

The meeting of the Board of Directors held in public will take place on
Wednesday 25 April 2018
Meeting room, Kingswood Surgery, Wetherby Road, Harrogate, HG2 7SA
Start: 9.00am Finish: 12.30pm

AGENDA			
Item No.	Item	Lead	Paper No.
9.00am – 10.50am			
	Patient Story		
1.0	Welcome and Apologies for Absence <i>To receive any apologies for absence: Dr N Lyth, Mr I Ward</i>	Mrs A Schofield, Chairman	-
2.0	Declarations of Interest and Register of Interests <i>To declare any interests relevant to the agenda and to receive any changes to the register of interests</i>	Mrs A Schofield, Chairman	2.0
3.0	Minutes of the Board of Directors meetings held on 28 March 2018 <i>To review and approve the minutes</i>	Mrs A Schofield, Chairman	3.0
4.0	Review Action Log and Matters Arising <i>To provide updates on progress of actions</i>	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 <i>To receive the report for comment</i>	Dr R Tolcher, Chief Executive	5.0a 5.0b
5.1	Bi-annual review of Strategic KPIs <i>To receive the report for comment</i>	Dr R Tolcher, Chief Executive	5.1
6.0	Report by the Finance Director <i>To receive the report for comment</i>	Mr J Coulter, Deputy Chief Executive/ Finance Director	6.0
6.1	Business Planning Update – Operational Plan 2018/19 <i>To receive the report for comment and approval</i>	Mr J Coulter, Deputy Chief Executive/ Finance Director	6.1
10.50am – 11.00am – Break			
11.00am – 12.30pm			
7.0	Report from the Chief Operating Officer <i>To receive the report for comment</i>	Mr R Harrison, Chief Operating Officer	7.0

8.0	Report by the Director of Workforce and Organisational Development <i>To receive the report for comment</i>	Mr P Marshall, Director of Workforce & Organisational Development	8.0
9.0	Report from the Chief Nurse <i>To receive the report for comment</i>	Mrs J Foster, Chief Nurse	9.0
10.0	Report from the Medical Director <i>To receive the report for comment</i>	Dr D Scullion, Medical Director	10.0
11.0	Annual Efficiency Programme Quality Impact Assessment <i>To receive the update</i>	Dr D Scullion, Medical Director / Mrs J Foster, Chief Nurse	
12.0	Oral Reports from Directorates <i>12.1 Planned and Surgical Care</i> <i>12.2 Children's and County Wide Community Care</i> <i>12.3 Long Term and Unscheduled Care</i>	Dr K Johnson Clinical Director Dr N Lyth, Clinical Director Mr A Alldred, Clinical Director	- - -
13.0	Committee Chair Reports <i>13.1 To receive the reports from the Quality Committee meetings held 4 April 2018.</i> <i>13.2 To receive the report from the Finance Committee meeting held on 19 April 2018 including proposed revised Terms of Reference</i>	Mrs L Webster, Quality Committee Chair Mrs M Taylor, Finance Committee Chair	13.1 13.2
14.0	Other matters relating to compliance with the Trust's Licence or other exceptional items to report, including issues reported to the Regulators <i>To receive an update on any matters of compliance:</i>	Mrs A Schofield, Chairman	-
15.0	Any other relevant business not included on the agenda <i>By permission of the Chairman</i>	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.

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	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 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	<ol style="list-style-type: none"> 1. Non-Executive Director of : <ul style="list-style-type: none"> • Charter Court Financial Services Limited, • Charter Court Financial Services Group Limited, • Exact Mortgage Experts Limited, • Broadlands Finance Limited • Charter Mortgages Limited. <p>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.</p> 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	<ol style="list-style-type: none"> 1. Private anaesthetic work at BMI Duchy hospital
Dr Claire Hall	Deputy Medical Director	<ol style="list-style-type: none"> 1. Trustee, St Michael's Hospice Harrogate
Mrs Joanne Harrison	Deputy Director of W & OD	None
Mr Jordan McKie	Deputy Director of Finance	<ol style="list-style-type: none"> 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

Report Status: Open

BOARD OF DIRECTORS MEETING

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

Present: Mr Jonathan Coulter, Deputy Chief Executive/Finance Director
Mrs Jill Foster, Chief Nurse
Mr Robert Harrison, Chief Operating Officer
Mr Phillip Marshall, Director of Workforce and Organisational Development
Mr Neil McLean, Non-Executive Director
Ms Laura Robson, Non-Executive Director
Mrs Angela Schofield, Chairman
Dr David Scullion, Medical Director
Mrs Maureen Taylor, Non-Executive Director
Mr Chris Thompson, Non-Executive Director/Vice Chairman
Dr Ros Tolcher, Chief Executive
Mr Ian Ward, Non-Executive Director

In attendance: Mr Andrew Alldred, Clinical Director for Long Term and Unscheduled Care
Dr David Earl, Deputy Medical Director
Dr Kat Johnson, Clinical Director, Planned and Surgical Care
Dr Natalie Lyth, Clinical Director, Children's and County Wide Community Services
Mrs Katherine Roberts, Company Secretary (minutes)
Dr Sylvia Wood, Deputy Director of Governance (minute 13)

1.0 Welcome and Apologies for Absence

Mrs Schofield welcomed observers to the meeting, this included Sheila Fisher (Public Governor) and Steve Treece (Public Governor).

She noted that apologies had been received from Lesley Webster, Non-Executive Director.

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 conflict of interest. It was however agreed that Mr Coulter and Mr Thompson could participate fully in any items which included reference to Harrogate Healthcare Facilities Management.

3.0 Minutes of the meetings of the Board of Directors on 28 February 2018

The draft minutes of the meeting held on 28 February 2018 were approved with one amendment.

Minute 6.1, third line should read "As Ms SP shared her experience".

APPROVED:

The Board of Directors approved the minutes of the meeting held on 28 February 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 46; Mrs Taylor confirmed the Finance Committee had completed a self-assessment, and would consider the committee's terms of reference in April 2018.

4.3 Action 72; Mrs Foster reported she had not yet met Ms Robson to discuss presentation and interpretation of data about nurse staffing levels. It was expected this would be completed before the April 2018 meeting.

4.4 Action 79: this action was complete and details were included within Mr Marshall's report.

4.5 Action 83; it was agreed this action was complete.

4.6 There were no other matters arising.

APPROVED:

The Board of Directors noted completed actions and received an update on actions and agreed to close actions 79 and 83.

Overview by the Chairman

Mrs Schofield thanked Mr Thompson for chairing the February 2018 meeting of the Board of Directors. She noted it was Mr McLean's last meeting as a member of the Board of Directors. She expressed her sincere thanks to Mr McLean; he had been a tremendous colleague and a very effective non-executive director. All members of the Board wished Mr McLean every success for his future life in the south of England.

It was noted that staff associated with Harrogate Healthcare Facilities Management had successfully transferred to the new company on 1 March 2018.

Members of the Board had attended an 'away day' during March 2018. This had provided an opportunity for the Board to receive a presentation about Human Factors, consider the Board Assurance Framework, receive an update on safeguarding duties and discuss the draft 2018/19 operational plan in more detail.

