Harrogate and District NHS Foundation Trust

The meeting of the Board of Directors held in public will take place on Wednesday 28 March 2018
Boardroom, Harrogate District Hospital, HG2 7SX
Start: 9.00am Finish: 12.00pm

AGENDA

Item No.	Item	Lead	Paper No.
	9.00am – 10.50am		
1.0	**Welcome and Apologies for Absence** *To receive any apologies for absence: none received*	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 28 February 2018** *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
6.0	**Report by the Finance Director** *To receive the report for comment*	Mr J Coulter, Deputy Chief Executive/ Finance Director	6.0
6.1	**Business Planning Update – Operational Plan 2018/19** *To receive the report for comment and approval*	Mr J Coulter, Deputy Chief Executive/ Finance Director	6.1
6.2	**Improvement & Transformation Update** *To receive the report for comment*	Mr J Coulter, Deputy Chief Executive/ Finance Director	6.2
	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
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
10.0	**Report from the Medical Director** *To receive the report for comment*	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	**Report from the Freedom to Speak Up Guardian** *To receive the report for comment*	Dr Sylvia Wood, Freedom to Speak Up Guardian	11.0
12.0	**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	 - - -
13.0	**Committee Chair Reports** *13.1 To receive the reports from the Quality Committee meetings held 7 March 2018.* *13.2 To receive the report from the Audit Committee meeting held on 8 March 2018.*	 Mrs L Webster, Quality Committee Chair Mr C Thompson, Audit Committee Chair	 13.1 13.2
14.0	**Freedom of Information Requests Annual Report 2017** *To receive and consider the report*	Mrs K Roberts, Company Secretary	14.0
15.0	**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	-
16.0	**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.*			

2.0

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 March 2018.

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 and Chairman of: • Northern Consortium UK Limited • Ahead Partnership (Holdings) Limited • Ahead Partnership Limited
Ms 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 companies, Newcastle Systems Management Limited and 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 Harrison	Deputy Director of W & OD	None
Mr Jordan McKie	Deputy Director of Finance	1. Familial relationship with NMU Ltd, a company providing services to the NHS
Mrs Alison Mayfield	Deputy Chief Nurse	None
Mr Paul Nicholas	Deputy Director of Performance and Informatics	None
Mr Phil Sturdy	Deputy Director of Estates	Close family member is employed by the Harrogate and District NHS Foundation Trust within the estates department.

Harrogate and District NHS Foundation Trust

Report Status: Open

BOARD OF DIRECTORS MEETING

Minutes of the Board of Directors' meeting held in public on
Wednesday 28 February 2018 at 9.00am in the Boardroom at Harrogate Hospital

Present:
Mr Jonathan Coulter, Deputy Chief Executive/Finance Director
Mr Robert Harrison, Chief Operating Officer
Mr Phillip Marshall, Director of Workforce and Organisational Development
Mr Neil McLean, Non-Executive Director (by telephone)
Ms Laura Robson, Non-Executive Director
Dr David Scullion, Medical Director
Mrs Maureen Taylor, Non-Executive Director
Mr Chris Thompson, Non-Executive Director/Vice Chairman (Chair)
Dr Ros Tolcher, Chief Executive
Mr Ian Ward, Non-Executive Director
Mrs Lesley Webster, Non-Executive Director

In attendance:
Mr Andrew Alldred, Clinical Director for Long Term and Unscheduled Care
Dr Claire Hall, Deputy Medical Director
Dr Kat Johnson, Clinical Director, Planned and Surgical Care
Dr Natalie Lyth, Clinical Director, Children's and County Wide Community Services (by telephone)
Mrs Alison Mayfield, Deputy Chief Nurse
Mrs Lynn Parsons, Executive Assistant (minutes section 1.0 to 5.0)
Mrs Katherine Roberts, Company Secretary (minutes)

1.0 Welcome and Apologies for Absence

Mr Thompson welcomed observers to the meeting, this included Tony Doveston (Public Governor), Ruth Irving (NED Insight programme – by telephone), and Mr Paul Widdowfield (HDFT Communications and Marketing Manager).

He noted that apologies had been received from Mrs Angela Schofield (Chairman) and Mrs Jill Foster (Chief Nurse).

2.0 Declarations of Interest and Board Register of Interests

No declarations of interest were received.

It was noted Mr Coulter and Mr Thompson were directors of Harrogate Healthcare Facilities Management. No agenda items were planned which would present a relevant conflict of interest.

3.0 Minutes of the meetings of the Board of Directors on 31 January 2018

The draft minutes of the meeting held on 31 January 2018 were approved with no amendments.

APPROVED:
The Board of Directors approved the minutes of the meeting held on 31 January 2018 as an accurate record of proceedings.

4.0 Review of Action Log and Matters Arising

4.1 Completed actions were noted.

4.2 Action 78; Mr Coulter confirmed that presentation of reporting about capital expenditure measure had been amended. It was agreed this action was closed.

4.3 There were no other matters arising.

APPROVED:
The Board of Directors noted completed actions and received an update on actions and agreed to close action 78.

Overview by the Chairman

Mr Thompson affirmed that the Board were aware of continued operational and financial pressures which would be a focus throughout the meeting.

He noted the inclement weather which had caused delays for some members of the Board in reaching the meeting.

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 highlighted that recent winter pressures and operational performance had continued throughout February 2018 and a high level of demand had caused a significant impact on elective flow. Although performance against two NHS performance targets (ED four hour wait and 18 week referral to treatment (RTT)) had again fallen short of the required level, evidence suggested the Trust had sustained quality care, with extended waiting time in elective Orthopaedics and Ophthalmology being the main specialities contributing to the adverse RTT performance. She noted that at such a busy time it was important to continue to focus on staff and patient resilience.

5.3 It was reported that the senior nursing team were exploring an increase in the number of recorded pressure ulcers, which was a great concern to all and had impacted on the safety thermometer.

5.4 Dr Tolcher reported that the Friends and Family Test scores remained overwhelmingly positive with 95.4% of patients reporting they had received positive care.

5.5 Further to the decision in late 2017 to undertake more detailed work around

avoidance of falls, Dr Tolcher noted that there had been a significant reduction in the number of falls, even though demand and activity had been higher than the same period last year.

5.6 The Trust's financial performance deteriorated in January 2018 with a loss of £850k which had contributed to a lower than anticipated surplus of £4k. Dr Tolcher confirmed the directorates continued to be really focused on achieving the Financial Recovery Plan. She noted that while achieving the 2017/18 control total remained possible this was very challenging.

5.7 In response to Mr Ward, Mr Coulter confirmed that if a surplus of £2m was not achieved over the next two month period the Trust would not be entitled to benefit from further sustainability and transformation funding and would face an increased control total for 2018/19.

5.8 The executive directors had undertaken a review of vacancy control measures and the impact on services of holding non-clinical posts, concluding that the enhanced vacancy control measures should be discontinued. Directorates would revert to the standard vacancy control processes with effect from April 2018. It was affirmed that funds remained in directorate budgets.

5.9 Dr Tolcher confirmed West Yorkshire and Harrogate Health and Care Partnership had submitted an expression of interest to NHS England and NHS Improvement to become an Integrated Care System. A series of 'confirm and check' meetings for each work stream were being completed.

5.10 The West Yorkshire Association of Acute Trusts WYAAT Committee in Common met on 27 February 2018. There were no issues to be reported to the Board.

5.11 With regard to the new company, Harrogate Healthcare Facilities Management Limited, Dr Tolcher anticipated that the TUPE transfer of staff would go ahead on 1 March 2018. The Trust continued to engage with the staff affected and communicate regularly with trade unions. It was noted that trade unions were balloting regarding their intention to undertake industrial action after the formation of the company and the Trust would make the necessary preparations to ensure services remained resilient. In response to Mr Ward's concerns regarding staff well-being, Mr Marshall reported that executive directors had met with many affected staff. He had also clarified some issues in relation to the pensions of affected staff.

5.12 Reviewing operational performance Mrs Taylor commented that throughout December 2017 and January 2018 quality indictors had remained largely unchanged however, the number of pressure ulcers had increased. Dr Tolcher responded that data demonstrated other fundamentals of care were being sustained and the reasons for this increase were being explored. Mrs Mayfield outlined work underway to reduce the number of pressure ulcers suffered by patients.

5.13 Mrs Roberts and Mr Harrison joined the meeting

5.14 Mrs Robson welcomed the reduction in the number of inpatient falls, but noted that the outcome of a recent Internal Audit regarding falls prevention was limited assurance. The audit found weaknesses in the documentation of risk assessments. Mrs Robson asked whether an audit of pressure ulcer prevention was planned. It was agreed the

senior nursing team would consider whether an audit of pressure ulcer prevention was required following introduction of new standard nursing documentation from April 2018, it was noted the documentation would include a focus on risk assessment

ACTION: The senior nursing team to consider whether an audit of pressure ulcer prevention was required following introduction of new standard nursing documentation from April 2018.

5.15 Mrs Taylor expressed concern that in light of January 2018 financial position the amendments to vacancy control measures were premature. Dr Tolcher noted the changes would not impact the cost base during 2017/18. She drew attention to the need to balance finance with quality of care and staff morale. These were difficult judgements but it was important the Trust did not compromise the efficiency and productivity of front line staff by holding support staff vacancies. Mr Coulter added that a vacancy control process remained in place at directorate level. He noted the importance of maintaining staff engagement, accountability and ownership. Mr McLean noted that the Quality Committee continued to monitor on a monthly basis the impact of the financial recovery plan on operations. He supported the reintroduction of flexibility for directorates.

APPROVAL:
The Board of Directors:

- **Noted the strategic and operational updates;**
- **Noted progress on risks recorded in the BAF and Corporate Risk Register and confirmed that progress reflected the current risk appetite.**
- **Endorsed use of the Trust's seal and agreement of a licence as detailed in the report.**

6.0 Patient Story

6.1 Mr Thompson welcomed Ms SP to the meeting. Ms SP said that on the whole the treatment she received at Harrogate Hospital had been of a good quality; most staff were caring. Ms SP shared her experience of being admitted for treatment via the Trust's Emergency Department. During her treatment it became apparent that although she was in receipt of a formal Gender Recognition Certificate her previous health records had not been sealed and her records contained references to her previous gender status. This was reinforced when one of the treating doctors referred to asp as 'he' on several occasions. In addition, on her discharge letter the doctor had referred to the patient as a 'Transsexual Female' rather than just 'female'.

6.2 Ms SP explained that she had raised concerns with the Trust's Patient Experience Team because the Trust had acted outside of current legislation and in a way which not only made her very uncomfortable, but discriminated against her. She commended the way in which her complaint had been handled by the Trust.

6.3 Members of the Board thanked Ms SP for sharing her experience and for helping the Trust to learn and improve. Dr Tolcher said the organisation was committed to ensuring dignity; she extended her apologies that the organisation had not got it right for Ms SP.

6.4 Dr Hall commented she had never received any direct training regarding gender reassignment. She queried whether there would be occasions when it would be necessary for clinicians to have information about gender reassignment for example in

relation to the potential implications of hormone therapy. Ms SP agreed both clinicians and patients had responsibility to ensure relevant health facts were disclosed, however it was important to separate gender history from hormone therapy.

6.5 Dr Scullion acknowledged the challenges of ensuring all staff were trained about gender reassignment and treated patients in a consistent manner. He noted everyone deserved respect and dignity, he suggested a simple approach was for clinicians to ask patients how they preferred to be addressed,

6.6 Dr Lyth commented on the complexity of sealing health records when patients receive a formal Gender Recognition Certificate. She highlighted the process followed to seal health records when children were adopted which had some similarities to this scenario and may be a sensible approach to emulate.

6.7 Mr Thompson concluded by thanking Ms SP for sharing her experience.

7.0 Integrated Board Report

7.1 Mrs Webster joined the meeting.

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

7.3 Mr Thompson sought an update on ongoing work to increase the focus on incident reporting. Mrs Webster explained this was one of the Trust's annual quality priorities. A Rapid Process Improvement Workshop (RPIW) had recently been completed. Work resulting from the RPIW was ongoing and would strengthen the incident reporting system and change the vocabulary associated with incident reporting. Dr Tolcher clarified this work was focused on altering the ratio of low and no harm incidents that were reported. She noted work planned by the Freedom to Speak Up Guardian to support a more open and transparent reporting culture.

7.4 Mr Alldred confirmed there had been an increase in prescribing and dispensing errors. He explained that these related to people receiving treatment at home delivered by a third party of behalf of the Trust. He noted there had been no patient harm as a result. He explained that the Trust was in dialogue with the third party company concerned and appropriate actions were being taken.

APPROVED:
The Board of Directors:

- **Received and noted the Integrated Board Report.**

8.0 Proposed amendments to the Trust Constitution

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

8.2 Mrs Roberts explained the amendments to the constitution resulted from the establishment of Harrogate Healthcare Facilities Management Limited. It was proposed that Harrogate Healthcare Facilities Management Limited should be permitted to appoint a stakeholder governor to the Council of Governors. This individual would be selected by the staff of Harrogate Healthcare Facilities Management Limited. It was noted the Council of Governors approved the proposed amendments to the constitution at the meeting on 3 February 2018.

8.3 The Board approved the proposed amendments to section 11.2 of the constitution.

APPROVED:
The Board of Directors:

- **Noted that on 3 February 2018 the Council of Governors approved the proposed amendments to the Harrogate and District NHS Foundation Trust Constitution.**
- **Approved the proposed amendments to the Harrogate and District NHS Foundation Trust Constitution.**
- **Noted the process to select the Stakeholder Governor, as agreed by the Harrogate Healthcare Facilities Management Limited Board.**
- **Noted the forthcoming process to undertake a review of the Constitution during early 2018.**

9.0 Finance Report including Financial Recovery Plan and CIP update

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

9.2 Mr Coulter reported the Trust had achieved a deficit position in January 2018. As a result the potential £400k of sustainability and transformation funding would not be received and therefore had not been accounted for.

9.3 He noted the main cost pressures during January 2018 related to winter pressures (£300k in month), lost elective activity (£250k in month), and additional staffing costs on wards and in theatres (£100k in month).

9.4 The report contained further details about progress against the financial recovery plan actions. He noted that spend had been well controlled during January 2018, the only exception was an increase on the forecast level of vacancy control.

9.5 Mr Coulter explained the Trust's position at the year-end would impact on the control total for 2018/19, if the control total was achieved the 2018/19 control total would be reduced by £500k as an incentive.

9.6 The Board noted a potential risk regarding the coding of sepsis. An initial review of national guidance suggested it would not affect the Trust's accounting approach. However this would need to be validated with the CCG.

9.7 The cash position was £5m behind plan. A number of actions were being taken to manage the situation; the CCG had agreed to pay the Trust early in March 2018. It was unclear when the Trust would receive the sustainability and transformation funding.

9.8 Mrs Webster queried whether Mr Coulter expected the Trust would achieve the forecast control total for 2017/18. Mr Coulter said it would be challenging for the Trust but remained achievable. He noted the Board may need to consider a number of important decisions at the end of March 2018 in order to support the Trust's position in 2018/19.

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

10.0 Business Planning Update – Operational Plan 2018/19

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

10.2 Mr Coulter drew attention to the letter received by the Trust from NHS Improvement. He noted the 2018/19 control total and an increase in the sustainability and transformation funding available to the Trust.

10.3 It was noted the capital programme for 2018/19 would be dependent upon cash available to support the Trust. If sustainability and transformation funding was achieved the capital programme could afford £7m. However should the Trust achieve a break-even position the capital programme would be £0m.

10.4 Mr Coulter noted a gap between the level of income planned by the Trust (£96m) and the level of funding which the CCG could afford (£92m). Mr Coulter highlighted that the Trust forecast reflected cost improvement plans (CIP) of £10.1m during 2018/19. Dr Tolcher commented on the need for the Board to look objectively at the organisation's cost base and seek to align more closely with the CCG's ability to pay. The Board would consider this further on the strategy away day on 12 March 2018.

10.5 Mrs Taylor noted the Long Term and Unscheduled Care (LTUC) directorate had failed to achieve the 2017/18 CIP target. Acknowledging the potential that the 2018/19 CIP may need to increase to £10m she sought feedback from the Clinical Directors about whether this level of CIP would be achievable.

10.6 Mr Alldred explained the LTUC directorate had not achieved the planned CIP because it had not been possible to remove beds due to non-elective activity and emergency department admissions. He confirmed plans for 2018/19 felt more manageable although it remained challenging. Dr Johnson and Dr Lyth both confirmed they were confident of achieving the planned level of CIP.

10.7 Mrs Webster sought assurance plans would be in place to ensure the Trust made a strong start to the new financial year. Mr Coulter confirmed the 2018/19 would be in place by late March 2018. He noted detailed work on phasing and risk assessing activity had been reported to the Finance Committee. Mr Harrison added that the new approach to risk assessment of forecast activity would support strengthened monitoring of activity during 2018/19.

APPROVED:
The Board of Directors noted the work that was on-going in relation to finalising the Operational Plan.

11.0 Report from the Chief Operating Officer

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

11.2 Mr Harrison noted A&E performance continued to be challenging and two patients had breached the 62 day cancer treatment target.

11.3 Mr McLean queried whether the retirement of Mr Leinhardt would reduce the service available to patients. Mr Harrison said he did not expect an impact for patients because robust risk assessed arrangements had been put in place which included locum

cover and a shared service between consultants. A business case was being developed for a substantive appointment.

11.4 Mrs Robson sought further information about the results of a recent SEND (Special Educational Needs and Disability) inspection in County Durham. Dr Lyth said that initial feedback about the Trust's contribution was positive, however partners were reflecting on feedback regarding wider multi agency working. The resulting action plan would be monitored by the directorate governance group to ensure learning was shared across all 0-19 areas.

11.5 Following a question from Mr Thompson Mr Alldred confirmed the results of the recent sentinel stroke national audit programme (SSNAP) were a focus for the directorate. A new approach to thrombolysis was being developed, which would involve the Emergency Department commencing treatment in some cases. Mr Harrison highlighted concerns regarding the data quality underpinning SSNAP results.

11.6 Mrs Taylor noted publication of the national maternity survey. Dr Johnson commented on deterioration in the survey results regarding choice on where to have a baby and also in relation to continuity across care. The results would be used to support continuous improvement however it was highlighted that the Trust was not a negative outlier compared to other Trusts.

APPROVED:
The Board of Directors:

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

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

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

12.2 Mr Marshall highlighted sections from his report including a visit to the Trust by Professor Ian Cummings (Chief Executive of Health Education England), sickness absence monitoring, mobilisation of new 0-19 children's services and staff survey results.

12.3 In addition Mr Marshall reported he had made a presentation to the agenda for change pay review panel.

APPROVED:
The Board of Directors:

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

13.0 Report from the Chief Nurse

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

13.2 Mrs Mayfield noted sections from the report including activities to support nurse recruitment and retention, the October 2017 nursing dependency study results, work to monitor falls, quality of care in the community and complaints received by the Trust.

13.3 Mrs Robson sought further information about the increase in complaints received in January 2018. It was noted activity increased from December 2017 onwards. Dr Scullion

and Dr Tolcher reflected on the complaints received and confirmed there were no significant concerns about the type and volume of concerns being highlighted, they noted some complaints received during the period had referred to incidents which had occurred in previous years. Dr Lyth shared feedback from service managers within her directorate which suggested staffing changes within the Patient Experience Team had resulted in a less experienced team and as a result fewer issues and concerns were being de-escalated at the first point of contact. Dr Scullion responded this was not something he had been made aware of, but he would discuss with the Head of Service.

13.4 Mrs Taylor queried whether Granby and Jervaulx wards required additional investment, while other wards appeared to have a disproportionate number of staff. Mrs Mayfield agreed a review was necessary but noted that the data needed to be triangulated with other measures and professional judgement.

APPROVED:
The Board of Directors:

- **Confirmed they were assured by the work being undertaken to improve nurse recruitment and retention and the governance process for assuring safe staffing levels;**
- **Noted the latest acuity and dependency study**
- **Noted the reporting of Director Inspections and Patient Safety Visits;**
- **Noted the increase in pressure ulcers;**
- **Noted the work around falls reduction;**
- **Confirmed they were assured about the monitoring of care provided by the CCT's;**

14.0 Report from the Medical Director

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

14.2 Dr Scullion highlighted the mortality update and a recent field safety notice from the Medicines Healthcare Regulatory Authority regarding products used in cytology detection for patients with breast cancer. He confirmed a total of 17 patients were affected and required re-testing. All retests were found to be correct; no patient had suffered harm or unnecessary treatment.

APPROVED:
The Board of Directors:

- **Received and noted the report.**

15.0 Fifth quarterly report on safe working hours for doctors and dentists in training

15.1 The report had been circulated in advance of the meeting and was taken as read. The Board agreed to the request from Health Education England for a download of exception reporting data for research purposes.

APPROVED:
The Board of Directors:

- **Received and noted the report.**
- **Agreed a download of exception reporting data to Health Education England for research purposes.**

16.0 Oral Reports from Directorates

16.1 Planned and Surgical Care Directorate

16.1.1 Dr Johnson provided a verbal update from the Planned and Surgical Care Directorate. She noted:

- The relocation of services from Mowbray Square to the Phoenix Unit had gone well.
- There were issues regarding achievement of the 18 week to treatment target for ophthalmology services. These related to a reduction in weekend work and nurse staffing. The team were considering ways to address these challenges.
- A new gastroenterology locum had been appointed and longer term succession plans were being developed.
- A 'flip' of wards was being considered. This was a recommendation from the Getting It Right First Time (GIRFT) review.
- The medical workforce were concerned about a recent GMC case (Dr Bawa-Garba) which had received media coverage. Dr Johnson said she had ensured there were very clear escalation and contingency processes to support staff and ensure patients received safe care in the event of short term and unexpected vacancies. .

16.2 Children's and County Wide Community Services Directorate

16.2.1 Dr Lyth provided a verbal update from the Children's and County Wide Community Services Directorate:

- The directorate had been subject to a SEND inspection in Durham and OFSTED inspection in Darlington.
- The Head of Safeguarding had decided to retire in May 2018, interviews for this post would be held during March 2018. Robust interim arrangements are in place.
- There were concerns regarding rota gaps, especially for middle grade paediatricians. The directorate were working on potential solutions.

16.3 Long Term and Unscheduled Care Directorate

16.3.1 Mr Alldred provided a verbal update from the Long Term and Unscheduled Care Directorate:

- In response to a number of concerns regarding staffing levels within the acute oncology service a review of the service was underway.
- Funding had been agreed with Macmillan to support a seven day specialist palliative care service.
- The Trust continued to work with Hambleton, Richmondshire and Whitby CCG on redesign of GP Out of Hours services.
- The histopathology service faced pressures due to 1.7 WTE consultant vacancies within the team. It had proved difficult to recruit to the specialty and therefore longer term plans were being considered.

17.0 Committee Chair Reports

Mr Thompson welcomed reports from the Board's committees.

17.1 Report from the Quality Committee meetings held on 7 February 2018

17.1.1 Mrs Webster noted the report had been circulated in advance of the meeting and was taken as read. She highlighted assurance received by the committee regarding falls management, the committee noted Mrs Foster was scheduled to attend the next Audit Committee to discuss a recent internal audit report which found limited assurance regarding falls management.

17.2 Report from the Finance Committee meeting held on 8 February 2018

17.2.1 Mrs Taylor noted the report had been circulated in advance of the meeting and was taken as read. She highlighted a focus on preparation of the 2018/19 operational plan and concern regard the Trust's cash position.

17.3 Report from the Audit Committee meeting held on 6 February 2018

17.3.1 Mr Thompson noted the report had been circulated in advance of the meeting and was taken as read. He highlighted a focus on falls and concerns regarding the process to awarding tenders for work at the front of Harrogate Hospital. It was confirmed that following the meeting members of the committee had confirmed they were satisfied with the approach adopted.

18.0 Council of Governors minutes of the meeting held 1 November 2017

The minutes from the Council of Governors meeting on 1 November 2017 were noted.

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

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

20.0 Any other relevant business not included on the agenda

The Board noted the death of Mr Stan Ash a longstanding employee of the Board, the expressed their condolences to Mr Ash's family.

21.0 Board Evaluation

Mr Thompson sought views about the meeting. Members of the Board expressed their thanks for Mr Thompson for chairing the meeting in Mrs Schofield's absence, particularly in the light of disruptions due to weather. The dial-in facility had proved effective.

22.0 Update on Schwartz Rounds

Ms Noreen Hawkshaw (Macmillan Lead Nurse for Cancer and End of Life Care) joined the meeting to provide a presentation regarding Schwartz Rounds.

23.0 Confidential Motion

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

The Board agreed the motion unanimously.

The meeting closed at 12.30pm.

NHS
Harrogate and District
NHS Foundation Trust

HDFT Board of Directors Actions Schedule
Action Log
March 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	April 2018 (date adjusted by Board in January 2018)	
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	March 2018 (date adjusted by Board in 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 Partnership; clarifying any governance implications.	Katherine Roberts, Company Secretary	April 2018	
76	November 2017	Consider the inclusion of measures demonstrating the pressures facing by community services within the IBR.	Mr Harrison, Chief Operating Officer	April 2018 (date adjusted by Board in January 2018)	
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 2018	

81	January 2018	Further consideration to include additional measures within the integrated board report regarding patient experience in adult and children community services.	Mr Harrison, Chief Operating Officer / Mr Alldred, Clinical Director LTUC / Dr Lyth, Clinical Director CCWC	April 2018	
82	January 2018	Mrs Schofield to reflect the boards appreciation of the continuing hard work and dedication shown by staff to patients during the 2017/18 winter in a further letter to staff in due course.	Mrs Schofield	March 2018	**Complete** letter sent by Chief Executive
83	January 2018	Mrs Schofield to write to the immunisation team to thank them for their initiative in successfully vaccinating an additional year group with no additional resource.	Mrs Schofield	March 2018	
84	January 2018	Following review of patient safety visit format proposals to be the Board for comment and consideration.	Mrs Foster	May 2018	
85	January 2018	Mrs Schofield to write to Mr David Leinhardt and express thanks on behalf of the Board.	Mrs Schofield	March 2018	**Complete** letter sent by Chief Executive
86	January 2018	Develop proposals for appropriate governance reporting between the Trust and Harrogate Healthcare Facilities Management (a wholly owned subsidiary company).	Mrs Roberts	March 2018	**Complete**, included on the private board agenda for discussion
87	February 2018	Senior nursing team to consider whether an audit of pressure ulcer prevention was required following introduction of new standard nursing documentation rom April 2018.	Mrs Foster	May 2018	

Harrogate and District NHS Foundation Trust

Date of Meeting:	28 March 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 reported a deficit in February of £651k, against a planned surplus of £329k; the year to date position is now £1,798k surplus, significantly behind the plan of £4,836k. • Winter pressures continue to drive high admission and bed occupancy rates. Use of escalation beds has led to higher than usual additional staffing costs and the loss of some income due to cancelled non-urgent elective inpatient activity. • The Trust achieved 93.8% against the 4-hour standard for people seen in the Emergency Department (ED) and 89.9% on the 18 week RTT standard (target 92%). • The staff engagement score for 2017, derived from the national NHS staff survey was 3.83 lower than the prior year's score but remains above average.		

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 identified.
Assurance:	Not applicable.

Action Required by the Board of Directors:

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

The high levels of demand for urgent and emergency care reported to the Board over the last three months have continued throughout February and March. Colleagues across the Trust are working exceptionally hard in order to sustain safe and dignified care for our patients and keep to a minimum the amount of disruption to planned care.

The number of non-elective admissions for the year to date is 3.6% higher than planned. Despite having an average length of stay which when compared to peers is average (non-elective admissions; 5.2 days) and in the top 25% (elective admissions; 1.9 days) the number of people experiencing a hospital length of stay *greater* than 7 days in HDH is high. Recent data shows that people with extended hospital stays account for around 64% of occupied beds which is one of the highest rates in Yorkshire and Humber Trusts. This is driven by high levels of clinical need and significant challenges to transfers of care. DTOCs attributed to health now account for more than 80% of delays with delays in health assessment and patient choice being the commonest reasons for delay. The Trust is working closely with commissioners and partners in North Yorkshire County and Leeds City Councils to seek solutions. NHSI and NHSE have recently written to A&E Delivery Boards asking them to identify improvement projects to support system working and we are keen to see projects which enable safe and timely discharge/transfers of care prioritised.

As a result of the operational pressures described above, performance on two national operational standards is below the required level this month. The Trust achieved 93.8% against the 4-hour standard for people seen in the Emergency Department (ED) and 89.9% on RTT (target 92%). The year to date achievement of the 4-hour standard however remains above the required 95%. Directorates remain focused on both mitigating the impact on patients and seeking longer term resolutions to correct performance. Improvements to patient flow are required in order to recover performance on the 4 hour standard although it should be noted that for the most critically unwell people arriving in the ED, a period of stabilisation which exceeds 4 hours is often clinically appropriate.

Performance on the 18 week RTT standard is compromised by medical and nurse staffing gaps for which there is no quick solution. It is foreseeable therefore that this target will not be recovered until Q1 or Q2 of 2018/19. The development of a new type of contract for elective care in 2018/19 will also influence the system level approach to improving waiting time performance. It is notable that the Trust breached its cap on agency spending in February, for the first time, and that this too is driven by enduring workforce challenges.

1.2 2017 National NHS Staff Survey

The results of the 2017 National NHS Staff Survey have been received and are now being reviewed at directorate level. There has been a small reduction in the Trust's overall engagement score, although the Trust is still ranked in the top category and has achieved one of the highest scores nationally. The national average engagement score also fell this year, compared to 2016.

The survey reports on 32 'key findings' and the Trust's scores were better than average in 19 of these, average in 10 and below average in three. Further details are contained in the Director of Workforce and OD's report. The results are based on a sample of 1,250 staff of whom 52% returned completed surveys (638).

2.0 FINANCIAL POSITION

2.1 Financial performance and Financial Recovery Plan (FRP)

The Trust reported a deficit in February of £651k, against a planned surplus of £329k. The drivers for the £980k variance mirror prior months with a shortfall in income (due in part to cancelled non-urgent elective work) and significant overspending on pay necessary in order to ensure safe staffing levels. This results in a year to date position of £1,798k surplus, significantly behind the plan of £4,836k. Regrettably, while we anticipate some improvement in the overall position in March this adverse position places the Q4 STF income at significant risk. Failure to achieve the full year control total would also mean that a £500k reduction to the 2018/19 control total will not be applied and the Trust will not be eligible for any additional year end STF allocations.

Further details are provided in the Finance Directors report.

3.0 STRATEGIC UPDATE

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

3.1 Integrated Care System development

The West Yorkshire and Harrogate Health and Care Partnership continues to work productively to progress towards becoming an Integrated Care System including the development of a Memorandum of Understanding (MoU) for the partnership, a financial strategy and a place-based approach to regulation and oversight.

On 20 March the full executive teams from each of the partners in WYAAT met for an OD session in order to further explore the opportunities for collaboration. This was a positive meeting with a growing sense of collaboration. The session included presentations and discussion on clinical service sustainability issues; workforce and the regional pharmacy supply chain.

4.0 WORKING IN PARTNERSHIP

4.1 Harrogate Health Transformation Board (HHTB)

The Provider Collaborative Group will now be known as the Harrogate Alliance and a Joint Management Team has been established to oversee operational delivery as well as service transformation. Terms of reference for both groups have been drafted. The next meeting is on 22 March and a verbal update will be provided to the Board.

The Harrogate Alliance submitted its response to the commissioner's indicative intentions at the start of the month and further dialogue is awaited.

5.0 SENIOR MANAGEMENT TEAM (SMT) MEETING

The SMT met on 21 March 2018. The following key areas are for noting:

- Safety concerns in ophthalmology due staffing gaps and the resulting long waits
- Sustainability concerns in respect of acute oncology services
- Opportunities to improve Hospital at Night arrangements were discussed
- The opportunity to further increase awareness of Human Factors as a source of incidents and errors, and how this can be addressed as part of the Trusts serious incident investigation process
- Following targeted improvement work on Byland ward there were no instances of higher grade pressure ulcers on the ward during February
- Following staff and governor engagement, Quality Account improvement priorities were agreed
- The key findings of the 2017 NHS National Staff survey were received and discussed
- A report on post-project evaluations will be brought to the SMT next month.

6.0 COMMUNICATIONS RECEIVED AND ACTED UPON OR TO NOTE

6.1 Letter from the Chief Inspector of the Healthcare Safety Investigation Branch

During March 2018 the Trust received a letter from the Chief Inspector of the Healthcare Safety Investigation Branch (HSIB) regarding investigation of maternity incidents. The HSIB will commence investigations into certain categories of maternity incidents during the 2018/19 year and they anticipate achieving full national coverage by April 2019.

Once rolled out the HSIB's investigations will be undertaken instead of those normally undertaken by the Trust's risk management team. However until the Trust receives formal notification from the HSIB, the Trust will continue to investigate maternity incidents as per our normal processes.

7.0 BOARD ASSURANCE AND CORPORATE RISK

7.1 Board Assurance Framework (BAF)

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 ↔*	*Unchanged at 1*	
BAF 5	Risk of maintaining service sustainability	*Amber 9 ↔*	*Unchanged at 1*	
BAF 9	Risk of a failure to deliver the Operational Plan	*Red 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 an insufficient 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 1*	✓
BAF 16	Risk that the Trust's critical infrastructure is not fit for purpose	*Amber 8 ↔*	*Unchanged at 1*	✓
BAF 17	Risk to senior leadership capacity	*Amber 8 ↔*	*Unchanged at 1*	

7.2 Corporate Risk Register (CRR)

Corporate risk register summary of changes: Updated February 2018

Ref	Description	Current risk score	Risk movement	Current progress score	Target date for risk reduction	Notes
CR2	Risk to the quality of service delivery in Medicine due to gaps in rotas following the Deanery allocation process	12	↔	2	*Aug-18*	
CR5	Risk to service delivery due gaps in registered nurses establishment	12	↓	2	*Mar-19*	*Risk score reduced to 12*
CR12	Risk to financial sustainability from failure to deliver the Clinical Transformation Programme at pace and scale	12	↔	4 ↓	*Mar-18*	*Progress score reduced to 4*
CR13	Risk to urgent care system due to a lack of capacity in the out of hospital services	12	↔	*2*	*Mar-18*	
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*	*Mar-18*	
CR17a	Risk of patient harm as a result of being lost to follow-up as a result of current processes	12	↔	*2*	*Apr-18*	*Target date extended to April 2018*
CR17b	Risk of patient harm as a result of being lost to follow up as a result of historic processes	12	↔	*3*	*Dec-18*	
CR18	Risk to provision of service and not achieving national standards in cardiology due to potential for lab equipment breaking down	12	↔	4 ↓	*Apr-18*	*Progress score reduced to 4. Target risk score increased to 9 by April 2018*
CR24	Risk to patient safety, quality, experience, reputation, staff wellbeing and associated effect on timely discharge from the reduction to baseline (2011) funding capacity	15	↔	*3* ↓	*Apr-18*	*Progress score reduced to 3*
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	↔	*1* ↑	*Apr-18*	*Progress score improved to 1*
CR26	Risk of inadequate antenatal care and patients being lost to follow up - due to inconsistent process for monitoring attendance at routine antenatal appointments in community	12	New	*3*	*tbc*	

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

CR26 – Risk of inadequate antenatal care and patients being lost to follow up - due to inconsistent process for monitoring attendance at routine antenatal appointments in community.

