director:	Jill Foster		
Author(s):	Jill Foster		
Report Purpose:	**Decision**		**Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓
Executive Summary:	• The risk remains high regarding Registered Nurse vacancies on in-patient wards. Nurse recruitment and retention initiatives continue to show a challenging but improving position in year • The number of unavoidable, as opposed to avoidable, category 3 pressure ulcers is increasing as per Trust target in both the Hospital and Community • The total numbers of in-patient falls in December reduced significantly compared to December 2016. • There has been no deterioration of quality of care by the community care teams(CCT's) • Complaints year to date are 11% lower. • UNICEF Baby Friendly Accreditation – the next steps • The Equality and Diversity work across the Trust is having a positive impact on vulnerable communities		

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

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

Action Required by the Board of Directors:
• Be **assured** by the work being undertaken to improve of nurse recruitment and retention and the governance process for assuring safe staffing levels • **Note** the reporting of Director Inspections and Patient Safety Visits • **Acknowledge** the receipt of North Yorkshire Safeguarding Adults Board Annual Report • Be **assured** of progress toward the Trust pressure ulcer target • **Note** the work around falls reduction • Be **assured** about the monitoring of care provided by the CCT's • **Note** the decrease in numbers of complaints received by the Trust year to date compared to 2016/17. • **Understand** the on-going work stream for Baby Friendly Accreditation • **Note** the participation of the Trust in the National Maternal and Neonatal Health Safety Collaborative • **Approve** the self-assessment grading for EDS2 2017/18

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.

Patient Safety

1. Nurse Recruitment

As the Board is aware there are thousands of Registered Nurse (RN) Vacancies across England. Nationally demand for qualified nurses is likely to exceed supply for the foreseeable future. In these challenging conditions the registered nurse vacancies in the in-patient areas at HDFT is one of the highest risks on the Corporate Risk Register. The Trust has developed a continuing, innovative approach to recruitment and retention in mitigation of these severe challenges.

1.1 The Trust's recruitment and retention working group continues to work toward zero vacancies. A recruitment event is being held on Saturday 3rd February 2018.
1.2 The next event is planned in March 2018.
1.3 The Trust has welcomed 25 newly qualified nurses between September and December. There are 3 newly qualified nurses starting in January and 4 in March 2018.
1.3 5 nurses have started in the Trust from the Global Exchange Scheme. We are expecting a further 2 nurses by April.
1.4 Long Term and Unscheduled Care (LTUC) currently has 15.64 RN vacancies compared to 22.82 RN vacancies last month. They have 10.1 Care Support Worker (CSW) vacancies compared to 8.4 CSW vacancies reported last month.
1.5 Planned and Surgical Care has 14.85 RN vacancies across their in-patient areas with no CSW vacancies.
1.6 In Main Theatres there are 11.71 Band 5 vacancies.
1.7 We have advertised for experienced Assistant Practitioners (Band 4 roles) to work on the Acute Floor. We have now appointed 3 individuals. They are completing their education programmes and have start dates for later in 2018.
1.8 In December the Executive Team approved support for an Associate Nurse programme. The academic and experiential training is a two year programme. Since approval we have recruited 12 candidates, 9 from our current Band 2 CSW workforce and 3 external candidates. They commenced at Bradford University on 22nd January 2018.
1.9 As I reported last month the current number of vacancies means there are significant gaps in the planned rosters for the wards. On a daily basis 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

1.10 The number of 'hours owed' to the Trust is decreasing.
1.11 The result of these actions are reported in the actual versus planned staffing levels in Appendix One

1.12 Current Situation on Adult In-Patient Wards

Ward	Registered Nurses			CSW's		
	Est.	Vac.	%	Est.	Vac.	%
Acute Admissions Unit	23.27	0.2	0.9	13.93	1.35	9.7
Byland	16.11	1.61	10	22.88	2.71	11.8
Clinical Assessment Team	25.03	7.1	31.6	16.5	3	18.2
Granby	12.47	0	0	12.5	2.08	16.6
Jervaulx	16.11	1.61	10	22.88	0.41	1.8
Lascelles	10.76	0	0	10.68	0	0
Oakdale	25.05	3.55	14.2	15.32	0.46	3
Trinity	11.01	0.76	6.9	13.27	0	0
Total	**139.81**	**15.64**	**11.2**	**127.96**	**10.01**	**6.9**
Farndale	13.92	4.67	34	17.32	3.34	
Wensleydale	16.74	0.31	2	12.51	4.41over	
Littondale	18.17	0.73	4	11.68	1.31 over	
Nidderdale	18.32	5.17	28	14.52	0.71 over	
Harlow	10.51	1	10	3.46	0	0
ITU	31.53	2.97	9	2.4	0.8	33.3
Total	**109.19**	**14.85**	**14**	**61.89**		

This chart shows the current ward establishments in whole time equivalents (WTE) and the number of vacancies by ward for registered nurses and care support workers.

Other ward and department Band 5 RN/ODP vacancies

Ward/Department	**Band 5 RN/ODP Vacancies**
Emergency Department	3.36
Adult Community Nurses (CCT's)	2.43
Main Theatres	RN 6.82 ODP 4.89
Day Surgery	RN 1.5
Maternity Unit	1.3
Woodlands	2.61
SCBU	1

1.13 Is the situation improving?

The situation is currently in an improved position.

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
18/05/17	Wensleydale	Green
01/06/17	Selby MIU	Green
16/06/17	ITU	Green
16/06/17	Littondale	Green
21/11/17	AMU	Red
19/12/17	AMU	Green
19/12/17	Granby	Red

2.3 There has been no Director Inspection Visits in July, August, September and October 2017. A full programme of inspection has been arranged from November.

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
25/04/17	Littondale
23/04/17	Granby
06/06/17	Byland
21/06/17	Pharmacy
27/06/17	Main Out-Patients Dept
06/07/17	Endoscopy
28/07/17	General Office
10/08/17	Main Theatres
22/08/17	Oakdale
02/11/17	Elective Assessment and Discharge Unit
10/11/17	Lascelles
21/12/17	Heart Centre

North Yorkshire Safeguarding Adults Board (NYSAB)

The Board is asked to note HDFT has received the Annual Report from NYSAB. The report has been formally received by the Quality Committee. It is available in the reading room.

Patient Outcomes

4 Pressure Ulcer Target 2017/18

4.1 As I have previously discussed 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 to zero. This target has been identified from the root cause analysis of category 3 and 4 pressure ulcers in 2016/17 which determined, in both the hospital and community, 66% of category 3 and 4 pressure ulcers analysed were deemed avoidable. The table below provides further detail of results to date.

April-Dec 2016 and April - Dec 2017 Comparison

Community Datix	2016	2017	Comparison
Category 2	131	136	4% ↑
Unstageable / Cat 3	62	65	5% ↑
Category 4	3	3	

Community RCA	2016	2017	Comparison
Avoidable	36	15	58% ↓
Unavoidable	28	43	54% ↑
Total	64*	58**	

Hospital Datix	2016	2017	Comparison
Category 2	123	132	7% ↑
Unstageable / Cat 3	25	36	44% ↑
Category 4	0	0	N/A

Hospital RCA	2016	2017	Comparison
Avoidable	16	12	25% ↓
Unavoidable	9	14	55% ↑
Total	25	26*	

*Note remaining RCAs pending

The numbers of avoidable category 3 pressure ulcers in hospital and the community are decreasing.

5 Falls

5.1 The total number of falls and the number of falls resulting in moderate harm including fractures is higher this year compared the same time period in 2016/17.

Due to the increased total number of falls year to date (YTD) and an increased number of falls with fractures the Trust Board has asked the Quality Committee to review the work stream regarding the prevention and management of falls. The Quality Committee received a position paper at December's meeting and was assured about the work in place to prevent and manage in-hospital

falls. The Chief Nurse met with the Matrons and Ward Managers to discuss the falls situation on Tuesday 5 December 2017 and agreed a number of immediate actions.

The total number of falls in December 2017 is **59** compared to **85** in December 2016.

6 Quality of Care in the Community (Adult Community Care Teams in Harrogate)

6.1 Since December 2017 to date the Community Care Teams have been experiencing significant pressure. Demand on the service coupled with the teams' capacity has meant the community OPEL score daily, as fluctuated between 2 and 4.

The Directorate has been monitoring a number of proxy indicators for deterioration in the quality of care. These indicators include the total number of and total number of avoidable pressure ulcers, end of life care issues, access to the service via the telephone and finally formal complaints. To date there has been deterioration or points of concern in any of these indicators. Therefore I believe increased service pressures have had minimal impact on the quality of care in the community.

Patient Experience

7 Complaints

7.1 The number of complaints received in November 2017 is 14. The number of complaints received in December 2017 is 14.

Of the 14 complaints received in November 2017, 11 have been graded Yellow and 3 green.

Of the 14 complaints received in December 2017, 10 have been graded Yellow and 4 green.

Of particular note in November 2017:

- 6 complaints about communication & attitude
- 3 complaints about delay / failure to treat or diagnose
- 2 complaints about incorrect / inappropriate treatment

Of particular note in December 2017 there has been an increase in complaints about communication & attitude.

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

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

7.3 The total number of complaints YTD is **149.** The total number of complaints for the same period of time in 2016/17 was **167**.

7.4 There has been an 11% decrease in the number of formal complaints compared to the same time period in 2016/17.

8 Baby Friendly Initiative – Next Steps

8.1 In receiving the UNICEF Baby Friendly Gold Standard Accreditation for the Maternity Unit the Trust has agreed to:

- Maintain a portfolio of activity, progress and outcomes related to the Baby Friendly standards, including internal audit results and relevant data.
- Submit the portfolio annually to UNICEF UK for review.
- Undergo an initial re-validation meeting in one year to discuss the first portfolio submission and then undergo on-going re-validation meetings every three years
- Commit to addressing falls in standards identified as part of the monitoring / re-validation process.
- Facilitate short notice (within one week) half day visits by a UNICEF UK assessor to spot check adherence to the standards as part of the standard programme of quality monitoring.