Mrs Schofield drew attention to a new 'app' which enabled people to listen to Harrogate Hospital Radio anywhere in the world.

The meeting would focus on the operational plan for 2018/19 and how the Trust would

work with partners in a different way following agreement of a new form of contract referred to as an 'Aligned Incentive Contract'.

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 confirmed there were no additional urgent matters to bring to the attention of the Board. She noted two risks regarding workforce which would be drawn out during the meeting.

5.3 Dr Tolcher noted that since her written report had been circulated to the Board the government had published the annual mandate to the NHS. There had been no significant changes to NHS policy.

5.4 The Board welcomed the recent announcement regarding the pay offer to staff on agenda for change terms and conditions.

5.5 During the previous week the Trust had signed a contract variation with Harrogate and Rural District Clinical Commissioning Group (the CCG), the result would be a new form of contract relationship with the CCG. Dr Tolcher confirmed this presented significant opportunity for the Harrogate health system but may also present a number of as yet unknown risks. There remained significant work to finalise schedules and agree shared assumptions with the CCG as part of managing risk for all parties.

5.6 Mr McLean sought assurance that the 2018/19 plan included realistic assumptions about levels of demand throughout the year. Dr Tolcher said she was confident in the forecasting used to develop the 2018/19 plan. She drew a distinction between elective and non-elective demand. Mr Harrison added that during 2017/18 there had been an unexpected growth in medical non electives, however there had been a marked reduction in surgical trauma non electives. He noted that the Trust had a higher than average rate of patients who remained admitted for longer than seven and twenty-one days. He confirmed that planned levels of demand suggested the Trust could run out of beds during the winter of 2018/19. The Trust and other partners in the health system were considering new ways of working to address this issue.

5.7 Mr Ward sought further information about the causes of delayed transfers of care (DTC). Mr Harrison explained there were a wide range of causes, often these patients requiring continuing healthcare assessments. He also noted the challenges presented by the saturated care home market in Harrogate.

5.8 Following a question from Mrs Webster, Mr Harrison agreed the impact of winter monies ceasing from April 2018 would be challenging for the Trust. In recent weeks the Trust had been forced to cancel a small number of elective procedures. He confirmed a number of schemes had been extended during the Easter period. It was hoped there would be a change in demand following the Easter 2018 period.

5.9 Mr Thompson queried any consequences for the Trust exceeding the agency spend cap during February 2018. Mr Coulter explained the agency ceiling was measured on an annual basis, and year to date the Trust was below the ceiling set by NHS Improvement; there would not therefore be any regulatory consequences for the Trust.

5.10 Mrs Taylor noted workforce gaps which had caused difficulties for the ophthalmology and oncology services. Dr Johnson provided further information about the Trust's response to the gap in ophthalmology trained nurses. This included training additional staff and considering support from private providers. Mr Alldred explained how the Trust was responding to the lack of a consultant oncologist. He noted this was a national workforce shortage, and the Trust was working closely with York & Leeds to develop and short term and long term plan to address the issue.

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 Finance Report including Financial Recovery Plan and CIP update

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

6.2 Mr Coulter reported the Trust had achieved a deficit of £600k during February 2018. The drivers for this position had been staffing costs, non-elective admissions and cancelled elective procedures.

6.3 There remained a focus on achieving the year end control total however this would require a change in position of £3.5m during March 2018. He noted operationally there would be minimal opportunity for the Trust to deliver this in the month of March 2018. However Mr Coulter was pursuing conversations with partners regarding any flexibilities which could be offered to the system. He noted that achieving the control total would result in £1.3m additional funding for the Trust. Moreover it would impact on the control total during 2018/19. In conclusion he noted the Trust's cash position remained challenging and was £5m behind plan.

6.4 Mr Thompson noted the risk that efforts to improve the year end position could have a negative impact on the organisation in the following financial year.

6.5 Mr Coulter reported that there would be significant money added to budgets for 2018/19 to meet cost pressures, however this would result in an increased cost improvement plan. The team had endeavoured to ensure budgets were realistic and directorates had been funded appropriately.

6.6 Ms McLean queried the Trust's underlying trading position if one off 'special' items were removed. Dr Tolcher reported that the Trust was expected to achieve a break even position and was therefore £2.4m away from the internal control total.

APPROVED:

The Board of Directors noted the contents of this report.

7.0 Business Planning Update – Operational Plan 2018/19

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

7.2 Mr Coulter explained the operational plan for 2018/19 had been built up through the Trust's four directorates. He noted the control total for 2018/19 would be £6.7m, which included £5.3m of sustainability and transformation funding. However subject to achievement of the 2017/18 control total there was a risk of an additional £500k pressure during 2018/19. The cost improvement plan target would be £10m. Mr Coulter provided reassurance that reporting against the plan would be transparent and enable the Board to monitor performance. The capital programme for 2018/19 would be dependent upon delivery of the financial plan or accessing external bids for other sources of funding.

7.3 It was noted that for planning purposes the national pay award to Agenda for Change staff had been assumed to be cost neutral to the Trust. Mr Coulter explained funding to support the pay award would be awarded directly to NHS trusts and would be based on payroll. This approach would therefore mitigate the risk that the Trust's non NHS commissioned services would not receive funding for the pay award. Mr Coulter highlighted a concern that vacancies would not be funded if they did not appear on the payroll system.

7.4 Although approval for the control total was not required until April 2018, Mr Coulter advised the Board should agree to the 2018/19 control total target. He identified a number of benefits, including access to sustainability and transformation funding and capital funding.

7.5 Mr Thompson and Mr Coulter declared an interest as directors of Harrogate Healthcare Facilities Management. It was agreed that Mr Coulter and Mr Thompson could participate fully in any items which included reference to Harrogate Healthcare Facilities Management.

7.6 Mr Thompson queried whether the Trust would receive funding for agenda for change staff employed by Harrogate Healthcare Facilities Management. Mr Coulter said he expected funding would be received during 2018/19 because although now employed by an independent entity, these staff remained on the Trust's payroll system (ESR).

7.7 It was agreed that at a future meeting, the Board would consider a proposal from Mr Harrison for funding for a pay award to be provided to Harrogate Healthcare Facilities Management to be included within the 2018/19 contract value. It would be up to the Harrogate Healthcare Facilities Management Board to decide if this funding should be passed on to Harrogate Healthcare Facilities Management staff.

7.8 The Board noted that the operational plan included plans to achieve the cost improvement plan target of £10m while sustaining patient safety.

7.9 Mr Harrison expressed concerns that the operational plan would require capital investment in order to establish an Ambulatory Care Unit which was expected to support a reduction in non-elective admissions and length of stay during winter 2018/19. Mr Coulter explained capital funding may be available to the Trust through the West Yorkshire and Harrogate Integrated Care System, but this would not be clear until mid-way through the financial year. The operational plan presented a balanced view of the risk that capital funds may not flow to the Trust in sufficient time to develop an Ambulatory Care Unit by winter 2018/19. The challenge of improving community infrastructure within Harrogate district to facilitate earlier discharge was noted.

7.10 It was confirmed that the Board did not need to approve the self-certification document attached to the paper.

7.11 The Board approved the 2018/19 operational. The importance of achieving an efficient run rate would be critical to delivering the plan. Plans were in place to address the risks the Trust faced in achieving the plan.