Risks removed from corporate risk register

None

Risks with amended target dates or target scores

CR18 - Risk to provision of service and not achieving national standards in cardiology due to potential for lab equipment breaking down. Target risk increased to C3 x L3 = 9 by April 2018.

CR17a - Risk of patient harm as a result of being lost to follow-up as a result of current processes. Target date extended to achieve C4 x L2 = 8 by 30 April 2018.

8.0 DOCUMENTS SIGNED AND SEALED

The following documents have been sealed during the month.

- In relation to the transfer of estates and facilities services from the Trust to Harrogate Healthcare Facilities Management Limited the Trust signed and sealed the following documents:
  - Debenture for £1million
  - Lease for the main Harrogate hospital site
  - Lease for 26 Wetherby Road
  - Lease for Heatherdene
  - Underlease for Lascelles.
- Sealed deeds of novation for contracts which will transfer from the Trust to Harrogate Healthcare Facilities Management Limited:
  - Imtech.
  - Medical Air Technology Limited
  - Swegon Service Limited
  - Avensys UK
- Signed and sealed a contract for the provision of public health services (growing health, growing well) with Stockton Borough Council.
- Signed and sealed a contract for the provision of 0-19 health child services with Stockton Borough Council.
- Signed and sealed Underlease in respect of Gibraltar House in Northallerton.
- Signed licences for the following North Yorkshire County Council Sites:
  - Skipton Childrens Centre.
  - County Hall Northallerton for the use of desk space in relation to the MAST service.
  - Ryedale Childrens Services Hub in Pickering.
  - Ripon and Harrogate Childrens Services Hub in Ripon.

Dr Ros Tolcher
Chief Executive
21 March 2018

Harrogate and District NHS Foundation Trust

Integrated board report - February 2018

Key points this month

1. The Trust reported a deficit in February of £651k, against a planned surplus of £329k. This results in a year to date position of £1,798k surplus, significantly behind the plan of £4,836k.

2. Performance against the 4 hour A&E standard was at 93.8% in February, an improvement on last month but remaining below the required 95% standard

3. The Trust also remains below the required 92% standard for 18 weeks for the third successive month, where performance was at 89.9% in February.

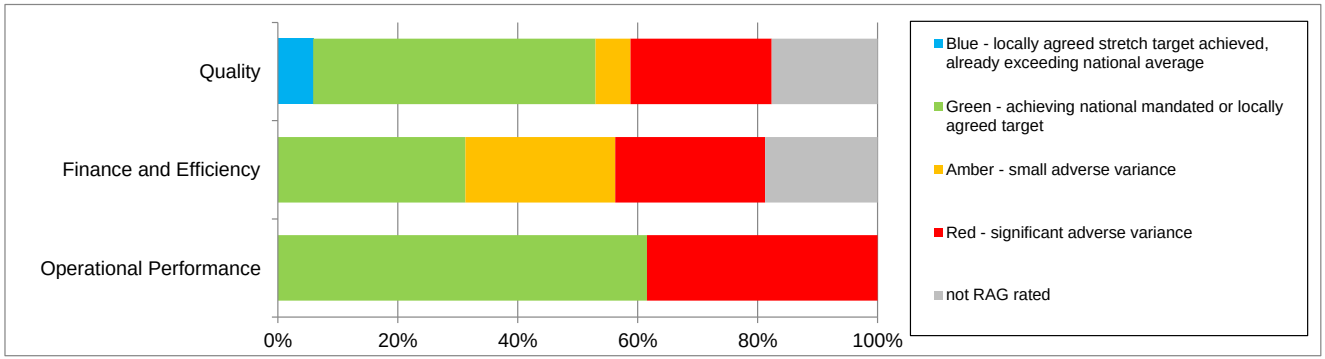
4. There was 1 hospital acquired C. diff case reported in February bringing the year to date total to 6 cases.

5. Staff sickness increased to 5.34% in January. This is correlated with an increase in agency spend seen in both January and February.

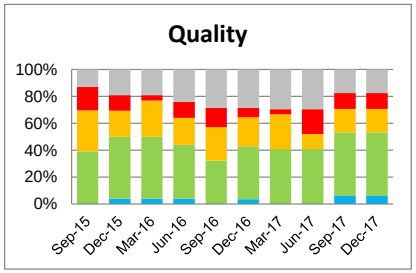
6. The number of complaints received this month has reduced significantly compared to last month.

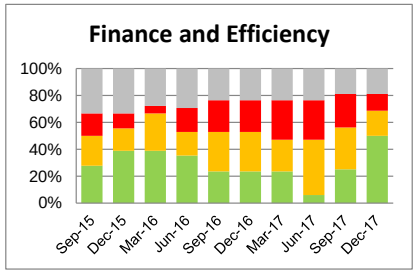
7. HDFT's standardised mortality rate reduced in the latest publications of both the HSMR and SHMI indicators.

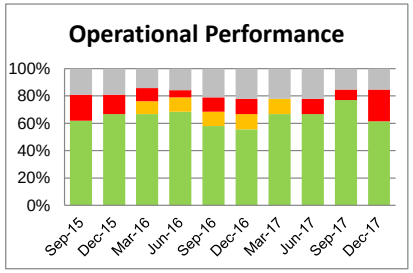
Summary of indicators - current month



Summary of indicators - recent trends







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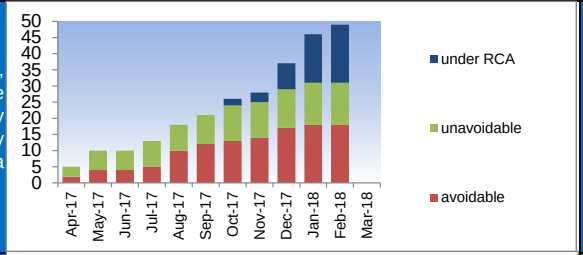
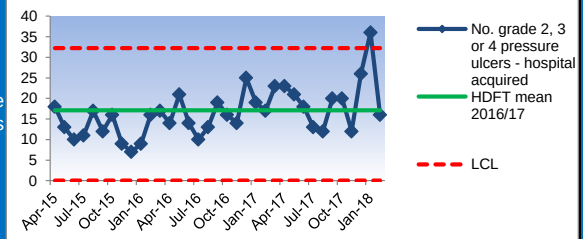
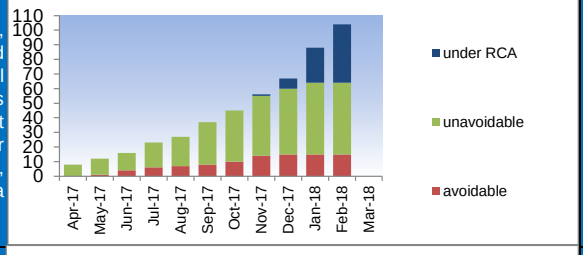
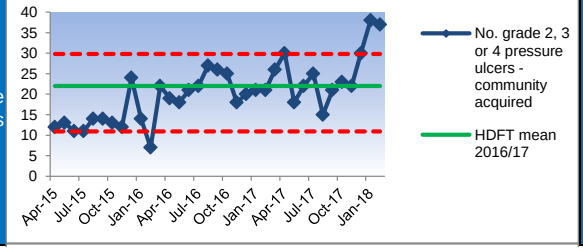
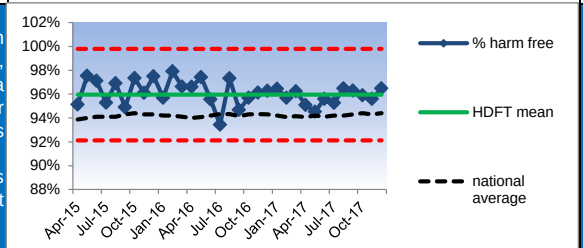
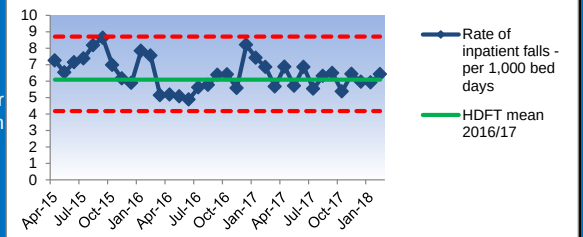
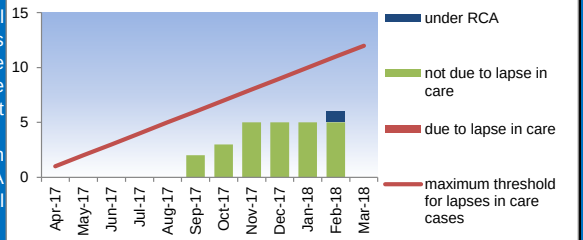
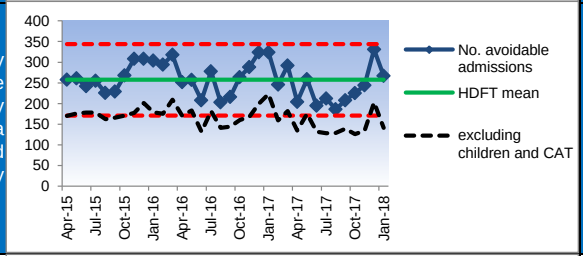
Quality - February 2018

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 3 hospital acquired unstageable or category 3 pressure ulcers reported in February, with the year to date total now at 49. Of these, 18 are still under root cause analysis (RCA), 18 have been assessed as avoidable and 13 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 February was 16, a significant decrease on last month. This brings the year to date total to 217, a 19% increase on the same period last year. Work is underway to identify the factors contributing to this increase and measures to detect and prevent pressure ulcers. A new risk assessment tool is being introduced across all inpatient ward areas.
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 16 community acquired category 3, category 4 (or unstageable) pressure ulcers reported in February, a reduction on last month. This brings the year to date total to 104. Of these, 40 are still under root cause analysis (RCA), 15 have been assessed as avoidable and 49 as unavoidable.
⚠	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 February was 37 cases, compared to 38 last month.

Quality - February 2018

NHS Harrogate and District NHS Foundation Trust

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Safety Thermometer - harm free care ✓	Measures the percentage of patients receiving harm free care (defined as the absence of pressure ulcers, harm from a fall, urine infection in patients with a catheter and new VTE) in the Safety Thermometer audits conducted once a month. The data includes hospital and community teams. A high score is good. Whilst there is no nationally defined target for this measure, a score of 95% or above is considered best practice.		The harm free percentage for January was 94.8%, an improvement on last month but remaining below 95%.
Falls ✓	The number of inpatient falls expressed as a rate per 1,000 bed days. The data includes falls causing harm and those not causing harm. A low rate is good.		The rate of inpatient falls was 6.42 per 1,000 bed days in February, an increase on last month and above the average HDFT rate for 2016/17. However, there were no falls causing moderate or severe harm in February.
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 was 1 case of hospital apportioned C. difficile reported in February bringing the year to date total to 6 cases. 5 of the 6 cases have had root cause analysis completed and agreed with HARD CCG. The outcome on all 5 cases was that no lapse of care had occurred. Root cause analysis is in progress for the 6th case. 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 267 avoidable admissions in January, a decrease on recent months. This metric is seasonal with less avoidable admissions in the summer compared to the winter months. However this month's figure is below the level reported in January last year (324). Adult admissions (excluding CAT attendances) also decreased this month to 141, compared to 203 last month.

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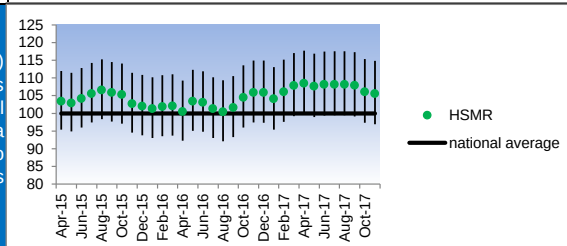
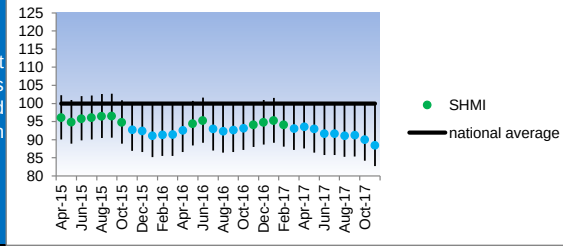
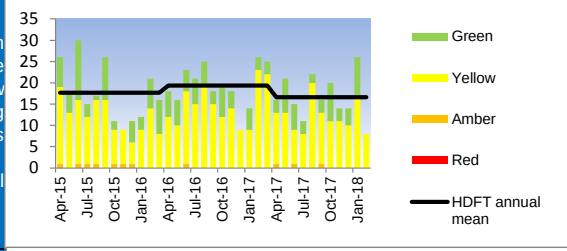
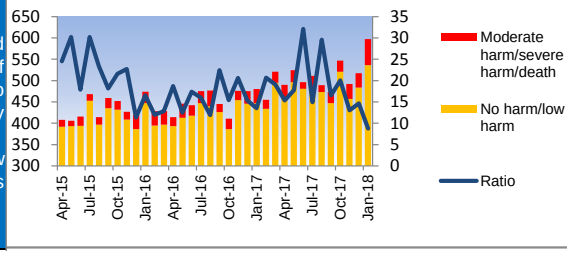
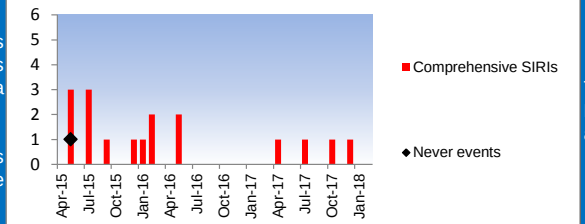
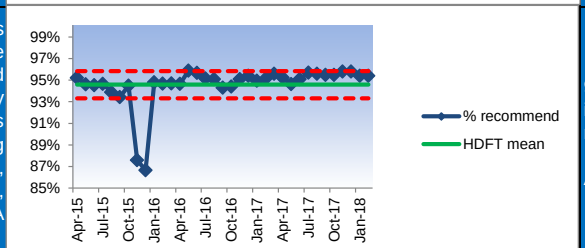
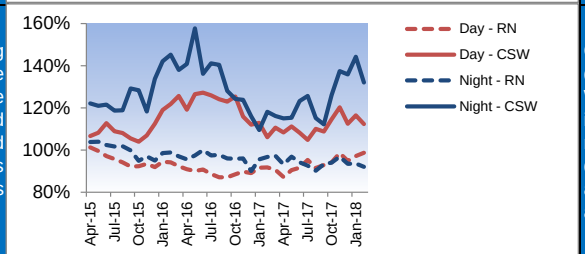
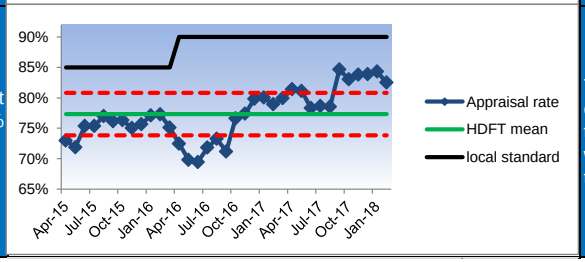
Quality - February 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Mortality - HSMR ✓	The Hospital Standardised Mortality Ratio (HSMR) looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care. A low figure is good.		HDFT's HSMR for the rolling 12 months ending October 2017 was 105.6, a decrease on last month and remaining within expected levels. At specialty level, one specialty continues to have a higher than expected standardised mortality rate (Geriatric Medicine). The latest HSMR data on HED includes the period to end December 2017 but reflective of the data position as at mid-January when the Trust was only partly coded for the month of December. 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.
Mortality - SHMI ✓	The Summary Hospital Mortality Index (SHMI) looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care. A low figure is good.		HDFT's SHMI decreased to 88.4 for the rolling 12 months ending November 2017 and remains below expected levels. At specialty level, four specialties (Respiratory Medicine, Gastroenterology, Geriatric Medicine and one small volume surgical specialty) continue to have a standardised mortality rate above expected levels.
Complaints ✓	The number of complaints received by the Trust, shown by month of receipt of complaint. The criteria define the severity/grading of the complaint with green and yellow signifying less serious issues, amber signifying potentially significant issues and red for complaints related to serious adverse incidents. The data includes complaints relating to both hospital and community services.		8 complaints were received in February, a significant reduction on last month, with no complaints classified as amber or red this month.
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 Apr-17 to Sep-17) shows that Acute Trusts reported an average ratio of 44 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 26, a minor 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.

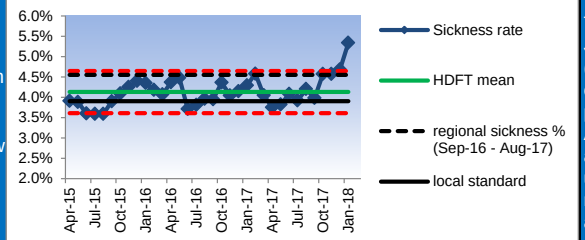
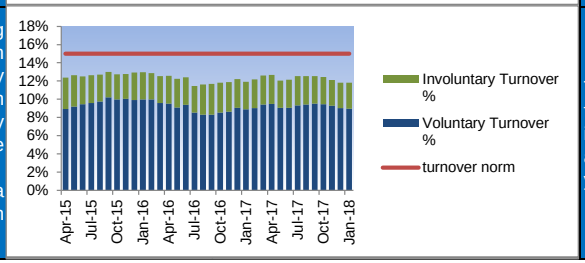
Quality - February 2018

Harrogate and District NHS Foundation Trust

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 were no comprehensive SIRIs and no Never Events reported in February. 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.		95.4% of patients surveyed in February would recommend our services, in line with recent months and remaining above the latest published national average (93%). Around 4,400 patients responded to the survey this month.
Safer staffing levels ✓	Trusts are required to publish information about staffing levels for registered nurses/midwives (RN) and care support workers (CSW) for each inpatient ward. The chart shows the overall fill rate at HDFT for RN and CSW for day and night shifts. The fill rate is calculated by comparing planned staffing with actual levels achieved. A ward level breakdown of this data is published on the Trust website.		Overall staffing compared to planned was at 105% in February, a decrease on last month (107%) 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 rate was at 82.5% in February. Preparations for the commencement of the appraisal period in April are under way. The HR team are scheduling training updates on the completion of appraisal which will be held in early April and this will be reported on monthly through the Directorate board reports.

Quality - February 2018

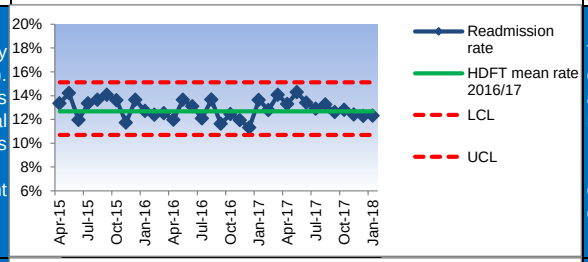
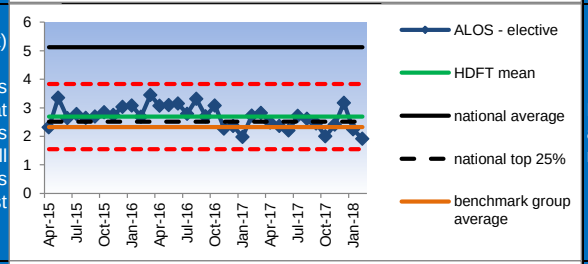
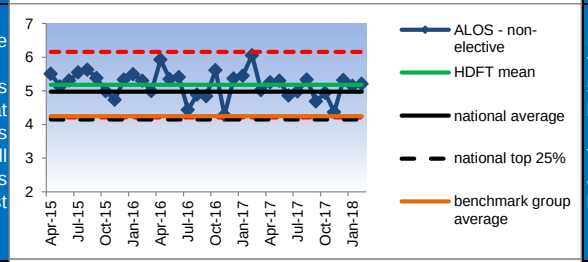
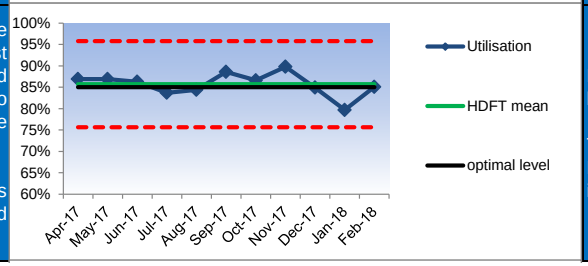
NHS
Harrogate and District
NHS Foundation Trust

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Mandatory training rates ✓	The table shows the most recent training rates for all mandatory elements for substantive staff.	See table below	The data shown is for the end of February and includes the staff who were TUPE transferred into the organisation on the 1st April 2016. The overall training rate for mandatory elements for substantive staff is 85%. 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 January is 5.34%. In January, the Trust had 134 long term sickness; of which 50 cases were closed (46 returned to work and 4 left the Trust). The cumulative absence rate is currently 4.61% from April 17 – January 18, an increase of 0.42 percentage points compared with the cumulative figure from the same period in 2016/17. An increase in short term absence is driving the increasing absence position and therefore the HR team are providing open sessions for managers to undertake case review for short term absence. Reporting for the completion of return to work interviews suggests that only 37% of these were undertaken and therefore this remains a focus.
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	73
Infection Prevention & Control (Including Hand Hygiene) 1	100
Infection Prevention & Control (Including Hand Hygiene) 2	77
Data Security Awareness	76
Preventing Radicalisation - Level 1 and 2 (December 2015)	97
Safeguarding Adults Awareness Elearning (Dec 2015)	95
Safeguarding Children & Young People Level 1 - Introduction eLearning	93

Harrogate and District NHS Foundation Trust

Finance and Efficiency - February 2018

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 emergency readmissions in January was 241. This equates to 12.3% when expressed as a percentage of all emergency admissions, no change on last month and remaining 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 February was 1.9 days. This is a decrease on last month and the Trust remains in the top 25% of Trusts nationally in the most recently available benchmarking data.
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 February was 5.2 days. This is a small increase on last month. The Trust remains in the middle 50% of Trusts nationally when compared to the most recently available benchmarking data. The number of patients with a length of stay of over 7 days accounts for around 64% of occupied beds at HDFT. This is the highest level reported by Yorkshire & Humber Trusts in daily sitrep submissions to NHS Improvement.
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.		Elective theatre utilisation was at 85.1% in February, an improvement on last month. This metric has been aligned with the new theatre utilisation dashboard. Further metrics from the new dashboard are being considered for inclusion in this report from April.

Finance and Efficiency - February 2018

NHS
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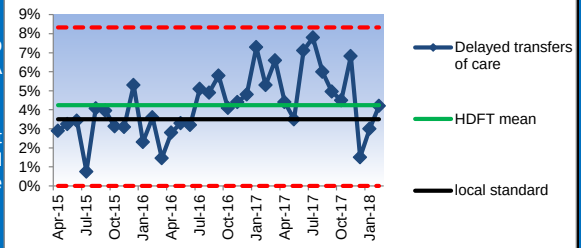
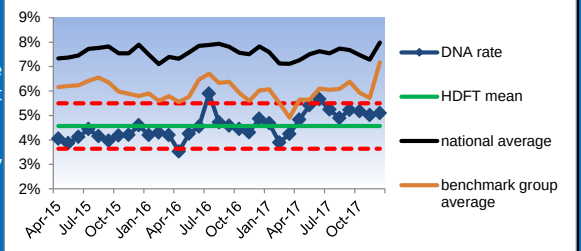
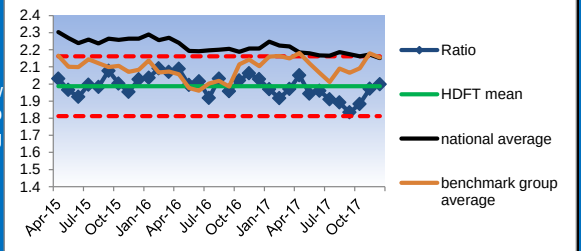
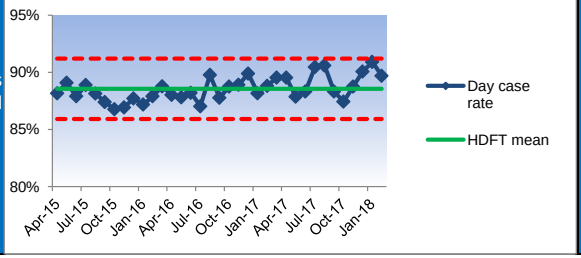
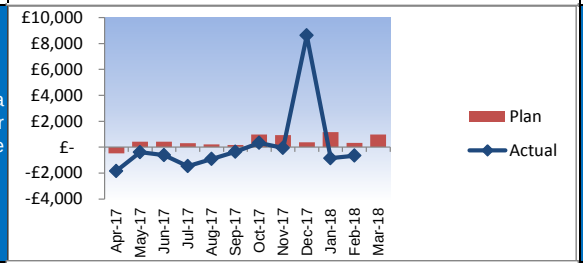
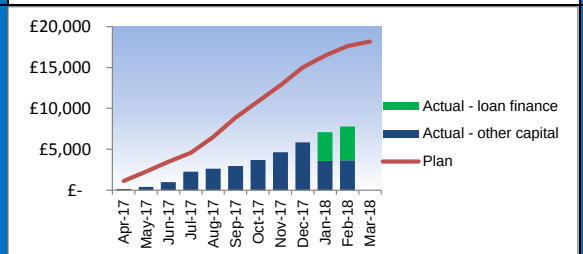
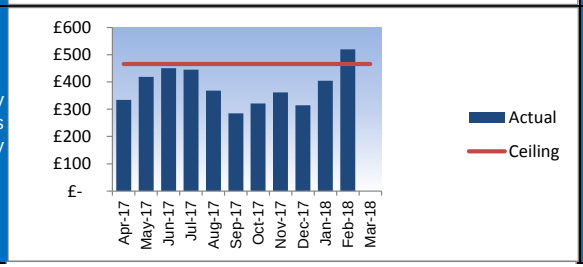
Indicator name / data quality assessment	Description	Trend chart	Interpretation
Delayed transfers of care ✓	The proportion of patients in acute hospital beds who are medically fit for discharge but are still in hospital. A low rate is preferable. A snapshot position is taken at midnight on the last Thursday of each month. The maximum threshold shown on the chart (3.5%) has been agreed with the CCG.		Delayed transfers of care were at 4.2% when the snapshot was taken in February. Health attributed delays account for >80% of delays and along with assessment delays and choice are the commonest reasons. In recent months, there has been a reduction in delays due to further non-acute NHS care. This is linked to increased bed capacity being available in Trinity and Hampden House due to winter funding. Although the position has improved in recent months, the February snapshot is above the 3.5% maximun threshold. Minimising the number of delayed patients has remained a significant challenge over the winter period and will continue to be a concern when winter funding for additional non-acute beds ceases at the end of March.
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 remains static at 5%. This is below that of both the benchmarked group of trusts and the national average, both of which reported an increase in December.
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 2.00 in December, an increase on last month but remaining 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 reduced to 89.7% in February but remains above the historical average.

Finance and Efficiency - February 2018

NHS Harrogate and District NHS Foundation Trust

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 Trust reported a deficit in February of £651k, against a planned surplus of £329k. This results in a year to date position of £1,798k surplus, significantly behind the plan of £4,836k. The figures above are inclusive of Sustainability and Transformation Funding. This equates to £3,336k to date. The Trust has received £2,455k of this, with the further £882k at risk as a result of the quarter 4 position.
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 / 2 Liquidity: 1 / 1 I&E Margin: 1 / 2 I&E Variance From Plan: 1 / 3 Agency: 1 / 1 **Financial Sustainability Risk Rating: 1 / 2**	The Trust reported a rating of 2 in February as a result of the variance to plan reported above.
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.		At 2.9% of total pay costs, the year to date figure for agency spend remains below the agency ceiling. Expenditure in February was a significant concern which is being investigated further. At £520k (3.9%), it is the first month that the Trust has breached the agency ceiling since the introduction of the ceiling in 2016.

Finance and Efficiency - February 2018

NHS
Harrogate and District
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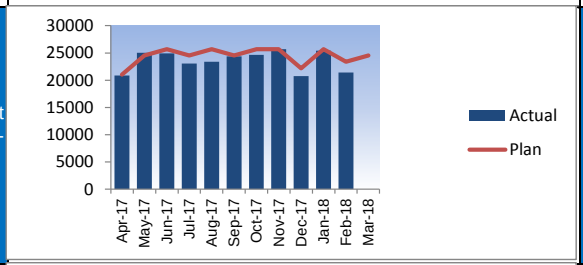
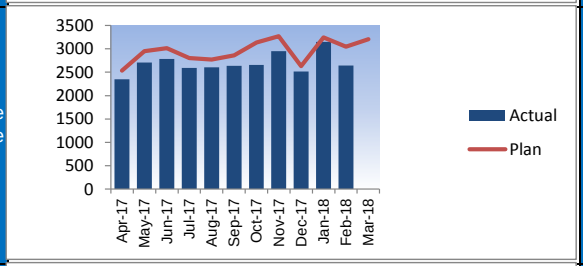
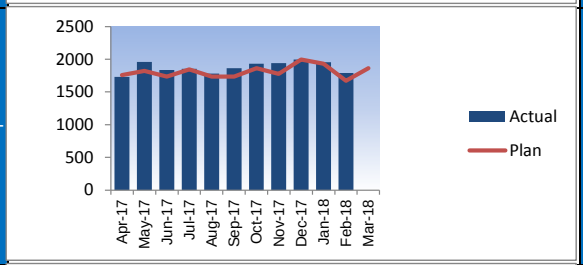
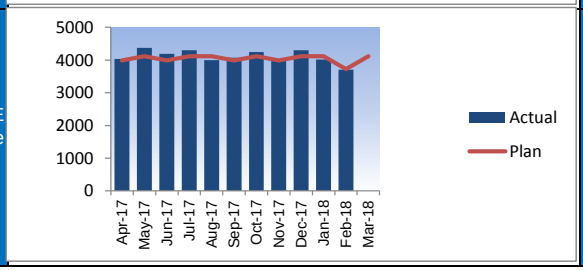
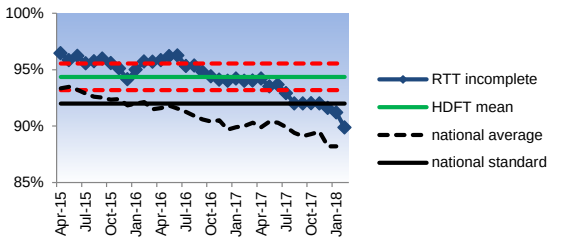
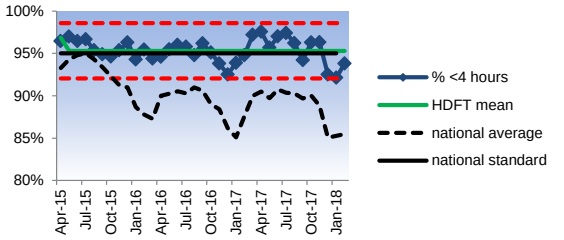
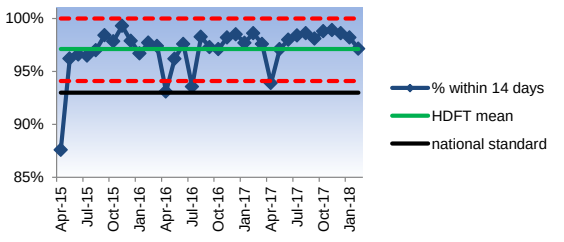
Indicator name / data quality assessment	Description	Trend chart	Interpretation
Outpatient activity against plan ✓	The chart shows the position against plan for outpatient activity. The data includes all outpatient attendances - new and follow-up, consultant and non-consultant led.		Outpatient activity was 8.4% below plan in the month of February and 2.9% below plan year to date. This is a deterioration on last month's position. Further information is provided in the Chief Operating Officer's report to board.
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 13.3% below plan in the month of February and 7.8% below plan year to date. This is a deterioration on last month's position. Further information is provided in the Chief Operating Officer's report to board.
Non-elective activity against plan ✓	The chart shows the position against plan for non-elective activity (emergency admissions).		Non-elective activity was 7.2% above plan in the month of January and 3.6% 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 0.4% below plan in the month of January but remain 2.1% above plan year to date.

Harrogate and District NHS Foundation Trust

Operational Performance - February 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
NHS Improvement Single Oversight Framework ✓	From October 2016, NHS Improvement use a variety of information to assess a Trust's governance risk rating, including CQC information, access and outcomes metrics, third party reports and quality governance metrics. The table to the right shows how the Trust is performing against the national performance standards in the "operational performance metrics" section.	<table><tr><th>Standard</th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4 to date</th><th>YTD</th></tr><tr><td>RTT incomplete pathways</td><td>93.8%</td><td>92.3%</td><td>91.9%</td><td>90.6%</td><td>92.2%</td></tr><tr><td>A&E 4-hour standard</td><td>96.7%</td><td>96.0%</td><td>94.9%</td><td>92.9%</td><td>95.4%</td></tr><tr><td>Cancer - 62 days</td><td>86.1%</td><td>88.9%</td><td>90.5%</td><td>90.4%</td><td>88.8%</td></tr><tr><td>Diagnostic waits</td><td>99.8%</td><td>99.6%</td><td>99.7%</td><td>99.3%</td><td>99.6%</td></tr></table>	In Quarter 4 to date, HDFT's performance was below the required level for 2 of the 4 key operational performance metrics - the A&E 4-hour standard and the 18 weeks standard, 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 89.9% in February, a deterioration on last month and remaining below the minimum standard of 92% for the third successive month. At specialty level, Trauma & Orthopaedics, Ophthalmology and Neurology were 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 February was 93.8%, an improvement on last month but remaining below the required 95% standard. This includes data for the Emergency Department at Harrogate and Ripon MIU. Performance for Harrogate ED was at 92.8%, an improvement on last month.
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.