8.2 SCBU and the 0 -5 Children's Service in North Yorkshire and the 0 – 19 Children's Services in Middlesbrough, County Durham and Darlington will continue work to maintain/gain the next level of accreditation.

9 National Maternal and Neonatal Health Safety Collaborative

9.1 For information the Trust has a place on wave 2 of the National Maternal and Neonatal Health Safety Collaborative which starts this April. The aim of the collaborative is to improve maternal safety nationally and our participation will ensure significant external support in safety and improvement science.

10 Equality and Diversity System for the NHS 2 (EDS2) update for 2017/18

10.1 The refreshed Equality Delivery System for the NHS (EDS2) was published in 2013 to help local NHS organisations in discussion with local people:

- Review performance for people with characteristics protected by the Equality Act 2010
- Improve performance for patients, public and staff

Part of the requirement for EDS2 for the Trust is to conduct an annual self-assessment against the goals and objectives of the scheme and publish the outcome of the self-assessment on the Trust's website. I have provided some refresher information about the goals and objectives of the scheme and detail of some of the equality and diversity work currently being undertaken across the Trust.

The Board is asked to approve the self-assessment grading 2017/18 for publication.

10.2 At the heart of EDS2 are 4 goals:

1. Better health outcomes
2. Improve patient access and experience
3. A represented and supported workforce
4. Inclusive leadership

And 18 outcomes to assess and grade against, asking the question “How well do people from protected groups fare compared with people overall?” Protected and disadvantaged groups are:

The EDS2 guidance suggests organisations might be selective in their choice of services to review, and the EDS2 outcomes that services are assessed and graded against, and that organisations can look at particular aspects of protected characteristics.

“……it is better to manage a comprehensive implementation of EDS2 over three to five years, through the use of informed selective choices at any one time”.

This is what we have been doing at HDFT, gradually improving our understanding of how well people from protected groups fare compared with people overall in relation to the wide variety and location of services and staff.

10.3 During 2017-18 we have:

- Embedded the governance arrangements.
- Progressed our work plan which is focused on local need.
- Gathered evidence and analysed results.

Key areas of progress:

- Achieving better health outcomes for patients with Learning Disabilities.

- Working with disadvantaged groups - Gypsy, Roma and Traveller Communities in Co Durham.
- HDFT Youth Forum.
- Highlighting to staff facilities for people with hearing impairment.
- Working towards full compliance with the Accessible information Standard.
- Dementia friendly signage on Jervaulx and Byland wards, dementia training, Matron for patients with dementia.
- Equality impact assessment toolkit developed.
- Lots of work on initiatives relating to safety:

    - Safety huddles - falls / pressure ulcers - focus on safety needs for specific patients.
    - Embedded risk assessment for patients with challenging behaviour.
    - Implemented pressure ulcer tools “Purpose T”, and “React to red” training in care homes.
    - Human factors training and application, and simulation training.
    - Review of training needs for staff caring for vulnerable people.
    - Clinical skills development, including naso-gastric tube insertion and position testing training and competency assessments.

- Changing Places - we have identified a location that will provide appropriate facilities within working hours in the new Endoscopy Unit.
- Engagement with a wide variety of local stakeholders via the Equality Stakeholder Group.
- In relation to our workforce:
    - A re-launch of the Workforce Equality Group which now meets quarterly with revised terms of reference.
    - Annual Workforce Race Equality Standard (WRES) return completed.
    - Armed Forces Covenant – HDFT has been recognised as one of the country’s leading employers for their support of the Armed Forces.
- Inclusive leadership and the Board:
    - Paper covering “drivers for improving impact assessments and developing focus on equality as well as quality” to Board of Directors in October 2017.
    - Stand about equality and diversity at Annual Members meeting.
    - Incorporating equality work into patient and public participation strategy work.
    - Equality impact assessment toolkit developed for all service improvement, transformation and cost improvement programme.
    - Well-led self-assessment completed and discussed at Board Development day in November 2017, with a focus on equality.
    - Designed and implemented a requirement to provide relevant information on equality for Board and committees for relevant papers, with a new front sheet with equality impact assessment introduced October 2017.

10.4 We have reviewed and updated the EDS2 self-assessment, using the grading matrix in EDS2:

Self-assessment grading 2016/17

Better health outcomes		Improved patient access and experience		A represented and supported workforce		Inclusive leadership	
1.1	Achieving	2.1	Achieving	3.1	Achieving	4.1	Achieving
1.2	Achieving	2.2	Achieving	3.2	Achieving	4.2	Undeveloped
1.3	Achieving	2.3	Achieving	3.3	Achieving	4.3	Developing
1.4	Developing	2.4	Achieving	3.4	Developing		
1.5	Achieving			3.5	Achieving		
				3.6	Achieving		

Self-assessment grading 2017/18

Better health outcomes		Improved patient access and experience		A represented and supported workforce		Inclusive leadership	
1.1	Achieving	2.1	Achieving	3.1	Achieving	4.1	Achieving
1.2	Achieving	2.2	Achieving	3.2	Achieving	4.2	Developing
1.3	Achieving	2.3	Achieving	3.3	Achieving	4.3	Developing
1.4	Achieving	2.4	Achieving	3.4	Developing		
1.5	Achieving			3.5	Achieving		
				3.6	Achieving		

We have refocused our equality objectives and will be updating our on-going work plan.

10.5 Proposed Equality Objectives for 2018-20

Better health outcomes:

- To ensure that our services provide effective and safe treatment and care that is sensitive to people's personal and cultural needs as well as appropriate to their clinical condition.

Improved patient access and experience:

- To strengthen our systems and processes to meet the requirements of the Accessible Information Standard, to continue to work with patients with learning disabilities to provide even better patient access and experience, and to introduce the Patient Participation Strategy.

A representative and supported workforce:

- To utilise the workforce equality group to deliver action plans focused on improving the availability of workforce equality information to assess our progress towards ensuring we have a representative and supported workforce.

Inclusive leadership:

- To ensure that Trust leaders have the right information and skills to promote equality within and beyond the organisation and to support their staff to work in a fair, diverse and inclusive environment.

The work plan for 2018-19 will include:

- Embedding the equality impact assessment processes and toolkit.
- Improving compliance with the Accessible Information Standard.
- Continuing to improve access and experience for people with learning disabilities.
- Supporting inpatients with hearing and sight impairment.
- Work to understand and meet the needs of people with gender identity issues and gender reassignment.
- Providing facilities that meet the requirements of “Changing places”.
- Complete and implement Patient Participation Strategy.
- Appointing Equality Champions to help us to begin to engage with staff around a number of areas which have been highlighted through WRES and EDS2 data sets.
- Refreshing the single equality scheme. It is likely this will be replaced with a strategy with more focus on inclusion and engaging with underrepresented staff groups.

Jill Foster
Chief Nurse
January 2018

Appendix One

Actual versus planned nurse staffing - Inpatient areas

The table below summarises the average fill rate on each ward during **December 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 December was **7.90** care hours per patient per day.

	Dec-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	98.3%	110.6%	92.7%	184.9%	4.10	3.30	7.40
Byland	96.4%	94.3%	66.7%	122.6%	2.20	3.50	5.70
CATT	99.7%	121.0%	92.3%	92.3%	4.30	3.00	7.30
Farndale	74.7%	103.6%	103.6%	157.1%	2.80	3.90	6.70
Granby	106.4%	143.5%	100.0%	140.3%	3.00	3.60	6.60
Harlow	100.0%	100.0%	100.0%	-	6.30	1.80	8.10
ITU/HDU	107.7%	-	109.7%	-	22.10	2.40	24.50
Jervaulx	105.4%	97.1%	67.7%	134.7%	2.40	3.70	6.10
Lascelles	97.0%	100.6%	100.0%	100.0%	4.10	3.90	8.00
Littondale	96.8%	141.3%	94.6%	158.1%	4.10	3.10	7.30
Maternity Wards	87.1%	75.0%	96.0%	96.8%	12.60	3.40	16.00
Nidderdale	99.8%	100.5%	103.2%	119.4%	3.10	3.40	6.50
Oakdale	79.7%	136.6%	87.9%	183.9%	3.70	3.80	7.50
Special Care Baby Unit	95.0%	0.0%	85.5%	-	17.00	0.00	17.00
Trinity	100.2%	98.4%	100.0%	100.0%	4.20	4.10	8.30
Wensleydale	87.9%	188.7%	100.0%	195.2%	3.40	4.30	7.70
Woodlands	80.3%	66.1%	92.5%	87.1%	8.70	2.20	10.90
Trust total	**94.9%**	**112.4%**	**93.4%**	**135.9%**	**4.40**	**3.50**	**7.90**

ED	84%	255%	94%	139%		

Further information to support the December data

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

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

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 (RM) gaps were due to vacancies and sickness in December and care staff gaps were due to sickness; however a professional assessment was made on a shift by shift basis to ensure that nurse staffing numbers matched the activity. The RM vacancies are in the process of being recruited to.

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

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

The staffing complement for the children's ward, Woodlands, is designed to reflect varying levels of occupancy. Although the day and night time RN and care staff hours are less than 100% in December due to staff sickness and vacancies, the ward occupancy levels vary considerably which means that particularly in this area the number of planned and actual nurses is kept under constant review.