APPROVED:

The Board of Directors:

- **Noted the Operational Plan for 2018/19 is being finalised for submission to NHSI on 30 April 2018.**
- **Approved the Summary Financial Plan to allow the issuing of budgets to budget holders prior to 1 April 2018.**
- **Approved the capital resources and Directorate priorities for 2018/19, noting that the decision to release schemes is dependent upon delivering the financial plan.**
- **Confirmed acceptance of the control total for 2018/19 as set by NHSI.**
- **Noted the progress being made in developing an aligned incentive contract with HaRD CCG.**

8.0 Integrated Board Report

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

8.2 Mr Thompson said he found information included within the report about incident reporting confusing and potentially misleading. Dr Scullion said the team were working on a new approach to incident reporting, a new version of the Datix system was being piloted with a test ward. Mrs Foster explained incident reporting was the focus of a two year quality priority which had been monitored by the Quality Committee, one year of the project remained. Mr Thompson suggested data should be rebased once the new system was introduced. Mrs Schofield highlighted results included within the staff survey which provided the Board with reassurance regarding incident reporting.

8.3 Following a question from Mrs Webster the Trust's challenged performance against referral to treatment targets was noted. Dr Tolcher expressed caution that performance against referral to treatment may not recover for twelve months, this would in part be due to the new Aligned Incentive Contract with the CCG.

8.4 Mr Ward drew attention to the sickness rate and noted the importance of return to work interviews in managing sickness absence. Mr Marshall highlighted work underway to support managers to address sickness absence. Mrs Foster noted the challenge for very busy staff to find time to undertake return to work interviews.

8.5 Following a question from Mrs Robson, Mr Harrison confirmed the Trust would review the impact of the orthopaedic locum appointed in December 2017. Although the locum had been flexible in his approach, capacity had been impacted by winter pressures and cancelled operations.

APPROVED:

The Board of Directors:

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

9.0 Improvement & Transformation Update

9.1 Mr Coulter noted links to the earlier discussion regarding the operational plan. The report had been circulated in advance of the meeting and was taken as read.

9.2 Mrs Schofield queried whether the transformation programme aligned with the West Yorkshire Association of Acute Trusts (WYAAT). Mr Coulter confirmed that although there were some linkages, the transformation plan largely focused on local internal opportunities for the Trust.

9.3 Following a question from Ms Robson, Mr Coulter explained the transformation programme was focused on cash releasing schemes. However it noted that this was more challenging to demonstrate for some projects, for example Web V.

10.0 Report from the Chief Operating Officer

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

10.2 Mr Harrison highlighted agreements signed by the Board in February 2018 to transfer estates and facilities staff to Harrogate Healthcare Facilities Management on 1 March 2018. Two trade unions had completed a ballot of staff to strike, neither union had received a mandate to strike.

10.3 The Board approved the Information Governance toolkit submission. It was confirmed the most recent position for compliance with mandatory Information Governance training was 87%, a level of 95% would need to be achieved by the end of March 2018.

APPROVED:

The Board of Directors:

- Received and noted the contents of the report.
- Approved the submission of the Information Governance Toolkit

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

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

11.2 Mr Marshall highlighted the staff survey results, gender pay reporting, pay award, flu campaign and progress to establish a collaborative medical bank.

11.3 The Board agreed Fit and Proper Person checks should revert to an annual check, with the exception of clearances from the Disclosure and Barring Service (DBS), which would remain at every three years.

11.4 **ACTION: Mrs Roberts to circulate link to a Health Education England video about the Global Health Exchange and Harrogate and District NHS Foundation Trust.**

11.5 Mr Ward highlighted the gender pay information, and noted the Trust had robust arrangements in place to ensure equal pay for all members of staff. Dr Lyth reflected that the new consultant contract would help address the gender pay gaps for women doctors.

APPROVED:

The Board of Directors:

- **Noted items included within the report.**
- **Agreed to publish the gender pay reporting.**

12.0 Report from the Chief Nurse

12.1 The report had been circulated in advance of the meeting and was taken as read. Mrs Foster highlighted recent director inspections and patient safety visits, an improvement in the number of pressure ulcers and falls, recent complaint numbers and quality of care for the community care teams.

12.2 Mrs Foster noted a gap within her report related to nurse staffing on adult inpatient wards. She confirmed that nurse vacancies across the Trust were at the lowest level for some time. However challenges to recruitment remained, particularly on CATT ward and in theatres.

ACTION: Mrs Foster to circulate information related to nurse staffing on adult inpatient wards and full details of the end of life bereavement survey to the Board.

12.3 Results of the recent end of life bereavement survey were noted, they provided assurance that overall the quality of care provided was good and patient and families felt supported. Mrs Foster noted ongoing actions to further improve end of life care. Mr Thompson noted that elements of the survey results presented a picture of staff under pressure.

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 reporting of Director Inspections and Patient Safety Visits;**
- **Noted the decrease in hospital acquired pressure ulcers;**
- **Noted the work around falls reduction;**
- **Confirmed they were assured about the monitoring of care provided by the CCT's;**
- **Noted the number of complaints in February;**
- **Confirmed they were assured by the feedback regarding the care given to patients and families as a patient dies.**

13.0 Freedom to Speak Up Guardian Report

13.1 Dr Wood, Freedom to Speak Up Guardian joined the meeting for this agenda item.

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

13.3 Dr Wood highlighted the links between her role as Freedom to Speak Up Guardian and supporting a culture of learning and improvement across the Trust. She explained she had received a small number of contacts from a variety of locations.

13.4 Following a question from Mr Ward, Dr Wood said that concerns raised with her had related to cultural issues at an individual team level. Barriers to team working could

potentially have a negative impact on the quality of care and harm the retention of staff.

13.5 Members of the Board expressed their support for Dr Wood and noted the importance of the Freedom to Speak Up Guardian role in promoting an open culture across the Trust.

APPROVED:

The Board of Directors:

- **Noted the content, actions and recommendations;**
- **Supported the actions and recommendations to progress a positive speaking up culture.**

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 included within his report. It was pleasing that both indicators had fallen during the month however the reasons for this change were unclear. He explained that the review of elderly care deaths had found no major lapses in coding although there would be further work on how terminology was used. It was also noted that due to the potential positive impact it would have on mortality measures, further discussion was required regarding the need for specialist palliative care input for all patients receiving end of life care. This would be discussed with relevant clinical teams. It was acknowledged that the Trust provides a high quality of care for patients at the end of life. Mr Alldred agreed the interaction between clinical teams and specialist end of life consultants was strong

APPROVED:

The Board of Directors:

- **Received and noted the report.**

15.0 Learning from Deaths Report

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

15.2 Dr Scullion noted the report included details of one case in which there was reasonable evidence of avoidability. The Board would receive full details of the serious incident in April 2018 (in private).

APPROVED:

The Board of Directors:

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

16.0 Oral Reports from Directorates

16.1 Long Term and Unscheduled Care Directorate

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

- There were pressures on the oncology service, as discussed earlier in the meeting.
- Pressure continued on the emergency department and non-elective

admissions. Another 'Every Hour Matters' week was planned following the Easter weekend.