Operational Performance - February 2018

NHS
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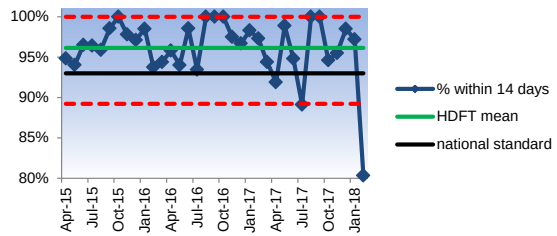
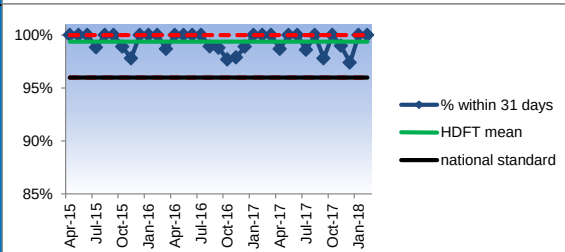
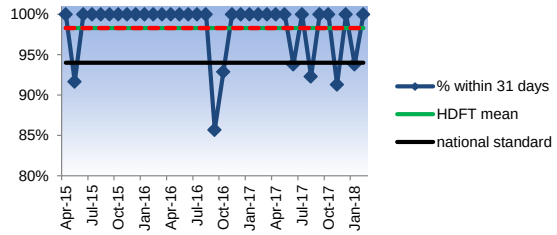
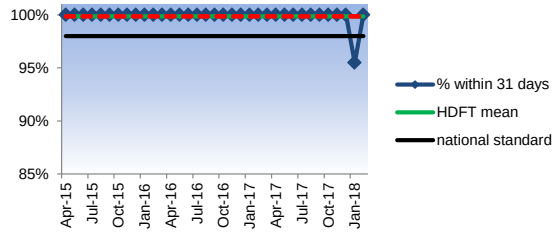
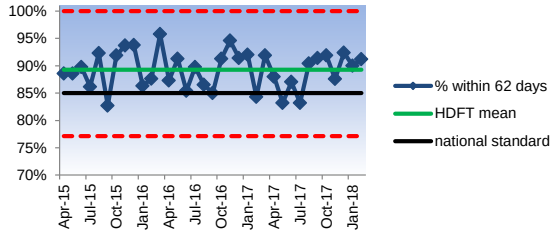
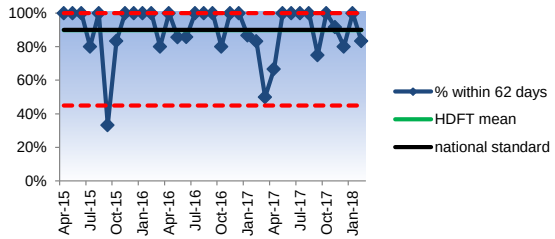
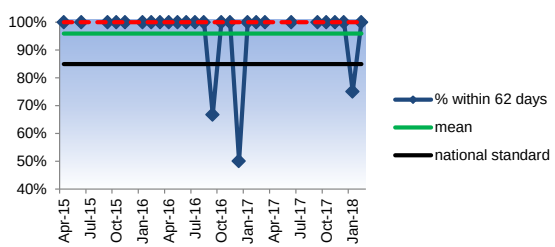
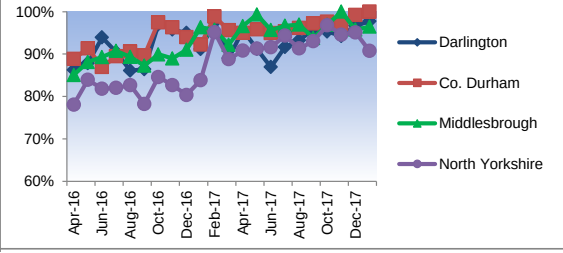
Indicator name / data quality assessment	Description	Trend chart	Interpretation
Cancer - 14 days maximum wait from GP referral for symptomatic breast patients ✓	Percentage of GP referrals for breast symptomatic patients seen within 14 days. The operational standard is 93%. A high percentage is good.		Provisional performance for February was at 80.3%, below the 93% standard. Managing the volume of referrals received was challenging and this was managed through Consultants doing additional clinics out of hours. For the month, 12 patients referred with non-cancer related breast symptoms were first seen outside day 14.
Cancer - 31 days maximum wait from diagnosis to treatment for all cancers ✓	Percentage of cancer patients starting first treatment within 31 days of diagnosis. The operational standard is 96%. A high percentage is good.		Delivery at expected levels.
Cancer - 31 day wait for second or subsequent treatment: Surgery ✓	Percentage of cancer patients starting subsequent surgical treatment within 31 days. The operational standard is 94%. A high percentage is good.		Delivery at expected levels.
Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug ✓	Percentage of cancer patients starting subsequent drug treatment within 31 days. The operational standard is 98%. A high percentage is good.		Delivery at expected levels.

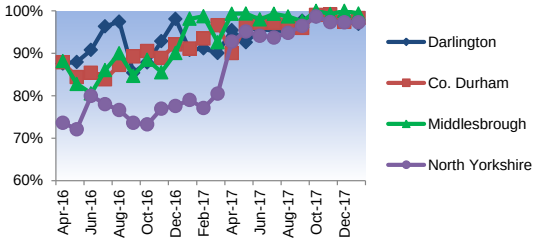
Operational Performance - February 2018

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 February is above the required 85% standard at 91.2% with 4.5 accountable breaches. Of the 11 tumour sites, 5 had performance below 85% in January - colorectal (1 breach), gynaecological (0.5), haematological (0.5), head and neck (1) and other (1). 3 patients waited over 104 days in February. The main reasons for the delays were complex diagnostic pathways and a delay in diagnostics.
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.		Provsional performance for February is at 83.3%, below the required 85% standard. However this related to 1 breach.
Cancer - 62 day wait for first treatment from consultant upgrade ✓	Percentage of cancer patients starting first treatment within 62 days of consultant upgrade. The operational standard is 85%. A high percentage is good.		Delivery at expected levels.
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 January, 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 - February 2018

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 January, the validated performance position is that 98% 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.

Harrogate and District NHS Foundation Trust

Data Quality - Exception Report

Report section	Indicator	Data quality rating	Further information
Quality	Pressure ulcers - community acquired - grades 2, 3 or 4	**Amber** 	The observed increase in reported cases over the last two years may be partly due to improvements in incident reporting during the period.
Finance and efficiency	Theatre utilisation	**Amber** 	This metric has been aligned with the new theatre utilisation dashboard from December 2017. Further metrics from the new dashboard are being considered for inclusion in this report from April 2018. The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. There are some known data quality issues with the utilisation data but it is anticipated that increased visibility of the data via the new dashboard will help to resolve these in the coming months.

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Indicator traffic light criteria

Section	Indicator	Further detail	Traffic light criteria	Rationale/source of traffic light criteria
Quality	**Pressure ulcers - hospital acquired**	No. category 3 and category 4 avoidable hospital acquired pressure ulcers	tbc	tbc
Quality	**Pressure ulcers - community acquired**	No. category 3 and category 4 community acquired pressure ulcers	tbc	tbc
Quality	**Safety thermometer - harm free care**	% harm free	Blue if latest month >=97%, Green if >=95% but <97%, red if latest month <95%	National best practice guidance suggests that 95% is the standard that Trusts should achieve. In addition, HDFT have set a local stretch target of 97%.
Quality	**Falls**	IP falls per 1,000 bed days	Blue if YTD position is a reduction of >=50% of HDFT average for 2016/17, Green if YTD position is a reduction of between 20% and 50% of HDFT average for 2016/17, Amber if YTD position is a reduction of up to 20% of HDFT average for 2016/17, Red if YTD position is on or above HDFT average for 2016/17.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
Quality	**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.

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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:	28 March 2018	**Agenda item:**	6.0
Report to:	Board of Directors		
Title:	Finance Report		
Sponsoring Director:	Jonathan Coulter, Deputy Chief Executive / Finance Director		
Author(s):	Finance Department		
Report Purpose:	**Decision** [ ] **Discussion/ Consultation** [✓] **Assurance** [✓] **Information** [✓]		
Executive Summary:	• The Trust reported a surplus position of £1,798k to date, resulting in a use of resource metric of 2. • The position in February was significantly challenging, with a deficit of £651k reported. • Cash continues to be a concern as a result of the financial position and the delays in receiving payment from Commissioners.		

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

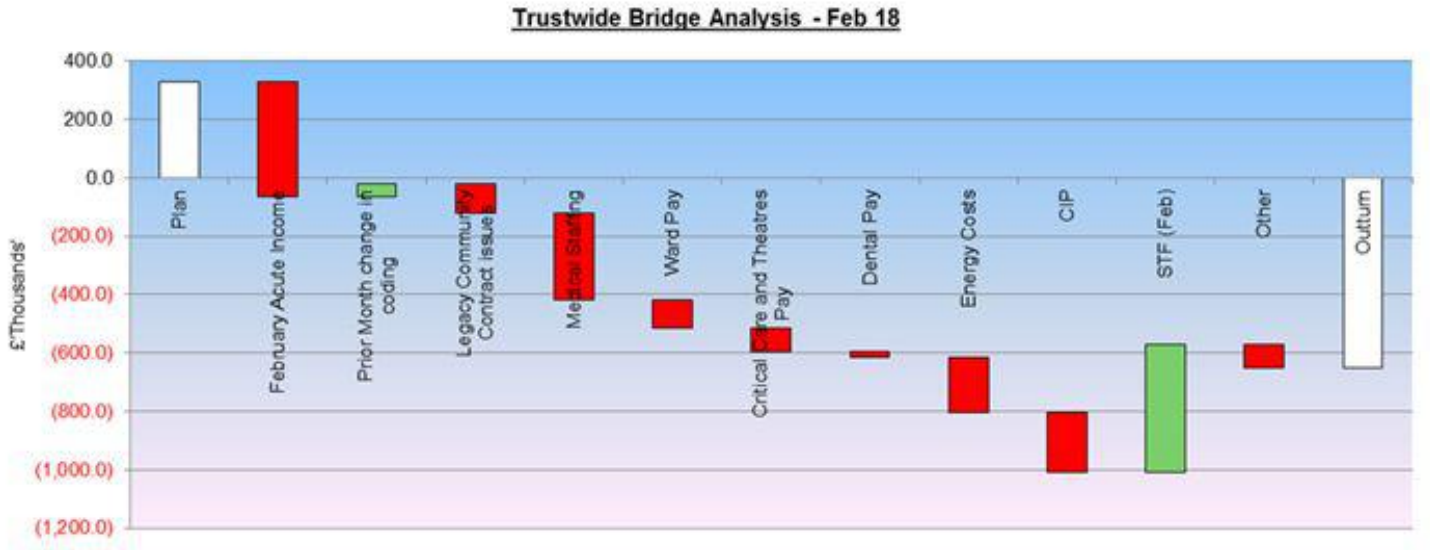
Key implications	
Risk Assessment:	The paper outlines the financial risks facing the Trust and the mitigations being put in place to resolve these in terms of revenue and cash.
Legal / regulatory:	None directly identified.
Resource:	The document outlines the financial challenges and approach to resolving these issues.
Impact Assessment:	A number of quality impact assessments are undertaken on elements of the recovery plan and CIP programme.
Conflicts of Interest:	None
Reference documents:	

Action Required by the Board of Directors:
The Board of Directors is asked to note the contents of this report.

February 2018 Financial Position

Financial Performance

• The Trust reported a deficit in February of £651k, against a planned surplus of £329k. The drivers for the £980k variance are outlined below.



• This results in a year to date position of £1,798k surplus. Accompanied with the adverse performance in January, the performance in February has resulted in the trust now being £3,038k behind plan. The last two months have been particularly challenging, and a number of the underlying operational financial issues the Trust has faced during the year have continued despite the positive impacts of the significant recovery actions which had a benefit in December.

• Agency Expenditure has significantly increased in February, as demonstrated in the IBR. The level of expenditure breached the in month agency ceiling. Spend in this area is a significant driver for the variances outlined above in Medical Staffing, Ward Pay and Theatre Pay costs.

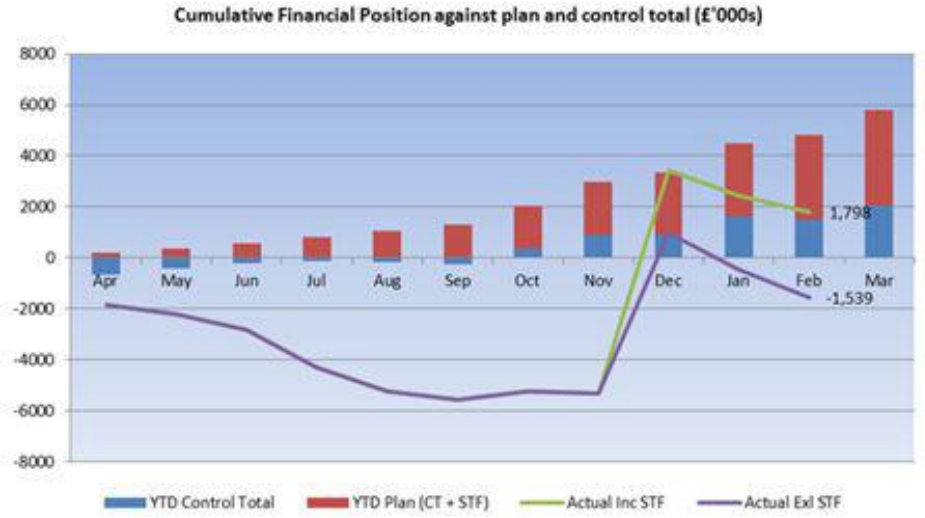
• Energy Costs are being investigated further to establish the drivers for this significant variance to plan.

• The Use of Resource rating for the Trust has also reduced to 2, against a plan of 1 as a result of the variance to plan.

February 2018 Financial Position

Financial Performance Cont.

- The benefits outlined in December ensured the Trust met its control total at quarter 3 and £2,455k of Sustainability and Transformation Funding (STF) has now been received. Performance against the control total is outlined in the graph below

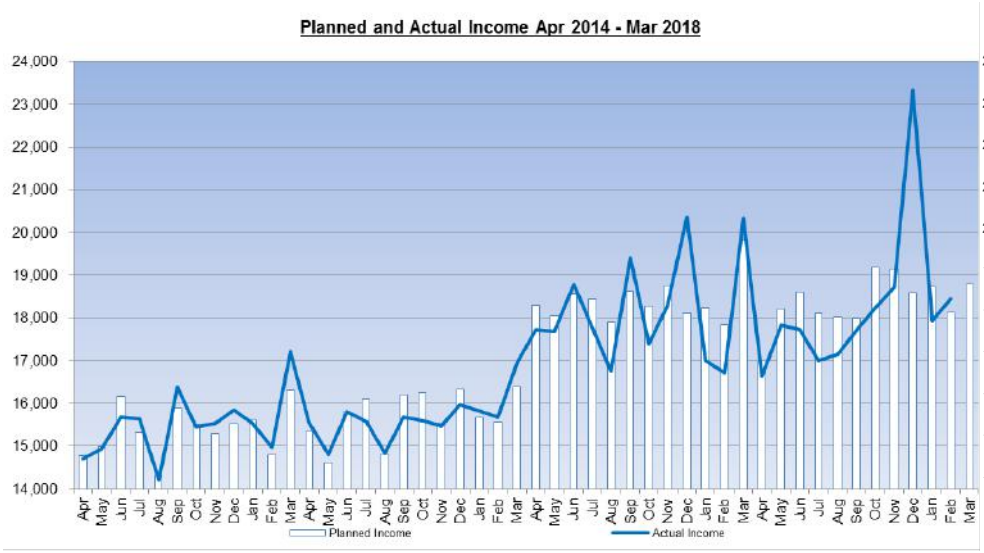


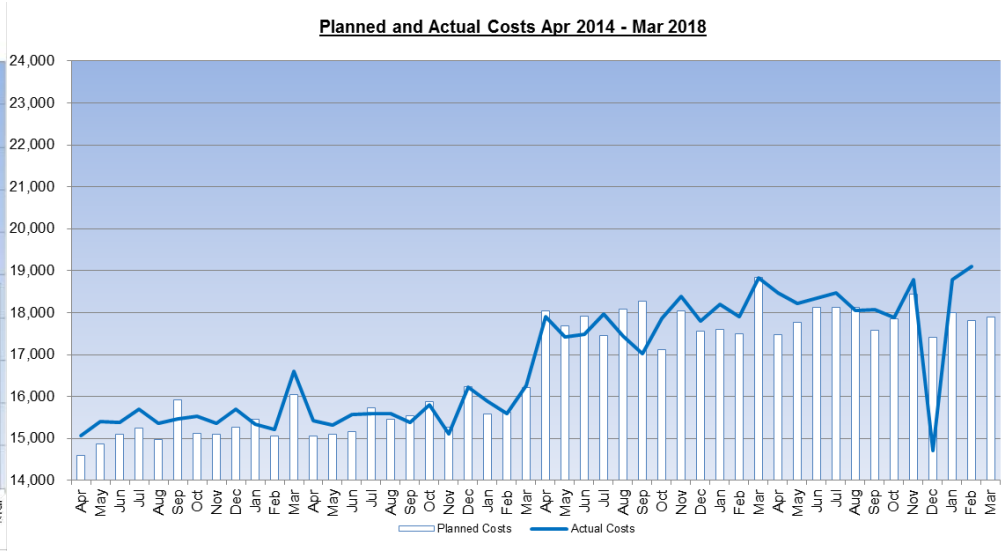
- The level of surplus required in month 12 means achievement of the control total in quarter 4 is increasingly challenging. This puts at risk the £1.3m of STF the Trust would be due if it reached the control total level, as well as any further incentive funds which were made available.

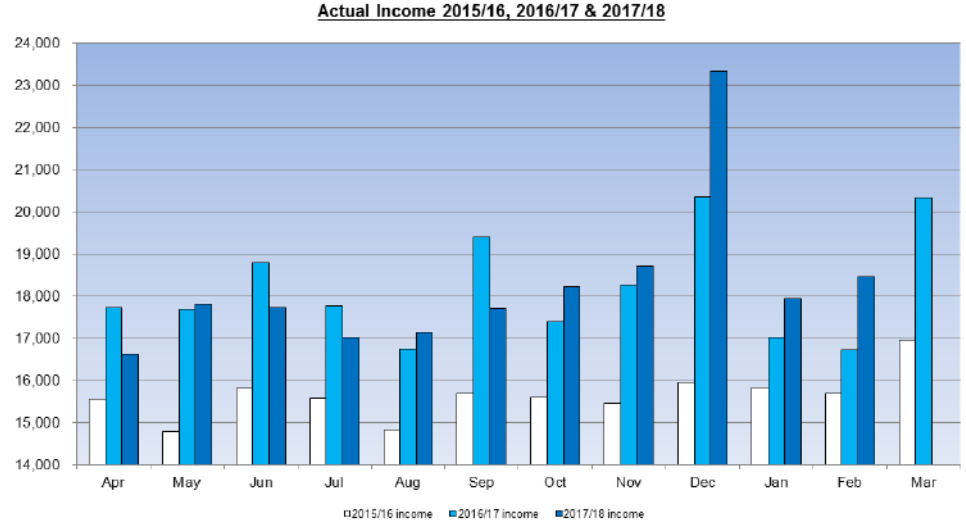
- If the Trust does not achieve the control total in 17/18, the 18/19 control total will increase by £500k.

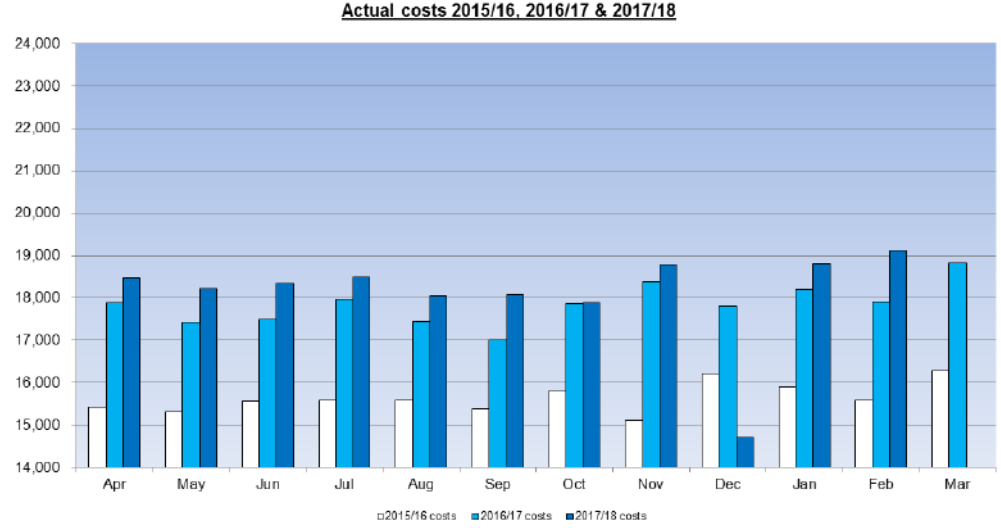
- The Trust ended February with a cash balance of £2,815k, although this included a number of prepayments received by the Trust which resulted in a more favourable position. It is likely that the Trust will be ending the financial year with a balance closer to £500k, as opposed to the plan of £6.3m. Cash is therefore being managed tightly, however, there is clearly an impact on the Trusts ability to support capital developments as a result of this.

2018/19 Run Charts









Activity summary – Year-to-date February 2018

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

	Jan-18				Feb-18				Feb-18 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	8472	8555	8753	-3.2%	7538	7778	7986	-5.6%	88527	89444	90554	-2.2%
Follow-up outpatients	16965	17159	16339	3.8%	14304	17132	14823	-3.5%	171607	176569	174089	-1.4%
Elective inpatients	287	344	320	-10.3%	275	336	313	-12.0%	3177	3597	3411	-6.9%
Elective day cases	2861	2904	2834	0.9%	2399	2712	2657	-9.7%	26451	28685	27278	-3.0%
Non-electives	1957	1930	1930	1.4%	1799	1670	1670	7.7%	20649	19867	19867	3.9%
A&E attendances	4017	4120	4120	-2.5%	3705	3721	3721	-0.4%	45221	44387	44387	1.9%

The impact of high non-elective bed occupancy continued in February with further cancellations of elective inpatient activity and the opening of additional beds to support patient flow. The Elective Admissions and Discharge Unit (EADU) on Swaledale ward was used for an additional 8 beds for the majority of the month, which EADU staff continued to support, with further additional staff also required at cost pressure, along with the recurrent use of CAT escalation bay. In addition, the bed pressures meant that the Surgical Assessment Unit (SAU) on Littondale ward continued to be used for beds which impacted on the flow of patients and resulted in patients being managed on the ward as ward attenders.

New patient activity in month fell short of both the original plan and the recovery plan. In particular the snow on the 28th February had a significant impact, with a number of clinics affected and some completely cancelled. ENT and Neurology were above plan for the first month this year following the recent recruitment to vacant consultant posts, however, T&O and Maxillofacial surgery were significantly behind plan.

The impact of vacant middle grade posts or doctors requiring greater supervision in a number of specialities continues to affect the delivery of follow up activity, specifically in T&O and Urology. Work continues to introduce new roles to manage this group of patients as effectively as possible, with the inclusion of more AHPs in the delivery of Hand and Shoulder clinics and Nurse practitioners in Ophthalmology.

During February, there were 25 elective cases cancelled due to bed pressures and trauma capacity; without these cancellations, the T&O team would have delivered their Elective plan. A number of other specialties were affected by these cancellations and the impact of snow on the 28th February, these were Gynaecology, Urology and General Surgery. Unfortunately these pressures continue into March with snow and bed pressures causing more recent cancellations, along with a flood in the main theatre department, which resulted in two theatres being closed for a full afternoon. Despite this, the directorate team continue to focus on progressing the use of the new theatres dashboard to improve theatre productivity.

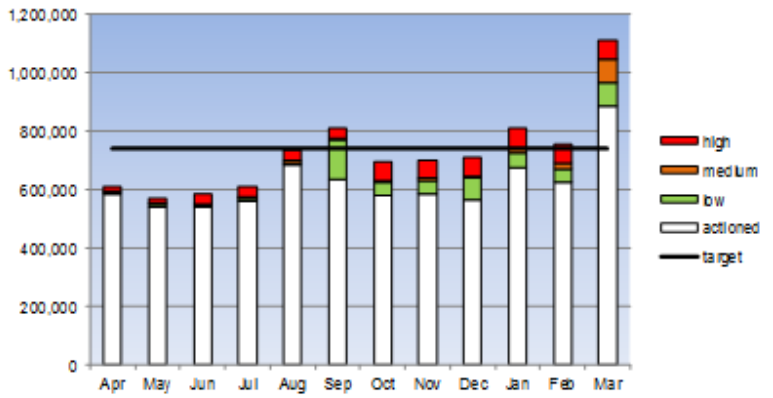
The nurse staffing difficulties in Ophthalmology continued to impact on activity in February, with the team only just able to cover the scheduled theatre sessions and therefore no additional recovery plan activity could take place. This remains an ongoing concern.

As part of the transformation programme (Productive Outpatients), a draft outpatient staffing structure was produced following extensive work by the Matron and Head of Nursing for Planned & Surgical Care including the review of other hospitals workforce structures. This is being shared with staff in March and the aim is to ensure a staffing structure that is fit for the future and is one to which it is possible to recruit.

Efficiency Update – 17/18

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 90% of this target, however the risk adjusted total outlines potential delivery of 86%. There has been a slow decline in both the planned and actioned schemes over the last quarter as shown on the following page.

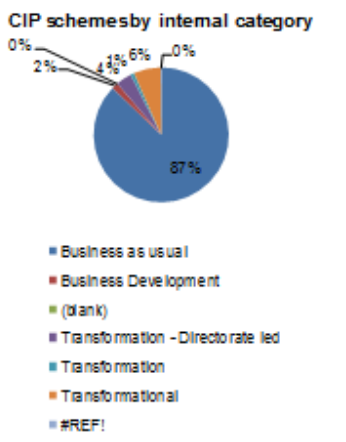
Trustwide Cost Improvement Programme 2017/18

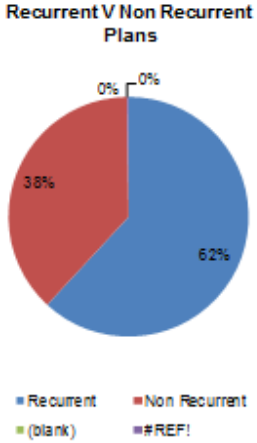


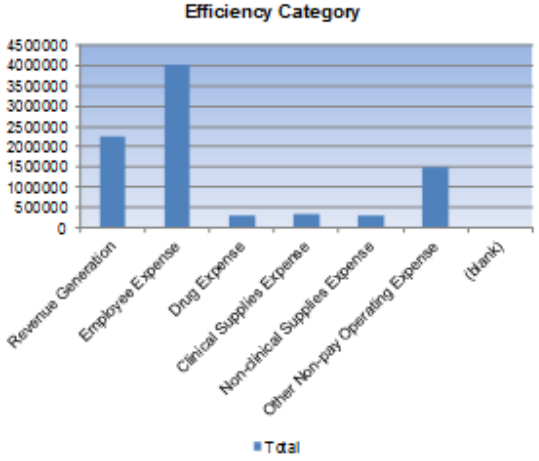
Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Trustwide	9,409,800	7,370,950	597,293	160,767	334,103	8,463,113	90%	8,133,813	86%
		%age of target	6%	2%	4%				

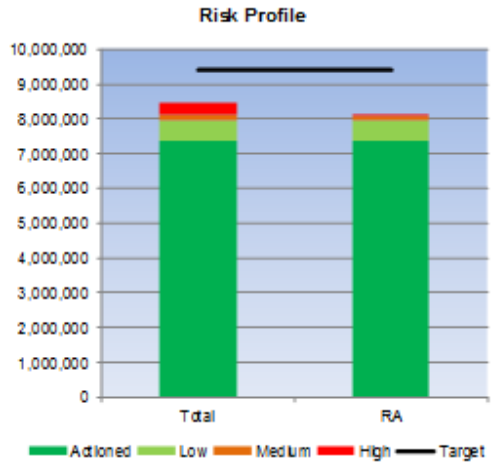
Top 10 unactioned schemes Top 10 as % of schemes - 10%

No.	Scheme	Directorate	Value	Risk
1	-	Planned Care	177,600	Actioned
2		LTUC	163,800	Low
3		Planned Care	125,000	High
4		Planned Care	92,470	High
5		Corporate	77,000	Low
6		CCCC	56,700	Actioned
7		LTUC	54,200	Low
8		Planned Care	50,000	High
9		Planned Care	28,800	High
10		Planned Care	28,800	High





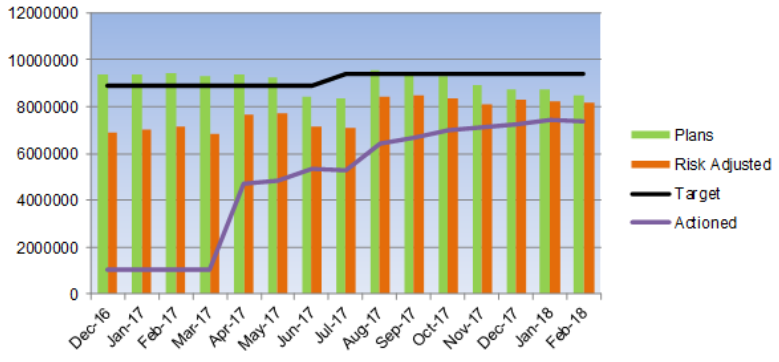




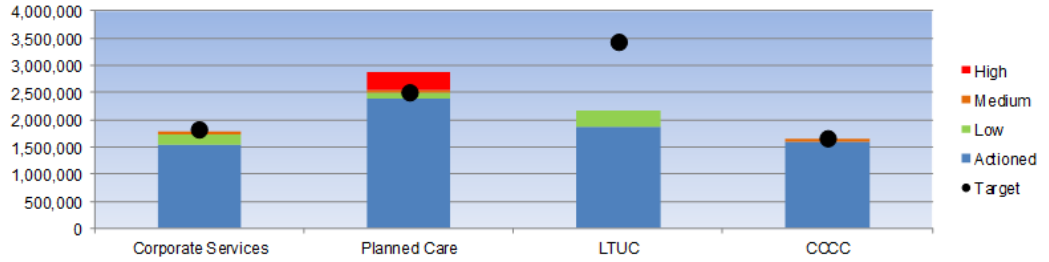
Efficiency Update -17/18 Continued

Trustwide Cost Improvement Programme 2017/18

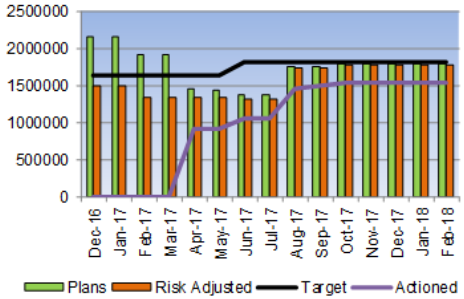
Trustwide Monthly Progress against Target (Full Year Effect)



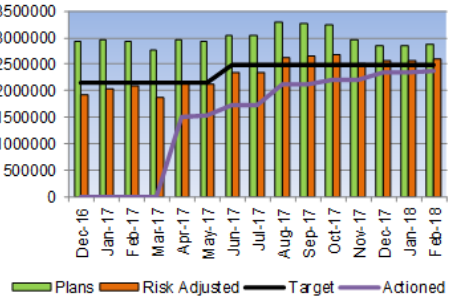
Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Corporate Services	1,818,900	1,539,550	202,900	49,300	0	1,791,750	99%	1,771,745	97%
Planned Care	2,497,100	2,371,000	115,293	48,667	334,103	2,869,063	115%	2,586,283	104%
LTUC	3,446,000	1,879,300	279,100	0	0	2,158,400	63%	2,144,445	62%
CCCC	1,647,900	1,581,100	0	62,800	0	1,643,900	100%	1,631,340	99%



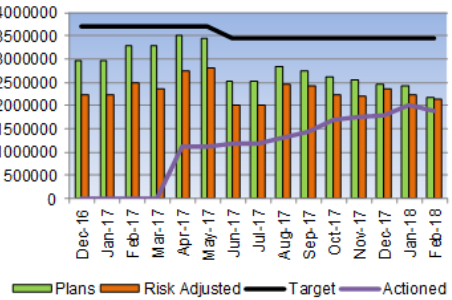
Corporate Monthly Progress against Target (Full Year Effect)



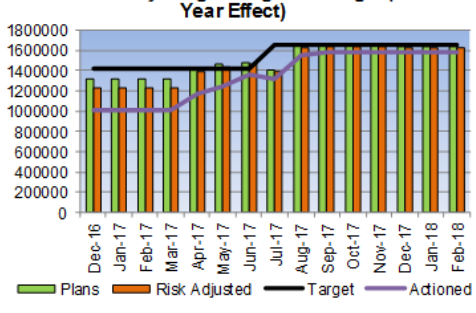
Planned Care Monthly Progress against Target (Full Year Effect)



Unplanned Care Monthly Progress against Target (Full Year Effect)



Childrens and County Wide Community Care Monthly Progress against Target (Full Year Effect)

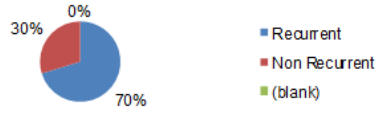


Corporate R - NR Split

Planned Care R - NR Split

Unplanned Care R - NR Split

Childrens and County Wide Community Care R - NR Split



Date of Meeting:	28 March 2018	**Agenda item:**	6.1
Report to:	Board of Directors		
Title:	Operational Plan 2018/19 Update		
Sponsoring Director:	Jonathan Coulter, Deputy Chief Executive / Finance Director		
Author(s):	Angie Gillet, Deputy Director of Planning and Business Development and Jordan McKie, Deputy Director of Finance		
Report Purpose:	**Decision** ✓ **Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓		
Executive Summary:	• The paper outlines the financial plan for 2018/19 and the assumptions that underpin the anticipated £6.7m surplus. • This plan meets the control total set by NHS Improvement for the Trust. The paper also outlines the impact on the capital programme if this surplus is achieved. • An update on the position with commissioners for contracts is also included.		

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 plan outlines the level of risk in the financial plan. The Efficiency programme is being developed with Quality Impact Assessments currently being finalised.
Legal / regulatory:	NHS Improvement Self Certification for Plan Submission
Resource:	The plan outlines the resource requirements planned for the Trust in 2018/19.
Impact Assessment:	Quality Impact Assessments are being undertaken with a paper to follow at the April Board meeting.
Conflicts of Interest:	None
Reference documents:	NHS Shared Planning Guidance - https://www.england.nhs.uk/deliver-forward-view/

Action Required by the Board of Directors:

The Board of Directors is asked to -

- Note the Operational Plan for 2018/19 is being finalised for submission to NHSI on 30 April 2018.
- Approve the Summary Financial Plan (App A) to allow the issuing of budgets to budget holders prior to 1 April 2018.
- Approve the capital resources (section 4.2 above) and Directorate priorities (App E) for 2018/19, noting that the decision to release schemes is dependent upon delivering the financial plan.
- Confirm acceptance of the control total for 2018/19 as set by NHSI
- Approve the self-certification document (App D) attached to this paper
- Note the progress being made in developing an aligned incentive contract with HaRD CCG

1. Background

1.1 An update on the progression of the operational plan was given to the Board of Directors at the February meeting. Further work has been undertaken to further develop the plan with a view to final submission to NHS Improvement (NHSI) in April 2018.