On Wensleydale ward although the daytime RN hours were less than planned bed occupancy fluctuated in this area during December and an assessment was undertaken on a shift by shift basis to ensure that the planned staffing matched the needs of the patients.

November Data (Included for information as there was no Chief Nurse Report in December 2017)

	Nov-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	98.8%	108.1%	99.2%	151.1%	4.30	3.10	7.40
Byland	103.0%	95.9%	73.3%	123.3%	2.40	3.60	6.00
CATT	96.6%	125.0%	97.9%	101.5%	5.00	3.60	8.70
Farndale	81.9%	146.1%	105.0%	161.7%	3.00	4.80	7.90
Granby	105.6%	157.5%	100.0%	136.7%	3.10	3.80	6.90
Harlow	105.0%	93.3%	100.0%	-	6.70	1.70	8.40
ITU/HDU	111.1%	-	108.0%	-	21.20	1.90	23.20
Jervaulx	116.9%	105.2%	75.6%	119.4%	2.70	3.90	6.60
Lascelles	104.5%	94.0%	100.0%	100.0%	4.30	3.60	7.90

Littondale	94.4%	146.7%	93.3%	190.0%	3.70	3.10	6.80
Maternity Wards	94.8%	84.2%	98.3%	90.0%	12.00	3.20	15.20
Nidderdale	97.8%	122.2%	106.7%	138.3%	3.40	4.10	7.50
Oakdale	89.0%	131.1%	95.0%	151.7%	4.40	3.70	8.00
Special Care Baby Unit	93.3%	0.0%	96.7%	-	20.20	0.00	20.20
Trinity	106.1%	201.7%	100.0%	200.0%	4.40	4.20	8.60
Wensleydale	90.0%	170.8%	101.7%	166.7%	3.20	3.60	6.80
Woodlands	76.7%	75.0%	92.2%	86.7%	8.40	2.30	10.70
Trust total	**98.5%**	**120.2%**	**96.8%**	**137.4%**	**4.60**	**3.60**	**8.20**

ED	85%	243%	85%	127%			

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Date of Meeting:	31/01/2018	**Agenda item:**	9.1
Report to:	Board of Directors		
Title:	Patient Safety Visits: Annual Report January 2017 – December 2017		
Sponsoring Director:	Jill Foster, Chief Nurse		
Author(s):	Dr Sylvia Wood, Deputy Director of Governance Michael England, Governance Officer		
Report Purpose:	**Decision** ✓ **Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓		
Executive Summary:	This report summarises patient safety visits undertaken since the last annual report to the Board of Directors in January 2017. It provides examples of issues raised. There are challenges within this process, and we are proposing that a review is now undertaken to consider whether this is the best way to achieve the aim of encouraging a focus on patient safety and quality, ensuring that the views and experiences of front line staff are heard, and promoting a culture of speaking up. We are proposing that the current process continues for the dates currently arranged until March 2018. We will seek feedback and suggestions from staff, executive and non-executive Board members and Governors.		

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

Key implications	
Risk Assessment:	None identified
Legal / regulatory:	None identified
Resource:	None identified
Impact Assessment:	Not applicable
Conflicts of Interest:	None identified
Reference documents:	Patient Safety Visits operating procedure and information leaflets
Assurance:	The patient safety visit programme provides assurance in relation to patient safety and staff engagement, and ward to board quality governance. The reports of patient safety visits are shared with the relevant ward or department, Directorate Governance Group or Board, and Senior Management Team.

Action Required by the Board of Directors:

- To receive and consider the assurance provided by the content of the report.
- To consider the challenges with the process that are highlighted and the proposal to review the value and format of patient safety visits.

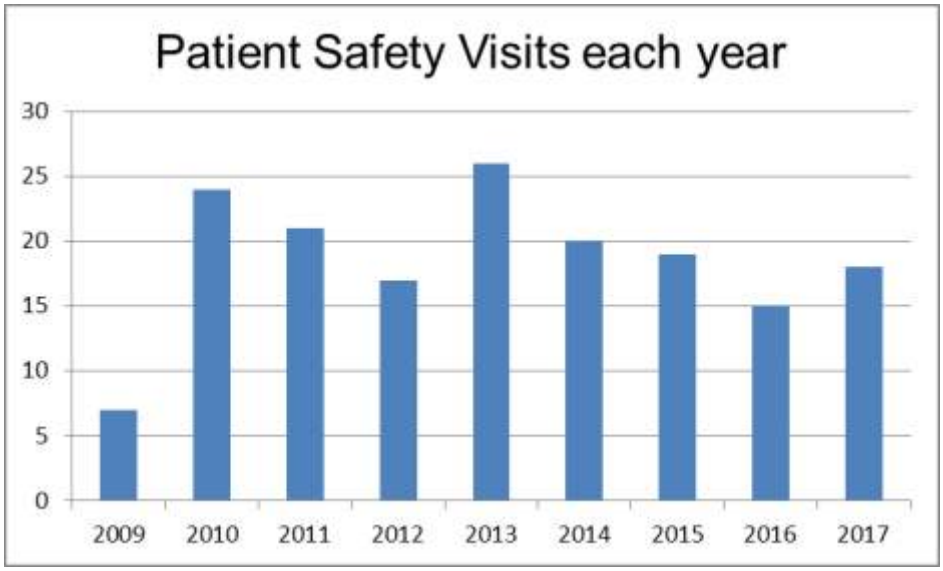
Patient Safety Visits: Annual Report January 2017 – December 2017

1. Background

Patient Safety Visits were introduced at HDFT in 2009. They are based on patient safety walkabouts that were originally designed to:

- Increase the awareness of safety issues among all staff;
- Make safety a priority for senior leaders by spending dedicated time promoting a safety culture;
- Educate staff about patient safety concepts such as incident reporting;
- Obtain and act on information that identifies areas for improvement;
- Build communication and relationships with frontline staff to work together to deliver safe care.

In that time 166 patient safety visits have taken place to wards and departments across the Trust. This includes all inpatient wards, 24 community areas, and 31 departments.



Year	Number of Visits
2009	7
2010	24
2011	21
2012	17
2013	26
2014	19
2015	19
2016	15
2017	18
Total	166

The Standard Operating Procedure for patient safety visits was last reviewed, updated and approved at Senior Management Team in January 2017.

The service or ward manager is sent a poster and leaflet before the visit to share with staff in order that they are clear about the purpose of the visit. They are encouraged to think about issues including:

- What we can do together to improve;
- Incident reporting and learning from incidents;
- Complaints and learning from complaints;
- Positive steps taken to improve patient safety.

All staff are encouraged to participate and have their concerns and ideas heard. The information says that visiting team will try to identify ways to address concerns in order to improve safety for patients and staff, and will aim to share good practice.

Staff are encouraged to use existing departmental and directorate structures and processes to share concerns, improve safety and manage risk. Occasionally issues are raised that are

appropriate to follow up as a matter of some urgency outside these established methods. These are identified at the time and recorded on the patient safety visit action log as high priority.

An Executive Director usually leads a patient safety visit with the Deputy Director of Governance and a Non-Executive Director, and members of the Council of Governors are invited to attend. Notes are taken during the visit and the reports are shared with the service, the visiting team, the relevant directorate, and Senior Management Team where key findings are highlighted and discussed.

The log of all visits undertaken is at Appendix 1.

2. Visits undertaken during 2017

Since January 2017 when patient safety visits were last reported to the Board of Directors, there have been visits to 18 services.

Three services have been visited for the first time during the period:

- Antenatal Clinic
- 0-19 Children's Service, Middleborough
- Elective Admissions/Discharge Unit

15 services have had a re-visit during the period:

- Jervaulx Ward
- Byland Ward
- Ripon Community Hospital
- Littondale Ward
- Endoscopy
- Main Theatres
- Lascelles Ward
- Granby Ward
- Pharmacy
- Main Outpatients
- Oakdale Ward
- Selby MIU
- Farndale Ward
- Harrogate Heart Centre
- General Office

The number of safety visits attended by executive, non-executive directors and governors:

Non-Executive Director		Executive director		Governors	
Sandra Dodson	1	Ros Tolcher	4	Yvonne Campbell	1
Ian Ward	3	David Scullion	3	Cath Clelland	1
Lesley Webster	2	Jonathan Coulter	1	Steven Treece	1
Chris Thompson	7	Jill Foster	4	Jane Hedley	2
Maureen Taylor	3	Phillip Marshall	4		
Neil Mclean	2	Rob Harrison	1		
Total	18		17		4

3. Visits not arranged or cancelled

In previous years there have been concerns raised about patient safety visits being cancelled at short notice. This is not a consistent issue and has been significantly improved since 2015. However some dates identified for potential patient safety visits are sometimes removed from diaries when it has not been possible to arrange a visit. Extra dates are arranged in order to allow for this.

	2015	2016	2017
Potential dates identified	29	23	24
Dates not utilised and therefore removed from diaries	6	7	6
Patient safety visits arranged and confirmed	23	16	19
Number of arranged visits cancelled	4	1	1
Number of visits undertaken	19	15	18

The one arranged visit which was cancelled during 2017 was due to staff sickness. The visit was rearranged for a different date later in the same week.

The following services were identified by the directorates as locations for a patient safety visit during 2017, but a visit was either not arranged or not undertaken in the period for the following reasons:

Yeadon/ Alwoodley Outreach Clinics: HDFT staff are only on site at Yeadon and Alwoodley outreach clinics when a clinic is running. During these times the staff have limited availability to speak with members of the visiting team. Alternative options include meeting with clinic leads or service managers outside clinic hours but the staff would be back on site at Harrogate District Hospital.

GP OOH: There continue to be issues with arranging a suitable time for a visit out of hours.