- The directorate were addressing pressures faced by the CATT ward, including staffing vacancies, the wellbeing of staff, and quality of care.
- There remained difficulties recruiting to two vacancies in the histopathology department.

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 were addressing gaps in the middle grade rota. These had resulted from a series of unforeseeable events.
- A new Head of Safeguarding had been appointed; an internal candidate had been successful.
- Durham Council had confirmed an extension to the 0-19 service contract until August 2020.
- The CQC had undertaken a CLASS inspection in Darlington.

16.3 Planned and Surgical Care Directorate

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

- Junior doctor gaps had contributed to unhappiness within the surgical speciality. Work was ongoing to ensure staffing gaps were escalated to ensure the directorate could support teams appropriately.
- The breast team had seen significant patient demand during March 2018. This was expected to continue following a forthcoming public health awareness campaign. The directorate were considering new ways of working with other Trusts to address the increased number of referrals.

17.0 Committee Chair Reports

Mrs Schofield welcomed reports from the Board's committees.

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

17.1.1 In Mrs Webster's absence Mrs Robson presented the report from the Quality Committee on 7 March 2018. The report had been circulated in advance of the meeting and was taken as read.

17.1.2 She noted a discussion regarding national guidance that the Trust should offer mothers a midwifery led unit. Following a discussion it was agreed that a strategic stance for maternity should be developed and presented in September 2018.

ACTION: Mrs Roberts to include strategic stance for maternity services to the Board work plan in September 2018.

17.2 Report from the Audit Committee meeting held on 8 March 2018

17.2.1 Mr Thompson presented a report from the Audit Committee on 8 March 2018. The report had been circulated in advance of the meeting and was taken as read.

18.0 Freedom of Information Requests Annual Report 2017

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

18.2 Mrs Roberts presented the Freedom of Information Requests Annual Report 2017. She noted work ongoing to support a further improvement in the number of Freedom of Information request responses provided within the statutory deadline. She expressed thanks to teams across the team for their efforts to provide information in a timely manner.

APPROVED:

The Board of Directors:

- **Noted and received the Freedom of Information Requests Annual Report 2017.**

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

There were no other items of business.

21.0 Board Evaluation

Dr Tolcher said she felt the meeting had included a balanced focus on quality and finance.

22.0 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.

HDFT Board of Directors Actions Schedule **Action Log** **April 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	Complete Update will be provided to the Board during the private section of the meeting.
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)	

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	
84	January 2018	Following review of patient safety visit format proposals to be the Board for comment and consideration.	Mrs J Foster, Chief Nurse	May 2018	
87	February 2018	Senior nursing team to consider whether an audit of pressure ulcer prevention was required following introduction of new standard nursing documentation from April 2018.	Mrs J Foster, Chief Nurse	May 2018	
89	March 2018	Mrs Roberts to circulate link to a Health Education England video about the Global Health Exchange and Harrogate and District NHS Foundation Trust.	Katherine Roberts, Company Secretary	April 2018	Complete Link circulated to Board
90	March 2018	Mrs Foster to circulate information related to nurse staffing on adult inpatient wards and full details of the end of life bereavement survey to the Board.	Mrs J Foster, Chief Nurse	April 2018	

Date of Meeting:	25 April 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:	<table border="1"> <tr> <td>Decision</td> <td></td> <td>Discussion/ Consultation</td> <td>✓</td> <td>Assurance</td> <td>✓</td> <td>Information</td> <td>✓</td> </tr> </table>			Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓
Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓				
Executive Summary:	<ul style="list-style-type: none"> The Trust reported an in month deficit of £0.3m, excluding the write-off of historic debts as a result of the 2016/17 contract settlement. This is £0.8m adverse of plan. The Trust did not deliver the agreed control total for 2017/18. As a result Q4 STF will not be received and the £0.572m incentive discount on the 2018/19 control total will not apply. The Trust delivered the required standards based on the full year for the A&E 4 hour wait; 18-week RTT and cancer 62 day pathways Non-elective demand has reduced to a seasonal norm but protracted length of stay remains a problem and is driving high levels of occupancy. 										
Related Trust Objectives											
<table border="1"> <tr> <td>To deliver high quality care</td> <td>✓</td> <td>To work with partners to deliver integrated care:</td> <td>✓</td> <td>To ensure clinical and financial sustainability:</td> <td>✓</td> </tr> </table>				To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓		
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:											
<ul style="list-style-type: none"> 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 Month 12 Operational Performance (details contained within the Integrated Board Report) and 2017/18 full year performance

Performance in month 12 presents a changing picture. While non-elective activity was below planned levels, the average length of stay for both elective and non-elective inpatients increased, contributing to high levels of bed occupancy and a negative impact on elective care. Attendances in the A&E department were 3.1% above plan for March resulting in a full year activity profile of 2% above plan. The Trust achieved 92.6% against the 4-hour ED 95% standard for the month of March and 90.2% against the RTT 18 weeks 92% standard. The Trust's Q4 performance was therefore below the required standard in Q4 for two of the four key operational performance metrics.

The number of inpatient falls reported has reduced again this month however higher than average numbers of category 2 and 3 pressure ulcers has contributed to a patient safety thermometer score of 94.7%, below the HDFT mean but above the national average.

The Trust's in month financial performance was £0.8m adverse from plan, excluding the write-off of debt in relation to the 2016/17 contract settlement. An absolute deficit in March was recorded for the first time. This position is driven by lost elective income due to winter pressures; the high cost of additional staffing to ensure safe care in the light of recent high levels of non-elective demand and extended length of stay and the write off of CCG historical debts as a result of contractual agreements. Further details are contained in the Finance Director's report.

While reporting on our month 12 performance it is also timely to reflect on the full year 2017/18. Our reported outturn of a surplus of £0.1m (before impairments and after receipt of S&T funding of £2.45m) falls short of the agreed control total. The challenge of reducing the underlying run rate has been partially mitigated by one-off benefits and significant changes are required in order to continue to drive this down in 2018/19. Current trajectories on key operational standards and modelling of forecast bed capacity requirements present a concerning picture.

Despite the many challenges facing the Trust over the last twelve months I am pleased to confirm that for the full year we achieved the key national operational standards relating to A&E, RTT and cancer pathways. Overall, 95.1% of people attending our A&E department were seen and either admitted or discharged within 4 hours. As well as a barometer of whole site working, this is an important patient safety metric. In addition, we achieved 92.1% on the 18 week referral to treatment standard and 88.9% on the 62 day cancer pathway (85% standard). Our metrics relating to fundamental standards of care show a reduction in falls but a small increase in the number of fractures as a result of falls; seven cases of C.Diff and a reduction in complaints. The total number of category 3 or unstageable pressure ulcers arising in hospital and community care has increased. The proportion deemed to be avoidable has however reduced.

The Trust's overall engagement score in the 2017 National NHS Staff Survey remained in the top quartile despite a reduction when compared to the 2016 result.

In addition to sustaining strong operational performance we opened our new Sterile Services facility, have progressed building work on a new Endoscopy suite which is on

track to go live in Q1 this year, and we created Harrogate Healthcare Facilities Management as a wholly owned subsidiary company. A number of bids for new services were successful and are now being mobilised. The Trust also provided support to the York / Scarborough health economy taking a three month partial divert of ambulances at the peak of winter pressures in order to protect the safety and dignity of people enduring long waits for care.