1.2 The purpose of this paper is to:-

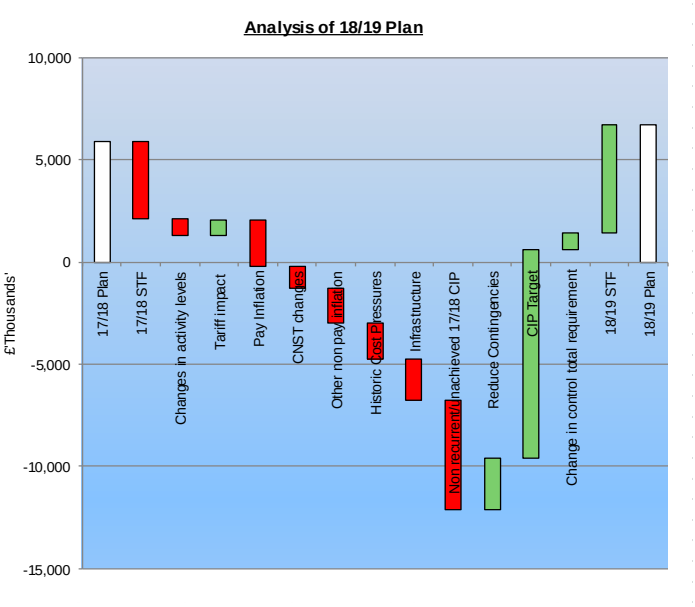
- Provide an update to the Board of Directors on the financial plan prior to the start of the new financial year in April 2018
- Approve the operational budgets for 2018/19 in line with our plan
- Approve the capital programme for 2018/19 in line with our plan.

2. Current Position

2.1 The diagram below outlines the key assumptions made in developing the Trust financial plan for 2018/19.

2018/19 Planning Assumptions

	£'000s
17/18 Plan	**5,909**
17/18 STF	- 3,777
Changes in activity levels	- 820
Tariff impact	725
Pay Inflation	- 2,235
CNST changes	- 1,103
Other non pay inflation	- 1,673
Historic Cost Pressures	- 1,763
Infrastructure	- 2,041
Non recurrent/unachieved 17/18 CIP	- 5,324
Reduce Contingencies	2,500
CIP Target	10,200
Change in control total requirement	839
18/19 STF	5,311
18/19 Plan	**6,748**



2.2 The above plan meets the control total requirement for 2018/19 set by NHSI of £6.7m. Depending upon the year end performance for 2017/18, this control could increase by £0.572m.

Agreeing to our control total allows access to funding streams such as STF, regional capital and potentially further transformation funding if the Health and Care Partnership (HCP) is successful in its application to become an Integrated Care System. These funding streams will be important to help ensure the future financial sustainability of both the organisation and the local health system.

It should be noted that if any organisation across the HCP does not sign up to their control total then the HCP will not be in a position to apply to be an ICS. From our

perspective, it is therefore important to agree our control total and set a plan that delivers this requirement.

The Board is therefore requested to confirm agreement to the control total as set by NHSI.

2.3 Attached at **Appendix A** is the Summary Trust Financial Plan for 2018/19.

2.4 Budgets for Directorates have been built up using the planning assumptions and resultant efficiency requirement. All Directorates have been actively involved in developing the financial plan and will be signing off their individual budgets before the end of March 2018. These can be found in **Appendix B.**

2.5 Details of the Directorate Efficiency position are included in **Appendix C.** The Quality Impact Assessment (QIA) of these schemes is being currently undertaken. A report on the output of the QIA process will follow in April.

2.6 The Board is requested to approve the summary financial plan and assumptions used, so that the budgets that have been created on this basis can be issued before 1 April 2018.

3. Operational Plan 2018/19

3.1 The Operational Plan is currently being finalised for agreement and sign off at the Board of Directors meeting on 25 April for submission to NHSI on 30 April. A draft plan was submitted to NHSI on 8 March 2018.

3.2 **Appendix D** details the self-certification required for approval by the Board of Directors.

4. Capital Investment Programme

4.1 Current Position

4.1.1 A number of capital projects are already being taken forward for implementation in 2017/18. These include:-

- Provision of new Endoscopy facilities
- Replacement of the Nuclear Medicine Scanner
- ED Primary Care streaming

4.1.2 Discussions have taken place with the Clinical/Corporate Directorates to identify the Intermediate and Small schemes to be included as part of the 2018/19 Capital Investment Programme which includes an allocation of resources to Theatres and Radiology, in addition to those already agreed for IT. An allocation will also be identified for Harrogate Healthcare Facilities Management to take forward agreed building maintenance schemes. This is linked to the operational schemes resource statement below.

4.1.3 As the Board is aware capital funding is at a premium, and it has been agreed with Directorates that no schemes can be progressed until the second quarter of 2018/19 at the earliest. The situation will then be reviewed based on the delivery of our

financial plan and the assurance in relation to delivery of the efficiency programme. Once this assurance has been received, further discussion will be held to agree whether the capital priorities should be progressed.

4.1.4 A bid for capital resources has been submitted as part of the STP wave 4. Our bid has focused on a phased redevelopment of the Hospital site to include the provision of an ambulatory care unit and an urgent care centre at the front of the hospital, the creation of a midwifery led unit and the utilisation of the Briary Unit to support the reconfiguration of wards to provide an elective care facility.

4.1.5 Additional capital funding will be sought through the STP and through the potential for fundraising in order to supplement the resources available to the Trust. There are a number of major schemes that are in the medium term plan (eg additional theatre capacity, additional CT capacity) that at present cannot be funded internally and will require cash from elsewhere.

4.2 Capital Investment Programme 2018/19 – operational schemes

4.2.1 The table below outlines the planned available resources for 2018/19.

	£m	**comment**
Depreciation funding	5.0	
Surplus	1.4	After CNST adjustment
S&T funding	5.3	Additional £1.5m
Total	**11.7**	
Loan repayments	-2.0	
b/f cash shortfall from 2017/18	-5.0	Non-cash benefits within 17/18 position (rates/elements of the HHFM benefits)
Sub total available for 2018/19	**4.7**	
Scenario:		
a. Deliver plan in 18/19	4.7	
b. Deliver breakeven in 18/19	0.0	Loss of £1.4m surplus and £5.3m S&T funding. No capital and cash position deteriorates
c. Deliver below breakeven	0.0	Loss of more than £1.4m surplus and £5.3m S&T funding. No capital and cash position deteriorates significantly

4.2.1 The current cash position is therefore restricting the ability to undertake capital investment, and the requirement to deliver our control total and therefore earn our S&T funding is paramount.

4.2.2 Given the limited capital resources available each Directorate has identified a list of priorities for consideration as and when capital funds become available. See **Appendix E** for details.

4.2.3 As in previous years, funding will be linked to assurance in relation to delivery of the efficiency programme and delivery of the financial plan. Once this assurance has been received, further discussion will be held to agree whether the capital priorities should be progressed.

5. Contract update

5.1 As the Board is aware, we have been progressing the development of an aligned incentive contract with HaRD CCG in relation to hospital services. This is to assist in the management of financial risk across the local health system and allow both organisations to work together to reduce costs and strive to deliver care within the resources that are available.

5.2 Good progress has been made and we have included an aligned contract value expectation of £94m in our respective draft plan submissions. Principles have been drafted and detailed work is ongoing to establish the necessary activity and cost triggers within the agreement. The contract variation will be signed this month, with a further few weeks required to finalise the financial arrangements in relation to activity and cost variations. This will be incorporated within our final plan submission at the end of April.

5.3 In terms of other contracts, all health contracts are materially agreed in terms of value for 2018/19 and are included within our financial plan. Our local authority existing contracts are set with agreed values, and we will be taking on additional contracts for 0-19 services in Stockton (April), Gateshead (July) and Sunderland (July), worth £16m per annum.

6. Conclusion

6.1 The Board of Directors is asked to:-

6.1.1 Note the Operational Plan for 2018/19 is being finalised for submission to NHSI on 30 April 2018.

6.1.2 Approve the Summary Financial Plan (App A) to allow the issuing of budgets to budget holders prior to 1 April 2018.

6.1.3 Approve the capital resources (section 4.2 above) and Directorate priorities (App E) for 2018/19, noting that the decision to release schemes is dependent upon delivering the financial plan.

6.1.4 Confirm acceptance of the control total for 2018/19 as set by NHSI

6.1.5 Approve the self-certification document (App XX) attached to this paper

6.1.6 Note the progress being made in developing an aligned incentive contract with HaRD CCG.

Summary Income and Expenditure Account

		units	sense		2017-18 Forecast	2018-19 Plan
Operating income (inc in EBITDA)						
NHS and Local Authority Clinical income		£m	(+ve)		198.52	211.67
Non-NHS and Local Authority Clinical income		£m	(+ve)		2.66	3.66
Non-Clinical income		£m	(+ve)		17.69	18.38
Total		**£m**			**218.87**	**233.71**
Operating expenses (inc in EBITDA)						
Employee expense		£m	(-ve)		-156.09	-162.19
Non-Pay expense		£m	(-ve)		-53.22	-67.41
CIP Requirement		£m	(-ve)		0.00	10.20
PFI / LIFT expense		£m	(-ve)		0.00	0.00
Total		**£m**			**-209.31**	**-219.40**
EBITDA		**£m**			**9.57**	**14.31**
margin %		%			4.37%	6.12%
Operating income (exc from EBITDA)						
Donations and Grants for PPE and intangible assets		**£m**	**(+ve)**		**0.00**	**0.00**
Operating expenses (exc from EBITDA)						
Depreciation & Amortisation		£m	(-ve)		-4.81	-4.51
Impairment (Losses) / Reversals		£m	(+/-ve)		0.00	0.00
Restructuring costs		£m	(-ve)		0.00	0.00
Total		**£m**			**-4.81**	**-4.51**
Non-operating income						
Finance income		£m	(+ve)		0.02	0.01
Gain / (Losses) on asset disposals		£m	(+/-ve)		0.00	0.00
Gain / (Losses) on transfers by absorption		£m	(+/-ve)		0.00	0.00
Other non - operating income		£m	(+ve)		0.00	0.00
Total		**£m**			**0.02**	**0.01**
Non-operating expenses						
Interest expense (non-PFI / LIFT)		£m	(-ve)		-0.25	-0.31
Interest expense (PFI / LIFT)		£m	(-ve)		0.00	0.00
PDC expense		£m	(-ve)		-3.08	-3.06
Other finance costs		£m	(-ve)		0.00	0.00
Non-operating PFI costs (e.g. contingent rent)		£m	(-ve)		0.00	0.00
Other non-operating expenses (including tax)		£m	(-ve)		0.00	0.00
Total		**£m**			**-3.33**	**-3.36**
Surplus / (Deficit) after tax		**£m**			**1.44**	**6.45**

Note - the above will need to be updated to reflect the HHFM transactions appropriately

Appendix B

	PSC	LTUC	CCCC	Corporate	Cross Directorate	Total
	£000's	£000's	£000's	£000's	£000's	£000's
Budget Upload 18/19	**52,080**	**56,636**	**38,460**	**22,037**	**0**	**169,212**
Service Developments *	0	0	0	0	0	0
Infrastructure	948	719	374	0	0	2,041
Cost Pressure Funding	1,096	519	168	848	1,908	4,539
Incremental Funding Med Staff	101	91	7	1	0	200
Pay Award 18/19 **	417	501	353	190	0	1,461
New Contracts	0	0	13,216	0	0	13,216
Sub total	**2,562**	**1,830**	**14,118**	**1,039**	**1,908**	**21,457**
Less CIP						
18/19 Target	**(1,705)**	**(1,645)**	**(1,126)**	**(1,125)**	**(5,099)**	**(10,700)**
Directorate Total	**52,936**	**56,821**	**51,452**	**21,951**	**(3,191)**	**179,969**
Hosted Services , Reserves and Central Costs						**39,135**
Costs exluded from EBITDA						**7,860**
Planned Surplus						**6,748**
Grand Total						**233,712**

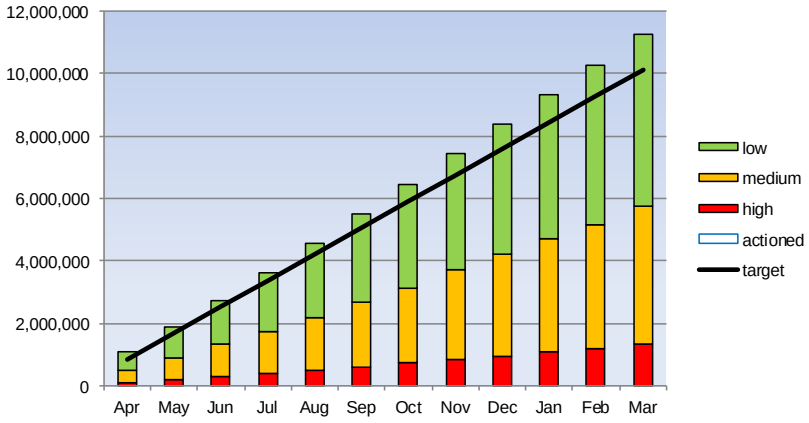
* Service developments will be assessed and prioritised upon delivery of the Efficiency Programme

** The pay award has been estimated at 1%, as the 18/19 award has not yet been announced

Appendix C – Efficiency Update – 18/19

- Below is an update of the 18/19 CIP position for the Trust. A further £500k is to be added to this target as a recognition of some of the planning pressures being faced in 2018/19, however, this may need to be considered further depending on cost pressures and service developments.

TRUSTWIDE CIP PROGRAMME

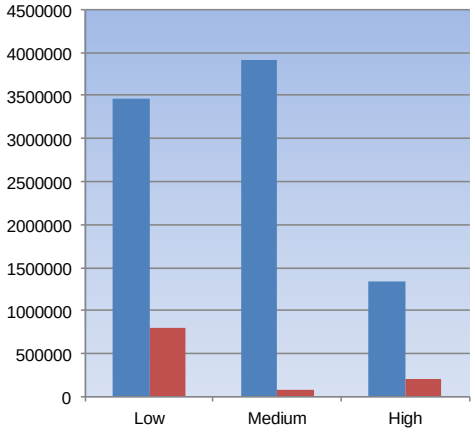


Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Corporate Services	10,101,000	0	5,219,050	4,275,231	979,669	10,473,950	104%	8,574,216	85%
		% age of target	52%	42%	10%				

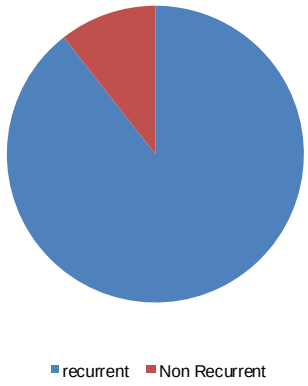
Top 10 schemes Top 10 as % of directorate schemes - 0%

No.	Scheme	Value	Risk
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

CIP schemes (R/NR) by Risk

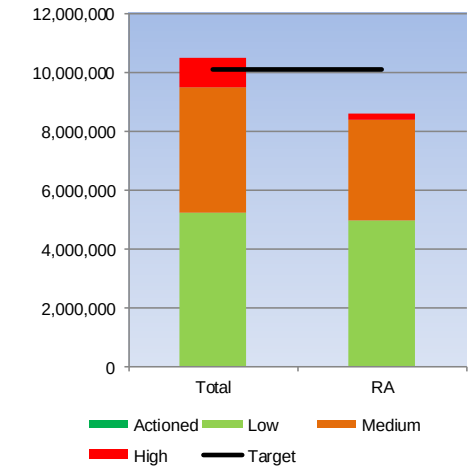


Recurrent V Non Recurrent Plans



Efficiency Category

Risk Profile



							Validations	
			00PLANCY	Maincode			Blank cells	Consistency with Pre pop or data entry
			Self-cert declarations					
			Plan					
			31/03/2019					
			Year Ending					
			DROP-DOWN	Subcode				
1	**Self certification**							
	1. Declaration of review of submitted data							
	The board is satisfied that adequate governance measures are in place to ensure the accuracy of data entered in this planning template.							
	We would expect that the template's validation checks are reviewed by senior management to ensure that there are no errors arising prior to submission and that any relevant flags within the template are adequately explained.	i	Confirmed	SEL0100		NA	OK	
	2. 2018/19 Control Total and Sustainability & Transformation Fund Allocation							
	The Board has accepted its control total and has submitted this operational plan for 2018/19 that meets or exceeds the required financial control total for 2018/19 and the Board agrees to the conditions associated with the Sustainability and Transformation fund	i	Confirmed - control total accepted: S&T fund allocation incorporated in the plan	SEL0110		NA	OK	OK
	3. 2018/19 Capital Delegated Limit							
	All NHS Trusts have a capital delegated limit of £15m. Foundation Trusts that fulfil any of the distressed financing criteria in rows 22-24 will have a capital delegated limit of £15m. As set out in the Capital regime, investment and property business case approval guidance for NHS Trusts and Foundation Trusts, providers with delegated capital limits require business case approval from NHS Improvement.							
	Foundation Trusts that do not fulfil any of the distressed financing criteria are subject to existing reporting and review thresholds as per the Supporting NHS Providers: guidance on transactions for NHS foundation trusts (March 2015) Appendix 1 and the Capital regime, investment and property business case approval guidance for NHS trusts and foundation trusts.							
	Please complete below.		FT	SEL0130		NA		
	Are you in Financial Special Measures?	i	Not in Financial Special Measures	SEL0140		NA	OK	OK
	If you are an FT, are you in breach of your licence? Or are you an NHS Trust?	i	Not in breach of Foundation Trust license	SEL0150		NA	OK	OK
	Have you received distressed financing or are you anticipating receiving this in either of the planning years?	i	Not in Receipt of Distressed Financing	SEL0160		NA	OK	OK
	Delegated capital limit (£000)		Existing reporting and review thresholds apply	SEL0170		NA		
	Adjusted delegated capital limit (£000)	i	N/A	SEL0175		N/A		
	The Board agrees to the delegated limit for capital expenditure and business case approvals in line with the Capital regime, investment and property business case approval guidance for NHS Trusts and Foundation Trusts.	i	Confirmed	SEL0180		NA	OK	
			Signed on behalf of the board of directors; and having regard to the views of the governors (for FTs):					
	In signing to the right, the board is confirming that:							
	To the best of its knowledge, using its own processes, the financial projections and other supporting material included in the completed Provider Financial Monitoring System (PFMS) Template represent a true and fair view, are internally consistent with the operational and, where relevant, strategic commentaries, and are based on assumptions which the board believes to be credible. This operating plan submission will be used to measure financial performance in 2018/19 and will be included in the calculation of the finance and use of resources metrics assessed under the Single Oversight Framework in 2018/19.	**Signature**	i	TBC on full submission			OK	
		Name		TBC on full submission			OK	
		Capacity		TBC on full submission			OK	
		Date		TBC on full submission			OK	
		Signature	i	TBC on full submission			OK	
		Name		TBC on full submission			OK	
		Capacity		TBC on full submission			OK	
		Date		TBC on full submission			OK	
							0	0

HDFT Annual Business Plan 2018/19
Summary of Directorate Capital Priorities

Planned and Surgical Care			
Scheme	Area	Cost £	Year
Endosopcy- New Department	Endoscopy	61,000	2018/19
Scopes - Endoscopy	Endoscopy	56,000	2018/19
OPTHALSUITE for backing up of OCT images	Ophthalmology	15,000	2018/19
Visucam 500 Fundus Camera	Ophthalmology	50,000	2018/19

Long Term and Unscheduled Care			
Equipment for 5 new rooms commissioned in the Heart Centre	Cardiology	50,000.00	2018/19
Cath Lab - Imaging (**Scheme deferred from 2016-17 program)**	Cardiology	450,000.00	2018/19
Haemo Dynamics Machine (Cath Lab) **(Scheme deferred from 2016-17 program)**	Cardiology	70,000.00	2018/19
Create a Combined Discharge hub (a location to bring together NYCC, SDS, Discharge Team, Voluntary Sector to support coordinated discharge planning)	Cardiology	50.000.00	2018/19
Post mortem tables	Mortuary	44770 Plus Estates, building and engineering works	2018/19

Children's and County Wide Community Care			
Improvement to Woodlands area for administering drugs. (Omnicell)	Woodlands	TBC	2017/18
System One Scanners	Community - Hambleton and Richmondshire	£6,100	2018/19
36* Laptops & 2*Scanners	Community - SLT and Specialist Children's Services	£67,716	2018/19
Paediatric Secretaries to move within CDC	CDC	TBC	2018/19

Theatres & DSU			
Scheme	**Area**	**Cost (£k)**	**Year**
Depth of anaesthesia monitoring	Anaesthetics	TBC	2018/19
Difficult intubation blade for Paeds (Videolarygoscope blade - Storz)	Anaesthetics	25,000	2018/19
IT equipment	Theatres Team	TBC	2018/19
Cameras for Arthroscopy	T&O theatres	100,000	2018/19
Cameras and Stacks	T&O theatres	60,000	2018/19
Hand held computers	Main Theatres	TBC	2018/19

Corporate			
Scheme	Area	Cost	Year
Chapel Ablutions facilities	Chapel	£5,000	2018/19
IT System	Company Secretary	£6,500 per annum	2018/19

IT			
Scheme	Area	Cost	Year
Replace Virtual Servers/storage	IT	750,000	2018/19
Replace Veeam Back-up Server, tape drive (20 TB)	IT	35,000	2018/19
SIP Phone replacements (300)	IT	30,000	2018/19
Core Switch Supervisor £15k, 4 x Cisco 2960 switches EOL £15K	IT	30,000	2018/19
Replace NYCC Community Laptops (6 years plus) Covers 0-19, Adult Services, SLT, Podiatry Specialist Services etc. (437 Laptops)	IT	301,014	2018/19
PC replacement program (200 PC's)	IT	142,555	2018/19
Email replacement of hardware and move to Exchange 2016	IT	400,000	2018/19
Web V	IT	1,300,000	2018/29

NHS
Harrogate and District
NHS Foundation Trust

Date of Meeting:	28 March 2018	**Agenda item:**	6.2
Report to:	Board of Directors		
Title:	Improvement and Transformation Update		
Sponsoring Director:	Jonathan Coulter, Deputy Chief Executive and Director of Finance		
Author(s):	Mikalie Lord, Programme Manager Clinical Transformation David Plews, Deputy Director – Improvement and Transformation		
Report Purpose:	**Decision**		**Discussion/ Consultation**		**Assurance**	✓	**Information**	
Executive Summary:	Following the publication of the Clinical Transformation Strategy in October 2017, scoping of projects for the 2018/19 financial year has been undertaken: • Against an ambition of £5m, a total of £1,447,900 in savings have been identified. • There is greater confidence however in the ability to realise those savings and that there are opportunities for further savings to be identified as the financial year progresses. As well as enabling the clinical transformation programme, the rapid improvement programme provides reactive capacity to meet demand for improvement facilitation as it arises. A programme status update is outlined.		

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:	Dependencies for and risks to delivery have been identified by the Programme Management Office which have been captured as risks within local project risk registers and where pertinent the Clinical Transformation Board's risk register also. There is a financial risk on the Corporate Risk Register which relates partly to the delivery of the Clinical Transformation Programme that is rated 12: Risk of financial deficit and impact on service delivery due to failure to deliver the Trust's annual plan by having excess expenditure or a shortfall in income.
Legal / regulatory:	None identified
Resource:	There are resourcing implications which will impact the realisation of the 2018 financial opportunities. A Project Manager vacancy (since July 2017) within the PMO is currently being recruited to. The vacancy has impacted upon the pace of scoping projects and in delivering existing projects. A business

	case to consider any further resourcing that may be required to ensure the needed pace and scale of delivery during the course of 2018/19 will be brought forward as required.
Impact Assessment:	Quality impact assessment screenings have been undertaken for each project. As yet there are no negative implications identified.
Conflicts of Interest:	None identified.
Reference documents:	Not applicable.
Assurance:	Clinical Transformation Board
Action Required by the Board of Directors:	
It is recommended that the Board: • *Accepts that there is further scoping needed to provide a financial "size of opportunity" for a number of projects that are not forecasted to commence delivery until late 2018/ early 2019.* • *Accepts that the current financial size of opportunity is a "within year" position, and that greater financial opportunities are forecasted to be realised in years three and four as part of the five year strategy.*	

Clinical Transformation Programme Update

Since the publication of the Clinical Transformation Strategy on 10 October 2017, the Programme Management Office and key stakeholders have scoped over 20 projects for the 2018/19 financial year; more than double that in the previous year[1]. This means that each project has had a Quality Impact Assessment conducted to ascertain positive and negative implications of the proposal and an assessment of the size of financial opportunity. A thorough programme-wide dependencies mapping exercise has been undertaken to identify implications for delivery.

As a result of this work, against an ambition of £5m in 2018/19, a value of £1,447,900 of savings has been identified. Although this falls short of the programme's ambition, there is greater confidence in the programme's ability to realise this conservative figure as a result of the facts that:

- Potential double counting has been eliminated,
- The schemes, and their associated savings, are based upon more robust scoping
- The schemes have conducted quality impact assessments, benefits mapping, risk identification and dependencies mapping
- Efforts have been made to ensure that this is reflective of in-year savings, and that other schemes such as Clinical Workforce Strategy and Agile Working are forecasted/ expected to provide more significant financial savings in years three and four of the strategy.

At present, the final programme value does not include further roll out of Outsourcing Printing and WebV. This is as a result of:

- Further efforts required to scope the financial savings attributed to the wider roll- out of outsourcing printing and its expansion into the use of email notification
- Further efforts required to review the financial benefits detailed within the WebV business cases versus the cost improvement plans for Corporate Services
- Limited capacity across the finance business partners to support the scoping of these financial savings
- Limited capacity within the Programme Management Office to support this work.

However there is greater potential to realise further savings as some projects are not forecasted to commence scoping or delivery until autumn/ winter of 2018. A summary of the completed milestones and next steps are illustrated in Table 1.

A detailed report on the achievements of the 2017/18 Clinical Transformation Programme will be presented to the Board in May along with any next steps and

[1] See Appendix A for a summary of the 2017/18 programme structure, Appendix B for a summary of the Clinical Transformation Strategy and Appendix C for a summary of the 2018/19 programme structure

recommendations for the programme as we enter delivery of the 2018/19 programme.

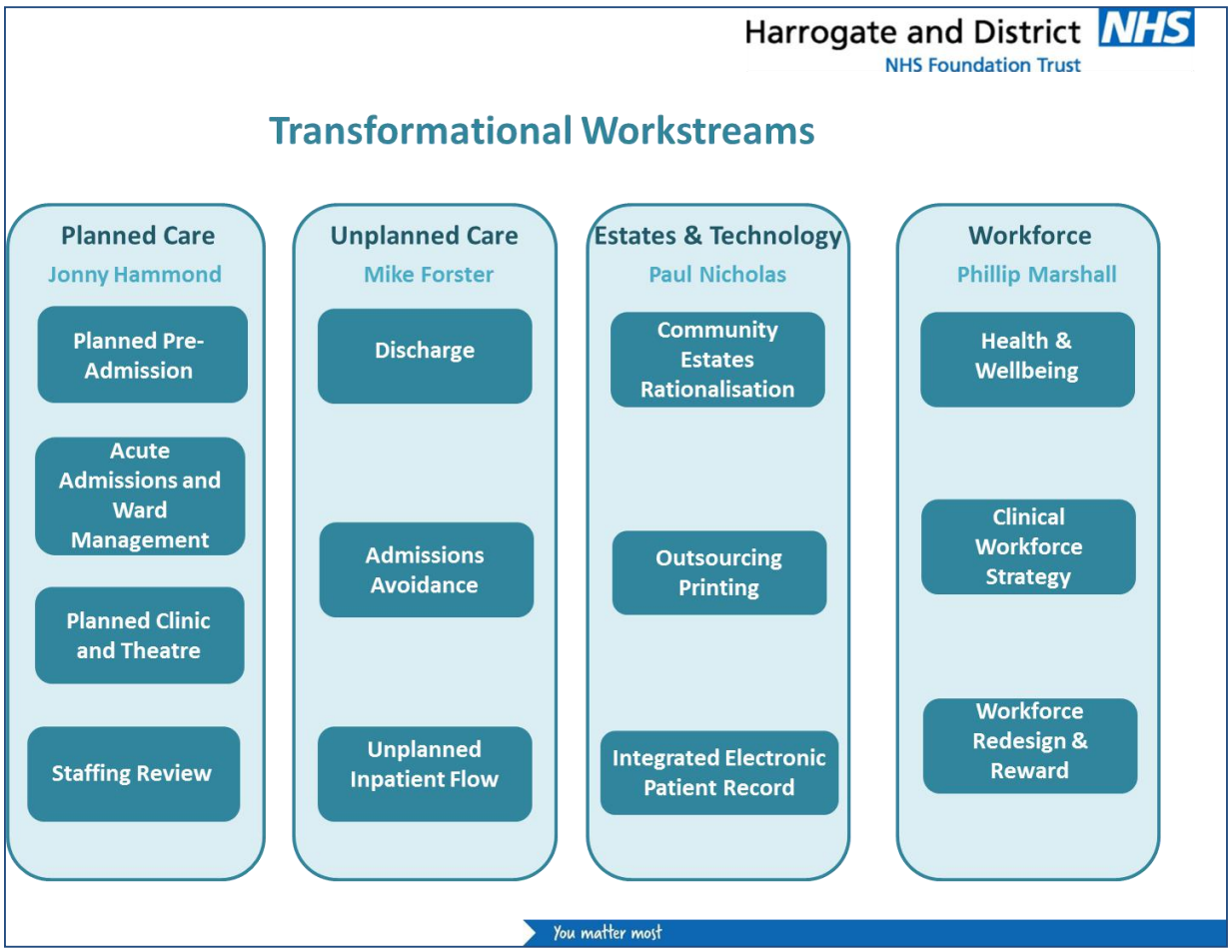
Table 1: *Summary of completed milestones and next steps*

Completed Milestones	Next Steps
Apply the transformation score card to proposed schemes	Finalise the financial savings attributed to Outsourcing Printing and WebV
Conduct Quality Impact Assessments	Finalise scoping for outstanding projects
Assess size of financial opportunity	Allocate PMO resource to projects according to size of opportunity (both financial and qualitative), complexity and support need
Develop project initiation documentation	
Identify risks and issues	
Identify benefits	
Conduct dependencies mapping	

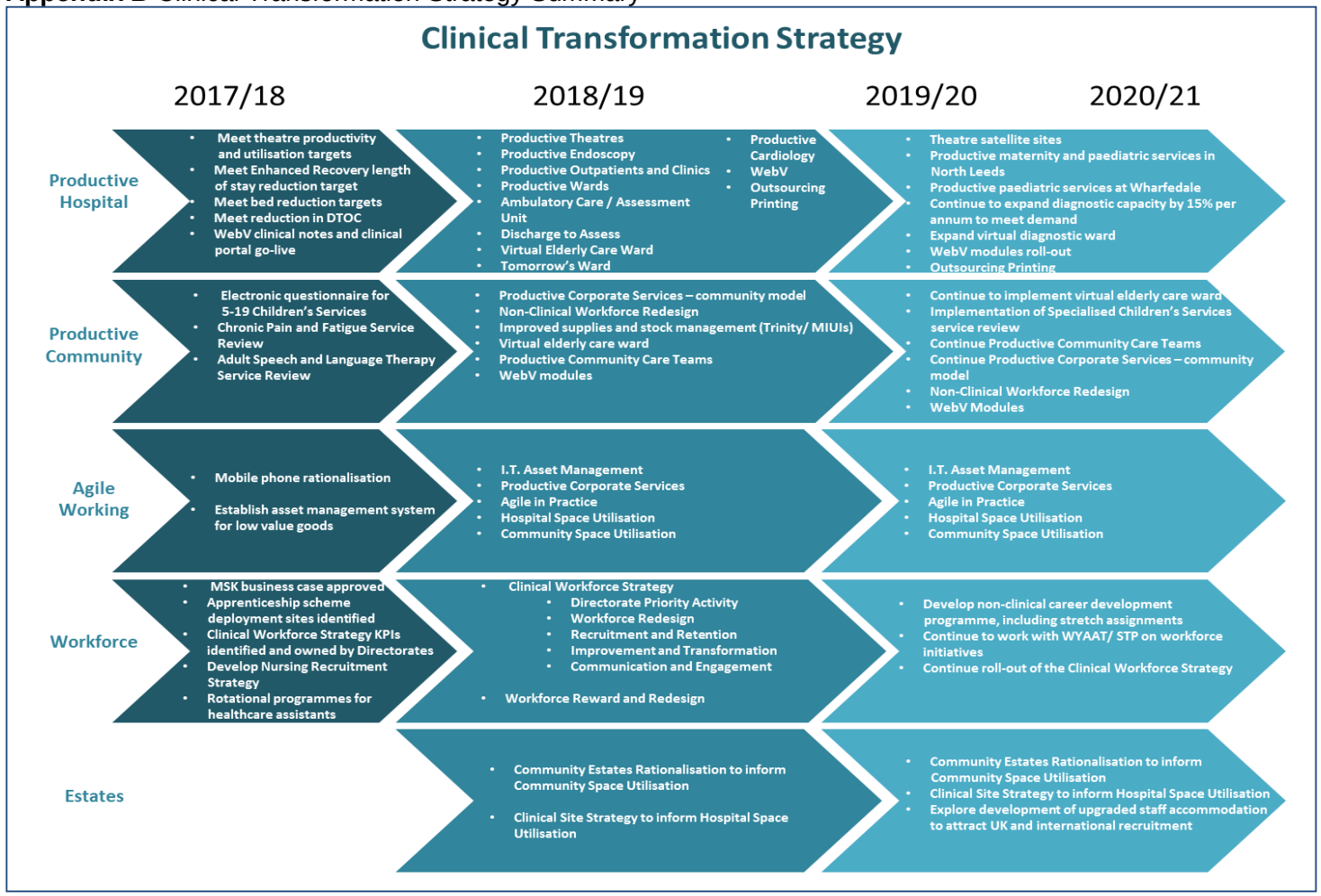
Improvement Programme Update

As well as enabling the clinical transformation programme, the rapid improvement programme provides reactive capacity to meet demand for improvement facilitation as it arises. A programme status update is outlined in **Appendix D**. The way that the programme is managed is being improved so that future schedules are prepared with more detail at an earlier stage to reduce the likelihood of uncertainty contributing to further volatility in the programme.