Community Children's Services: Patient safety visits to the Community Children's Services in Middlesbrough, Darlington and County Durham were suggested. A visit took place to the County Durham Community Children's Service at Stanley Education Centre in 2016 and Middlesbrough Community Children's Service at Beresford Building in September 2017. Visits to other locations could be planned for the coming year.

4. Sample of issues raised at patient safety visits

A small sample of issues recorded from patient safety visits during 2017 has been included to illustrate some of the findings.

Good practice

Good team working continued to be reported in a number of areas this year including Jervaulx, Granby and Oakdale Wards. Farndale and Byland Ward staff talked about the introduction of a number of patient safety schemes including falls safety huddles, safer discharge projects, tabards for nurses undertaking medicine ward rounds to reduce interruptions, pressure ulcer care bundles and a staff newsletter to share the outcome of root cause analyses. Pharmacy highlighted their performance against the findings of the Carter Review, with good performance for medicines optimisation within 24 hours at 87% and the best in the region. They were increasing the number of pharmacists actively prescribing from 10% in Feb 2016 to 17% at the time of the visit, with aspirations to achieve 58% by 2018.

Themes and ongoing issues

All inpatient areas visited during the year reported issues around the shortage of both medical and/or nurse staffing. There were examples of incidents that had occurred as a result of staffing shortages such as a patient being delayed going to theatre because there were not enough qualified nurses on the ward to deliver a blood transfusion, and staff having to work longer hours with limited breaks. Associated with this was concern about the redeployment of nursing staff to other areas in order to cover nurse staffing gaps. These

issues provided an opportunity for the visiting teams to listen to those concerns and to highlight actions being taken to improve the position.

The functionality of a number of different IT software and hardware systems across areas was a frequent issue. Most of the issues have been followed up with IT or the relevant systems team following the visit, with a number of actions being taken forward such as the roll out of Web-V to address integrated system issues, and work to address IT hardware issues by the IT department.

There were a number of areas where concerns raised at previous visits had improved or resolved. Lascelles staff reported that maintenance delays had improved and that Estates were usually able to respond very quickly to any higher priority reports. General Office staff reported that there had been some improvement in delays in doctors producing death certificates, although there continued to be issues with ensuring relevant deaths are reported in a timely manner to the Coroner where this is appropriate. The team were aware that they could escalate any significant delays to the Medical Director, and were encouraged to report any incidents on Datix in order that any incidents could be addressed and monitored.

High priority issues

Following a patient safety visit there is usually a quick debrief between members of the visiting team in order to identify any actions to be followed up promptly.

Problems with the batteries and swipe card access for mobile medicine cabinets (Medcarts) were raised by Jervaulx Ward staff. A review was requested and work was undertaken rapidly to replace defective batteries and to replace electronic screens with laptops. This offered some improvement but issues with swipe card access have more recently been a concern again. An urgent review has been undertaken and actions agreed to effectively resolve the issues and the associated clinical risk. Actions include replacing the card lock system with a lock and key. Together with replacement of the remaining electronic screens with laptops, this removes the need for batteries on the Medcarts and will address the ongoing problems associated with failing batteries.

Staff in some areas reported that the use of falls sensors was not effective or efficient. Oakdale ward reported a number of falls in spite of using falls sensors. The Medical Devices Safety Officer undertook a review of the devices on a number of wards and reported various issues related to the design and use of the devices, leading to the loss and breakage of units. It is understood that colleagues across the region have had similar problems. The issue has been followed up at The Equipment Group.

5. Challenges

Whilst the visiting team almost always report some positive outcomes from patient safety visits, we recognise that are challenges, including:

- When wards and services are very busy, staff are only able to participate for a short time and there is always a concern that participation impacts on work load;
- Particularly in small teams, there may be one or two staff members at a time meeting potentially 5 members of the visiting team. This can be intimidating, particularly for junior members of the team;
- The most useful visits are those where staff are clear about the purpose of the visit and have had an opportunity to think about issues they might want to highlight. Whilst the situation has improved, it is disappointing that despite the effort that goes into the arrangements, staff are sometimes unprepared and unclear about the purpose of the visit;

- The collective resource that is involved in a patient safety visit is considerable, particularly when visiting a more distant community location.

Although a systematic evaluation of feedback from staff following a patient safety visit has not been undertaken, the informal feedback received from managers and staff is that they value the opportunity to meet senior leaders and raise concerns with them. However following some recent feedback that staff, particularly junior staff are not very keen to talk to the visiting team, a service manager explored this with their staff and suggested:

- Staff were keen to have some more ideas of what they might talk about with some examples of what has been said or done as result of visits in the past, 'you said; we did' examples;
- Talking in groups would be easier – although this is the ideal format it is not always easy for small teams;
- Despite best efforts, some staff still feel they might say the wrong thing.

Given that we did receive some feedback from a member of staff who was criticised by their manager for raising concerns at a patient safety visit, some of these concerns are understandable.

6. Conclusion

Patient safety visits have provided valuable opportunities to increase the awareness of safety issues, promote a safety culture and build communication and relationships with frontline staff to work together to deliver safe care. However, given the challenges highlighted, we are proposing that this might be a good moment to review patient safety visits – how they are done, what we want to achieve, whether staff, executive and non-executive Board members and Governors find them useful, and whether there are alternative methods that should be considered.

Whatever we do – we want to encourage the sense that we are all focused on patient safety and quality, that understanding the views and experiences of front line staff is important, and the culture of speaking up!

We are proposing that the process continues without significant changes for the dates currently arranged by the Executive Assistants office, but that during this time the Trust's approach to patient safety visits will be reviewed. We will seek feedback and suggestions from staff, executive and non-executive Board members and Governors, and alternative models for engaging with staff in relation to patient safety.

Appendix 1: Log of all patient safety visits undertaken

Site	1st Visit	2nd Visit	3rd Visit	4th Visit	5th Visit	6th Visit
Jervaulx	11/01/2010	12/08/2011	11/09/2013	11/03/2015	13/07/2016	16/05/2017
Byland	16/11/2009	08/06/2011	23/10/2013	11/03/2015	13/07/2016	06/06/2017
Woodlands/SCBU	11/03/2010	29/11/2011	08/11/2013	08/04/2015	27/09/2016	
Ripon Community Hospital	30/06/2011	21/03/2013	28/08/2013	09/05/2014	28/02/2017	
Littondale	03/11/2009	02/06/2011	16/10/2013	07/10/2015	25/04/2017	
Endoscopy	18/11/2010	05/03/2013	24/10/2013	23/04/2015	06/07/2017	
Main Theatre	07/05/2010	03/07/2012	12/09/2013	03/09/2015	10/08/2017	
Lascelles	01/03/2009	07/07/2011	11/10/2013	12/05/2016	10/11/2017	
ED	25/10/2010	17/11/2011	30/10/2013	13/08/2015		
Fountains/Bolton/AMU/CAT	15/04/2010	02/11/2011	04/10/2013	09/09/2015		
Nidderdale	01/02/2010	13/10/2011	10/10/2013	01/12/2015		
Radiology	20/05/2010	25/07/2011	12/03/2014	13/04/2016		
Critical care (ITU/HDU)	12/11/2009	27/06/2011	11/06/2014	06/05/2016		
Maternity (Pannal)	09/03/2010	01/05/2012	03/10/2013	02/08/2016		
Wensleydale	08/02/2010	05/07/2011	14/08/2013	25/11/2016		
Granby	07/12/2009	21/11/2011	18/09/2013	23/05/2017		
Pharmacy	09/12/2010	25/10/2012	19/11/2014	21/06/2017		
Outpatients	06/08/2010	22/11/2012	26/09/2014	27/06/2017		
Oakdale	05/03/2010	04/10/2012	21/08/2013	22/08/2017		
Harlow	25/01/2010	11/05/2012	11/02/2014			
PAAU	24/09/2010	10/08/2012	31/03/2015			
Therapy Services	14/06/2010	13/07/2012	05/05/2015			
Day Theatre	03/06/2010	01/08/2011	25/09/2015			
Phlebotomy	28/09/2009	12/03/2013	13/11/2015			
Selby MIU	02/08/2012	05/09/2013	14/09/2017			
Harrogate Heart Centre	20/10/2011	23/01/2013	21/12/2017			
Haematology/Transfusion	23/08/2010	06/10/2011				
CSSD	30/09/2010	31/10/2011				
Swaledale	21/12/2009	14/11/2011				
Hotel Services	16/12/2010	14/09/2012				
Elmwood	19/07/2010	14/11/2012				
Biochemistry	29/11/2010	21/01/2013				
Pathology	10/12/2010	30/01/2013				
Critical care Outreach	07/12/2010	13/02/2013				
Site Co-ordinators	28/11/2011	07/03/2013				
Scarborough Podiatry	04/09/2012	01/04/2015				
Ripon RRT	31/07/2012	05/11/2015				
Kingswood Dental Surgery	14/05/2014	27/09/2016				
Farndale	23/08/2013	09/02/2017				
General Office	28/11/2014	28/07/2017				
Askham Grange	08/12/2011					
Northallerton prison	12/12/2011					
Monkgate dentistry	03/05/2012					
SALT – Northallerton	07/08/2012					
Isles lane VWT	06/09/2012					
Knaresborough Health Visiting	09/11/2012					