I would like to record my thanks to colleagues across the Trust who have worked tirelessly to deliver care of the highest quality while striving to manage costs, income and performance and drive innovation. The year ahead looks equally challenging and I recommend a very strong focus on staff well-being, engagement and resilience. If current performance trajectories are sustained then maintaining our current operational performance in 2018/19 presents significant risks.

2.0 FINANCIAL POSITION

2.1 Financial performance

An in month deficit £0.3m is £0.8m adverse of plan and resulted from adverse variance in both income and expenditure. Both pay and non-pay costs were higher than planned in month.

The Trust has reported an outturn for 2017/18 of a surplus of £0.1m before impairments and after receipt of S&T funding. This is £5.8m below plan. If S&T funding is excluded, the outturn was a deficit of £2.4m, which is £4.5m behind our planned surplus of £2.1m. The impact of this in 2017/18 is that Q4 STF will not be received.

Of note overall is the high cost of covering workforce gaps in order to ensure service continuity and safe staffing levels. Overall, pay costs for staff in post underspent by £1.8m however covering gaps and staffing additional beds above establishment cost in excess of £6m contributed very significantly to the failure to achieve the Trust's Control Total.

The Trust has agreed an Aligned Incentive Contract with Harrogate and Rural District CCG for 2018/19. The governance and mechanisms for delivering the contract are being developed. This approach offers new opportunities to secure long term financial balance for Harrogate provided actions to manage demand and cost are effective, and clinical interventions are optimised. Work is underway to further understand the financial risks for the system and how these can be managed.

NHS Improvement has been closely briefed throughout the year in terms of risks and mitigations. We await further information on the approach to financial assurances by the regulator in 2018/19.

3.0 STRATEGIC UPDATE

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

Work continues to agree a Memorandum of Understanding between the West Yorkshire and Harrogate system partners. The Board will consider a confidential paper on this

during its private session. A key part of securing an agreement based on mutual accountability will be the adoption of control totals by NHS organisations and agreement on the use of any national transformation funding.

The WYAAT Programme Executive discussed the recommendations from the vascular networks options appraisal. A final decision on this is due at the WYAAT Committee in Common on 24 April.

4.0 WORKING IN PARTNERSHIP

4.1 Harrogate Health Transformation Board (HHTB)

The HHTB is transitioning to a new model of partnership working. The overarching group will become the Harrogate System Leadership Group which will drive delivery of whole system plans, including the design and delivery of the emerging commissioner specified integrated community services. The provider alliance group has established a Joint Operational Delivery Group chaired by the HDFT Operational Director, and an Integrated Community Services re-design programme group co-chaired by a GP and NYCC Director.

5.0 SENIOR MANAGEMENT TEAM (SMT) MEETING

The Senior Management Team met on 19 April. The following key matters are for noting:

- The main focus of the meeting was a discussion on the risks and opportunities of the Aligned Incentive Contract. Managing run rate and the drivers of cost will be key. GP and consultant engagement was noted as a critical success factor;
- It was noted that there have been two inpatient deaths attributed to hospital acquired influenza;
- Month 12 and full year operational performance was reviewed;
- A new locum oncologist is in post;
- An update on 7-day services was received. Further work within existing resources is feasible and should help improve the overall position. This is included as one of the Trust's 2018/19 Quality Priorities;
- The Quality Account improvement priorities were agreed; and
- An update on the Private Patient development work was received. A step change in income has already been achieved in Q4 compared to prior months.

6.0 COMMUNICATIONS RECEIVED AND ACTED UPON OR TO NOTE

6.1 Letter from NHS Improvement and NHS England: Next steps on the development of your STP estate strategy and next wave STP capital bidding process

The Trust received a letter from NHS Improvement and NHS England outlining guidance for development of sustainability and transformation partnerships (STP) estate strategies. All STPs have been asked to undertake strategic, system-wide reviews of estates and then submit a draft STP estate strategy by 16 July 2018. The letter makes clear that any STP capital available must be targeted at the schemes for which it will demonstrably deliver the greatest clinical and financial sustainability.

6.2 Letter from NHS Improvement and NHS England: Working Closer Together

In late March 2018 the Trust received correspondence which outlined key steps that NHS Improvement and NHS England were taking to bring their organisations closer together. Subject to their Boards' approval of more detailed proposals, they will begin to establish the following working arrangements from September 2018:

- Increased integration and alignment of national programmes and activities – one team where possible; and
- Integration of NHS England and NHS Improvement regional teams, to be led in each case by one Regional Director working for both organisations, and a move to seven regional teams to underpin this new approach.

7.0 BOARD ASSURANCE AND CORPORATE RISK

7.1 Board Assurance Framework (BAF)

No additional risks have been added to the BAF this month however the wording of BAF#16 has been revised to encompass the risk in respect of bed capacity. As such, the action plan score has been re-set at 4.

Following further work, links between the BAF and the Trust's Strategic Key Performance Indicators have now been mapped.

A summary of current risks and progress scores is presented below. A more detailed, confidential quarterly review of strategic and operational risks will be discussed by the Board in its private session.

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 ↔	Reduced to 2	
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 standards of care and the organisation's reputation for quality fall because quality does not have a sufficient priority in the Trust (New description)	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 (including estates, diagnostic capacity, bed capacity and IT) is not fit for purpose (New description)	Red 12	Reduced to 4	
BAF 17	Risk to senior leadership capacity	Amber 8 ↔	Unchanged at 1	

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

7.2 Corporate Risk Register (CRR)

Corporate Risk Register Summary

Corporate risk register summary of changes: Updated April 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	Mar-19	Target date extended
CR5	Risk to service delivery due gaps in registered nurses establishment	12	↔	2	Mar-19	
CR13	Capacity to support timely discharge for community ready patients	12	↔	2	Mar-19	Risk description amended; target date extended
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-19	
CR17a	Risk of patient harm as a result of being lost to follow-up as a result of current processes	12	↔	4	Apr-18	Progress score reduced
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	Mar-19	Target date extended
CR24	Risk to patient safety, quality, experience, reputation, staff wellbeing due to reduced capacity in the Community Care teams (CCTs).	15	↔	3	Mar-19	Risk description amended; target date extended
CR25	Risk to quality of care due to lack of capacity in the acute and community services to meet anticipated increased demand during winter months	12	↔	1	Apr-18	Risk to be re-defined
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	↔	3	tbc	Target date to be defined by directorate
CR27	Risk to service delivery due to failure to have sufficient cash to support the capital programme including replacement of equipment due to delay in payment from commissioners or shortfall in delivering the financial plan	12	↔	2	Apr-19	
CR28	Risk of harm to the quality of the service due to staff shortages in Ophthalmology clinics	12	New	tbc	tbc	New risk added

Progress key

1 = fully on plan across all actions

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

3 = actions defined - work started but behind plan

4 = actions defined but largely behind plan

5 = actions not yet fully defined

Risks added to the corporate risk register

CR28 - Risk of harm to the quality of the service due to staff shortages in Ophthalmology clinics

Risks removed from corporate risk register

None.