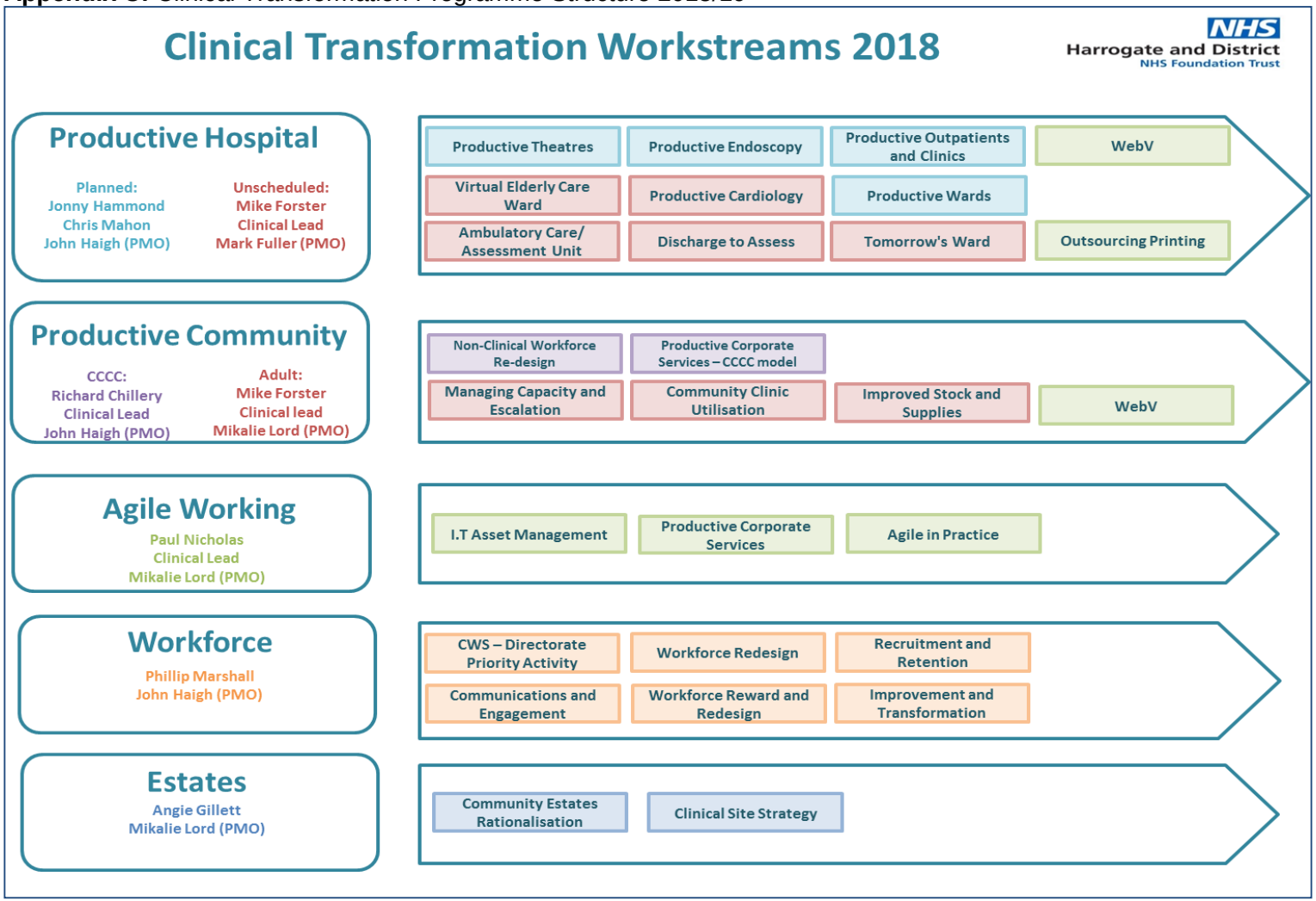
Appendix A: Clinical Transformation Programme Structure 2017/18



Appendix B Clinical Transformation Strategy Summary



Appendix C: Clinical Transformation Programme Structure 2018/19



You matter most

Appendix D Improvement Events Status Board (see page 9)

RPIW name	Proposed month	Directorate	Proposed sponsor	Proposed workshop leads	Format	Date of event *16 weeks in advance*
Incidents reporting	Nov-17	Corporate	Jill Foster and David Scullion	Mark Fuller and Claire Arditto	Full RPIW	20-23 Nov 2017
STP-wide collaborative medical bank	October/November 2017	Corporate	Dr Bryan Gill (BTHNHSFT)	David Plews and Chris Mannion	3 day workshop	13 Oct, Then 29 - 30 Nov 2017
SALUS	Jan-18	CWCC	Richard Chillery	David Plews	*This is now a 90 minute workshop*	17-Jan-18
Podiatry	Feb-18	CWCC	Richard Chillery	Beth Barron and Robin Pitts	Full RPIW	w/c 5 Feb 2018
CWS - ambulatory care workforce	Mar-18	LTUC		Mark Fuller/Michelle Page	2 day workshop	21 and 23 March 2018
Non-pay costs (focus on travel)	Feb-18	CWCC	Richard Chillery	John Haigh	1 day workshop	Tuesday 27th Feb 2018
Lower GI cancer pathway (instead of enhanced recovery)	Mar-18	PSC	Dr. Kat Johnson	Mark Fuller	2 day workshop	
Increasing the productivity of pre-op assessment	Mar-18	PSC	Jonathan Coulter	Mark Fuller	2 day workshop	
Pathway to Station View and Trinity	Apr-18	LTUC	Andy Alldred	Michelle Page & Claire Arditto	Likely to take the form of stakeholder meetings instead	
Supporting patient choice when going into care	May-18	LTUC	Rob Harrison	Mark Fuller & Lorraine Cooper	2-3 day workshop	
Lean ward stores, looking at ways to standardise stores and reduce spend	Jun-18	LTUC	Mike Forster	Mark Fuller	2-3 Day workshop + follow up programme	
Delirium pathways	June / early July 2018	LTUC	Andy Alldred	Alison Mayfield & Beth Barron	Full RPIW	
Updated and streamlined information to support discharge	Jun-18	LTUC	Mike Forster	Mark Fuller	Short series of workshops	
Multiple pathways improvement: - PEG Pathway - breast cancer pathway - endoscopy for inpatients - lower GI	Early July, TBC	PSC	Andy Alldred	Mark Fuller	Full RPIW	
New staff referral pathway for MSK services	Sep-18	Workforce	Phillip Marshall	Mark Fuller & Paul Nicholas	2 day event following options appraisal for MSK business case	
Improve accuracy of PDD's and their use in management of flow	TBC	LTUC	Not applicable	Clinical colleague TBC	1 day training event	
ECIP codes and electronic capture and roll out of process being trailed on Jervaulx	N/A	LTUC	Not applicable	Not applicable	Business and usual/phased training and roll out programme	
Learning from the IRS (New Care Models) with current pressures within our CCT's.	TBC inconsultation with TEWV and other system partners	Trust wide	Rob Harrison (TBC)	Mark Fuller & Michelle Page (TBC)	2 day workshop	
Completion of the bed modelling work	N/A	LTUC	Not applicable	Not applicable	N/A	
Lancaster model	TBC	CWCC	Dr. Natalie Lyth	Mark Fuller	TBC	

Harrogate and District NHS Foundation Trust

Date of Meeting:	28 March 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:	• Positive results for the childhood immunisation service specifically highlighted in 2016/17. • Harrogate Healthcare Facilities Management (HHFM) commenced operations on 1 March 2018. • The Board is asked to note performance against the Information Governance Toolkit and approve it for submission.		

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:	IG Toolkit Compliance
Resource:	None identified.
Impact Assessment:	Not applicable.
Conflicts of Interest:	Mr Coulter and Mr Thompson section 6.0
Reference documents:	
Assurance:	IG Toolkit Compliance

Action Required by the Board of Directors:

It is recommended that the Board:

- *Notes items included in the report.*
- *Approves the submission of the IG Toolkit*

1.0 SERVICE ACTIVITY

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

	Jan-18				Feb-18				Feb-18 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	8472	8555	8753	-3.2%	7538	7778	7986	-5.6%	88527	89444	90554	-2.2%
Follow-up outpatients	16965	17159	16339	3.8%	14304	17132	14823	-3.5%	171607	176569	174089	-1.4%
Elective inpatients	287	344	320	-10.3%	275	336	313	-12.0%	3177	3597	3411	-6.9%
Elective day cases	2861	2904	2834	0.9%	2399	2712	2657	-9.7%	26451	28685	27278	-3.0%
Non-electives	1957	1930	1930	1.4%	1799	1670	1670	7.7%	20649	19867	19867	3.9%
A&E attendances	4017	4120	4120	-2.5%	3705	3721	3721	-0.4%	45221	44387	44387	1.9%

The impact of high non-elective bed occupancy continued in February with further cancellations of elective inpatient activity and the opening of additional beds to support patient flow. The Elective Admissions and Discharge Unit (EADU) on Swaledale ward was used for an additional 8 beds for the majority of the month, which EADU staff continued to support, with further additional staff also required at cost pressure, along with the recurrent use of CAT escalation bay. In addition, the bed pressures meant that the Surgical Assessment Unit (SAU) on Littondale ward continued to be used for beds which impacted on the flow of patients and resulted in patients being managed on the ward as ward attenders.

New patient activity in month fell short of both the original plan and the recovery plan. In particular the snow on 28 February had a significant impact, with a number of clinics affected and some completely cancelled. ENT and Neurology were above plan for the first month this year following the recent recruitment to vacant consultant posts, however, T&O and Maxillofacial surgery were significantly behind plan.

The impact of vacant middle grade posts or doctors requiring greater supervision in a number of specialities continues to affect the delivery of follow up activity, specifically in T&O and Urology. Work continues to introduce new roles to manage this group of patients as effectively as possible, with the inclusion of more AHPs in the delivery of Hand and Shoulder clinics and Nurse practitioners in Ophthalmology.

During February, there were 25 elective cases cancelled due to bed pressures and trauma capacity; without these cancellations, the T&O team would have delivered their Elective plan. A number of other specialties were affected by these cancellations and the impact of snow on 28 February, these were Gynaecology, Urology and General Surgery. Unfortunately these pressures continue into March with snow and bed pressures causing more recent cancellations, along with a flood in the main theatre department, which resulted in two theatres being closed for a full afternoon. Despite this, the directorate team continue to focus on progressing the use of the new theatres dashboard to improve theatre productivity.

The nurse staffing difficulties in Ophthalmology continued to impact on activity in February, with the team only just able to cover the scheduled theatre sessions and therefore no additional recovery plan activity could take place. This remains an ongoing concern.

As part of the transformation programme (Productive Outpatients), a draft outpatient staffing structure was produced following extensive work by the Matron and Head of Nursing for Planned & Surgical Care including the review of other hospitals workforce structures. This is being shared with staff in March and the aim is to ensure a staffing structure that is fit for the future and is one to which it is possible to recruit.

2.0 EMERGENCY CARE SERVICES AND CESSATION OF WINTER FUNDING FOR 2017/18

The Harrogate healthcare system has received non-recurrent WYAZ (West Yorkshire Accelerator Zone) and Winter funding for a number of initiatives that have supported flow through HDFT during Winter 2017/18. However, all of these schemes will stop at the end of March 2018. This presents a risk to the Trust given we have seen an increase in medical acute activity in 2017/18 (currently running 9% above planned levels). The key risks relate to weekend and on the day transport home for patients and out of hospital bed capacity for rehabilitation. These risks will be discussed at the A&E Delivery Board in late March. The potential impact is a reduction in ED 4-hour performance and an increase in acute bed occupancy. This is clearly a significant concern as the non-elective bed occupancy remains very high and ED performance remains below the national standard at present with the additional schemes in place.

3.0 CANCER SERVICES

Performance

Performance against the 14 day standard for breast symptomatic patients was below the required 93% standard at 80.3% in February. Managing the volume of breast referrals was challenging, in particular non-cancer related symptomatic referrals, and this was managed through Consultants doing additional clinics out of hours. For the month, 12 patients referred with non-cancer related breast symptoms were first seen outside day 14.

Trust performance for the 62 day standard was above 85% for the seventh consecutive month in February with 91.2% of patients treated within 62 days.

Inter-Provider Transfer (IPT) performance

As stated above, 62-day performance for February with the current allocation rules is at 91.2%. A total of 12 patients were treated at tertiary centres in the month following a 2WW referral to Harrogate. Of these, 7 were transferred by day 38 (58.3%).

Shadow reporting of the 62 day standard shows that when re-allocation rules are applied, performance would be around 0.1% lower for February, but would remain above 85% for all allocation scenarios.

The table below illustrate HDFT's performance when re-allocation rules are applied. However, please note that the rules used in the table below relate specifically to those initially set out in the original templates produced by NHSE and WYH. Since this time, colleagues from across the region have attended a workshop delivered by NHSE which contained a more detailed and complex explanation of how re-allocation will be managed and reported when the new national Cancer Waiting Times database becomes operational. Work is currently ongoing to analyse these more complicated re-allocation rules so that we can understand the implications and impact on local and regional performance.

ACTUAL performance	Q2	Oct-17	Nov-17	Dec-17	Q3	Jan-18	Feb-18	Q4	YTD
Total	**180.0**	**67.5**	**60.0**	**46.0**	**173.5**	**44.0**	**51.0**	**95.0**	**614.0**
Within 62 days	**160.0**	62.0	52.5	42.5	**157.0**	39.5	46.5	**86.0**	**545.5**
Outside 62 days	**20.0**	5.5	7.5	3.5	**16.5**	4.5	4.5	**9.0**	**68.5**
Performance	**88.9%**	91.9%	87.5%	92.4%	**90.5%**	89.8%	91.2%	**90.5%**	**88.8%**

Re-allocation (NATIONAL)	Q2	Oct-17	Nov-17	Dec-17	Q3	Jan-18	Feb-18	Q4	YTD
Total	**178.0**	**67.0**	**60.0**	**45.5**	**172.5**	**43.5**	**50.5**	**94.0**	**608.0**
Within 62 days	**157.5**	61.0	52.5	43.0	156.5	38.0	46.0	**84.0**	**535.5**
Outside 62 days	**20.5**	6.0	7.5	2.5	16.0	5.5	4.5	**10.0**	**72.5**
Performance	**88.5%**	91.0%	87.5%	94.5%	**90.7%**	87.4%	91.1%	**89.4%**	**88.1%**

Difference (National/Actual)	Q2	Oct-17	Nov-17	Dec-17	Q3	Jan-18	Feb-18	Q4	YTD
Total	**-2.0**	**-0.5**	**0.0**	**-0.5**	**-1.0**	**-0.5**	**-0.5**	**-1.0**	**-6.0**
Within 62 days	-2.5	**-1.0**	0.0	0.5	**-0.5**	-1.5	-0.5	**-2.0**	**-10.0**
Outside 62 days	0.5	**0.5**	0.0	-1.0	**-0.5**	1.0	0.0	**1.0**	**4.0**
% difference	**-0.4%**	-0.8%	0.0%	2.1%	**0.2%**	-2.4%	-0.1%	**-1.2%**	**-0.8%**

Re-allocation (WYH policy)	Q2	Oct-17	Nov-17	Dec-17	Q3	Jan-18	Feb-18	Q4	YTD
Total	**177.5**	**66.5**	**60.0**	**46.5**	**173.0**	**42.5**	**50.5**	**93.0**	**604.0**
Within 62 days	**157.0**	60.5	52.5	44.0	**157.0**	37.0	46.0	**83.0**	**531.5**
Outside 62 days	**20.5**	6.0	7.5	2.5	**16.0**	5.5	4.5	**10.0**	**72.5**
Performance	**88.5%**	91.0%	87.5%	94.6%	**90.8%**	87.1%	91.1%	**89.2%**	**88.0%**

Difference (WYH policy/Actual)	Q2	Oct-17	Nov-17	Dec-17	Q3	Jan-18	Feb-18	Q4	YTD
Total	**-2.5**	**-1.0**	**0.0**	**0.5**	**-0.5**	**-1.5**	**-0.5**	**-2.0**	**-10.0**
Within 62 days	**-3.0**	-1.5	0.0	1.5		-2.5	-0.5	**-3.0**	**-14.0**
Outside 62 days	**0.5**	0.5	0.0	-1.0	**-0.5**	1.0	0.0	**1.0**	**4.0**
% difference	**-0.4%**	-0.9%	0.0%	2.2%	**0.3%**	-2.7%	-0.1%	**-1.3%**	**-0.8%**

IPTs SENT (actual patients treated at Tertiary centres)	Q2	Oct-17	Nov-17	Dec-17	Q3	Jan-18	Feb-18	Q4	YTD
Total	**50**	**12**	**13**	**8**	**33**	**10**	**12**	**22**	**155**
Within 38 days	**30**	6	12	6	**24**	6	7	**13**	**91**
Outside 38 days	**20**	6	1	2	**9**	4	5	**9**	**64**
Performance	**60.0%**	50.0%	92.3%	75.0%	**72.7%**	60.0%	58.3%	**59.1%**	**58.7%**

4.0 CHILDREN'S SERVICES

Medical staffing in acute paediatrics continues to be a concern with 3.5wte gaps at the middle grade level. There is a national issue in regards to availability and supply of paediatric-trained SAS doctors and also fill rates for ST3+ trainees. The Trust has recently had limited success with international recruitment with the appointment of one candidate who will commence in post shortly.

An agreement has been reached within North Yorkshire in regards to the Tier 1 level of the continence pathway and the delivery expectations by the HDFT Healthy Child Teams. Work is currently underway with commissioners and the wider system to review the Tier 2 and 3 offers.

An unannounced CLAS (Children Looked After and Safeguarding) inspection is currently underway within the Darlington locality. This is a multiagency review which includes the healthy child services delivered by HDFT. At the end of a 4 week review programme the outcome will be provided verbally with the final feedback being provided 6-8 weeks following the conclusion of the inspection.

5.0 CHILDHOOD IMMUNISATION SERVICE

The Childhood Immunisation Programme which is offered to 41,000 children in primary schools across North Yorkshire (including the City of York) reached above the national average vaccination uptake rate. With the geography of this county, this has been a huge achievement. The team have also instigated a new online consent system which has meant the service has become paper free and access is improved for children not in main stream school provision.

The HPV vaccination programme (offered to year 8 girls in school) reached 98% for the childhood immunisation service in the academic year 2016/17. This is one of the highest uptake records in the country over the entire HPV programme which has been running since 2007. The small but dedicated team should be commended for this achievement.

For the upcoming three years NHS England has just re-commissioned the team to deliver services across North Yorkshire and York. The service in addition to this has recently been awarded the childhood flu contract for the Leeds local authority.

6.0 ONCOLOGY SERVICE

Following the departure of the Trusts full time Oncologist in May 2017 the Trust has been reliant on additional sessions from visiting Oncologists from Leeds and York, along with Locum consultants. The Trust has tried on a number of occasions to recruit to the vacant posts, however, there has been no success. This is due to a national shortage of Oncology Consultants but also due to the stand alone nature of the current post. The most recent agency consultant left the Trust week commencing 12 March which leaves a gap in acute oncology provision and specific tumour site outpatient capacity.

Currently the LTUC Directorate is looking to identify a replacement locum Consultant and have come to agreement with Leeds and York Trusts to identify short term cover arrangements. We are grateful for the support offered from the neighbouring Trusts and will be working with them over the coming weeks to develop an alternative long term solution.

7.0 TRANSFERS OF ESTATES AND FACILITIES FUNCTIONS TO HARROGATE HEALTHCARE FACILITIES MANAGEMENT (HHFM)

Following the decision by the Board of Directors (in the private session on 28 February 2018) of the transfer of estate and facilities functions to Harrogate Healthcare Facilities Management (HHFM), the new company commenced operations on 1 March 2018. In reaching its decision, the Board received advice from Hempson's Solicitors and Ernst & Young.

The transfer was enacted by a suite of legal agreements which received approval by the Board. These included:

- Business Transfer Agreement
- Revised Articles of Association for Harrogate Healthcare Facilities Management Limited
- Written Resolution to adopt revised Articles of Association
- Operated Healthcare Facilities Agreement
- Corporate Support Service Level Agreement
- Loan Agreement
- Debenture Agreement
- Deed of Covenant relating to the Sir Robert Ogden Centre
- A number of leases, under leases and licences to occupy.

8.0 HDFT CQC INSIGHT FOR ACUTE NHS TRUSTS

CQC published the latest Insight packs for all Trusts on 22 February 2018. Updates are due to be published monthly going forward, although not all indicators are updated in the pack each month. The packs incorporate over 300 data indicators that align to CQC's key lines of enquiry for that sector. These 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, composed of 12 specific indicators where performance is highly correlated to inspection ratings, has deteriorated this month and the Trust is now within the middle 50% of acute trusts (top 25% last month). However the only indicator with a declining performance is staff flu vaccination uptake (based on the change from Sept 15 – Feb 16 to Sept 16 – Feb 17).

There are currently no active outliers for maternity and 1 for mortality which relates to the acute cerebrovascular disease (stroke) alert which CQC raised in late 2016 and for which the Trust has already carried out a clinical case note review.

Of the 77 Trust-wide indicators, there is no change with the headline performance this month:

- 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 - 4 (6%)
  - Deaths in low-risk diagnosis groups (Dr Foster intelligence Oct 2017)
  - Help with eating (CQC inpatient survey May 2017)
  - Stability of Nursing and Midwifery staff
  - Stability of other clinical staff
- Declined - 3 (5%)
  - Flu vaccination uptake
  - Inpatient response rate for FFT
  - Patient-led assessment of environment for dementia care

9.0 INFORMATION GOVERNANCE TOOLKIT AND GENERAL DATA PROTECTION REFORM (GDPR) UPDATE

<u>Information Governance Toolkit submission 2017/18</u>

The Information Governance Toolkit is a Department of Health Policy delivery vehicle that NHS Digital is commissioned to develop and maintain. The toolkit is separated into six categories:

- Information Governance Management

- Confidentiality and Data Protection Assurance
- Information Security Assurance
- Clinical Information Assurance
- Secondary Use Services Assurance
- Corporate Information Assurance

The Trust is required to carry out self-assessments of their compliance against the IG requirements. The purpose of the assessment is to enable organisations to measure their compliance against the law and central guidance and to see whether information is handled correctly and protected from unauthorised access, loss, damage and destruction.

Requirement 112 sets out the need for staff to have appropriate and up-to-date Information Governance (Data Security) training with an anticipated compliance level of 95%. The current position (as at 21 March 2018) is:

	Total	Complete	%
Children's and County Wide Community Care	1133	978	86.3%
Corporate Services	390	346	88.7%
Long Term and Unscheduled Care	1546	1126	72.8%
Planned and Surgical Care	1029	799	77.6%
Trustwide	4098	3249	79.3%

The figures above reflect the number of staff who have completed training within the last 12 months. On the basis on the assurances by directorates and the close management of this issue by Directorate leads it is recommended that level 2 compliance is recorded for this requirement. On this basis, the following tables set out the final submission for 2017/18 and the board is asked to approve this.

Information Governance Toolkit	2015/16 Final Submission	2016/17 Final Submission	2017/18 Final Submission
1. Information Governance Management	86%	86%	86%
2. Confidentiality and Data Protection Assurance	87%	87%	87%
3. Information Security Assurance	73%	73%	73%
4. Clinical Information Assurance	100%	100%	100%
5. Secondary Uses Assurance	91%	87%	87%
6. Corporate Information Assurance	77%	77%	77%
Total	**84%**	**83%**	**83%**

83% = Satisfactory, Evidenced Attainment Level 2 or above on all requirements.

Attainment Levels				
Level 0	**Level 1**	**Level 2**	**Level 3**	**Not Relevant**
0	0	22	22	1

General Data Protection Reform (GDPR) update

The General Data Protection Reform (GDPR) is EU legislation that will be applicable as law in EU member States (e.g. the UK) from 25 May 2018, irrespective of national legislation.

When the Data Protection Bill becomes law it will supersede the Data Protection Act 1998 as the Data Protection Act 2017. It will explicitly bring provisions of the GDPR in to UK law and establish continuity of the GDPR in the UK post Brexit.

Organisations are obliged to demonstrate that they comply with the new law	*We do a lot of this through our policies and procedures*
Appointment of Data Protection Officer mandatory for all public authorities	*Our Data Protection Officer is Paul Nicholas, Deputy Director of Performance and Informatics*
Significantly increased penalties possible for any breach of the Regulation – not just data breaches	*Extended from £500,000 to €20,000,000 or 4% of global turnover*
Data Protection Impact Assessment required for high risk processing	*Previously known as a Privacy Impact Assessment or known locally as an Information Governance Assessment*
Legal requirement for security breach notification	*We have 72 hours to report a breach to the Information Commissioners Office from the time it has been identified. It is key that breaches are reported immediately via Datix.*
Data protection issues must be addressed in all information processes	*This will be done by assessing the need for data protection impact assessment at an early stage, and incorporating data protection measures by default in the design and operation of information systems and processes*
Removal of charges, in most cases, for providing copies of records to patients or staff who request them	*We used to charge up to £50 for providing copies of records and had up to 40 from payment to provide the records*
Specific requirements for transparency and fair processing	*We will be updating our current Privacy Notice and creating a new Privacy Notices for staff*
Requirement to keep records of data processing activities	*We will be strengthening our data mapping and records inventory work to include new lawful basis for processing data*
Tighter rules where consent is the basis for processing	*Consent must be freely given, specific, informed, explicit and verifiable*

The new Information Governance Toolkit 2018/19 will incorporate GDPR.

Final 22 March

Date of Meeting:	28 March 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:	• National Staff Survey 2017 - overview of results • Gender Pay Gap Report - duty to publish • Harrogate Healthcare Facilities Management - update on outstanding issues		
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) National Staff Survey

The Trust has now received the results from the 2017 National Staff Survey. These results have been benchmarked against other Trusts within the Combined Acute and Community Trusts category. The overall staff engagement score ranked the Trust as 'above average' (the best category) in the Combined Acute and Community Trusts category.

A sample of staff was surveyed between 9 October and 1 December 2017. In total 1,250 surveys were distributed to members of HDFT staff and 638 were completed, representing a 52% response rate. This is significantly higher than the national average return rate in the Combined Acute and Community Trusts category, which was 43%. The Trust had the third highest response rate in the country in this category.

Results are presented in 32 key areas known as 'Key Findings' as well as a measure of overall staff engagement. Of the 32 Key Findings:

- 19 were above average* for the Combined Acute and Community Trusts category;
- 10 were within the average range;
- 3 were below average.

**It should be noted that 'above average' is the highest rank possible in the category of Combined Acute and Community Trusts.*

A detailed overview is provided in the Annex to this paper.

b) Sickness Absence

The overall sickness absence rate across the Trust for January 2018 has shown a further increase, rising from 4.68% in December to 5.36% (up by 0.68%) which is 1.46% above the overall Trust target of 3.9%. In comparison with January 2017 which was at 4.29%, the 2018 figure is 1.07% higher. In January, and similar to the December increase, this is likely to be, at least partially, due to the winter and other pressures across the Trust this year. The top reason for absence across all four Directorates for January 2018 was colds and flu.

Looking at the overall sickness and the split between short and long-term, short-term absence has increased significantly in January moving from 2.27% in December to 3.39%, an increase of 1.12%. Long-term sickness absence has seen a decrease of 0.44%, from 2.41% in December to 1.97% in January.

From the staff returning from long-term sickness absence there was a return to work rate of 43% in November, decreasing in December to 22.45%, and then rising in January to a return rate of 35%.

Looking across the Directorate sickness absence rates there has been an increase across all four Directorates.

<u>Children's and Countywide Community Care</u>

Has moved from 3.90% to 5.05%, which is an overall increase of 1.15%. This absence rate is made up of 2.75% short-term absence and 2.30% long-term sickness absence.

Corporate Services

Has seen a slight increase moving from 3.35% to 3.94%. This absence rate is made up of 2.68% short-term absence and 1.25% long-term.

Long Term and Unscheduled Care

Has seen an increase from 5.16% to 5.69%, which is a 0.53% increase.

Planned and Surgical Care

Has seen an increase from 5.81% to 6.26%. This absence rate is made up of 4.16% short-term absence and 2.10% long-term.

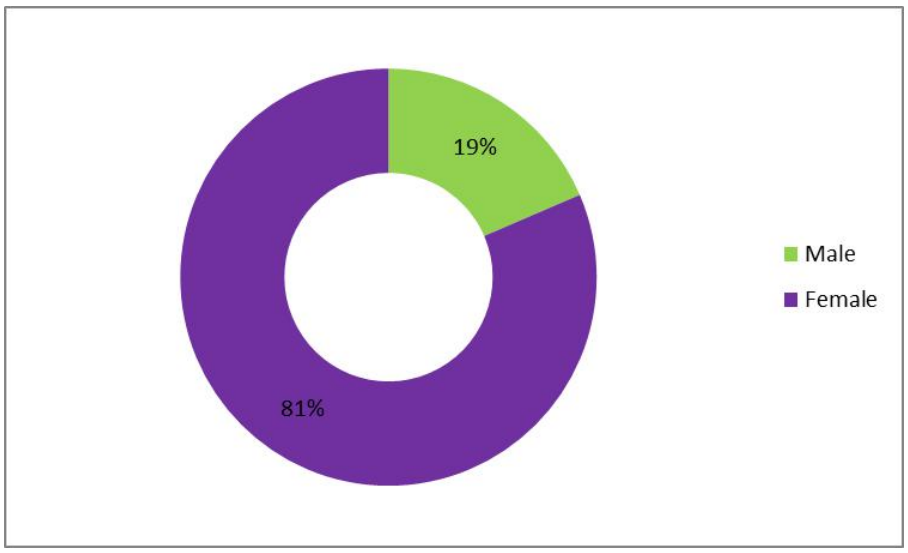
'Hot spot' areas have been identified and the HR lead is working continuously with staff in each of these areas to support a reduction in absence rates; this is being tackled by managing absence in accordance with the Managing and Promoting Health and Wellbeing policy and actively creating action plans to support employees back into work. The HR lead continues to work cohesively across all Directorates and this has helped to facilitate effective return to work plans consistently across the Trust, which in turn has helped drive down long-term sickness absence figures.

Looking at the data for January 2018 the intention will be to focus more closely on short-term sickness absence across the Trust to be proactive in trying to bring down these figures, and work has begun to look at areas where improvements can be made. This will include an absolute focus on the completion of supportive return to work interviews following each episode of absence.

c) Gender Pay Gap

New regulations enacted in 2017 now require the Trust to undertake detailed analysis relating to gender pay. The Trust is required to publicise a specific data set relating to a snapshot date of 31 March 2017.

The Trust employed 4303 staff on 31 March 2017 in a variety of different roles across the Trust. The workforce gender split at the time was as follows.



From this information it is clear that a high proportion of the Trust workforce is female, the new regulations have been brought in to highlight any potential imbalances with the purpose of sparking necessary debate allowing for meaningful actions to be taken.

It is important to highlight the difference between equal pay and a gender pay gap. Equal pay is unlawful and relates to men and women receiving different pay for work of equal value, whereas gender pay analyses the differences in average pay for men and women within an organisation. It is entirely possible to have a significant gender pay gap whilst having complete pay equality.

The Trust uses the Agenda for Change job evaluation framework when banding non-medical roles. This framework provides assurance that equal pay for equal work is recognised i.e. someone entering the Band 5 scale with the same level of qualification and experience would be paid the same irrespective of gender and have the same opportunity to progress up the pay scale annually. Similar pay frameworks are in place for Medical and Dental staff and Very Senior Managers.

Methodology

Data for this report has been prepared using the national dashboard via the Business Intelligence reporting tool which is part of the Trust's Electronic Staff Record system. The dashboard is able to pull data for all staff groups including all staff on Agenda for Change terms and conditions, Very Senior Managers and Medical and Dental staff.

The Regulations are clear that for the purposes of the headcount data all individuals employed by the Trust on the snapshot date should be included, each part-time or job-share individual counts as one employee.

The Trust is required to publicise the data externally on the Trust website and, in addition, the Trust will need to submit the data via a national portal to allow for detailed benchmarking to take place. The Trust will publish data externally by 30 March 2018, following the Board meeting.

Gender Pay Information

The Trust is required to publish six key metrics, the outcomes of which are summarised in the next two sections of this report.

In order to calculate the overall gender pay gap the average hourly rate for each individual was required; an overall average could then be calculated allowing for the gender pay gap to be calculated.

Gender	Avg. Hourly Rate	Median Hourly Rate
Male (£)	21.06	14.56
Female (£)	15.71	14.56
Difference (£)	5.35	0.00
Pay Gap %	25.39	0.00

As shown, the Trust is reporting a 25% gender pay gap, meaning that based on an average hourly rate men are paid 25% more than women. To understand this further a detailed analysis by staff group was undertaken with some staff groups showing that

women are paid more than men, including Nursing and Midwifery and Additional Clinical Services.

It has been reported that the Medical and Dental staff group may have an impact on the gender pay gap. Excluding medical and dental staff from the calculations significantly changes the above information to demonstrate that women are paid 4.03% more than men based on an average hourly rate.

The Trust currently has 133 Consultants; 62 of those are female and 71 male. Whilst there is only a small difference in the gender split of the consultant body, as the Trust employs fewer men overall the number of male consultants as a proportion of the overall male workforce is higher than that of female consultants. Overall this contributes to the gender pay gap.

To gain further understanding of the potential reasons for the reported gender pay gap the quartile analysis shown below was undertaken, demonstrating that the highest proportion of males is found in the upper quartile, this is 35.67% of the overall male workforce. In contrast, the lowest proportion of females is found in the top quartile (73.10%) which is 22.16% of the overall female workforce.

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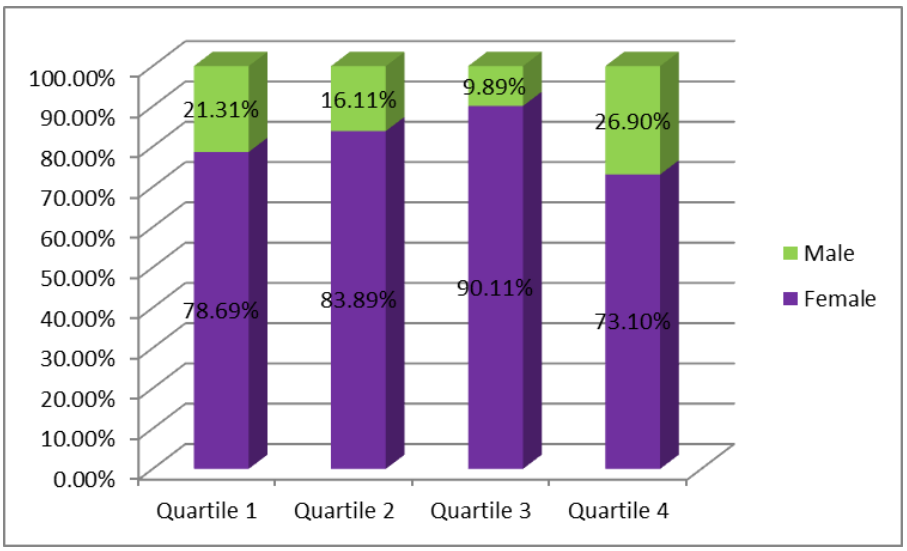


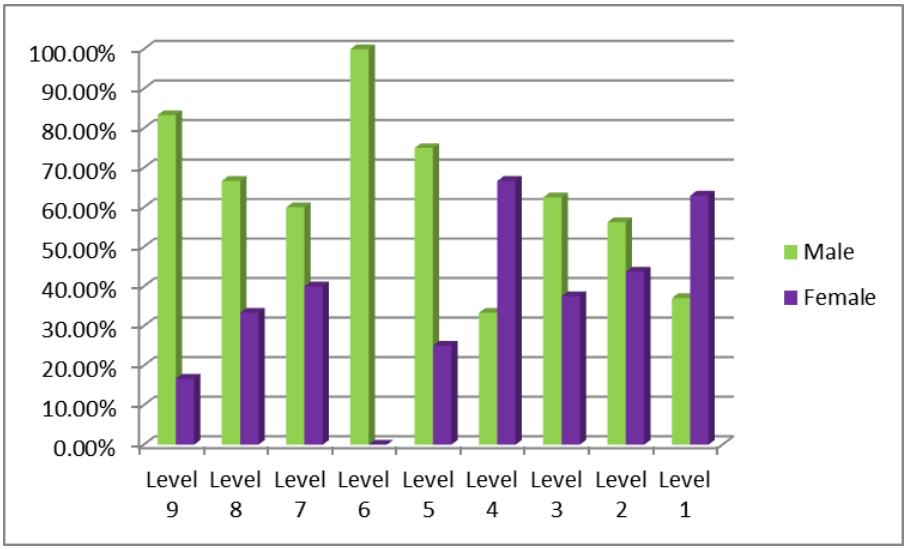
Bonus Pay Gap information

The figures below reflect an average of the Clinical Excellence Award payments for consultant medical staff received in the relevant period up to 31 March 2017. These awards recognise individuals who demonstrate achievements in developing and delivering high quality patient care over and above the standard expected of their role.