Boroughbridge VWT	29/01/2013					
HDH Catering Services	06/03/2014					
Hornbeam – harrogate community nursing team	03/04/2014					
Ripon community nursing team	29/04/2014					
Selby/York GPOOH	29/05/2014					
Selby HV team	10/07/2014					
Scarborough – childrens services and sexual health	25/07/2014					
Blood Sciences Lab	13/08/2014					
SROMC	11/09/2014					
Portering Services	05/11/2014					
Selby/York Podaitry	03/12/2014					
Easingwold – specialist childrens service	18/12/2014					
York Wheelchair Services	30/04/2015					
Domestic Services	07/05/2015					
Ophthalmology	09/06/2015					
Medical Day Unit	24/11/2015					
Skipton Podiatry	17/12/2015					
The Equipment Library	08/06/2016					
Ripon Ultrasound	14/06/2016					
Scarborough Wheelchair Service	28/06/2016					
Scarborough Equipment Store	28/06/2016					
Orthopaedic Outpatient's	01/07/2016					
Sewing Room	27/09/2016					
Stanley Education Centre	25/10/2016					
CATT	06/12/2016					
ANC	06/01/2017					
Beresford Building	26/09/2017					
EADU	02/11/2017					
Catterick GPOOH						
5-19 Community Services (Skipton)						
Safeguarding Children						
Child Health Records						
0-5 Oakbeck Children's Centre						
5-19 Sherburn Library						
Dr Piper House						
Key	Visits undertaken since last report to Board (Jan 2017)					
	HDFT service no longer provided					
	Visits not arranged					

Date of Meeting:	31 January 2018	**Agenda item:**	9.2
Report to:	Board of Directors		
Title:	Infection Control Update		
Sponsoring Director:	Mrs Jill Foster, Chief Nurse		
Author(s):	Dr Jenny Child, Director of Infection Prevention and Control		
Report Purpose:	**Decision**		**Discussion/ Consultation**		**Assurance**	✓	**Information**	
Executive Summary:	• There are at least four respiratory viruses currently circulating within the organisation. • There have been four clusters of cases on Byland, Jervaulx, Granby and Littondale. • Respiratory Virus Testing; the trust has been trialling in-house diagnostic testing using a rapid multiplex PCR system (ePlex).		

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

Key implications	
Risk Assessment:	None identified.
Legal / regulatory:	None identified.
Resource:	None identified.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.
Reference documents:	None.
Assurance:	

Action Required by the Board of Directors:

It is recommended that the Board notes the Infection Control Update.

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Harrogate and District NHS
NHS Foundation Trust

January 2018

INFECTION PREVENTION AND CONTROL REPORT

Monthly IPC dashboard, 23rd January 2018 HDFT

Month	*C. difficile*		MSSA BSI		MRSA BSI		*E. coli* BSI		Klebsiella BSI		*P. aeruginosa* BSI		Confirmed 'flu cases (hospital)
	HAI	CAI	HAI	CAI	HAI	CAI	HAI	CAI	HAI	CAI	HAI	CAI	
April	0	2	0	1	0	1	2	8	2	3	0	0	
May	0	2	1	2	0	0	0	12	0	3	1	0	
June	0	0	0	5	0	0	3	10	0	3	0	0	
July	0	1	0	4	0	0	1	14	1	2	1	0	
August	0	0	1	1	0	0	3	15	0	4	0	0	
September	2	2	1	3	0	0	2	12	1	1	0	2	1
October	1	6	0	1	0	0	1	10	0	1	0	1	7
November	2	1	0	2	0	0	0	3	0	4	0	1	3
December	0	2	1	5	0	0	2	5	0	0	0	0	37**
January	(0)	(1*)	(0)	(4)	0	0	0	(11)	0	1	0	0	(62)
February													
March													
Running total	5	17	4	28	0	1	14	100	4	22	2	4	110

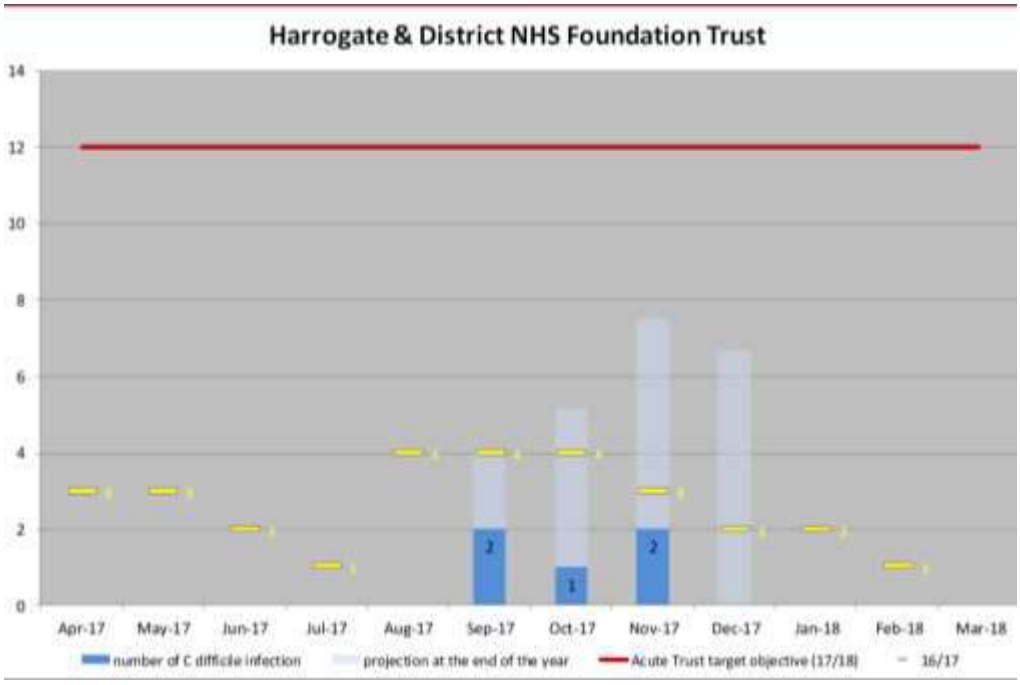
NB figures for January 2018 are provisional and were correct up until the 23rd January.

*This patient had been discharged from Byland three days before the postitive specimen was sent in by the GP.

** includes a member of staff diagnosed with swine flu who presented to the GP.

Hospital apportioned *C. difficile*, April to December 2017

Source: Yorkshire and Humber Field Epidemiology Service monthly bulletin, Leeds, 16/1/18



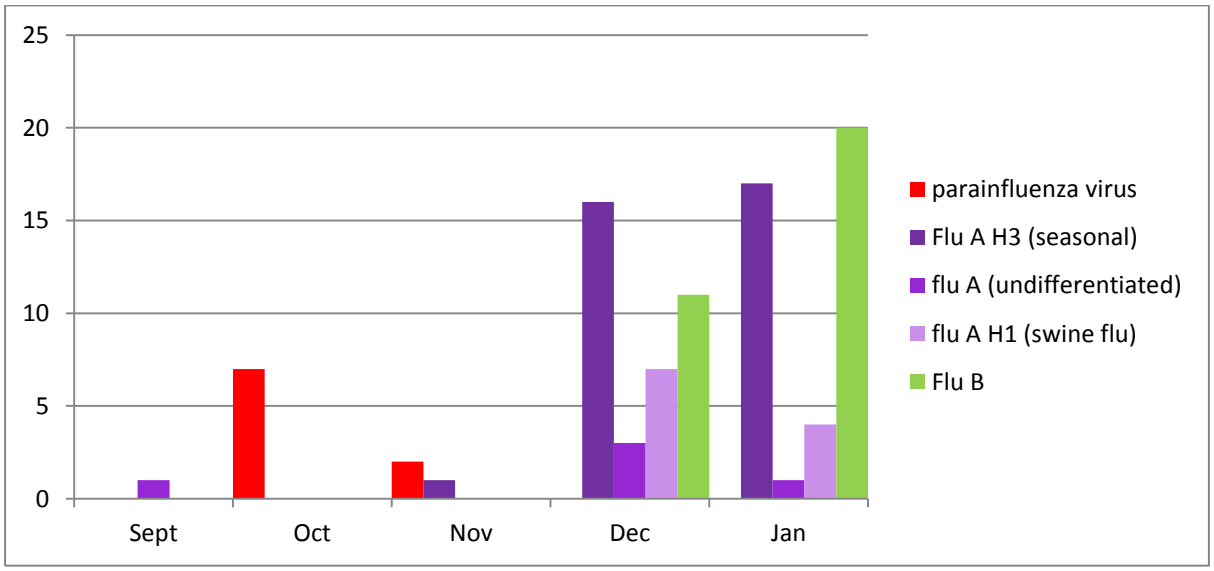
Respiratory viruses

'Flu season has well and truly arrived.

There are at least four respiratory viruses circulating:

- Flu A (H3 seasonal; H1 "swine" flu; undifferentiated)
- 'Flu B
- RSV (data not shown)
- 'parainfluenza (September/October, two of whom required ITU admission)

Confirmed 'flu cases, HDFT September 1st 2017 -12th January 2018



At the time of writing (23/1/18) parainfluenza has disappeared, 'flu A and 'flu B cases are rising, with 'flu A replacing flu B again. Flu A is currently the predominant strain.
PHE announced last week that 'Flu B is not covered in the current trivalent vaccine, which is used for staff and (we think) by most GPs in the community.
So far, the vast majority of the confirmed flu cases have been elderly. Many have been vaccinated, but the 'flu vaccine is known not to work so well in older people.

We have had clusters of cases on Byland, Jervaulx, Granby and Littondale.
So far this season, seven patients with 'flu have been admitted to ITU/HDU, one of whom died.

Respiratory Virus Testing
As of the 19th January, we have been trialling in-house diagnostic testing using a rapid multiplex PCR system (ePlex). This is a molecular test which detects 18 different viral targets in just under two hours. It costs approximately £98 per test.
We are offering this service seven days a week, from 9am-6pm as of Friday 19th January. Samples received between 6 and 8pm will be run overnight, those received after 8pm will be run first thing in the morning.
We will report out

- Negatives (no virus detected)
- Positive (for either flu A, flu B, RSV or mycoplasma)
- Negative for flu A, flu B, RSV or mycoplasma (other viruses will be reported at the discretion of the IPCT/duty microbiologist).