Risks with amended target dates or target scores

See summary

8.0 DOCUMENTS SIGNED AND SEALED

The following documents have been sealed during the month:

- Contract for the provision of Public Health Services Family Outreach and Volunteer Services with Stockton Upon Tees Borough Council; and
- Sub Contract for the provision of Public Health Services Family Outreach and Volunteer Services with Family Action

Dr Ros Tolcher
Chief Executive
April 2018

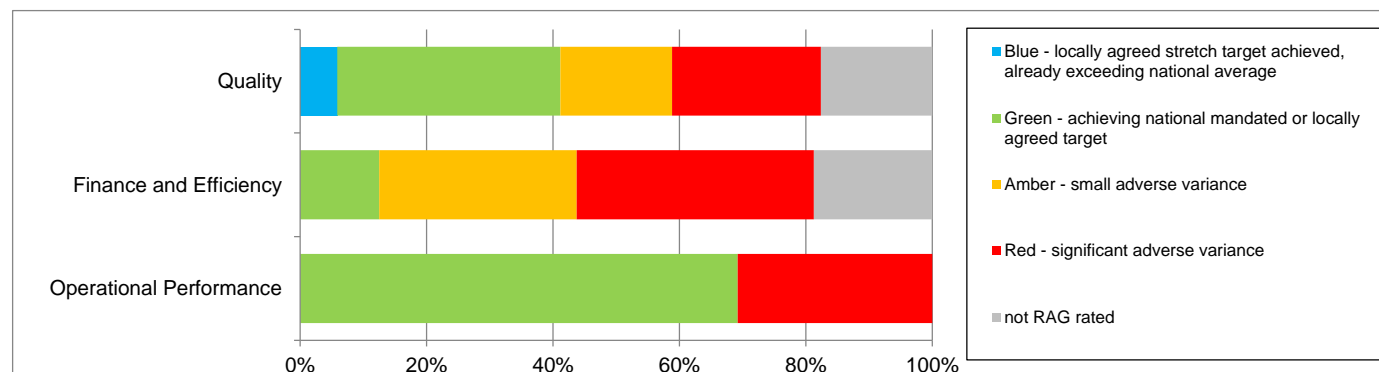
Date of Meeting:	25 April 2018	Agenda item:	5.0b								
Report to:	Board of Directors										
Title:	Integrated Board Report										
Sponsoring Director:	Dr Ros Tolcher, Chief Executive										
Author(s):	Ms Rachel McDonald, Head of Performance & Analysis										
Report Purpose:	<table border="1"> <tr> <td>Decision</td> <td></td> <td>Discussion/ Consultation</td> <td>✓</td> <td>Assurance</td> <td>✓</td> <td>Information</td> <td>✓</td> </tr> </table>			Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓
Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓				
Executive Summary:	<p>The Trust is required to report its operational performance to NHS Improvement and to routinely submit performance data to NHS England and Harrogate and Rural District CCG. The Board of Directors are asked to note that:</p> <ul style="list-style-type: none"> • The Trust financial position for 2017/18 is currently being finalised, however, it is expected that the final position pre-impairments will be a surplus of £0.1m, significantly behind the planned surplus position of £5.9m. • In Quarter 4, 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. However the Trust achieved all 4 standards for the overall year 2017/18. • There was 1 hospital acquired C. diff case reported in March bringing the year to date total to 7 cases, a significant reduction on the number of cases reported last year. • Staff sickness decreased in February but remains above the 3.9% local standard. • Elective and outpatient activity remains below plan. • With the exception of the 2WW standard for breast symptomatic patients, all cancer waiting times standards were achieved for each quarter of 2017/18. 										
Related Trust Objectives											
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To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓						
Key implications											
Risk Assessment:	Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF 4: risk of a lack of interoperable systems across New Care Models partners; BAF 9: risk of a failure to deliver the operational plan; BAF 10: risk of a breach of the terms of the NHS Provider licence; BAF 16: risk to delivery of integrated care models.										
Legal / regulatory:	None identified.										
Resource:	Not applicable.										
Impact Assessment:	Not applicable.										
Conflicts of Interest:	None identified.										
Reference documents:	None.										
Assurance:	Report reviewed monthly at Senior Management Team in Operational Delivery Group.										
Action Required by the Board of Directors:											
The Board of Directors are asked to receive and note the content of the report.											

Integrated board report - March 2018

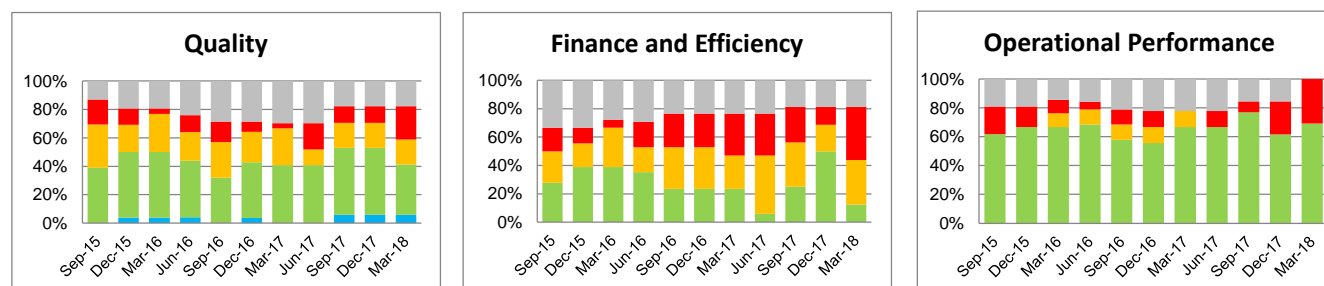
Key points this month

1. The Trust financial position for 2017/18 is currently being finalised, however, it is expected that the final position pre-impairments will be a surplus of £0.1m, significantly behind the planned surplus position of £5.9m.
2. In Quarter 4, 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. However the Trust achieved all 4 standards for the overall year 2017/18.
3. There was 1 hospital acquired C. diff case reported in March bringing the year to date total to 7 cases, a significant reduction on the number of cases reported last year.
4. Staff sickness decreased in February but remains above the 3.9% local standard.
5. Elective and outpatient activity remains below plan.
6. With the exception of the 2WW standard for breast symptomatic patients, all cancer waiting times standards were achieved for each quarter of 2017/18.