Gender	Mean Bonus	Median Bonus
Male (£)	11,418.23	7,458.97
Female (3)	8,704.60	4,363.54
Difference (3)	2,713.63	3,095.44
Pay Gap %	23.77	41.50

The Trust currently employs 133 Consultants; 62 of those are female and 71 male. Of those 62 females, 36 (58.06%) received a Clinical Excellence Award payment. Of the 71 males, 44 (61.9%) received a Clinical Excellence Award.

A higher level of Clinical Excellence Award attracts a higher payment; the graph below shows the proportion of men receiving an award at each level. Whilst there is no significant difference in the number of awards received it appears more men receive a higher level of award which contributes to the overall bonus pay gap.



Traditionally the medical workforce was predominantly male whereas there is now a more balanced representation. It is therefore anticipated that the bonus pay gap will reduce over time as more senior female medical staff become eligible for higher levels of Clinical Excellence awards.

In addition to the above, the Trust issues Long Service Awards. In the relevant period the Trust issued 158 long service awards; 82% were issued to females with the remaining 18% being issued to males. All Long Service Awards carry the same financial value of £40 meaning that the gender bonus gap would be zero.

Taking both Clinical Excellence Awards and Long Service Awards into account, as a proportion 4.66% of females received a bonus compared to 9.11% of males.

Regional Comparison

Across the Yorkshire and Humber region a benchmarking exercise has been undertaken to understand regional variability. The results show a range of pay gaps between 7% and 33%, which is reported to be broadly in line with the rest of the NHS. The analysis indicates acute Trusts tend to report a higher gender pay gap. The mean gender pay gap for the public sector is reported by the Office of National Statistics as 17.7%.

At 25.39% the Trust's mean gender pay gap is, therefore, above that for the wider public sector but within the range for NHS Trusts in the region. In the main this is due to the impact of medical staff, without the inclusion of medical staff the Trust is significantly below the public sector average.

Reducing the Gender Pay Gap

Whilst it is acknowledged that to narrow and close the gap significant societal changes may be required, the Trust is passionate about promoting workforce equality and reducing the gender pay gap. In pursuit of this the Trust is committing to the following actions:

- Raise awareness and be more responsive to flexible working opportunities through internal communications and training
- Explore options for female Leaders programme to encourage women to progress more quickly into managerial and leadership senior roles
- Evaluate current recruitment practices, to ensure that the Trust does all it can to encourage applications to achieve a more even gender balance
- Continue in its efforts to encourage more female applicants, both internal and external, to senior medical positions
- Consider the use of additional training, e.g. unconscious bias training
- Continue work in relation to encouraging more applications for Clinical Excellence Awards from women and providing support for individuals who have submitted unsuccessful applications in the past
- Establish a staff network to explore the findings; this network will be open to all staff.

The above actions, and any further analysis required, will be undertaken by the Workforce Equality Group.

d) Flu Vaccine 2018-2019

Further to my report at the January meeting and an evaluation of the vaccine options available for next year's flu campaign, it has been agreed that the Trust will purchase Quadrivalent Influenza Vaccine from two separate suppliers. This is in line with the most recent recommendations from NHS England and Public Health England for health workers under 65 years of age. For those over 65 years of age a small number doses of Adjuvant Trivalent vaccine will be purchased. The Quadrivalent vaccine is assessed as being more effective that the Trivalent vaccine administered this year.

All these vaccines also have low ovalbumin levels, these being a concern expressed by some staff. The cost is significantly higher than in 2017-2018 due to the higher cost per dose and the slightly greater number of doses being ordered, in line with the increasing number of staff in the Trust.

e) Flu vaccinations 2017- 2018 – staff declining vaccination

A short survey has been undertaken of those staff who had refused vaccination during the 2017-18 programme to date. This was designed to try and identify common issues and, if possible address them in the 2018-19 campaign and increase the percentage uptake within the Trust and in patient-facing staff in particular.

Forty eight staff (of which 46 were clinical/frontline staff) actively declined vaccination, 96% of these by responding to the reminder letter sent in December to staff not yet recorded as vaccinated (44 within final uptake denominator group/still employed and working at end of February – 1.45%).

Ten staff indicated that they had been given medical advice against being vaccinated (9 within final uptake denominator group/still employed and working at end of February – 0.3%).

Reasons given for not accepting the offer of vaccination were:

No reason given	23
Previous side effects/reaction	15
Medical advice	10
Not been vaccinated/not had flu before, good absence record, don't feel at risk	4
Prefer natural treatments, don't want chemicals injected, professional athlete	3
Vaccine doesn't protect against all flu strains	2
Hypersensitive	1
Done own research	1
Pregnant	1
Object to financial "bonus" for Trust	1

This data relates to all staff through the period October – February (including leavers)

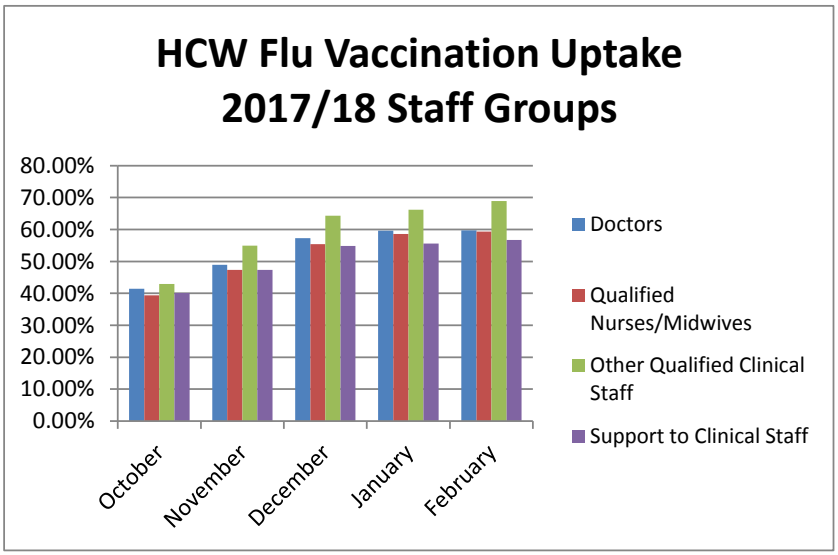
Additional comments provided:

- Want to build up my own immunity
- Campaign feels like coercion, makes me want to rebel
- Negative press coverage about last year's efficacy

f) Flu update 2017-2018

Uptake for clinical/frontline staff groups included in formal national data submission:

	October	November	December	January	February
Doctors	41.4%	48.9%	57.3%	59.6%	59.8%
Qualified Nurses/Midwives	39.4%	47.3%	55.4%	58.6%	59.4%
Other Qualified Clinical Staff	42.9%	54.9%	64.3%	66.2%	68.9%
Support to Clinical Staff	40.1%	47.3%	54.8%	55.6%	56.7%
Total	40.5%	48.8%	57.0%	59.3%	60.4%
Denominator	*3093*	*3028*	*3032*	*3028*	*3032*



To date 2518 staff have been recorded as vaccinated (including any who have since left the Trust); 2191 (87%) have been vaccinated by the Trust's Occupational Health (OH) department and the Trust's 'Flu Champions'. Of these 1830 are included in the clinical/frontline healthcare worker uptake shown in the above charts.

Of the staff vaccinated by HDFT OH department and HDFT Flu Champions; 56.7% were vaccinated by OH and 43.3% were vaccinated by Flu Champions.

We had 11 hospital-based and 11 community-based Flu Champions who completed the required training to act as a staff flu vaccinator.

Analysis of vaccination uptake by whether staff are hospital or community-based shows that both sub-groups have had an improved uptake this year. The percentage uptake amongst community-based staff has almost doubled compared to last year:

	2016/17	2017/18
Community based staff	28.7%	54.6%
Hospital based staff	48.1%	63.0%

Approval was given in December for staff to access vaccination via a local community pharmacy and claim reimbursement of cost if they had difficulty accessing vaccination via drop-in sessions or Flu Champions

The final vaccination uptake data submission up to end of February has been made, this being the data time point to be used for assessment against the associated CQUIN target.

The targets for healthcare worker flu vaccination uptake in the two-year CQUIN scheme relating to 2017/18 - 2018/19 are for 70% uptake in 2017/18 and 75% uptake in 2018/19; however, there is a partial payment scale for uptake of 50% or above.

The CQUIN for HDFT is valued as follows:

- Acute contract: £75,776 over two years
- Community contract: £8,663 over two years.

Therefore, there was a total of £42,219 to be achieved this financial year if we met 70% compliance. Our final compliance enables HDFT to achieve a partial payment of 50% for this financial year. This equates to £21,109. This has been calculated as follows:

- Acute: £75,776 / 2 = £37,888 / 50% = £18,944
- Community: £8,663 / 2 = £4331.50 / 50% = £2,165

g) Job Planning

FEBRUARY 2018 JOB PLANNING CENTRAL REPORT - CONSULTANTS										
Directorate	Number of Consultants	Current Job Plans (ie < 12 months)	%	Job Plans older than 12 months	%	Number of Consultant with no Job Plans recorded	%	In progress	Previous month current JPs	RAG
C & CWCC	13	11	84.62%	2	15.38%	0	0.00%	0	90.00%	
LT & UC	58	47	81,03%	6	10.34%	2	3.45%	3	80.36%	
P & SC	68	50	73.53%	5	7.35%	1	1.47%	2	74.24%	
Total	**139**	**108**	**77.70%**	**13**	**9.35%**	**3**	**2.16%**	0	**78.03%**	

FEBRUARY 2018 JOB PLANNING CENTRAL REPORT - SAS GRADES										
Directorate	Number of SAS Doctors	Current Job Plans (ie < 12 months)	%	Job Plans older than 12 months	%	Number of SAS Doctors with no Job Plans recorded	%	In progress	Previous month current JPs	RAG
C & CWCC	6	2	33.33%	4	66.67%	0	0.00%	3	100%	
LT & UC	12	6	50.00%	6	50.00%	0	0.00%	0	54.55%	
P & SC	32	13	40.63%	5	15.63%	13	50.00%	1	32.25%	
Total	**50**	**21**	**42.00%**	**15**	**30.00%**	**13**	**26.00%**	0	**44.00%**	

The February job planning figures (shown above) show that whilst there has been reduction in the overall figures, it is marginal. The job planning summit with LTUC examined the position with a number of doctors and it is expected that the position in this Directorate will improve significantly by the end of March. The summit with P&SC was postponed for operational reasons and has been rescheduled for 19 April. In C&CWCC a number of Job Plans expired in January and early February and, because of the small numbers overall, this has had a disproportionate effect on the percentages. With service delivery pressures, including SAS rota gaps in Paediatrics which have required Consultant cover, and a singleton Clinical Lead, these have not yet been addressed; the position for this Directorate has deteriorated but plans are in place to ensure that the outstanding Job Plans are finalised as soon as practicable.

h) Governance of One to One Care

Work has started to review the current governance arrangements for deciding how best to meet the needs of those patients who require one-to-one care.

This is based on an observed parallel that a process of escalation, involving Executive Directors if required, for deciding to pay above-cap rates for doctors is in place, but there is no similar process of escalation in place for deciding to provide one-to-one care. Both these scenarios create additional financial pressures - and the conclusion is that governance arrangements for one-to-one care decisions may therefore benefit from a rapid review.

i) Visit of the Nursing and Midwifery Council – 8 March

The alteration to the Trust's pre-registration adult nursing placements to a Harrogate Pathway, whereby all placements over the three-year degree programme with the University of York will take place with HDFT alone, was deemed a major modification to the degree programme by the Nursing & Midwifery Council (NMC).

The Trust's decision was therefore subject to a review by the NMC, which took place at Trust Headquarters on 8 March.

The verbal feedback from the NMC reviewer on the day of the review was that the Harrogate Pathway had been approved, subject to one condition, which was that, as a result of feedback given by students interviewed as part of the review, the NMC

requires assurance that students on placement at HDFT are allowed to work on a supernumerary basis, and that they receive the required 40% of working time with their Mentor.

j) Review of Fit and Proper Persons Test and Disclosure and Barring Service Clearances

The triennial review of those members of staff who are required to undertake the Fit and Proper Persons Test (FPPT) has been completed successfully. This comprised 17 of the 23 staff in total who are subject to the test. The remainder will be reviewed as the third anniversary of their appointment approaches. The review is required as part of Schedule 5 of the FPPT regulations.

The Board of Directors has previously decided (in 2016) that an annual review of the FPPT was not required and adopted a risk-based review of the FPPT, for those covered by it, every three years. In light of anecdotal evidence and updated guidance from the CQC, the Trust Board will be requested to review this decision at the March meeting and revert to an annual check, with the exception of clearances from the Disclosure and Barring Service (DBS), which will remain at every three years.

k) Reform of Agenda for Change Terms and Conditions

In the November Budget, the Chancellor stated that additional funding for Agenda for Change staff could be made available dependent on successful talks on pay structure modernisation to improve recruitment and retention.

In light of the Budget announcement, NHS Employers has been in constructive discussions with trade union colleagues to explore whether an agreement could be reached.

On 21 March NHS Employers announced that a Framework Agreement had been reached with the NHS Council for the reform of the NHS pay structure and terms and conditions for all Agenda for Change staff. The next stage is for the NHS trade unions to set in motion a consultation period with their members on the proposed agreement, with any ballots likely to report by the beginning of June at the latest. If the trade unions approve the proposed Framework Agreement it is expected that the NHS Pay Review Body will endorse it ready for implementation from July 2018, backdated to 1 April 2018.

There are a number of elements to the proposed Framework Agreement but the main items are:

- A three year fully-funded pay deal covering 2018/19 - 2020/21, which would reform the pay structure delivering fewer pay points, faster progression, and higher starting salaries, and award a 6.5 per cent increase over the three years to the top of pay scales (staged as 3% in 2018/19, 1.7% in 2019/20 and 1.67% in 2020/21)
- A new system of pay progression
- A minimum rate in the NHS of £17,460 from 1 April 2018 – compliant with Living Wage Foundation Living Wage, and the closure of Band 1
- Terms and conditions improvements including enhanced shared parental leave, child bereavement leave, and a national framework on buying and selling leave

- Changes to terms and conditions so that preferential sick pay for those on spine points 1 – 8 will be phased out, and unsocial hours rates for Band 1 – 3 will be adjusted to be more closely aligned with those for Bands 4 - 7
- Closer alignment for ambulance staff with other staff on Agenda for Change
- Development of a joint programme of work to improve health and wellbeing to improve attendance levels and reduce sickness absence
- A commitment for the NHS Staff Council to negotiate a provision for apprenticeship pay, and look at the scope for a national agreement on bank and agency working.

Board members will wish to note that the proposed Agreement includes a new system of pay progression which is very similar to that already operated at HDFT since 2014. The Trust was asked to submit a copy of our award-winning local scheme to NHS Employers as part of their evidence gathering for the 2018/19 pay round.

The Government has confirmed that, in accordance with the Chancellor's 2017 Budget announcement, additional money will be made available to fund the increased salary cost, so it will not have to come from existing NHS budgets. NHS Improvement has confirmed that funding for the proposed NHS Agenda for Change staff pay agreement will be provided direct to NHS organisations in 2018/19. An appropriate mechanism for distributing the funding in future years is currently being considered. Assurance has been given that NHS providers will receive the appropriate funding to remunerate NHS staff employed on local authority commissioned contracts.

I was pleased to be invited by NHS Providers to present evidence to the NHS Pay Review Body in London to inform this year's pay round.

l) West Yorkshire and Harrogate Excellence Centre

The Trust is a member of this organisation. The project team has been busy securing quality training and development interventions around communication skills, health and wellbeing education, the Care Certificate ,Personal Development and Apprenticeships .

The majority of the subjects on offer will be delivered through direct training and reflect local priority areas as identified by employer stakeholders whilst aiming to support workforce development. Most of the training is aimed at staff in support roles, although a couple of interventions will enable organisations to build capacity and so will be appropriate for supervisors and registered staff. The intention is to have some funded provision available in all localities across West Yorkshire.

m) NHS Improvement Whistleblowing Support Scheme

NHS Improvement (NHSi) is piloting a whistleblowing support scheme (WSS) for former NHS staff who have raised concerns and are trying to get back into NHS employment, as recommended in Sir Robert Francis's Freedom to Speak up review. The Trust was requested to advise NHSi as to whether it had any clauses in settlement agreements with former employees which would be enforced and would prevent ex-employees from completing the WSS application process. This would enable NHSi to communicate that HDFT would not take action against any former employees for divulging necessary information to complete an application for the scheme. The Trust has confirmed that there are no clauses in settlement agreements with former employees which would prevent those individuals from completing the WSS application process.

n) Harrogate Health Facilities Management

The transfer of the staff and the creation of HHFM as an operating company providing services to the Trust in respect of Estates and Facilities occurred on the 1 March 2018. Appointments have been recommended to the Board with regard to the Chair of HHFM and subsequently the appointment and recruitment of the remaining Non-Executive Directors will commence.

The new management team, along with HR colleagues, has held a number of staff engagement sessions with the teams regarding the values and ethos of the company, the operating name, uniform and communication channels. These have been well attended, with over 100 staff attending to date. These will continue until the 23 March and a follow on session will be arranged for the senior management.

P Marshall
Director of Workforce and Organisational Development
March 2018

Annex: Overview of National Staff Survey 2017 results

Annex to W&OD Report
March 2018

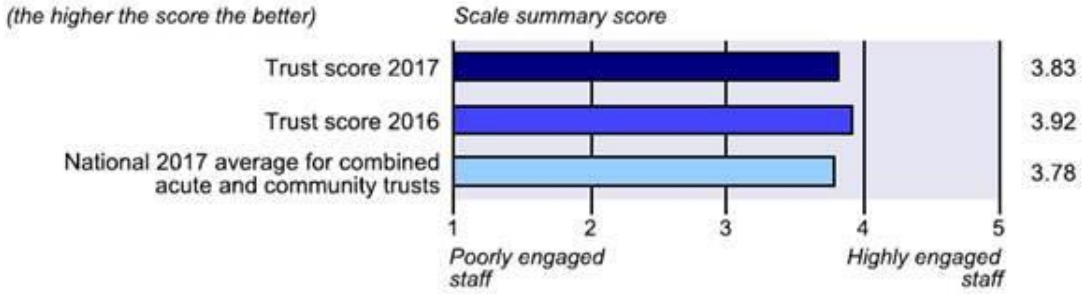
Detailed overview of the National Staff Survey Results 2017 for HDFT

Staff Engagement

"Health care is a people business. The quality of care that patients receive depends first and foremost on the skill and dedication of NHS staff. Highly engaged staff – and by this we mean individuals who are committed to their organisations and involved in their roles – are more likely to bring their heart and soul to work, to take the initiative, to 'go the extra mile' and to collaborate effectively with others." Source: Kings Fund 2015

The figure below shows how the Trust compares with other Combined Acute and Community Trusts on an overall indicator of Staff Engagement. Possible scores range from one to five, with one indicating that staff are poorly engaged (with their work, their team and their trust) and five indicating that staff are highly engaged.

The Trust's overall Staff Engagement score of 3.83 is ranked 'above average' (highest/best rank) in the Combined Acute and Community Trusts category. Nationally, the staff engagement score has decreased for the first time since the 2014 survey; from 3.82 to 3.80.



The Staff Engagement score is calculated using the results from 3 key findings; specifically:

- KF1: Staff recommendation of the organisation as a place to work or receive treatment (reduction from 3.96 in 2016 to 3.79 in 2017)
- KF4: Staff motivation at work (reduction from 3.99 in 2016 to 3.95 in 2017)
- KF7: Percentage of staff able to contribute towards improvements at work (reduction from 75% in 2016 to 70% in 2017)

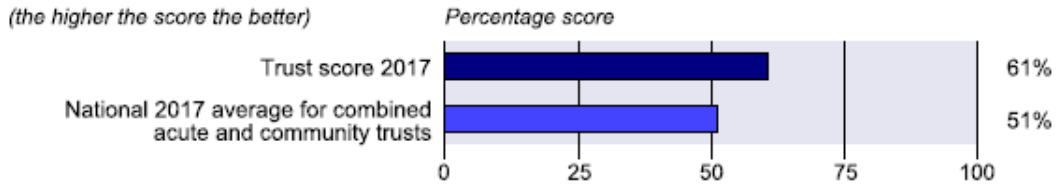
The scores for Key Findings 1 and 4 are above the national average, whilst Key Finding 7 is the same.

We are currently scoping our Staff Engagement strategy for 2018-2021 - #Year of Engagement – which will focus on raising the profile of staff engagement throughout the organisation so that this becomes the 'way we do things here'. The strategy will be aligned to the Clinical Workforce Strategy KPIs and monitored through the Clinical Transformation Board.

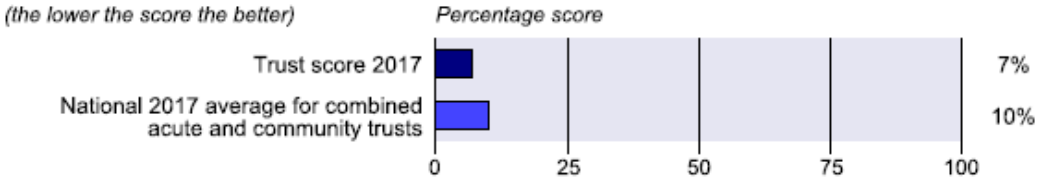
The top five ranking scores for HDFT were as follows:

Final 22 March

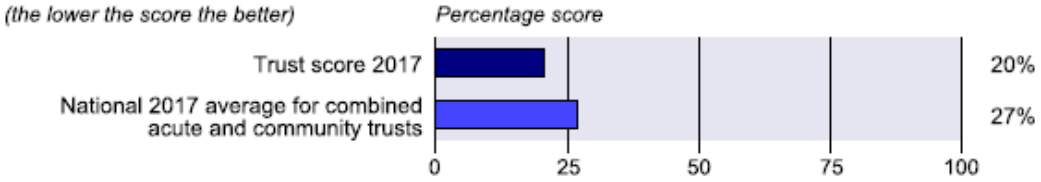
✓ KF15. Percentage of staff satisfied with the opportunities for flexible working patterns



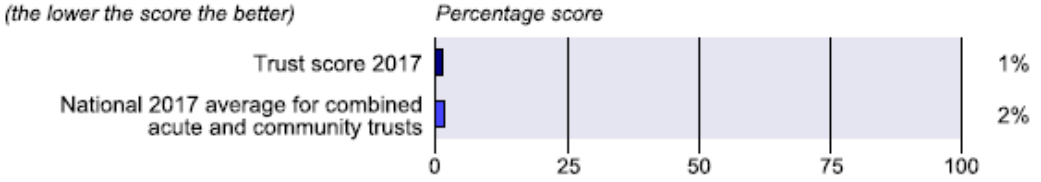
✓ KF20. Percentage of staff experiencing discrimination at work in the last 12 months



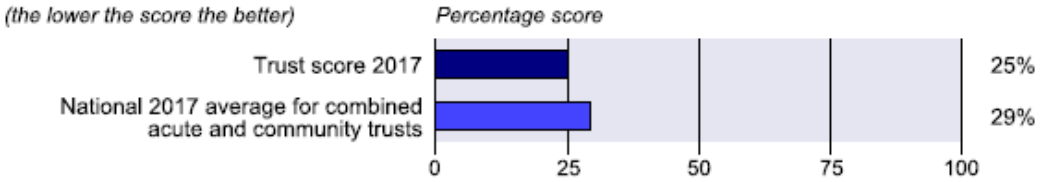
✓ KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months



✓ KF23. Percentage of staff experiencing physical violence from staff in last 12 months



✓ KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

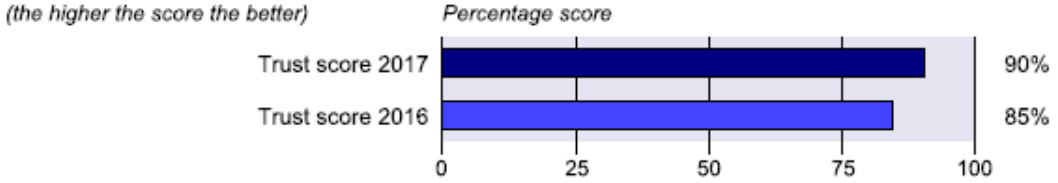


The largest local change for HDFT was for the Key Finding: Percentage of staff appraised in the last 12 months. Our score increased from 85% in 2016 to 90% in 2017, which reflects the positive approach to managing appraisals through an 'appraisal window' this financial year.

Final 22 March

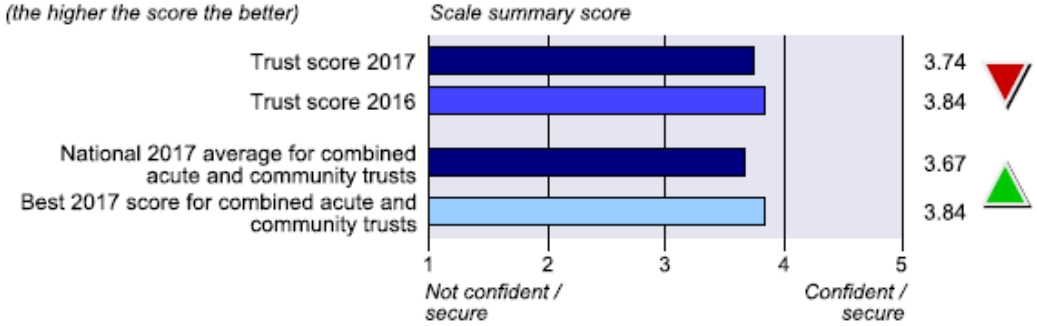
WHERE STAFF EXPERIENCE HAS IMPROVED

✓KF11. Percentage of staff appraised in last 12 months

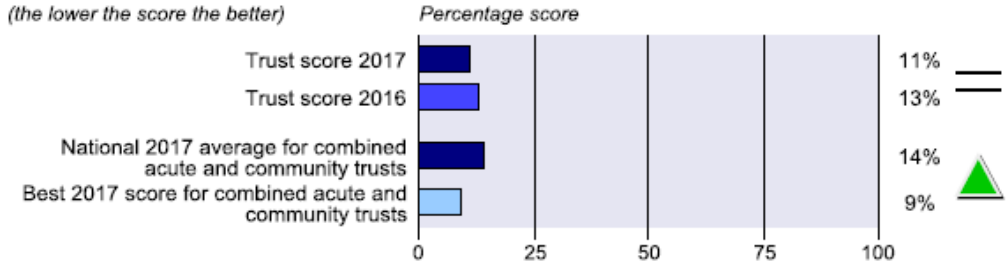


Five areas for improvement were identified by HDFT from last year's survey. Two of these areas have shown improvement in this year's survey.

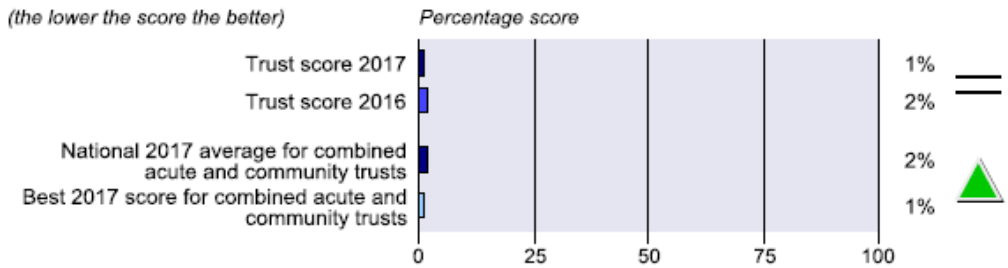
KEY FINDING 31. Staff confidence and security in reporting unsafe clinical practice



KEY FINDING 22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

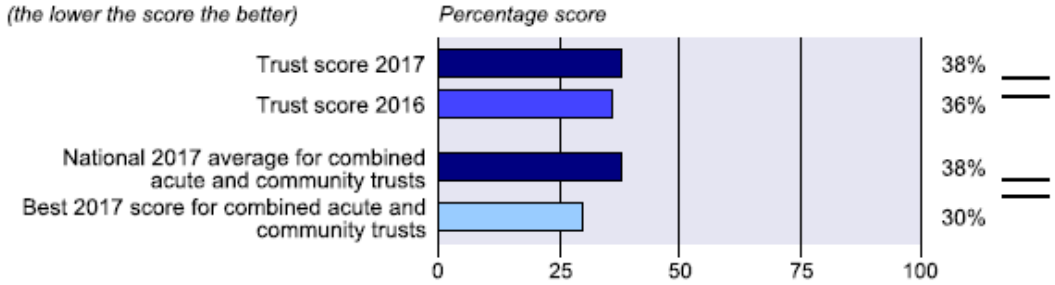


KEY FINDING 23. Percentage of staff experiencing physical violence from staff in last 12 months

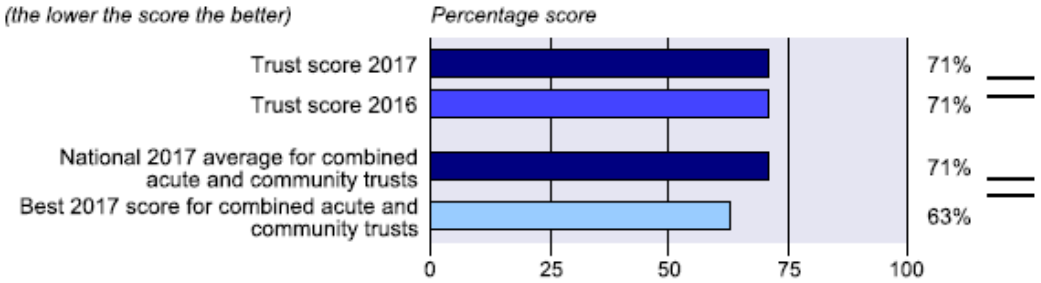


Final 22 March

KEY FINDING 17. Percentage of staff feeling unwell due to work related stress in the last 12 months



KEY FINDING 16. Percentage of staff working extra hours



We have made significant progress to develop and improve upon these key findings within our staff engagement action plan for 2017/18, and recognise that these will remain an area of focus which will continue into the 2018/19 plan to drive improvement.

HDFT scored below average in three out of the 32 key findings:

- Percentage of staff reporting errors, near misses or incidents witnessed in the last month *(HDFT 90%, national average 91%)*
- Staff satisfaction with the quality of work and care they are able to deliver *(HDFT 3.84, national average 3.90)*
- Percentage of staff reporting most recent experience of violence *(HDFT 62%, national average 67%)*

There are some really positive results in here which we should be proud of; some of which were on our staff engagement plan last year to improve. There are also some areas to focus on, which we will hopefully be able to start to address through our proposals for staff engagement this year.

Harrogate and District NHS Foundation Trust

Date of Meeting:	28 March 2018	**Agenda item:**	9.0
Report to:	Board of Directors		
Title:	Chief Nurse Report		
Sponsoring Director:	Jill Foster, Chief Nurse		
Author(s):	Jill Foster, Chief Nurse		

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 category 3 and unstageable pressure ulcers in the community remain about the same. The number of hospital acquired pressure ulcers, categories 2-3 and unstageable has significantly fallen in February 2018.
- The proportion of category 3 and unstageable pressure ulcers deemed to be avoidable has reduced.
- The total numbers of in-patient falls in February 2018 reduced compared to February 2017.
- The number of complaints received in February is the lowest in month received so far this year, and the lowest monthly total ever.
- The Bereavement Survey for 2017 provides evidence that generally people are satisfied with the level of support they receive prior to and after their relative's death.

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.
- **Note** the decrease in hospital acquired pressure ulcers.
- **Note** the work around falls reduction.
- Be **assured** about the monitoring of care provided by the CCT's.
- **Note** the number of complaints in February.
- Be **assured** by the feedback regarding the care given to patients and families as a patient dies.

Harrogate and District NHS Foundation Trust

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 RN 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 towards zero vacancies. Services and departments are continuously recruiting and the next Trust event is planned for April 2018.

1.2 The Trust has welcomed 27 newly qualified nurses between September and January. A further four nurses will commence between February and April 2018

1.3 Five nurses have started in the Trust from the Global Learners Programme. We are expecting a further three nurses by April 2018. Four nurses have successfully completed NMC registration to date.

1.4 Long Term and Unscheduled Care (LTUC) currently has 14.77 RN Band 5 vacancies across their inpatient areas. They have 11.67 Care Support Worker (CSW) vacancies.

1.5 Planned and Surgical Care has 13.73 RN Band 5 vacancies across their in-patient areas with 0.42 CSW vacancies.

1.6 In Main Theatres there are 11.39 Band 5 vacancies.

1.7 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.