The test will be restricted for those patients in whom a positive or negative result will make a tangible difference to treatment or isolation, ie:

- patients who are sick enough to warrant an inpatient hospital stay,
- who have had 'flu like symptoms for up to five days; longer for the severely immunocompromised.

The decision to admit a patient or not should be made on clinical grounds, not on the basis of a single lab test. It will not be used on samples from GPs (for whom we can still send samples to Leeds) or from A&E unless the patient is being admitted.
Only one test per patient will be permitted; if a duplicate test is ordered, the result of the previous test will be immediately flagged up to the requestor. Clearance swabs are not required.

Why we had to implement this
We have been sending samples for respiratory virus testing to Leeds. Although the virology laboratory normally provides a good service, when the demand is high, the turnaround time is far slower than we need and rather erratic, with results taking anything from 1-7 days. This makes it difficult to know who to isolate, and to make the best use of available side rooms.
The cost of each test was £38.10 with additional taxi transport costs over weekends.

Positives, but not negatives, are phoned through. Most positive 'flu results were phoned through within 48 hours (66%), with results taking 1-4 days longer to appear on ICE. Even so, just over half of all patients had been discharged by the time the duty microbiologist received the verbal result.

In practice, negative reports, which are currently taking on average five days from the time of being taken to appearing on ICE, are just as important as positive ones in terms of deciding who doesn't need a side-room after all.

Many patients are started empirically on Tamiflu (oseltamivir) before the results are received. A more timely result would mean that only patients with confirmed 'flu would be given this drug which can have significant side-effects.

Dr Jenny Child, DIPC
23th January 2018

Date of Meeting:	31 January 2018	**Agenda item:**	10.0
Report to:	Board of Directors		
Title:	Report from the Medical Director		
Sponsoring Director:	Dr David Scullion, Medical Director		
Author(s):	Dr David Scullion, Medical Director		
Report Purpose:	**Decision**		**Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓
Executive Summary:	• There have been no mortality alerts generated for the period November 2016 to October 2017. The HSMR remains stable at 108.1. SHMI has increased to 91.3 but remains below expected levels. • The never events list has been updated following recent consultation. There have been some minor adjustments to the existing list and two new never event added. • GIRFT report on vascular surgery has been received • Litigation in surgical specialties data pack received. Trauma and Orthopaedics, General Surgery, Urology and Vascular Surgery are in the 1st quartile. There will be a focused deeper dive in Ophthalmology. • A new CEO and Clinical Director of CRN Yorkshire and Humber have been appointed. They are Amanda Tortice and Professor Alistair Hall respectively. • Guidance on cross cover for Doctors in training has been received from HEE. • Mr David Leinhardt, Consultant General and Colorectal Surgeon, will be retiring from NHS practice on 31st January 2017. David has been a Consultant in Harrogate for 23 years.		

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

Key implications	
Risk Assessment:	None identified.
Legal / regulatory:	Statutory obligations of the Trust in relation to research Governance.
Resource:	None.
Impact Assessment:	None.

Conflicts of Interest:	None identified.
Reference documents:	None
Assurance:	
Action Required by the Board of Directors:	
• It is recommended that the Board receives and notes the report.	

MD report January 2018

1. **Mortality update:**

There have been no mortality alerts generated for the period November 2016 to October 2017.

The HSMR remains stable at 108.1. SHMI has increased to 91.3 but remains below expected levels.

Two senior Consultants attended the Tier 2 structured judgment review training in Sheffield in December. Given the winter pressures on the medical service in particular, I was not able to meet with them in December to discuss their view on the roll-out of the process internally. I am intending to meet with both on January 22nd and will be able to provide a verbal update as necessary.

The Q2 data completed by end of December 2017 is attached for comment and discussion. In line with national requirements, this will be a quarterly report to the public section of Board. The data is presented one quarter in arrears.

A number of NHS Trusts have received FOI requests form the Health Service Journal relating to the recently published mortality report to Board (this is actually public information). The HSJ seems particularly interested in published data on avoidable mortality. This is an unnerving request, not only given the embryonic nature of the reporting process, but also in speculating what lies behind such a request. We await publication. Is this the start of the feared "league table"?

The Royal College of Physicians has issued a statement to Trusts, a copy of which is in the reading room. It is short and worth reading, the view of avoidability accurately reflecting the medical community with whom I have been associated.

Both I and a number of NEDs are planning to attend a masterclass in mortality statistics in Leeds on 12th February.

2. **Updated Never Events List 2018:**

The never events list has been updated following recent consultation. There have been some minor adjustments to the existing list and two new never events added:

- Undetected oesophageal intubation
- Unintentional connection of a patient requiring oxygen to an air flowmeter

The document is currently being studied and information disseminated. Particular emphasis is placed on systems in place to prevent the recently added events and to ensure changes to existing events are captured monitored through Directorate Governance processes. The detail will be discussed at IPSSG.

No events have been removed from the list.

3. **GIRFT update:**

Report on vascular surgery. A copy of the report has been received. This is embargoed though I am not of the view that any of the 17 recommendations contained within it are contentious. The main thematic recommendations relate to:

- Reducing waits for treatment
- Adopting a networked model of service delivery
- Reducing length of stay and readmissions
- Optimising and standardising data quality

A number of more detailed recommendations are contained within the report. The content of the report firs well with the current consultation on vascular service reconfiguration in WYandH. You will be aware that the bulk of HDFT vascular service is delivered through York. We will need to ensure that similar standards of service delivery are applied to all of HDFT service users. I am confident this will be the case.

Litigation in Surgical Specialties Data Pack: The purpose of the report is to make the Trust aware of litigation data across the surgical specialties that can be benchmarked against other Trusts. Particular emphasis should be paid to those specialties in the top quartile. In our case this is Ophthalmology. It is recommended that the relevant claims are reviewed in detail, not only clinically but to include all relevant statements and medicolegal data. This review should be triangulated against learning themes. I am meeting with the head of risk management and a senior Ophthalmology Consultant in order to agree the timeframe for this piece of work.

In terms of good practice, Trauma and Orthopaedics, General Surgery, Urology and Vascular Surgery are in the 1st quartile.

I have agreed that a Consultant Ophthalmologist (Dr Mackenzie) will review the case notes and claims data for Ophthalmology and report back to me. In addition to the focused deeper dive in Ophthalmology, I have circulated the information to all of the relevant surgical specialities to discuss though their governance processes.

4. **Research update:**

A new CEO and Clinical Director of CRN Yorkshire and Humber have been appointed. They are Amanda Tortice and Professor Alistair Hall respectively. Amanda was previously head of the Newcastle Joint Research Office and Professor Hall is a cardiologist in Leeds. Both appointees are of high calibre and well placed to continue and build on the success of the network in recent years.

The network funding allocation for the coming year is an uplift of 0.5%. In the context of widespread funding cuts, this should be viewed as positive and recognises the success of the network in its overall contribution to NIHR output. Harrogate has played a significant part in this success. The recruitment target for the year remains a challenge, though one which is certainly within reach.

5. **Guidance on cross cover for Doctors in training:**

It is no coincidence that this document has arrived from HEE in the midst of one of the busiest periods in NHS memory. The guidance is sensible and balanced; the recommendations contained therein being those that any reasonable Local Education Provider would naturally follow. There is additional guidance on reporting to Deaneries for the period of duration of cross cover. As a general principle, such action would only be necessary as a last resort in times of unforeseen clinical workforce pressure.

An additional document on high impact actions to improve the life of doctors in training has also been received. As expected a number of these have already been addressed, though some could be improved.

6. Public Health Update:

Recent communications have been received on the increased incidence of influenza and related viruses, and an outbreak of measles in Leeds. The impact on the Trust has come from the former rather than latter, and a new system of same day viral testing is now in place to identify and treat cases as soon as possible. There are regular updates from Dr Child, DIPC. Information is disseminated to relevant acute clinical areas.

7. Retirements:

Mr David Leinhardt, Consultant General and Colorectal Surgeon, will be retiring from NHS practice on 31st January 2017. David has been a Consultant in Harrogate for 23 years and one of his many achievements has been his leadership of the colorectal cancer MDT service since its inception. The reputation of the unit remains strong with consistent excellent patient feedback and outcomes.

I am sure the Board would like to thank David for his dedicated service to the Trust and wider NHS, and wish him a long and happy retirement.

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Date of Meeting:	December 2017	**Agenda item:**	10.1
Report to:	Board of Directors		
Title:	Learning from deaths report Q3 2017/18		
Sponsoring Director:	Dr David Scullion, Medical Director		
Author(s):	Dr Sylvia Wood, Deputy Director of Governance		
Report Purpose:	**Decision**		**Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓
Executive Summary:	Board to note first report of learning from deaths process		

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

Key implications	
Risk Assessment:	The learning from deaths process aims to identify areas where improvements can be made to patient care which will reduce clinical risk. Good practice should also be documented.
Legal / regulatory:	There is a requirement to collect and publish specific information on deaths including learning points every quarter with a paper and agenda item to public Board meetings from Q3 2017/18 onwards.
Resource:	There is a time resource required to undertake the case note reviews, data collection and analysis.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.
Reference documents:	1. HDFT Learning from Deaths Policy. 2. National guidance on learning from death (NHSI March 2017) 3. Learning, candour and accountability: a review of the way Trusts review and investigate the death of patients in England (CQC December 2016)
Assurance:	Quarterly report will be reviewed at Improving Patient Safety Steering Group.