Summary of indicators - current month



Summary of indicators - recent trends



Quality - March 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Pressure ulcers - hospital acquired 	<p>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.</p>		<p>There were 7 hospital acquired unstageable or category 3 pressure ulcers reported in March, giving a year to date total of 56. This is a significant increase on the number reported in 2016/17 (33).</p> <p>This year's ambition was to reduce the number of avoidable category 3 (or above) pressure ulcers. Of the 2017/18 cases, 22 are still under root cause analysis (RCA), 21 have been assessed as avoidable and 13 as unavoidable. In 2016/17, 19 cases were avoidable meaning that we have not achieved this year's ambition. No category 4 hospital acquired pressure ulcers were reported in 2017/18.</p>
	<p>The chart includes category 2, 3 and 4 and unstageable hospital acquired pressure ulcers. The data includes hospital teams only.</p>		<p>The number of hospital acquired category 2-4 (or unstageable) pressure ulcers reported in March was 36, an increase on last month. This brings the year to date total to 253, a 23% increase on 2016/17.</p> <p>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.</p>
Pressure ulcers - community acquired 	<p>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.</p>		<p>There were 10 community acquired category 3, category 4 (or unstageable) pressure ulcers reported in March, a reduction on last month. Of the 2017/18 cases, 49 are still under root cause analysis (RCA), 16 have been assessed as avoidable and 50 as unavoidable.</p> <p>The year to date total for 2017/18 is 115, compared to 79 reported in 2016/17. However this year's ambition was to reduce the number of avoidable category 3 (or above) pressure ulcers and the proportion of avoidable cases has reduced significantly this year - from 53% in 2016/17 to 24% for the 2017/18 cases with a completed RCA.</p>
	<p>The chart includes category 2, 3 and 4 and unstageable community acquired pressure ulcers. The data includes community teams only.</p>		<p>The number of community acquired category 2-4 (or unstageable) pressure ulcers reported in March was 28 cases, a reduction on last month. This brings the year to date total to 310, a 17% increase on 2016/17.</p>

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 March was 94.7%, remaining below 95%. The majority of harms reported this month were old category 2 pressure ulcers and falls causing no harm. However there were 2 falls causing moderate harm reported (0 last month).
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.		<p>The rate of inpatient falls was 5.32 per 1,000 bed days in March, a decrease on last month and below the average HDFT rate for 2016/17. However, there were 2 falls resulting in a fracture in March (0 last month).</p> <p>In 2017/18, there were 700 inpatient falls reported in total equating to an average rate of 6.10 per 1,000 bed days, no change on the average rate in 2016/17. However the number causing moderate harm was 21, compared to 15 last year.</p>
Infection control 	<p>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.</p> <p>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.</p>		<p>There was 1 case of hospital apportioned C. difficile reported in March bringing the total for 2017/18 to 7 cases. This is a significant reduction on 2016/17 when 29 cases were reported. Of the 7 cases for 2017/18, 4 have had root cause analysis completed and agreed with HARD CCG. The outcome on all 4 cases was that no lapse of care had occurred. Root cause analysis is in progress for 2 cases and root cause analysis has not yet started for the 7th case.</p> <p>No hospital apportioned MRSA cases were reported in 2017/18.</p>
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.		<p>Provosional data indicates that there were 276 avoidable admissions in February, a decrease on recent months. However this month's figure is above the level reported in February last year (246).</p> <p>Adult admissions (excluding CAT attendances) also decreased this month to 175, compared to 199 last month.</p>



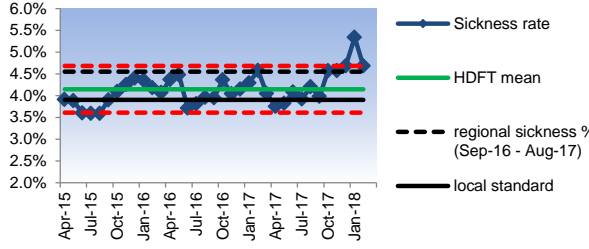

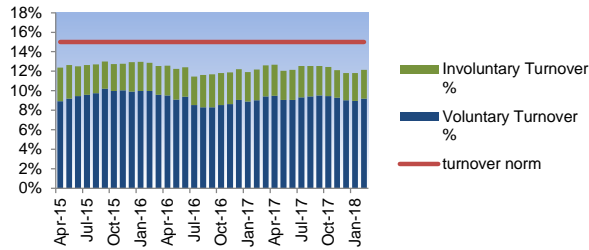
Quality - March 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Mortality - HSMR 	<p>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.</p>		<p>HDFT's HSMR for the rolling 12 months ending December 2017 was 107.9, an increase on last month but remaining within expected levels. At specialty level, two specialties have a higher than expected standardised mortality rate (Geriatric Medicine and Respiratory Medicine).</p> <p>The latest HSMR data on HED includes the period to end January 2018 but reflective of the data position as at mid-February when the Trust was only partly coded for the month of January. 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.</p>
Mortality - SHMI 	<p>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.</p>		<p>HDFT's SHMI increased to 89.1 for the rolling 12 months ending December 2017 but remains below expected levels.</p> <p>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.</p>
Complaints 	<p>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.</p>		<p>26 complaints were received in March which is above the average for 2016/17. However no complaints were classified as amber or red this month. The complaints received this month are in relation to a number of different HDFT services but of particular note were 3 complaints related to Byland ward.</p> <p>The total number of complaints received in 2017/18 was 209, a 10% reduction on 2016/17.</p>
Incidents - all 	<p>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</p>		<p>The latest published national data (for the period Apr - 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 published ratio was 26, a minor improvement on the last publication but remaining in the bottom 25% of Trusts nationally. HDFT's latest local data gives a ratio of 15, a deterioration on this position. 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.</p>

Quality - March 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Incidents - SIRIs and never events 	<p>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.</p> <p>Only comprehensive SIRIs are included in this indicator, as concise SIRIs are reported within the pressure ulcer / falls indicators above.</p>		<p>There was 1 comprehensive SIRIs and no Never Events reported in March. In 2017/18, there were 5 comprehensive SIRIs and no Never Events reported. This compares to 2 comprehensive SIRIs and no Never Events reported in 2016/17.</p>
Friends & Family Test (FFT) - Patients 	<p>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.</p>		<p>95.6% of patients surveyed in March would recommend our services, in line with recent months and remaining above the latest published national average (93%).</p> <p>Around 1,100 patients responded to the survey this month. This is significantly lower than the normal monthly average of around 4,000 responses and is due to a problem with the automated phone call surveys during March. Work is underway with the supplier of this service to understand and resolve these issues.</p>
Safer staffing levels 	<p>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.</p>		<p>Overall staffing compared to planned was at 105% in March, no change on last month and 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.</p>
Staff appraisal rates 	<p>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.</p>		<p>The Trust appraisal rate was at 82.4% in March. The appraisal window has opened running from 1st April - 30th September 2018. All staff are included in this process with the exception of Medical and Dental staff. Guidance and infographics have been produced and are available in the appraisal toolkit via the intranet and bespoke training sessions are being developed through HR Business Partners to meet individual Directorate needs. Monthly reports to Directorates will be produced to demonstrate performance and monitor progress.</p>