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

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

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1.10 Current Situation on Adult In-Patient Wards

Ward	Registered Nurses			CSW's		
	Est.	Vac.	%	Est.	Vac.	%
Acute Admissions Unit	23.27			13.93		
Byland	16.11			22.88		
Clinical Assessment Team	25.03			16.5		
Granby	12.47			12.5		
Jervaulx	16.11			22.88		
Lascelles	10.76			10.68		
Oakdale	25.05			15.32		
Trinity	11.01			13.27		
Total	**139.81**			**127.96**		
Farndale	13.92	4.39	32%	16.32	3.34	20%
Wensleydale	16.74	1.97	12%	11.51	4.41 0ver	
Littondale	18.17	2.53	14%	13.44	0.69	5%
Nidderdale	18.32	3.49	19%	14.92	0	0%
Harlow	10.51	0	0%	3.46	0	0%
ITU	31.53	1.35	4%	2.9	0.8	33.3%
Total	**109.19**	**13.73**	**13%**	**62.55**	**0.42**	**1%**

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	4.97
Adult Community Nurses (CCT's)	1.43
Main Theatres	RN 7.5 ODP 3.89
Day Surgery	RN 2.91 ODP 0.20
Maternity Unit	1.3
Woodlands	3.2
SCBU	0

1.11 Is the situation improving?

The nursing vacancy situation remains about the same as last month's 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:

NHS
Harrogate and District
NHS Foundation Trust

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
24/01/18	Oakdale	Green
14/02/18	CATT	Red
28/02/18	CATT	Green

2.3 Granby – rate red due to cannula compliance. Subsequent visits show they are making progress with the most recent score being 20/21 against seven cannulas.

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 sub-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
16/01/18	CSSD
30/01/18	Medical Records
09/02/18	Site Services (Portering)

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.

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Last month I reported there had been an increase in the number of community acquired category 3 and unstageable pressure ulcers, particularly in Harrogate North and South CCT's. The numbers in February remain about the same. As last month, the proportion of category 3 and unstageable pressure ulcers deemed to be avoidable has reduced.

Last month also saw a rise in hospital acquired pressure ulcers categories 2-3 and unstageable. I am pleased to report the number of hospital acquired pressure ulcers categories 2-3 and unstageable are significantly lower in February.

In particular, in January, I reported an increased incidence of avoidable category 3 / unstageable pressure ulcers on Byland ward and that Matron was overseeing a detailed action plan for this area, focusing on timely risk assessment, handover, documentation and an intensive education programme. I am pleased to report Byland has had no category 3 / unstageable pressure ulcers in February.

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 to he 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 5 December 2017 and agreed a number of immediate actions.

Since December 2016 the total number of falls has decreased each month;

The total number of falls in December 2017 is **59** compared to **85** in December 2016.
The total number of falls in January 2018 is **64** compared to **77** in January 2017.
The total number of falls in February 2018 is **61** compared to **64** in February 2017.
There has been no falls with moderate harm, including fractures, in February 2018.

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, has fluctuated between 2 and 4. This has continued throughout January 2018.

The Directorate has been monitoring a number of proxy indicators for deterioration in the quality of care. These indicators include the total number of pressure ulcers and total number of avoidable pressure ulcers, end of life care issues, access to the service via the telephone and finally formal complaints.

Last month I reported an increase in January in the number of category 3 and unstageable pressure ulcers particularly in Harrogate North and South CCT's and that 1 formal complaint had been received. The number of category 3 and unstageable pressure ulcers remain about the same in February. There have been no End of Life issues raised in February and no complaints received regarding the Community Care Teams.

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Patient Experience

7. Complaints

7.1 The number of complaints received in February 2018 is eight.

Of the eight complaints received in February 2018, all have been graded Yellow.

Of particular note, in February 2018 there has been an increase in the number of complaints about delays or failure to diagnose.

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	26	8		
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 **183**. The total number of complaints for the same period of time in 2016/17 was **202**.

8.0 End of Life Care

8.1 This section is to provide information to the Trust Board about how we know if the care provided by the Trust prior to and following a death is of high quality. A bereavement survey is conducted annually of deaths in hospital. In total the survey asks 30 questions related to the experience of patients and their families. For this report I have chosen to highlight the responses to 19 questions as examples of the subject matter covered by the survey.

It is the aim of the Trust to ensure that events preceding and following the death of a patient are managed sensitively, efficiently and with the knowledge and understanding of the relatives/carers. Patients, relatives and carers have the right to receive a high standard of care, advice and support from well informed staff. Local objectives clearly highlight the need to care for people in a timely way and have their care co-ordinated and delivered in accordance with their wishes through a personalised care plan to:

- Enhance dignity, choice and equality.
- Increase likelihood that death will occur in the patient's preferred place of care.
- Palliate symptoms.
- Improve communication between patient, families and professionals.

We also recognise the importance of gathering and acting upon feedback from patients and relatives in order to ensure we are delivering a holistic and patient-focused service, and to identify any areas for improvement as we constantly strive to provide excellent care. To achieve this HDFT, in 2016, established a local bereavement survey as one of the ways to measure how well we are doing in this important area, with the aim to gather feedback on the quality of care the Trust is providing to dying patients and their relatives/carers. The objectives of the survey are;

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- To better understand how well the Trust is performing against the National Institute for Health and Care Excellence (NICE) Quality Standards for End of Life Care for Adults (QS13, 2011).
- To identify areas of high patient satisfaction where we need to maintain a high quality service.
- To identify any areas where bereaved relatives think we could be doing better, in order that we can implement improvements.
- To consider feedback in comparison to the 2016 local bereavement survey results.

8.2 The results of the 2017 Bereavement Survey in comparison to 2016.

1. There was enough help available to meet his/her personal care needs, such as washing, personal hygiene and toileting needs.

	2016 Survey (n=110)*	2017 Survey (N=100)
Strongly agree	50 (45%)	**43 (43%)**
Agree	53 (48%)	**46 (46%)**
Neither agree nor disagree	3 (3%)	**6 (6%)**
Disagree	3 (3%)	**4 (4%)**
Strongly disagree	1 (1%)	**1 (1%)**

**2 people left this question blank*

2. There was enough help with nursing care, such as giving medicines and helping him/her find a comfortable position in bed.

	2016 Survey (n=110)*	2017 Survey (N=100)
Strongly agree	51 (46%)	**40 (40%)**
Agree	51 (46%)	**45 (45%)**
Neither agree nor disagree	3 (3%)	**9 (9%)**
Disagree	4 (4%)	**6 (6%)**
Strongly disagree	1 (1%)	**0**

**2 people left this question blank*

3. The bed area and surrounding environment was comfortable for him/her.

	2016 Survey (n=110)*	2017 Survey (N=100)
Strongly agree	43 (39%)	**42 (42%)**
Agree	56 (51%)	**45 (45%)**
Neither agree nor disagree	8 (7%)	**8 (8%)**
Disagree	0	**2 (2%)**
Strongly disagree	3 (3%)	**3 (3%)**

**2 people left this question blank*

4. Did you have confidence and trust in the nurses who were caring for him/her?

	2016 Survey (N=112)	2017 Survey (N=100)
Yes, in all of them	89 (79%)	**81 (81%)**
Yes, in some of them	22 (20%)	**19 (19%)**
No, not in any of the nurses	1 (1%)	**0**

5. Did you have confidence and trust in the doctors who were caring for him/her?

	2016 Survey (n=106)*	2017 Survey (n=99)*
Yes, in all of them	89 (84%)	**84 (84%)**
Yes, in some of them	17 (16%)	**12 (12%)**
No, not in any of the doctors	0	**3 (3%)**

**6 people left this question blank in 2016 and 1 person left this question blank in 2017*

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6. The nurses had time to listen and discuss his/her condition with me.

	2016 Survey (n=111)*	2017 Survey (N=100)
Strongly agree	51 (46%)	**48 (48%)**
Agree	42 (38%)	**33 (33%)**
Neither agree nor disagree	10 (9%)	**8 (8%)**
Disagree	7 (6%)	**8 (8%)**
Strongly disagree	1 (1%)	**3 (3%)**

**1 person left this question blank*

7. The doctors had time to listen and discuss his/her condition with me.

	2016 Survey (N=112)	2017 Survey (n=99)*
Strongly agree	50 (45%)	**45 (45%)**
Agree	39 (35%)	**32 (32%)**
Neither agree nor disagree	11 (10%)	**14 (14%)**
Disagree	7 (7%)	**6 (6%)**
Strongly disagree	5 (4%)	**2 (2%)**

8. In your opinion, during the last two days, did s/he appear to be in pain?

	2016 Survey (n=106)	2017 Survey (n=99*)
Yes, all of the time	8 (7%)	**3 (3%)**
Yes, some of the time	41 (39%)	**32 (32%)**
No, s/he did not appear to be in pain	57 (54%)	**64 (64%)**

**1 person left this question blank*

9. In your view, did the doctors and nurses do enough to help relieve the pain?

	2016 Survey (n=106)	2017 Survey (n=99*)
Yes, all of the time	63 (59%)	**64 (64%)**
Yes, some of the time	17 (16%)	**14 (14%)**
No, not at all	4 (4%)	**2 (2%)**
Not applicable, s/he was not in pain	22 (21%)	**19 (19%)**

**1 person left this question blank*

10. During the last two days, how involved were you with the decisions about his/her care and treatment?

	2016 Survey (n=108)*	2017 Survey (n=97)*
Very involved	61 (56%)	**56 (56%)**
Fairly involved	30 (28%)	**25 (25%)**
Not involved	17 (16%)	**16 (16%)**

**4 people left this question blank in 2016 and 3 people left this question blank in 2017*

11. Did the healthcare team explain his/her condition and/or treatment in a way you found easy or difficult to understand?

	2016 Survey (n=110)*	2017 Survey (n=98)*
Very easy	71 (65%)	**56 (56%)**
Fairly easy	30 (27%)	**28 (28%)**
Fairly difficult	2 (2%)	**3 (3%)**
Very difficult	0	**1 (1%)**
They did not explain it	7 (6%)	**9 (9%)**

**2 people left this question blank in 2016 and 2 people left this question blank in 2017*

12. How would you assess the overall level of emotional support given to <u>you</u> by the healthcare team?

	2016 Survey (n=108)*	2017 Survey (n=94)*
Poor	9 (8%)	**8 (8%)**
Fair	20 (19%)	**11 (11%)**
Good	36 (33%)	**34 (34%)**
Excellent	43 (40%)	**41 (41%)**

**4 people left this question blank in 2016 and 6 people left this question blank in 2017*

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13. Before s/he died, were you told s/he was likely to die soon?

	2016 Survey (n=110)*	2017 Survey (n=98)*
Yes	86 (78%)	**75 (75%)**
No	24 (22%)	**23 (23%)**

**2 people left this question blank in 2016 and 2 people left this question blank in 2017*

14. Did a member of the healthcare team talk to you about what to expect when s/he was dying (e.g. symptoms that may arise)?

	2016 Survey (n=105)*	2017 Survey (n=97)*
Yes	56 (53%)	**45 (45%)**
No	49 (47%)	**52 (52%)**

**7 people left this question blank in 2016 and 3 people left this question blank in 2017*

15. Would a discussion about what to expect when s/he was dying have been helpful?

	2016 Survey (n=103)*	2017 Survey (n=93)*
Yes	29 (28%)	**33 (33%)**
No	24 (23%)	**25 (25%)**
Not applicable	50 (49%)	**35 (35%)**

**9 people left this question blank in 2016 and 7 people left this question blank in 2017*

Of the 52 people who said they weren't told what to expect when their loved one was dying, 26 (50%) said this discussion would have been helpful.

16. In your opinion did s/he die in the right place?

	2016 Survey (n=109)*	2017 Survey (n=98)*
Yes, it was the right place	83 (76%)	**81 (81%)**
No, it was not the right place	12 (11%)	**6 (6%)**
Not sure	12 (11%)	**10 (10%)**
Don't know	2 (2%)	**1 (1%)**

**3 people left this question blank in 2016 and 2 people left this question blank in 2017*

17. I was given enough help and support by the healthcare team at the actual time of his/her death.

	2016 Survey (n=106)*	2017 Survey (n=93)*
Strongly agree	53 (50%)	**52 (52%)**
Agree	30 (28%)	**25 (25%)**
Neither agree nor disagree	16 (15%)	**8 (8%)**
Disagree	6 (6%)	**4 (4%)**
Strongly disagree	1 (1%)	**4 (4%)**

**6 people left this question blank in 2016 and 7 people left this question blank in 2017*

18. After s/he had died, did individuals from the healthcare team deal with you in a sensitive manner?

	2016 Survey (n=108)*	2017 Survey (n=97)*
Yes	101 (93%)	**88 (88%)**
No	3 (3%)	**5 (5%)**
Not applicable	4 (4%)	**4 (4%)**

***4 people left this blank in 2016 and 3 people left this question blank in 2017*

19. Overall, in your opinion, were you adequately supported during his/her last two days of life?

	2016 Survey (n=102)*	2017 Survey (n=94)*
Yes	92 (90%)	**82 (87%)**
No	10 (10%)	**12 (13%)**

**10 people left this question blank in 2016 and 6 people left this question blank in 2017*

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8.3 The results of the 100 returns analysed in this report are mainly positive, with a small improvement compared to the 2016 results in the following areas: privacy and cleanliness of the bed area and surrounding environment, the control of pain and restlessness and emotional support from the healthcare team. In addition there has been an increase in respondents feeling their loved one had died in the right place and that the nurses and doctors had time to listen and discuss the patient's condition.

However several areas have shown an increase in negative responses compared to the 2016 survey. These areas include: basic care received, respondents confidence and trust in doctors and nurses, and spiritual support for patients and relatives/friends. There has been an increase in responses stating discussions with the healthcare team regarding the patients care would have been helpful, which I believe reflects the current pressure the healthcare teams are under throughout HDFT.

Unfortunately there has been a decrease in positive responses to the patient being treated with respect and dignity in the last two days of life, this decrease was for both doctors and nurses. The final question asks the respondent if they felt adequately supported during their loved one's last two days of life. Unfortunately 3% fewer respondents answered 'yes' compared to the 2016 survey.

The overall question, "In your opinion, were you adequately supported during his/her last two days of life?" scored 90% in the 2016 report and 87% in the current 2017 report. This indicates that in general people are satisfied with the level of support being received.

8.4 Next Steps

The results of the survey have been considered by the End of Life Care Working Group and a number of actions have been developed.

8.5 For Noting

All returned surveys were reviewed by the Consultant in Palliative Medicine and/or the member of the Palliative Care Nursing Team on receipt, so individual responses have already been escalated to the relevant matron or team as needed.

Jill Foster
Chief Nurse
March 2018

Harrogate and District NHS Foundation Trust

Appendix One

Actual versus planned nurse staffing - Inpatient areas

The table below summarises the average fill rate on each ward during **February 2018.** 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 February was **7.60** care hours per patient per day.

	Feb-2018						
	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	98.0%	118.4%	94.2%	215.5%	4.06	3.65	7.70
Byland	107.6%	98.0%	69.0%	133.3%	2.44	3.72	6.16
CATT	103.5%	123.8%	96.0%	106.4%	4.34	3.05	7.38
Farndale	122.6%	88.1%	100.0%	116.1%	2.90	3.01	5.91
Granby	103.5%	164.3%	100.0%	137.5%	2.90	3.72	6.62
Harlow	107.1%	100.0%	100.0%	-	4.94	1.83	6.77
ITU/HDU	105.8%	-	102.1%	-	23.87	1.36	25.22
Jervaulx	114.0%	106.3%	72.0%	141.7%	2.57	3.99	6.56
Lascelles	99.1%	98.6%	100.0%	100.0%	4.25	3.86	8.11
Littondale	91.1%	134.3%	83.3%	164.3%	3.17	2.55	5.72
Maternity Wards	90.4%	72.3%	97.8%	73.2%	15.90	3.64	19.54
Nidderdale	87.3%	99.0%	79.8%	105.4%	3.28	3.02	6.30
Oakdale	94.7%	151.2%	90.2%	194.6%	4.37	4.34	8.70
Special Care Baby Unit	92.1%	0.0%	101.8%	-	17.78	0.00	17.78
Trinity	114.7%	117.0%	100.0%	100.0%	3.00	2.97	5.97
Wensleydale	94.5%	136.6%	100.0%	141.1%	3.31	2.92	6.23
Woodlands	81.7%	110.7%	82.1%	100.0%	7.99	3.32	11.31
Trust total	**99.6%**	**112.4%**	**92.6%**	**133.2%**	**4.32**	**3.28**	**7.60**

ED	96%	193%	87%	82%			

Further information to support the February data

On the medical wards AMU, Jervaulx, Byland, CATT and Oakdale, where the 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 RNs. The Trust is engaged in an extensive recruitment plan in response to this.

On CATT and Harlow Suite the increase in RN day duty hours above plan was to support the opening of additional escalation beds in February, as required.

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

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

On Littondale and Nidderdale wards the RN hours were less than planned due to vacancies and sickness in February.

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. The day and night time RN hours are less than planned in February due to vacancies however 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 Trinity ward the increase in the Daytime RN hours is to support the opening of additional beds to support winter pressures

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Date of Meeting:	28 March 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:	The report includes: • Mortality update; the HSMR and SHMI have fallen in the latest published update. • Stroke services update; Communication has been received from NHSI/NHSE regarding 7 day services for stroke. • Critical Care Peer Review; in general the report was very positive one but highlighted a number of areas of concern. • Information on visa refusals; request for information has been received from the Dept. of Health and Social Care regarding the number of Tier 2 visa refusal experienced by Trusts.		

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.
Impact Assessment:	None.
Conflicts of Interest:	None identified.
Reference documents:	None
Assurance:	Not applicable, this report is reserved to the Board of Directors.

Action Required by the Board of Directors:

- It is recommended that the Board receives and notes the report.

1. Mortality update

Both the HSMR and SHMI have fallen in the latest published update.

The HSMR has fallen to 105.6 and the SHMI to 88.4. The former remains within the expected range and the latter below the expected range. At specialty level, the same four specialties have a higher than expected standardised mortality rate for SHMI – Respiratory Medicine, Geriatric Medicine, Gastroenterology and Plastic Surgery. The plastic surgery relates to the same death as last month.

The Care of the Elderly Team continues to meet with representatives of Clinical Coding to ensure accuracy and completeness. The clinical view remains that coding overall is rigorous and no major omissions have been identified in case note reviews. Adding frailty surrogate codes (previously not coded) would not have affected HSMR or SHMI significantly. A local agreement has been reached to code as “senility” when frailty is documented.

Overall it was felt that a large number of elderly medical patients were very frail and at high overall risk of death. I have been made aware of no major lapses in care.

It was noted that many patients did not have a code for specialist palliative care. This may be because geriatricians usually feel happy and competent to manage end of life care and at present the Specialist Palliative Care team do not routinely review everyone on the CPLD if there are no specialist palliative care needs. If the organisation thinks there needs to be a change in practice, then this could be discussed with Palliative Care.

Therefore actions are as follows:

1. Care of the Elderly will continue to undertake bi-monthly mortality reviews using SJMR (Datix)
2. Clinical Coding will produce a local policy for the coding of frailty using ‘senility’ .
3. The organisation to decide whether all patients on CPLD need specialist palliative care review even if needs are being met. This is the only thing that we think would alter the mortality measurements (eg in 9/30 patients reviewed).

I am due to attend a meeting in London to discuss arrangements for the national implementation of the Medical Examiner post. I will provide a verbal update to Board as necessary.

Implementation of the ReSPECT pathway has met with slow progress. A meeting with Commissioners and a GP representative has taken place and feedback indicates that enthusiasm for this process in primary care would be less than overwhelming as it was viewed as under-resourced.

I am currently working with our local Trust Lead to identify measures to resurrect the process. Possibilities include:

- A local pilot study on selected wards using only patients of enthusiastic GP surgeries.
- A separate meeting with myself and commissioners only.

- Liaising with colleagues across the region who are more advanced in the process in order to understand how these challenges have been addressed locally.
- Explore whether progress can be made through the CQUIN route.
- Highlight the subject matter at YORLMC with a view to backing the project.

As always I will update Board on progress.

The latest quarterly Learning from Deaths report is included for discussion as paper 10.1.

2. Stroke services update:

At the time of writing I am not aware of any significant progress in the regional reconfiguration of stroke services. To date no decision has been made as to the location of Hyperacute Stroke services.

Communication has been received from NHSI/NHSE regarding 7 day services for stroke. Standard 2 mandates that patients admitted acutely to hospital should be seen within 14 hours of admission by a Consultant or suitable senior representative.

In the case of stroke services, the latest national clinical guideline (October 2016) advises that ***'people with suspected acute stroke … should be admitted directly to a hyperacute stroke unit and be assessed for emergency stroke treatments by a specialist physician without delay'*.**

For acute stroke, this guidance has been changed.

- For clinical standard 2, confirmed acute stroke patients with a low risk of mortality (<10% in the first 72 hours) can be reviewed by a consultant within 14 hours of admission using either telemedicine (via a video link) or by telephone. This should be followed by a face to face consultant review within 24 hours of admission.
- Each acute trust which admits acute stroke patients should confirm that this guidance is in operation through the creation of a local written protocol agreed by the trust Medical Director.

This seems a reasonable and pragmatic change in practice. The revised guidance will henceforth be used to inform next iteration of the 7-Day Services self-assessment survey (Spring 2018).

3. Critical care Peer Review:

The Trust recently received a peer review report from the WY Critical Care Network. The report was in general, a very positive one. Areas of concern were highlighted, an action plan for which is being led by Dr Rob Tuffin.

Areas to address are:

- Dedicated Anaesthetic rota for ITUY/HDU
- Provision of dedicated supernumerary shift coordinator
- Nurse cover to general ward areas

- Impact of work pressures on QI activity
- Less than 50% of nursing staff possessing critical care award
- Delay in discharge > 4hrs is from decision to discharge is greater than the national average
- Gaps in rehabilitation assessment and daily therapy

Areas of good practice include:

- Consultant of the week model
- Daily MDT with full attendance
- Post-discharge CCN follow up
- Clinical Psychology support
- Well established CCOT service and PatientTrak escalation

4. Information on visa refusals:

A request for information has been received from the Dept. of Health and Social Care regarding the number of Tier 2 visa refusal experienced by Trusts and the estimated impact this has had on patient care and service delivery. The Trust has responded to this welcome request, hopefully a sign that the current processes are less than purposeful and that Departmental lobbying may take place at the highest level. At the time of writing, there has been no notification of change of immigration rules. I remain hopeful.

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Date of Meeting:	28 March 2018	**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 quarterly report of learning from deaths process. Findings from ongoing review of deaths following cardiac arrest are also included.		

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.
Legal / regulatory:	There is a requirement to collect and publish specified 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:	HDFT Learning from Deaths Policy
Assurance:	Learning from quarterly reports will be reviewed at the Improving Patient Safety Steering Group.

Action Required by the Board of Directors:

It is recommended that the Board

- Notes items included within the report;

Learning from deaths report: Q3 20171/8

The Trust published its Learning from Deaths Policy in September 2017.

For those patient deaths meeting the criteria for a detailed review of case notes, the Medical Director appoints 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 problems in the care provided to the patient who died in order to learn from what happened.

The NMCRR data collection sheet 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 based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible.

In addition to this process, during 2017/18 some specific focused reviews 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.

Results

The date of death (or admission if the date of death is not recorded on the SJR) is the date that has been used for the data analysis rather than the date that the SJR was undertaken. Some of the recent SJRs have been undertaken on deaths that occurred during 2014 – 2017 for the reasons outlined above.

The updated number of SJRs during previous periods has therefore also been included in this report for information.

Numbers of case note reviews and deaths

	2014/15	2015/16	2016/17	2017/18			
				Q1 2017/18	Q2 2017/18	Q3 2017/18	Total
No of SJRs	4	27	40	2	8	13	94

	2017/18			
	Q1 2017/18	Q2 2017/18	Q3 2017/18	Total
No of inpatient deaths	145	140	167	N/a
No of SJRs	2	8	13	23

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 NHS England.

Assessment of care provided Q3 2017/18

	Good or excellent care (score 4-5)	Average care (score 3)	Poor care (score 1-2)	N/a	Total
Admission and initial management	12	0	1	0	13
On-going care	11	0	0	2	13
Care during procedure	0	0	0	13	13
Peri-operative care	0	0	0	13	13
End of life care	8	0	0	5	13
Overall assessment of care received	11	0	1	1*	13
Overall assessment of patient record	11	0	1	1*	13

*not recorded

Problems with care Q3 2017/18

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. A significant proportion of the case reviews were undertaken using the earlier proforma.

- 1 case with no problems with care documented
- 1 case with problems with care – see below for problems by type and harm
- 11 cases not documented

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 case documented - probable harm	0	1 case documented - probable harm	0	0	0	0

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
1	10	0	1	1	0	0

The one case scored as "3 – probably avoidable, more then 50/50" is the same case that had poor care documented and problems with care. This case was reported through Datix and has been investigated as a serious incident (SI). The SI report will be presented to the Board of Directors in March 2018.

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

1. The likelihood and type of final illness could have been anticipated with advanced care planning in the community and the patient could have died within a more homely environment.
2. A patient admitted with a non-haemorrhagic stroke was assessed for thrombolysis. The patient was on warfarin and had INR 1.9 so thrombolysis was contraindicated. However the patient was given aspirin which increased the risk of a haemorrhagic infarct.

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 methodology for documentation of SJR

Cardiac arrests

All hospital cardiac arrests are reported to the National Cardiac Arrest Audit (NCAA) to monitor and report on the incidence of, and outcome from, in-hospital cardiac arrest in order to foster improvements in the prevention, care delivery and outcomes from cardiac arrest. It is a joint initiative between the Resuscitation Council (UK) and ICNARC (Intensive Care National Audit & Research Centre) and is included in the Department of Health Quality Accounts.

Further learning is sought by case notes reviews of all in-hospital cardiac arrests which are reviewed by the Resuscitation Committee to identify any areas of learning to share and determine whether the resuscitation is deemed appropriate or inappropriate; therefore this information is also being considered in this report.

Numbers of cardiac arrests and case note reviews

	2017/18			
	Q1 2017/18	Q2 2017/18	Q3 2017/18	Total
No of inpatient cardiac arrests	8	11	16	35
No of case note reviews	8	11	16	35
No of appropriate cardiac arrests	4	3	13	20
No of inappropriate cardiac arrests	4	8	3	15

Reflection

The cardiac arrest case note reviews show that the care provided prior to and during resuscitation calls is of a high standard, following national guidelines and hospital policy with no omissions in care. However there are significant numbers (43%) of cardiac arrests that have been deemed inappropriate by the Resuscitation Committee. It is important to appreciate that these decisions are made by the Resuscitation Committee with the benefit of hindsight so are likely to be easier decisions to determine without clinical and time pressures and the need for difficult discussions with patients and their relevant others as DNACPR decision making is a complex and sensitive topic.

The reasons for deeming resuscitation inappropriate are detailed below (some cases had more than one reason why the resuscitation was deemed inappropriate by the resuscitation committee):

Patient had a DNACPR decision in place but not known of or not found	Resuscitation stopped quickly due to futility therefore DNACPR should have been considered pre arrest	Patient had life limiting illness so a DNACPR should have been considered	DNACPR put in place post arrest therefore should have been considered prior to arrest
4	4	6	4

Learning

The SJRs and case note reviews of cardiac arrest patients both emphasise the increasing frailty and complexity of patients, some of whose death in hospital is expected. It is therefore important that discussions and realistic treatment plans are in place for these patients including whether cardio pulmonary resuscitation would be clinically appropriate. It is recommended that these patients should have had discussions about resuscitation or their future care discussed as part of advanced care planning either prior to or on admission to hospital. Annual DNACPR audit identifies that this occurs for many patients but should happen in more situations to ensure that patients receive appropriate and realistic treatment and that this is communicated with them.

1. Local dissemination of findings through feedback to clinicians and teams and across the organisation where appropriate. This will be led through the Resuscitation Committee and escalated to the Improving Patient Safety Steering Group (IPSSG) where appropriate.

2. Inclusion of findings from case note reviews in resuscitation training and DNACPR decision making training materials.
3. Implementation of the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) process in the trust and ideally in partnership with GPs to improve advanced care planning and discussion of resuscitation for patients and relevant others across all care areas.

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.

Date of Meeting:	28 March 2018	**Agenda item:**	11.0
Report to:	Board of Directors		
Title:	Freedom to Speak Up Guardian Report		
Sponsoring Director:	Dr Ros Tolcher, Chief Executive		
Author(s):	Dr Sylvia Wood, Deputy Director of Governance and Freedom to Speak Up Guardian		
Report Purpose:	**Decision**		**Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓
Executive Summary:	Freedom to Speak Up Guardians are to provide regular, comprehensive reports to their Board so that barriers to speaking up are identified and addressed. This report outlines current work at national and local level and proposes actions and recommendations to support the development of a positive speaking up culture within all parts of the organisation.		

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:	There is a risk that poor standards of care can proliferate unless patients and staff are listened to and their concerns welcomed and acted upon.
Legal / regulatory:	All NHS trusts were required to appoint a Freedom to Speak Up Guardian and an assessment of speaking up is at the heart of the well led domain of CQC inspections of NHS trusts.
Resource:	There is a time resource required to progress the actions and recommendations from national and local findings.
Impact Assessment:	This work aims to impact positively on all staff but particularly on staff who might be more vulnerable to speaking up.
Conflicts of Interest:	None identified.
Reference documents:	HDFT Speaking Up Policy
Assurance:	This report provides assurance that the Board is informed about national and local work in relation to developing a culture of speaking up about concerns.

Action Required by the Board of Directors:

It is recommended that the Board:

- Notes the content, actions and recommendations;
- Supports the actions and recommendations to progress a positive speaking up culture.

Introduction

> *"It became clear to me from the Mid-Staffordshire inquiries and the Freedom to Speak Up review that poor standards of care can proliferate unless both patients and staff are listened to by the leaders of our health services and their concerns welcomed and acted upon. A crucial part of the change of culture required to ensure that this happens is that all who work in the service accept their responsibility to raise issues of concern and to support others who do so. Speaking up should be the norm, not a dangerous exception to a general practice of keeping one's head down. Every healthcare leader from ward to board level has to promote a culture where speaking up about legitimate concerns can occur without fear of harassment, bullying or discrimination.*
>
> *I recommended that every provider should have a Freedom to Speak Up Guardian, someone acting with the authority of the leadership, trusted by staff, and capable of independent judgement and action, to help ensure that concerns are listened to and those who raise them are appropriately supported."*
>
> Sir Robert Francis QC
> National Guardian's Office Annual Report 2017

Guardians are to challenge and change culture within their organisations so that barriers to speaking up, whatever they are, wherever they are, are identified and addressed.

An important part of the process is for each Freedom to Speak Up (FTSU) Guardian to provide in person regular, detailed and comprehensive Board reports, to support the development of a positive speaking up culture.

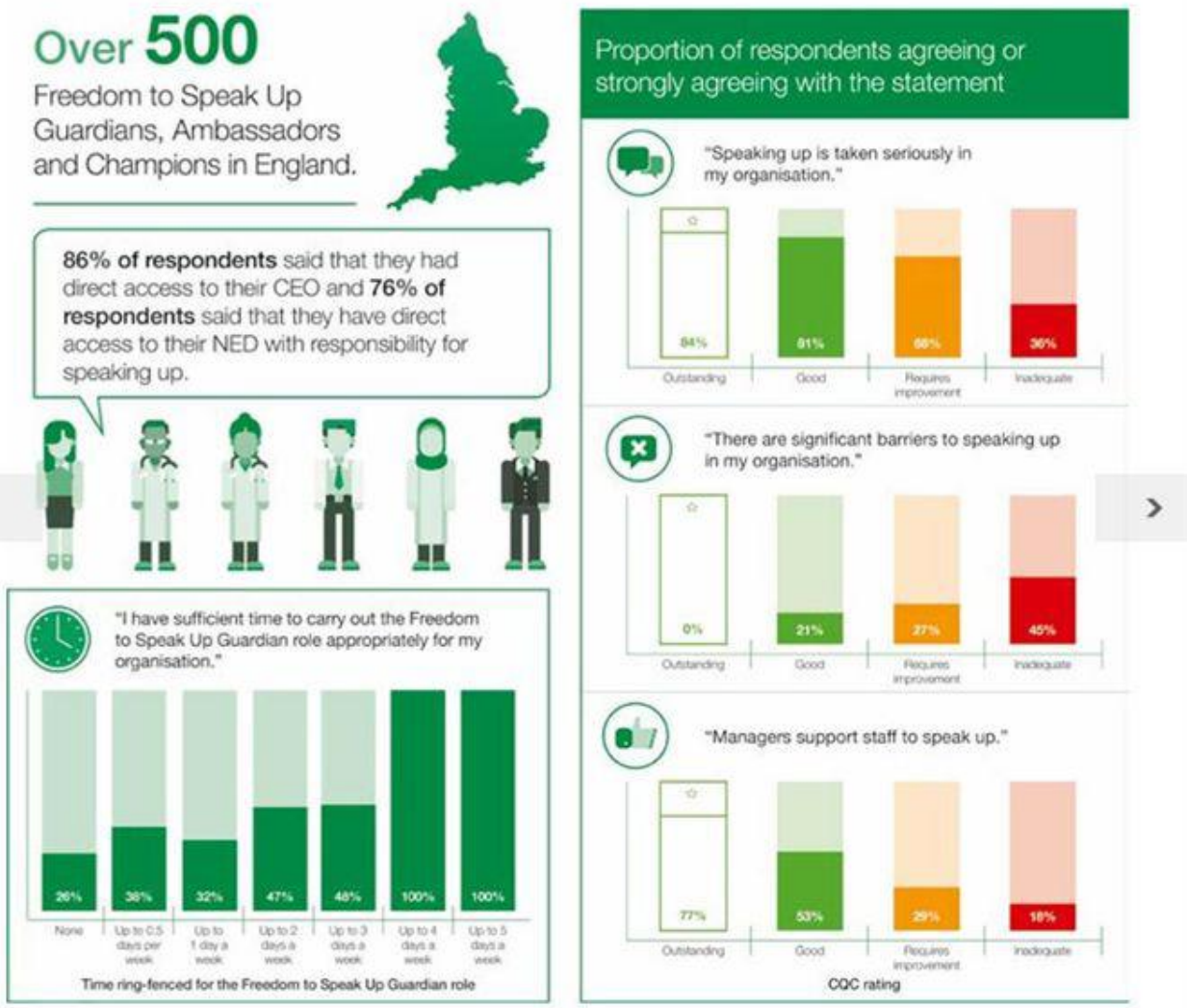
National Picture

National Guardian's Office data

The National Guardian's Office (NGO) is an independent body sponsored equally by the Care Quality Commission (CQC), NHS Improvement and NHS England, with a remit to lead culture change in the NHS so that speaking up becomes business as usual. A quarterly data submission is requested from each guardian within trusts and the results published.

- 4,654 cases raised to date, approximately 1/3 include an element of patient safety or quality of care.
- Results from the first FTSU Guardian Survey (2017) conducted by the NGO suggest a correlation between CQC rating and the support that leaders and managers give to speaking up.
- The survey resulted in the development of 10 principles related to the FTSU Guardian role and highlighted concern about the support and resource available to the guardians.

National Guardian's Office



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Case reviews

In June 2017, following listening events earlier in the year, the NGO launched a pilot of its case review process, based on the principles set out in the Freedom to Speak Up review. Individuals or organisations are able to refer cases to the NGO where they think there is evidence that the handling of a speaking up case did not meet with good practice. The purpose of a case review is to identify areas that can be improved, make recommendations on how improvements can be made and commend examples of good practice. Case reviews are to promote learning, so trusts have been encouraged to reflect on the recommendations and to look at how they might improve and apply the learning to their own cultures and processes.