Action Required by the Board of Directors:

It is recommended that the Board

- Notes items included within the report;

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Title: Learning from deaths report

Report to: Board of Directors

Report from: Dr David Scullion, Medical Director and Executive Lead for Learning from Deaths, HDFT

Date: December 2017

Introduction

The Trust published its Learning from Deaths Policy in September 2017. There is a requirement to publish the data collected as a result of the processes outlined within the policy every quarter as a standing agenda item at a public Board meeting from Q3 2017/18.

For those patient deaths meeting the criteria for a structured review of case notes, the Medical Director will appoint a clinician with appropriate expertise to undertake a structured judgement review (SJR). Whenever possible, the clinician will not have been involved in the care of the patient who died.

A case note review is to determine not only examples of good practice, but also whether there were any lapses in the care provided to the patient who died in order to learn from what happened.

The National Mortality Record Review (NMCRR) data collection proforma is used for the SJR. This is a validated methodology available from National Mortality Case Record Review (NMCRR) programme resources | RCP London. The Trust has a number of clinicians trained to undertake the structured judgement review using the proforma. It is planed to train more. It is based upon the principle that clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible. Examples of good and poor care are highlighted.

For this first report all of the SJRs that have been undertaken since the process started have been reviewed up to and including Q2 2017/18. The results are presented below. Future reports will focus on the findings of new reviews undertaken and any learning opportunities identified. It is likely numbers will be less in quarterly reports going forwards. The process is new, likely to be iterative and will undoubtedly evolve form experience both internally and externally.

Specific focused reviews of patient sub-groups have been undertaken:

- Deaths of patients as a result of cerebrovascular disease which were identified as a potential outlier by the CQC in 2016.
- Deaths of patients with chronic obstructive pulmonary disease during the 2014 national audit. This was a recommendation from the audit for each hospital to undertake a deep-dive into the care received by patients who died during the audit period, to look for both deficiencies in care and examples of good practice end-of-life care that might be used for learning and quality improvement purposes.

- Review of elderly medical deaths in response to a rising HSMR (Q3 data collection to be reported in Q4).

Results

Numbers of deaths and case note reviews

	Pre 2016/17	2016/17	Q1 2017/18	Q2 2017/18	Total
No of inpatient deaths	N/a	666	145	140	N/a
No of SJRs	31	26	2	8	67

All cases of a patient with learning disabilities dying in hospital are automatically referred to the national LeDeR programme. This is the national multi-agency programme for review of death in patients with learning disabilities commissioned by NHSE.

Assessment of care provided

	Good or excellent care (score 4-5)	Average care (score 3)	Poor care (score 1-2)	N/a	Not recorded
Admission and initial management	58	5	4	0	0
On-going care	52	4	1	10	0
Care during procedure	9	2	1	55	0
Peri-operative care	3	1	0	63	0
End of life care	55	4	1	7	0
Overall assessment of care received	56	7	3	0	1
Overall assessment of patient record	61	4	2	0	0

Problems with care

The more recent version of the SJR proforma has a section that enables the identification of problems in care by the categories in the table below. The earlier version of the proforma did not contain this section and therefore a significant proportion of the case reviews undertaken did not include this data.

- 27 cases with no problems with care

- 10 cases with problems with care (16 types of problem specified, though death not avoidable)
- 30 cases did not have the section (previous iteration of the SJR)

Numbers of problems identified by type and by harm						
Problem in assessment, investigation or diagnosis	Problem with medication, IV fluids, Electrolytes, oxygen	Problem related to treatment and management plan	Problem of any other type not fitting the categories above	Problem related to operation / invasive procedure	Problem with infection management	Problem in clinical monitoring
1 - not indicated 1 - no harm 1 - probable harm 1 - harm	2 - no harm 2 - probable harm	1 - no harm 1 - probable harm 1 - harm	1 - no harm 1 - possible harm	1 - harm	1 - probable harm	1 - harm

Avoidability scores

Not documented	6 Definitely not avoidable	5 Slight evidence of avoidability	4 Possibly avoidable but not very likely, less than 50/50	3 Probably avoidable, more than 50/50	2 Strong evidence of avoidability	1 Definitely avoidable
2	48	11	5	1	0	0

The one case scored as 3 – probably avoidable, more then 50/50:

> Deterioration occurred associated with dramatic drop in BP due to IV Labetalol (an antihypertensive). Aggressive lowering of BP in acute ischaemic stroke is potentially hazardous due to loss of brain blood flow autoregulation. Close BP monitoring is required and action to correct it if falls too much. Recommendation at that time would have been to consider lowering a BP>220 systolic in ischaemic stroke outside of thrombolysis. The lead clinician for stroke has undertaken a learning event for staff in order to minimise the risk of repeat incidents. The pathway for the management of hypertension in acute stroke has been clarified.

Other specific learning points identified (though not directly causing death)

1. Value of direct arterial monitoring to assist in evaluation of the deteriorating patient
2. Care when placing chest drains out of hours. Is this always necessary? The respiratory team have reinforced learning with doctors in training
3. The value of post-mortem examination in clarifying the cause of death
4. More consistent use of advanced care plans
5. Stopping unnecessary medications close to end of life (heparin)
6. Alternative administration mode of medications for patients with Parkinson's Disease and who are nil by mouth (NBM)

7. Measures for admission avoidance at end of life
8. More thought to pre-operative management of elective surgery in frail elderly.
    - Care with length of time NBM pre-operatively.
    - Early scheduling on elective theatre list.

Reflection

In general the reviews were of good quality with numerous detailed descriptions of good practice. In a smaller proportion of cases, examples of where practice could be improved were documented. The great majority of these did not affect the eventual outcome.

Learning

1. Local dissemination through feedback to teams and across the organisation where appropriate. This will be led through the Improving Patient Safety Steering Group (IPSSG)
2. At national level through the new web based method for SJR

Summary

This is a new process. The concept of avoidability is a controversial one and there remain differing views between the regulatory and medical community on its validity as a metric for good care. Trusts have been given a firm undertaking that the data is for the purposes of transparency and learning and will not be used to produce league tables or be subject to extrapolation unsupported by evidence.

The numbers of deaths in hospital that can be unequivocally shown to be truly avoidable are fortunately rare. The mortality review process is reproducible and provides a rich seam of learning which, albeit not necessarily affecting outcomes, will allow us to improve end of life care in many patients.

Reviews also emphasise the increasing frailty and complexity of medical elderly patient in particular, and confirm the excellent care received by the great majority of patients whose death in hospital is expected.

Board Committee report to the Board of Directors

Committee Name:	Quality Committee (QC)
Committee Chair:	LA Webster
Date of last meeting:	06/12/2017 & 10/01/2018
Date of Board meeting for which this report is prepared	January 2018

Summary of live issues and matters to be raised at Board meeting:
Board request for QC to seek assurance: **Falls**- Analysis of patient falls completed. No single area of concern identified, therefore specific interventions, tailored to the individual ward unit are being devised. Risk of falls causing harm to patients, remains a concern and will remain under scrutiny by being monitored at SMT and by the Improving Fundamental Care Steering Group, specific concerns will be escalated back to QC by members. QC will receive the annual report on falls in May. *(NB: Planned ward moves in Feb 18 flagged as a potential high risk period with increased vigilance required)* **Hot Spots Discussed:** Financial Recovery Plan (FRP) – Recruitment Problems, concerns reported within the Patient Experience Team in December had improved following secondment of staff and recruitment approval. Overall recruitment concerns in relation to the FRP continue and close monitoring of complaints remain in place to measure risk. Community Services – significant demand on staff over the Christmas period discussed. Flu – the number of cases in January identified as a serious concern and the importance of Staff vaccination (at 56.9% at time of meeting) was re-iterated with all members focussed on the message to get the remaining front line staff to be vaccinated. **Reports heard:** **December –** • Quarter 2 update reports for the Trust's 5 annual Quality Priorities heard, with all priorities delivering well against planned objectives. • Patient Experience Report • Patient Safety Report • NICE Compliance Report • Analysis of Patient Falls

Reports heard:
January –

- Maternity Assurance Statement – new report developed for the committee in response to changes in IBR. (*The new report included information from the Yorkshire and Humber maternity dashboard, which the service uses to benchmark itself against other organisations and this mirrored information published in national reports.*) The QC agreed the report included the right level of data to provide assurance on the quality of care for service users. The report would be received bi-annually next due July 18.
- North Yorkshire Adult Safeguarding Board Annual Report received.
- Clinical Audit Plan Qtr 2 verbal progress report heard

Quality Account – The timetable for the preparation of the 17/18 Account and the development of the 18/19 Quality Priorities tabled

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

- Impact of financial recovery plan and delay in recruiting support staff
- Adult Community Services on OPEL 4, the highest level, at the time of the meeting
- On-going work required to reduce the risk of falls causing harm
- 43% of front line staff have not been vaccinated against Flu virus

Matters for decision

None

Action Required by Board of Directors:

1. Note risks highlighted above
2. Note action for development of Annual Quality Account for 17/18

Harrogate and District NHS
NHS Foundation Trust

Board Committee report to the Board of Directors

Committee Name:	Finance Committee
Committee Chair:	Maureen Taylor
Date of last meeting:	11th December 2017
Date of Board meeting for which this report is prepared	31st January 2018

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

1. The letter to NHS Improvement dated 15th November 2017 was discussed. Based on the current financial position it is unlikely that the Trust will secure S & T funding for 2017.
2. Month 8 figures were not available but indications were that November had been the best month yet for activity. However, there had been a spike in ward pay that needed investigation.
3. The recovery plan had been discussed in detail at the November Board meeting and no further issues were raised.
4. The cash position at the end of November was improved due to the loan received for the Endoscopy scheme. A discussion took place about the Trust's debtors and what measures were being put in place to collect sums due. The cash position is impacting on our ability to pay our creditors.
5. Progress and next steps were discussed in relation to the development of the 2018/19 Operational Plan and wider strategic plan. Discussion took place in relation to forecast levels of activity and the new risk based approach to this. The committee questioned a number of individual elements including CIP, capacity plans and recruitment.
6. An update on benchmarking initiatives was received which included the latest Service Line Reporting information for the Trust. This information is now included in quarterly reviews with Directorates.
7. The Committee received an update report on the Web-V project. This showed that expenditure was generally on track although there is some delay in delivering the various modules and a reduction in the financial value of forecast benefits. There has been a positive response from staff and patients.
8. The committee received a paper on BAF 15 – misalignment of Commissioner/partner strategic plans and a discussion took place around the issues. There continues to be a difference in forecasts between HaRD CCG and the Trust and a dispute process has commenced in relation to specific outstanding service areas.
9. The Committee received an update on the Trust's success in recent tenders for services.

10. Agreed a minor amendment to Terms of Reference to reflect the Trust's subsidiary company. Agreed to re-consider in April.
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 and 2017/18 continue to impact on the Trust's cash position.
Matters for decision
None

Action Required by Board of Directors: None

Board Committee report to the Board of Directors

Committee Name:	Audit Committee
Committee Chair:	Chris Thompson
Date of last meeting:	Thursday 7th December 2017
Date of Board meeting for which this report is prepared	Wednesday 31st January 2018

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

1. This was the first meeting of the Committee since September, so there was a degree of "catching up" by considering minutes from the 3 most recent meetings of both the Corporate Risk Review Group and the Quality Committee.

2. The Committee reviewed the latest versions of the Corporate Risk Register and focused on the continuing work taking place around Opthalmology follow-ups and the risk of Cyber attack – particularly in the context of recent directions received from NHS Improvement. It was noted that the Trust would be taking advantage of an offer of assistance with penetration testing from NHS Digital.

3. The Committee considered the outcomes of the annual process of self-assessment of effectiveness. It was agreed that there should be greater consideration given to the benefits of requesting the attendance at the Committee of a broader range of senior executives from the Trust as this would provide a more comprehensive understanding of the internal controls and processes with the organisation and the effectiveness of their operation.

4. The Committee's Terms of Reference were reviewed following recent consideration by the Board of Governors. It was agreed that a couple of minor amendments were required around membership and terminology and that these should incorporated in the document that is presented to the Trust Board in January. The changes would be notified to the Board of Governors at their next meeting.

5. During the consideration of the Internal Audit periodic Report there was discussion around the apparent reduction in speed of implementation of Internal Audit Recommendations and it was noted that this was largely due to a systems problem that has been preventing auditees from entering updates. It was agreed that this should be closely monitored and reviewed again at the next Committee meeting.

6. Some concerns had been raised by Internal Audit regarding the processes around safeguarding and it was agreed that the Trust Board should be provided with further guidance around safeguarding requirements and issues, particularly in the light of the impending departure of the NED who takes a lead on this. There was also a need to see improvements in the speed for undertaking the necessary assessments.

7. There was discussion around how the role of Internal Audit and the Audit Committee would change with the launch of the new HHFM company. It was agreed that the opportunities for creating a Group Audit Committee should be explored, so as to avoid and potential gaps in oversight, particularly during the early months of the new company.

8. The Committee noted the recent report from NHS Resolution regarding the process for managing claims for clinical negligence. Concern was raised at the potential increase in the premium from NHS Resolution for 2018/19 from £4.1m to £5.3m, although it was recognised that there may be some opportunities to reduce this amount. It was also noted that NHSI may consider appropriate changes to control totals, although this has yet to be confirmed. It was agreed that this would be revisited as part of the year end processes.

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

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

Matters for decision

The Board is asked to approve the revised Terms of Reference for the Committee

Action Required by Board of Directors:

The Board is asked to note the considerations that took place at the meeting of the Audit Committee on the 7th December and approve the revised Terms of Reference for the Committee

AUDIT COMMITTEE TERMS OF REFERENCE

Accountable: to the Board of Directors

Reporting: to the Board of Directors

Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

Membership

The Committee shall be appointed by the Board from amongst the non-executive directors of the Trust and shall consist of not less than three members. One member of the Committee should have recent and relevant experience (e.g. audit/financial accounting/financial management) and o~~. ~~ne member of the Committee should also be a member of the Quality Committee. One of the members will be appointed Chair of the Committee by the Board. The Chairman of the organisation shall not be a member of the Committee.

Quorum

A quorum shall be two members.

Attendance

The Finance Director, members of the Senior Finance Team, the Deputy Director of Governance, the Company Secretary~~Deputy Director of Corporate Affairs~~ and appropriate internal and external audit representatives shall normally attend meetings. The Local Counter Fraud representative shall also attend twice per year and the Local Security Management Specialist on an annual basis. At least once a year the Committee should meet privately with the external and internal auditors.

The Chief Executive should be invited to attend and should discuss at least annually with the Audit Committee the process for assurance that supports the Annual Governance Statement. He or she should also attend when the Committee considers the annual accounts. All other executive directors should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director.

Governors are also invited to attend the Audit Committee meetings in an observational capacity.

A secretary appointed to the Committee shall attend to take minutes of the meeting and provide appropriate support to the Chair and Committee members.

Frequency

Each Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. A benchmark of six meetings per annum at appropriate times in the reporting and audit cycle is suggested. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. Details of the estimated cost of such advice should be advised to the Finance Director for budgetary, cash flow and control purposes.

Duties

The duties of the Committee can be categorised as follows:

Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board
- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
- The policies and procedures for all work related to fraud and corruption as set out in ~~Secretary of State Direction~~the NHS Protect Counter Fraud Standards for Providers ~~s~~ and as required by the Counter Fraud and Security Management Service
- The procedures for detecting fraud and whistle blowing (HDFT's Whistle Blowing Policy) and ensure that arrangements are in place by which staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting, financial control or any other matters.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources.

It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal
- Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework
- Considering the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise audit resources
- Ensuring that the internal audit function is independent; adequately resourced and has appropriate standing within the organisation
- Annual review of the quality and effectiveness of internal audit.

External Audit

The Committee shall review the work and findings of the external auditors appointed by the Council of Governors and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the external auditors, and reporting annually to the Council of Governors by way of an evaluation of the external auditors' performance and whether they should be reappointed
- Recommendation of the audit fee to the Board (and Governors if a new appointment) and pre-approve any fees in respect of non-audit services provided by the external auditors and to ensure that the provision of non-audit services does not impair the independence or objectivity of the external auditor
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
- Annual review of the quality and effectiveness of external audit.

The External Auditor or Head of Internal Audit may, at any time, request a meeting if they consider it necessary.

Clinical Assurance

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health Arms Length Bodies or Regulators/Inspectors (for example, the Care Quality Commission, NHS ResolutionLitigation Authority, etc.) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies, etc.)

The Quality Committee will provide assurance from the clinical audit function. The Audit Committee will review the work of the Quality Committee by receiving minutes, and exception reports from the non-executive director who is a member of both committees. In addition, the Company SecretaryDeputy Director of Governance also attends both committees.

The Audit Committee will receive minutes and regular reports from the Corporate Risk Review Group.

Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work and receive the counter fraud annual report.

Security Management Service

The Committee shall satisfy itself that the organisation has adequate arrangements in place for Security Management Services and that the Committee will receive from the Local Security Management Specialist an annual report on its activities and plan for the following year.

Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit) as they may be appropriate to the overall arrangements.

Financial Reporting

The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Audit Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted miss-statements in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit
- Schedule of losses and special payments
- Letter of representation
- Qualitative aspects of financial reporting
- The going concern assumption
- The extent to which the financial statements are affected by any unusual transactions in the year and how they are disclosed
- Any reservations and disagreements between the external auditors and management which had not been satisfactorily resolved.

Standing Orders, Standing Financial Instructions and Standards of Business Conduct

The Committee will review, on behalf of the Board, the operation of and proposed changes to the Standing Orders, Standing Financial Instructions, and HDFT's Code of Business Conduct, including Staff Registers of Interest.

Quality Account

The Quality Committee will approve the Quality Account and present it to the Audit Committee. The Audit Committee will review the Quality Account and submit it to the Board.

Other Matters

The minutes of Audit Committee meetings shall be formally recorded by the Secretary and submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

The Committee will report to the Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and 'embeddedness' of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against external regulations including the Care Quality Commission.

The Committee shall also:

- Review third party assurances (both clinical and relating to financial management)
- Review Post Project Evaluations and Single Tender Actions
- Receive an annual report on procurement activity and savings
- Review the Treasury Management Policy, on behalf of the Board, and receive the annual report on treasury activity.

The Committee shall be supported administratively by the Secretary, whose duties in this respect will include:

- Agreement of agenda with Chair and attendees and collation of papers
- Taking the minutes
- Keeping a record of matters arising and issues to be carried forward
- Advising the Committee on pertinent areas

Where disagreements between the Audit Committee and the Board cannot be resolved, the Audit Committee shall report the issue to the Governors. If the issue still cannot be resolved the Audit Committee shall report the issue as part of the report on its activities in the Annual report and Financial Statements.

As agreed with the Governors, the Audit Committee Chairman shall be available to attend the AGM and shall answer questions through the Chairman of the Board of Governors on the Audit Committee's activities and responsibilities.

Review

These Terms of Reference will be reviewed annually, in conjunction with a review of the effectiveness of the Committee.

January 2018~~7~~