Reviews have been undertaken in Southport and Ormskirk Hospital NHS Trust, and North Lincolnshire and Goole NHS Foundation Trust and the findings published – see Case reviews | Care Quality Commission. These are useful and interesting publications; the key relevant recommendations are:

Southport and Ormskirk Hospital NHS Trust

1. Ensure that managers and leaders responsible for handling concerns provide feedback to every individual who speaks up including actions they intend to take in response.
2. Ensure provision of appropriate resources for the role of Freedom to Speak Up Guardian, in line with guidance provided by the NGO, including sufficient cover to support their work in their absence, and alternative routes to handle speaking up matters to overcome any possible conflicts.
3. Have effective systems to monitor the development of a positive speaking up culture.
4. Develop an action plan to develop a working culture that is free from bullying.
5. Take effective steps to ensure vulnerable groups are free to speak up e.g. BME, junior doctors, agency staff.

North Lincolnshire and Goole NHS Foundation Trust

1. When a worker is going through disciplinary process with patient safety matters, the trust should continue to provide a worker with support to speak up.
2. Seek to ensure staff who have previously spoken up are not victimised or suffer retaliation.
3. Ensure all HR policies and procedures meet the needs of workers who speak up. Letters about suspension should include ability to speak to the FTSU guardian.
4. The Freedom to Speak Up Guardian should ensure that their regular reports to the trust board are sufficiently detailed and comprehensive to support the development of a positive speaking up culture.
5. Review all policies relating to the reporting and handling of incidents to be aligned with good practice in relation to FTSU.

Tackling Bullying – A Call to Action

In 2016 as a result of NHS staff survey results, former Department of Health (DH) minister, Ben Gummer chaired a roundtable of NHS leaders and academic experts to review bullying in the NHS. Following this he asked the Social Partnership Forum (SPF) to develop a plan to tackle bullying in the NHS. On the 7th December 2016 the Tackling Bullying Call to Action was launched. A range of suggested actions supported by resources, advice, guidance and good practice are available to help organisations develop their own plans in partnership to tackle bullying.

The agreed goal is for NHS organisations to provide excellent, compassionate leadership in a supportive culture where staff can flourish and problem behaviours such as bullying disappear. The Call to Action invites all NHS organisations to:

- achieve the overarching leadership and cultural change to tackle bullying
- support staff to respectfully challenge problem behaviours
- publish their plans and progress so staff, patients and the public can hold them to account.

CQC well-led

The National Guardian's Office has worked with the CQC to ensure that an assessment of speaking up is at the heart of inspecting the well led domain. The CQC also support the call to action and have suggested that CQC inspectors can:

✓ Ask whether Trusts are signed up to the Call to Action
✓ Look at what measurable action Trusts are taking
✓ Look at how they are monitoring progress

There are several key lines of enquiry and prompts relevant to speaking up and bullying including:

- W3.1: Do staff feel supported, respected and valued?
- W3.3: Do staff feel positive and proud to work in the organisation?
- W3.4: Is action taken to address behaviour and performance that is inconsistent with the vision and values, regardless of seniority?
- W3.5: Does the culture encourage openness and honesty at all levels within the organisation, including with people who use services, in response to incidents? Do leaders and staff understand the importance of staff being able to raise concerns without fear of retribution, and is appropriate learning and action taken as a result of concerns raised?
- W3.9: Are there cooperative, supportive and appreciative relationships among staff? Do staff and teams work collaboratively, share responsibility and resolve conflict quickly and constructively?

Therefore how trusts support speaking up and actions being taken in relation to Call to Action will potentially affect the overall rating inspectors give for well led.

Local Picture

The HDFT Freedom to Speak Up (FTSU) Guardian was appointed October 2016. This was a role that was added to the existing role and responsibilities of the Deputy Director of Governance with the agreement that this would be reviewed following experience in the role. There was not a process of open recruitment and there is currently no protected time to undertake the role.

Actions taken to date

The specific actions taken so far by the FTSU Guardian include:

- Whistleblowing Policy updated to reflect national policy and renamed Speaking Up Policy;
- NHS Employers "Draw the Line" action plan developed and being progressed;
- Team Brief updates: Nov 2016, May 2017, Feb 2018;
- Staff bulletin updates: May, June, August 2017;
- Report to Audit Committee and paper to Board of Directors: September 2017;
- Quarterly reporting to National Guardians Office;
- Attended meetings with Partnership Forum, staff governors, B&H advisors;
- Attended conferences arranged by the National Guardians Office;
- Attended one meeting of regional FTSU guardians – recommended by the NGO for support and sharing of experience;
- Inclusion of reference to the FTSU Guardian and the Trust's encouragement for individuals to 'Speak Up' in the HR module of the Pathway to Management programme;

- Inclusion of FTSU element in the new Risk Management e-learning package, a mandatory eLearning course for all staff (excluding OOH GPs) although implementation is yet to be confirmed;
- The potential for conflict with the Deputy Director of Governance role is recognised and alternative contacts and support are always highlighted in communications and the policy.

Number of contacts

The guardian works alongside many existing systems and processes for staff to raise concerns. The cases logged and reported below are those which are specifically raised to the FTSU Guardian, and do not include cases raised directly with other departments e.g. HR, nor does it include cases where the FTSU Guardian has been asked for advice, without direct contact from the relevant staff member.

The numbers of cases are small. This might mean that staff successfully raise concerns within existing processes e.g. with line managers, risk management reporting, HR reporting. However it might also mean that there is insufficient staff knowledge and confidence in the FTSU Guardian role to encourage reporting of concerns.

	Q1	Q2	Q3	Q4 (to date)
Cases referred	4	2	2	0
Raised anonymously	0	0	0	
Element of patient safety / quality	1	0	0	
Element of bullying / harassment	4	2	2	
Suffering detriment as a result of speaking up	0	0	0	

As numbers are small there is a risk of identifying staff by publishing detail of contacts by location and staff groups, but it is possible to say:

- Staff groups represented include nursing, support services and administration;
- Staff speaking up have been Band 2 to Band 6;
- Staff speaking up have been based in acute and community services.

Themes

- Concerns have been raised by more than one member of staff from two teams;
- Staff are raising concerns confidentially because they fear any impact on their job. On a number of occasions staff have not wanted me to share their name with any others for fear of recrimination from either peers or managers, which limits the actions that can be taken;
- There has been an element of perceived bullying and harassment in all cases – either impacting on the member of staff raising the concern or on their colleagues. Issues relate to personalities and perceived power;
- A lack of confidence expressed by more than one reporter in their HR business partners because they are perceived as instinctively supporting the view of the manager;
- Good people management is sometimes lacking within some teams.

Learning

- Need to establish methods of triangulating intelligence from FTSU reporting with other data relating to teams to identify hot-spots of concerns and enable focused work when confidential reporting means some concerns cannot be addressed openly;

- Even with the small number of cases raised to the FTSU Guardian, there is evidence that culture of speaking up is not established in some teams, and this may be more widespread than the limited examples to date;
- Whilst a culture of speaking up is easy to advocate, it can be challenging for those who feel their jobs and personal well-being may be in jeopardy if they act in this constructive way;
- There is a need to ensure managers are trained and supported to manage staff effectively, and to encourage speaking up as a way of improving;
- A perception of rapid escalation into formal HR processes when perhaps good supportive line management would be appropriate but is lacking;
- Insight into disciplinary processes suggests a need to review these to ensure consistency and fairness, and the provision of appropriate advice and support for staff.

Internal Audit on speaking up and whistleblowing

NHS Audit Yorkshire published their report on 26 February 2018 and offered an opinion of significant assurance that effective processes are in place to enable staff to raise a concern and whistle blow in accordance with the findings of the 'Freedom to Speak Up' report. However there are 8 medium priority and 2 low priority recommendations that require action.

Staff Survey 2017 – HDFT results

There are 5 key questions that particularly relate to FTSU work:

Area and related Staff Survey Question	2016	2017	Average (median) for combined acute and community trusts
Do staff know how to report concerns? (Q13a)	97	94	95
Do staff feel secure in reporting concerns? (Q13b)	77	75	70
Did staff actually report concerns? (Q11c)	94	96	95
Are staff encouraged to report concerns? (Q12b)	90	90	88
Do staff feel that they are treated fairly after reporting concerns? (Q12a)	60	59	55

Q11c is linked to the work already happening about Datix and encouraging reporting.

Although HDFT is performing above average on the other questions, Simon Stevens highlighted at the national FTSU conference on 6 March 2018 that nationally the results for Q12a is significantly lower than for the other questions – and that is a real concern and should be a focus of effort.

Actions planned

Internal Audit recommendations include:

- Ring-fencing of time and resources for FTSU Guardian to dedicate to the role for dealing with concerns, attending training and regional/national forums, and progressing improving actions identified by self-assessment.
- Development of a comprehensive role description for the FTSU Guardian as fulfilled.
- Formalisation of the FTSU Guardian's records with appropriate access restrictions.
- Regaining momentum with respect to raising and maintaining staff awareness of how to raise concerns by advancing intention of introducing FTSU ambassadors/champions and progressing positive ideas accrued.
- Assessment of effectiveness of measures taken to encourage staff to 'Speak Up' through Trust-wide engagement.

- Inclusion of the procedure for staff to raise concerns in the classroom-based section of the Trust's Corporate Induction for new starters.
- Development of a specific process for formally identifying and implementing learning outcomes from concerns raised including the establishment of a central record of tracked lessons learned to ensure improvements take place in practice where required.

In addition, actions identified from work to date and informed by NGO case reviews:

1. Review and triangulate relevant data to identify hot spots / areas of concern for focused work, including:

    - Incidents and complaints;
    - NHS staff survey (questions related to staff engagement and speaking up);
    - WRES data;
    - Bullying and harassment (B&H) reports;
    - Grievance cases;
    - Exit interviews;
    - Staff suspensions and any linked to bullying / speaking up;
    - Learning from rulings from employment tribunals involving staff;
    - Staff sickness, stress and retention data.

2. Regular communication and awareness raising:

    - Promote role, contact details and culture of speaking up;
    - Feedback actions taken in response to speaking up and to tackle barriers to speaking up;
    - Feed into meetings – directorate, teams, managers, senior nurse / Matrons;
    - Recruit speaking up / fairness champions across different staff groups, teams, acute and community services to promote and provide increased visibility of the culture of speaking up, and support for staff;
    - Consider local survey to evaluate culture, awareness, which staff groups feel vulnerable when speaking up, and repeat to monitor effectiveness of actions;
    - Change language - focus on behaviours and relate back to values and behaviours.

3. Ensure staff are skilled to deal positively with issues raised:

    - Promote to all staff the awareness of the positive benefits of speaking up and the need to tackle perceived bullying behaviours;
    - Include awareness about policy and resources and culture at induction, with credit card sized information;
    - Ensure additional training and resources for those with responsibility for handling concerns in accordance with NGO guidance, empowering managers to address concerns positively.

4. Clear policies, processes and information:

    - Review and update Speaking Up Policy, and develop a policy on a page;
    - Review Incident Policy to ensure reference to speaking up;
    - Review HR policies especially B&H Policy and Disciplinary Policy, to ensure fair and compassionate management of staff.

5. Board awareness and support. The Board could:

    - Support protected time for the FTSU Guardian role;

- Ensure regular reporting of speaking up findings within the governance framework with monitoring of learning, progress and impact of actions would raise the profile of the work;
- Support a link to “Call to Action” and anti-bullying work being led by HR;
- Take opportunities to raise the profile of speaking up;
- Ensure staff feel that they are treated fairly after reporting concerns by actively promoting what a “just culture” means locally so *all* staff feel confident that reporting concerns is about improving underlying systems, processes, behaviours and working practices;
- Promote compassionate and inclusive leadership.

Recommendations

Although there have been a small numbers of contacts to the Freedom to Speak up Guardian to date, the organisation cannot be complacent. The individuals who have raised their head and spoken up have cast some light on behaviours within teams which do not fit with the Trust’s values and expectations. The information available from other trusts also provides useful insight and learning.

Linking to the “Call to Action”, focusing on promoting a “just culture”, and developing compassionate and inclusive leadership will positively shape the behaviour of everyone who works in the organisation, the quality of care it provides and its overall performance.

Working with colleagues, the Freedom to Speak up Guardian role can play an important part in driving the cultural change toward supporting staff to speak up so that this becomes a normal and positive behaviour that is seen to contribute to a better working environment for staff and a safer environment for patients. There are a number of actions that have been identified to contribute to this and the Board is asked to provide its support to enable these actions to be developed.

Harrogate and District NHS
NHS Foundation Trust

Board Committee report to the Board of Directors

Committee Name:	Quality Committee (QC)
Committee Chair:	LA Webster
Date of last meeting:	7 March 2018
Date of Board meeting for which this report is prepared	28 March 2018

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

Hot Spots and Financial Recovery Plan Discussion:

- Planned and Surgical Care Directorate flagged a higher number of pressure sores experienced in some areas over the Christmas period and Root Cause Analysis were underway to identify if any were avoidable.
- Concerns were raised that 'winter pressures' additional financial support will cease on 31/03/2018, however, we are not experiencing a reduction in the requirement of the schemes being funded by this cash. A plan to deal with this is being developed.
- HHFM – The committee heard about contingency arrangements which could be implemented should industrial action take place.

Board Request for QC to seek assurance:

- **E-coli –** IP&C month report received and discussed, this is also discussed at SMT each month.
- **Falls: -** QC received the National Audit of Inpatient Falls 2017. This paper shows a reduction in falls of 30%, but also highlighted areas where further activity and focus can be applied to continue this positive trend. QC remains assured that appropriate action is underway to continue to reduce the risk of avoidable falls for our patients.

Reports Received:

- Patient Safety Report – Q3
- Patient Experience Report – Q3
- NICE Compliance Report – Q3
- Nurse Competencies Update Report
- Draft – 'new look' Quality Dashboard
- National Maternity and Perinatal Audit Action Plan – QC noted risk of delivering a quality service to patients due to an inability to provide a Midwife led unit. The committee requests that this should be considered at the next appropriate Board Strategy event.

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

No 'Midwife Led' service offering for patients.

Matters for decision

None

Action Required by Board of Directors:
Note request for above risk to be considered at next appropriate strategy event.

Harrogate and District NHS
NHS Foundation Trust

Board Committee report to the Board of Directors

Committee Name:	Audit Committee
Committee Chair:	Chris Thompson
Date of last meeting:	Thursday 8th March 2018
Date of Board meeting for which this report is prepared	Wednesday 28th March 2018

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

1. The Committee discussed the presentation that had been given by the CQC Interim Head of Hospital Inspection for Yorkshire & Humber to the Audit Yorkshire conference. The presentation set out the relevance for Audit Committees of the Key Lines of Enquiry that are being adopted by the CQC as part of their Well Led inspections. It was agreed that consideration will need to be given as to whether the committee's terms of reference will need to be extended.
2. Business Assurance Framework. The Committee had no particular concerns in connection with the specific detail within the BAF but did agree that it was appropriate to consider how it could best be utilised as the Trust approached target positions in respect of a number of risks. How could we be assured that the risks remain relevant and fully considered? It was noted that this would be considered at the next Board Strategy Day.
3. Two significant issues were considered in connection with the preparation of the annual financial statements:
   a. The treatment of the debtor that has arisen in connection with the Capital goods Scheme following the HHFM transaction
   b. The valuation of fixed assets at 1 April 2017 and at 31 March 2018.

   The Committee was in agreement with the proposed treatment for both of these issues.
4. The Committee considered the Trusts reliance on a series of third party assurances in connection with the preparation of the financial statements and was comfortable with such reliance being assumed.
5. Consideration was given to the evidence available to support the Trusts fitness to register with the CQC and the Committee confirmed that did support the conclusion regarding the fitness to register.
6. The Committee considered the changes that were being proposed to the Trusts accounting policies for the preparation of the financial statements and confirmed that, subject to some minor final changes to be agreed with KPMG, the accounting policies that were proposed to be adopted were acceptable and appropriate.
7. The Committee considered a series of factors that were relevant in considering whether it was appropriate for the financial statements to be prepared on a "going concern" basis. The Committee concluded that it was appropriate to prepare the financial statements on a going concern basis.

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

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

Matters for decision

There are no matters on which a decision from the Board is required

Action Required by Board of Directors:

The Board is asked to note the following issues that were considered by the Audit Committee in connection with the preparation of the annual financial statements for the Trust, and the conclusions that were reached by the Committee:

1. The treatment of the debtor that has arisen in connection with the Capital goods Scheme following the HHFM transaction
2. The valuation of fixed assets at 1 April 2017 and at 31 March 2018.
3. Reliance on third party assurances
4. The accounting policies to be adopted by the Trust
5. The preparation of the financial statements on a going concern basis

NHS
Harrogate and District
NHS Foundation Trust

Date of Meeting:	28 March 2018	**Agenda item:**	14.0
Report to:	Board of Directors		
Title:	Freedom of Information Requests Annual Report 2017		
Sponsoring Director:	Dr Ros Tolcher, Chief Executive		
Author(s):	Mrs Katherine Roberts, Company Secretary		
Report Purpose:	**Decision**		**Discussion/ Consultation**		**Assurance**	✓	**Information**	✓
Executive Summary:	• During 2017 the Trust received 638 requests under the Freedom of Information (FOI) Act; this was an increase of 7% on 2016. • The Trust's FOI Policy was revised in September 2017. • A total of 123 (19%) were responded past the 20 day deadline for responses. • Exemptions were applied to 162 FOI requests, the most frequent exemption applied was section 40; personal information. • A total of thirteen complaints/appeals were reviewed, all but one were upheld. There have been no formal referrals to the Information Commissioner. • In October 2017 the Trust refreshed the 'Publication Scheme' available on the Trust's website.		

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:	If the Trust fails to manage FOI request within the Act there is a risk that the Information Commissioner may find the Trust has breached the FOI Act and could issue a decision notice requiring the Trust to take action to put things right. Moreover if the Trust failed to adopt a publication scheme or publish required information the Information Commissioner could enforce compliance.
Legal / regulatory:	As a public body the Trust is required to comply with the Freedom of Information (FOI) Act.
Resource:	None identified.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.
Reference documents:	Information Commissioner's Guide to FOI: https://ico.org.uk/for-organisations/guide-to-freedom-of-information/ Trust's FOI Policy: https://www.hdft.nhs.uk/content/uploads/2015/11/FINAL-Freedom-of-Information-Policy-Sept-2017-v7.pdf

	Trust's Publication Scheme: https://www.hdft.nhs.uk/freedom-of-information/publication-scheme-2/
Assurance:	Monthly reports regarding FOI are presented to the Trust's Information Governance Working Group.
Action Required by the Board of Directors:	
The Board of Directors is invited to note and receive the Freedom of Information Requests Annual Report 2017.	

Freedom of Information Requests Annual Report 2017

Background

As a public body the Trust is required to comply with the Freedom of Information (FOI) Act 2000. This requires that the Trust provides the public access to information held by the organisation.

Once an FOI request is received the Trust has 20 working days in which to respond and provide the requestor with the information sought. In certain scenarios the Trust is able to apply one of the exemptions defined within the FOI Act, this means that the Trust can withhold and not release the information requested. Some of these exemptions require that the Trust assesses the public interest with releasing or withholding the information.

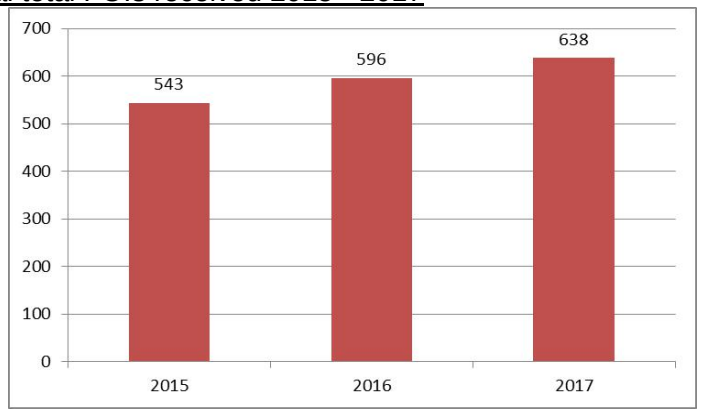
If people who request information are unhappy with the response they receive from the Trust they can submit a complaint and ask the Trust to conduct an 'internal review' whereby a senior staff member who has had no previous involvement in the original request will consider the Trust's initial response. In addition, if a person who requests information believes that the Trust did not dealt with their complaint properly, they can contact the Information Commissioner.

The Trust has a 'Publication Scheme' which sets out categories of information that the Trust undertakes to publish, it is based on the ICO's NHS Model Publication Scheme. It can be accessed via the Trust's website and includes the following types or 'classes' of information:

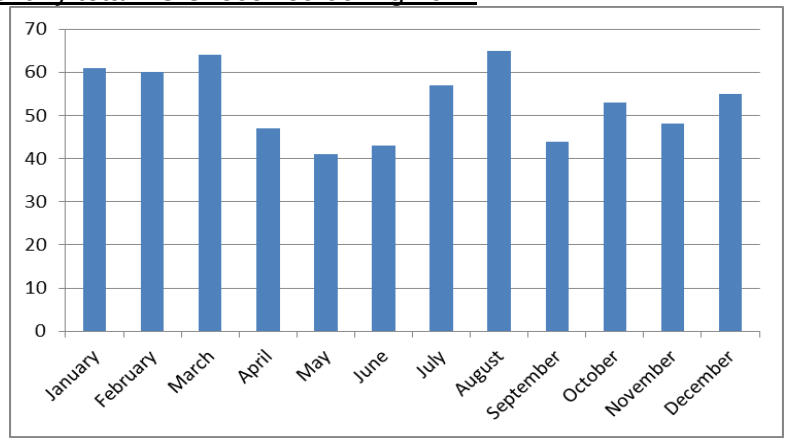
- Who we are and what we do;
- What we spend and how we spend it;
- What are our priorities and how are we doing;
- How we make decisions;
- Our policies and procedures;
- Lists and registers; and,
- The services we offer.

Number of FOI requests received
During 2017 the Trust received 638 FOI requests; this was an increase of 7% on 2016.

Annual total FOIs received 2015 - 2017



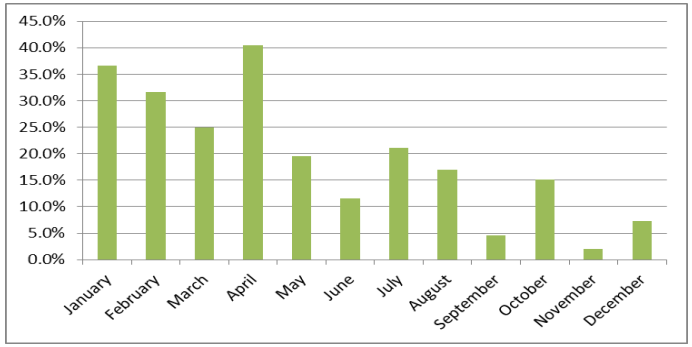
Monthly total FOIs received during 2017



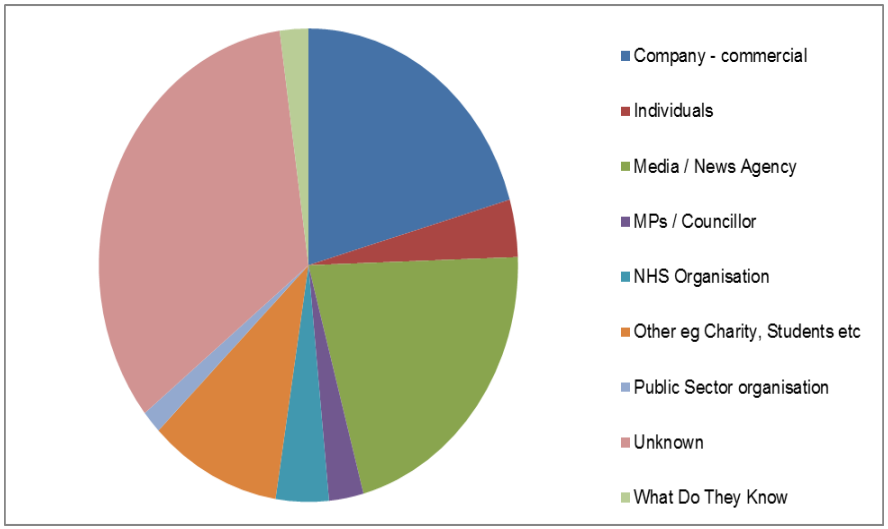
Responses within statutory deadline
The Trust is required to respond to all FOI requests within 20 working days. A total of 123 (19%) were responded past the deadline. It should be noted this is an improvement on performance during 2016 which was 25%. Moreover there was a significant improvement in the timeliness of responses during the second half of 2017.

	Total FOIs received in month	FOIs exceeded Deadline
January	61	22
February	60	18
March	64	14
April	47	17
May	41	8
June	43	5

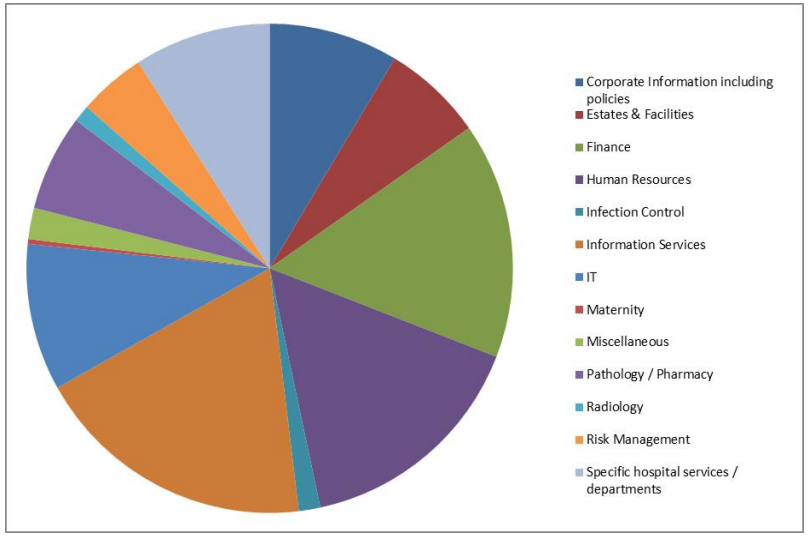
	Total FOIs received in month	FOIs exceeded Deadline
July	57	12
August	65	11
September	44	2
October	53	8
November	48	2
December	55	4
Total	**638**	**123**



Category of requestor
The source, or category, of requestor is recorded by the Trust, and was as follows during 2017.



Topic of data requested
The type of data requested is recorded by the Trust, and was as follows during 2017.



Exemptions
Exemptions were applied to 162 FOI requests, of these the exmptions applied most frequently were as follows:

Section	Exemption	Total applied during 2017
12	Requests where the cost of compliance exceeds the appropriate limit	24
21	Information reasonably accessible to the applicant by other means	21
40	Personal information	59
41	Information provided in confidence	18
43	Commercial interests	12

Complaints and Appeals

During the year the Trust received a total of thirteen complaints or appeals regarding information the Trust provided under the FOI Act. In accordance with the Trust's FOI Policy these cases were reviewed by Mr Paul Nicholas, Deputy Director of Performance and Informatics/Data Protection Officer. Mr Nicholas upheld the Trust's initial response in all but one of the thirteen cases.

No formal complaints were referred to the Information Commissioner (ICO). However during 2017 one case was reviewed informally by the ICO and the Trust took resulting action to comply with the ICO's recommendation.

Publication Scheme

In October 2017 the Trust refreshed the Publication Scheme which is available on the Trust's website. The Publication Scheme mirrors the ICO requirements for NHS Trusts. It is available to view at: https://www.hdft.nhs.uk/freedom-of-information/publication-scheme-2/

Conclusion

The Trust has put in place robust procedures for receiving, processing and responding to requests made under the FOI Act. 2017 has seen a continued increase in the number and complexity of requests received. It is disappointing that the Trust failed to respond to 19% requests within the 20 day deadline; however it should be noted that there was a significant improvement in the timeliness of responses provided during the second half of 2017. The Trust is compliant with the ICO's requirements regarding the Publication Scheme.

Harrogate and District NHS Foundation Trust

HARROGATE AND DISTRICT NHS FOUNDATION TRUST
GLOSSARY OF ABBREVIATIONS

A

A&E	*Accident and Emergency*
AfC / A4C	*Agenda for Change*
AHPs	*Allied Health Professionals*
AMM	*Annual Members' Meeting*
AMU	*Acute Medical Unit*
AQP	*Any Qualified Provider*

B

BAF	*Board Assurance Framework*
BME	*Black and Minority Ethnic*
BoD	*Board of Directors*

C

CATT	*Clinical Assessment, Triage and Treatment Ward*
C.Diff	*Clostridium difficile*
CCCC	*Children's and County Wide Community Care Directorate*
CCG	*Clinical Commissioning Group*
CCU	*Coronary Care Unit*
CE / CEO	*Chief Executive Officer*
CEA	*Clinical Excellence Awards*
CEPOD	*Confidential Enquiry into Perioperative Death*
CIP	*Cost Improvement Plan*
CLAS	Children Looked After and Safeguarding Reviews
CoG	*Council of Governors*
COO	*Chief Operating Officer*
CORM	*Complaints and Risk Management*
CQC	*Care Quality Commission*
CQUIN	*Commissioning for Quality and Innovation*
CRR	*Corporate Risk Register*
CSW	*Care Support Worker*
CT	*Computerised Tomography*
CT DR	*Core trainee doctor*

D

Datix	*National Software Programme for Risk Management*
DBS	*Disclosure and Barring Service*
DNA	*Did not attend*
DoH	*Department of Health*
DoLS	*Deprivation of Liberty Safeguards*

Dr Foster	*Provides health information and NHS performance data to the public*
DToC	*Delayed Transfer of Care*

E

E&D	*Equality and Diversity*
eNEWS	*National Early Warning Score*
ENT	*Ear, Nose and Throat*
ERCP	*Endoscopic Retrograde Cholangiopancreatography*
ESR	*Electronic Staff Record*
EWTD	*European Working Time Directive*

F

FFT	*Friends and Family Test*
FC	*Finance Committee*
FOI	*Freedom of Information*
FT	*NHS Foundation Trusts*
FY DR	*Foundation Year doctor*

G

GIRFT	Get it right first time
GPOOH	GP Out of Hours
GWG MD&C	Governor Working Group – Membership Development and Communications
GWG V&E	Governor Working Group – Volunteering and Education

H

HaRD CCG	*Harrogate and Rural District Clinical Commissioning Group*
HaRCVS	*Harrogate and Ripon Centres for Voluntary Service*
HBC	*Harrogate Borough Council*
HDFT	*Harrogate and District NHS Foundation Trust*
HDU	*High Dependency Unit*
HEE	*Health Education England*
HFMA	*Healthcare Financial Management Association*
HHFM	*Harrogate Healthcare Facilities Management Ltd*
HR	*Human Resources*
HSE	*Health & Safety Executive*
HSMR	*Hospital Standardised Mortality Ratios*

I

ICU or ITU	*Intensive Care Unit or Intensive Therapy Unit*
IG	*Information Governance*
IBR	*Integrated Board Report*
IT or IM&T	*Information Technology or Information Management & Technology*

K

KPI *Key Performance Indicator*
KSF *Knowledge & Skills Framework*

L

LAS DR *Locally acquired for service doctor*
LAT DR *Locally acquired for training doctor*
LCFS *Local Counter Fraud Specialist*
LMC *Local Medical Council*
LNC *Local Negotiating Committee*
LoS *Length of Stay*
LPEG *Learning from Patient Experience Group*
LSCB *Local Safeguarding Children Board*
LTUC *Long Term and Unscheduled Care Directorate*

M

MAPPA *Multi-agency Public Protection Arrangements*
MARAC *Multi Agency Risk Assessment Conference*
MASH *Multi Agency Safeguarding Hub*
MDT *Multi-Disciplinary Team*
Mortality rate *The ratio of total deaths to total population in relation to area and time.*
MRI *Magnetic Resonance Imaging*
MRSA *Methicillin Resistant Staphylococcus Aureus*
MTI *Medical Training Initiative*

N

NCEPOD *NCEPOD (National Confidential Enquiry into Perioperative Death)*
NED *Non-Executive Director*
NHSE *National Health Service England*
NHSI *NHS Improvement*
NHSR *National Health Service Resolution*
NICE *National Institute for Health & Clinical Excellence*
NMC *Nursing and Midwifery Council*
NPSA *National Patient Safety Agency*
NRLS *The National Reporting and Learning System*
NVQ *National Vocational Qualification*
NYCC *North Yorkshire County Council*

O

OD *Organisational Development*
ODG *Operational Delivery Group*
OSCE *The Objective Structured Clinical Examination*

P

PACS *Picture Archiving and Communications System – the digital storage of x-rays*
PbR *Payment by Results*
PEAT *Patient Environment Action Team*

PET	*Patient Experience Team*
PET SCAN	*Position emission tomography scanning system*
PHSO	*Parliamentary and Health Service Ombudsman*
PMO	*Project Management Office*
PROM	*Patient Recorded Outcomes Measures*
PSC	*Planned and Surgical Care Directorate*
PST	*Patient Safety Thermometer*
PSV	*Patient Safety Visits*
PVG	*Patient Voice Group*

Q

QIA	*Quality Impact Assessment*
QIPP	*The Quality, Innovation, Productivity and Prevention Programme*
QPR	*Quarterly Performance Review*

R

RCA	*Route Cause Analysis*
RTT	*Referral to Treatment. The current RTT Target is 18 weeks.*

S

SALT	*Speech and Language Therapy*
SAS DR	*Speciality and associate specialist doctors*
SCBU	*Special Care Baby Unit*
SHMI	*Summary Hospital Mortality Indicator*
SI	*Serious Incident*
SID	*Senior Independent Director*
SIRI	*Serious Incidents Requiring Investigation*
SLA	*Service Level Agreement*
SMR	*Standardised Mortality rate – see Mortality Rate*
SMT	*Senior Management Team*
SpR	*Specialist Registrar – medical staff grade below consultant*
ST DR	*Specialist trainee doctors*
STEIS	*Strategic Executive Information System*
STP	*Sustainability and Transformation Plan*

T

TOR	*Terms of Reference*
TU	*Trade Union*
TUPE	*Transfer of Undertakings (Protection of Employment) Regulations 2006*

V

VC	*Vice Chairman*
VSM	*Vey Senior Manager*
VTE	*Venous Throboembolism*

W

WTE	*Whole Time Equivalent*
WY&H HCP	*West Yorkshire and Harrogate Health Care Partnership*
WYAAT	*West Yorkshire Association of Acute Trusts*

Y

YTD	*Year to Date*

Further information can be found at:
NHS Providers – Jargon Buster –
http://nhsproviders.org/programmes/governwell/information-and-guidance/jargon-buster

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