Quality - March 2018

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.	<table><thead><tr><th>Competence Name</th><th>% Completed</th></tr></thead><tbody><tr><td>Equality, Diversity and Human Rights - Level 1</td><td>87</td></tr><tr><td>Fire Safety Awareness</td><td>71</td></tr><tr><td>Infection Prevention & Control (Including Hand Hygiene) 1</td><td>99</td></tr><tr><td>Infection Prevention & Control (Including Hand Hygiene) 2</td><td>76</td></tr><tr><td>Data Security Awareness</td><td>92</td></tr><tr><td>Preventing Radicalisation - Level 1 and 2 (December 2015)</td><td>96</td></tr><tr><td>Safeguarding Adults Awareness Elearning (Dec 2015)</td><td>95</td></tr><tr><td>Safeguarding Children & Young People Level 1 - Introduction eLearning</td><td>91</td></tr></tbody></table>	Competence Name	% Completed	Equality, Diversity and Human Rights - Level 1	87	Fire Safety Awareness	71	Infection Prevention & Control (Including Hand Hygiene) 1	99	Infection Prevention & Control (Including Hand Hygiene) 2	76	Data Security Awareness	92	Preventing Radicalisation - Level 1 and 2 (December 2015)	96	Safeguarding Adults Awareness Elearning (Dec 2015)	95	Safeguarding Children & Young People Level 1 - Introduction eLearning	91	The data shown is for the end of March and excludes the Harrogate Healthcare Facilities Management (HHFM) staff who transferred into the new organisation on the 1st March 2018. The overall training rate for mandatory elements for substantive staff is 86%.
Competence Name	% Completed																				
Equality, Diversity and Human Rights - Level 1	87																				
Fire Safety Awareness	71																				
Infection Prevention & Control (Including Hand Hygiene) 1	99																				
Infection Prevention & Control (Including Hand Hygiene) 2	76																				
Data Security Awareness	92																				
Preventing Radicalisation - Level 1 and 2 (December 2015)	96																				
Safeguarding Adults Awareness Elearning (Dec 2015)	95																				
Safeguarding Children & Young People Level 1 - Introduction eLearning	91																				
Sickness rates 	<p>Staff sickness rate - includes short and long term sickness.</p> <p>The Trust has set a threshold of 3.9%. A low percentage is good.</p>		Sickness absence reduced in February to 4.68% from 5.34% the previous month. The HR team continues to focus attention on the management of short term absence and ensuring robust processes are in place across departments, with an emphasis on the completion of return to work interviews.																		
Staff turnover rate 	<p>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.</p> <p>Data from the Times Top 100 Employers indicated a turnover rate norm of 15%, i.e. the level at which organisations should be concerned.</p>		Labour turnover remains static at 12%. Following attendance at the NHS Improvement Masterclass in November, colleagues from HR and Corporate Nursing teams have been working up an engagement plan focusing on Care Support Worker and Registered Nurse retention. A paper will be presented to Director Team this month detailing the plan and the baseline data for consideration. The intention is to undertake focus groups with the inpatient ward areas and theatres in the first instance with a phased roll out plan across other key areas.																		

Finance and Efficiency - March 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Readmissions 	<p>% 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.</p>		<p>The number of emergency readmissions (after PbR exclusions applied) in February was 249. This equates to 13.8% when expressed as a percentage of all emergency admissions, an increase on last month and above the HDFT average rate for 2016/17.</p> <p>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.</p>
Length of stay - elective 	<p>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.</p>		<p>HDFT's average elective length of stay for March was 2.8 days. This is an increase on last month and places the Trust in the middle 50% of Trusts nationally in the most recently available benchmarking data.</p>
Length of stay - non-elective 	<p>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.</p>		<p>HDFT's average non-elective length of stay for March was 5.6 days. This is an increase on last month. The Trust remains in the middle 50% of Trusts nationally when compared to the most recently available benchmarking data.</p>
Theatre utilisation 	<p>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.</p> <p>A higher utilisation rate is good as it demonstrates effective use of resources. A utilisation rate of around 85% is often viewed as optimal.</p>		<p>Elective theatre utilisation was at 84.9% in March, a slight reduction on last month and just below the 85% optimal level. This utilisation only reflects the elective lists that took place as planned and does not factor in planned elective lists that were cancelled. A list cancellation metric is being incorporated into the new theatres dashboard and will be considered for inclusion in this report from April.</p>

Finance and Efficiency - March 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Delayed transfers of care 	<p>The proportion of patients in acute hospital beds who are medically fit for discharge but are still in hospital. A low rate is preferable.</p> <p>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.</p>		<p>Delayed transfers of care were at 4.5% when the snapshot was taken in March, above the 3.5% maximum threshold. Minimising the number of delayed patients has remained a significant challenge over the winter period and remains a concern as winter funding for additional non-acute beds ceased at the end of March. Minimising the number of delayed transfers of care was a key priority for the Every Hours Matters initiative held in the first week of April.</p>
Outpatient DNA rate 	<p>Percentage of new outpatient attendances where the patient does not attend their appointment, without notifying the trust in advance.</p> <p>A low percentage is good. Patient DNAs will usually result in an unused clinic slot.</p>		<p>HDFT's DNA rate increased to 5.8% in January. This is in line with the benchmarked group of trusts and below the national average.</p>
Outpatient new to follow up ratio 	<p>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.</p>		<p>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 January, no change on last month and 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.</p>
Day case rate 	<p>The proportion of elective (waiting list) procedures carried out as a day case procedure, i.e. the patient did not stay overnight.</p> <p>A higher day case rate is preferable.</p>		<p>The day case rate was 90.0% in March, no change on last month. The average day case rate for 2017/18 overall was 89.3%, compared to 88.6% in 2016/17.</p>

Finance and Efficiency - March 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation																					
<div>Surplus / deficit and variance to plan</div> <div></div>	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.		<p>The Trust financial position for 2017/18 is currently being finalised, however, it is expected that the final position pre-impairments will be a surplus of £0.1m, significantly behind the planned surplus position of £5.9m. This considerable adverse variance to plan has resulted in significant pressure on the Trust's resources as a result of the subsequent availability of cash to support capital developments.</p> <p>These figures include Sustainability and Transformation Funding of £2.45m. Without this, the Trust would have reported a deficit position of £2.4m, £4.5m behind plan. The underlying position represents a notable pressure to the new financial year and highlights the pressures faced by the Trust currently.</p>																					
<div>NHS Improvement Single Oversight Framework - Use of Resource Metric</div> <div></div>	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.	<table><thead><tr><th>Element</th><th>Plan</th><th>Actual</th></tr></thead><tbody><tr><td>Capital Service Cover</td><td>1</td><td>2</td></tr><tr><td>Liquidity</td><td>1</td><td>1</td></tr><tr><td>I&E Margin</td><td>1</td><td>3</td></tr><tr><td>I&E Variance From Plan</td><td>1</td><td>4</td></tr><tr><td>Agency</td><td>1</td><td>1</td></tr><tr><td>Financial Sustainability Risk Rating</td><td>1</td><td>3</td></tr></tbody></table>	Element	Plan	Actual	Capital Service Cover	1	2	Liquidity	1	1	I&E Margin	1	3	I&E Variance From Plan	1	4	Agency	1	1	Financial Sustainability Risk Rating	1	3	<p>The Trust reported a rating of 3 in March as a result of the variance to plan reported above. The element related to the variance to plan is a 4, automatically triggering an overall position of 3.</p>
Element	Plan	Actual																						
Capital Service Cover	1	2																						
Liquidity	1	1																						
I&E Margin	1	3																						
I&E Variance From Plan	1	4																						
Agency	1	1																						
Financial Sustainability Risk Rating	1	3																						
<div>Capital spend</div> <div></div>	Cumulative Capital Expenditure by month (£'000s)		<p>Capital Expenditure ended the year behind plan due to natural slippage in relation to large schemes and a need to actively manage the Trust cash position overall.</p>																					
<div>Agency spend in relation to pay spend</div> <div></div>	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.		<p>Following a spike in spend during February, March returned to expenditure levels which are similar to the rest of the year. Agency expenditure represented 2.9% of the Trust pay bill.</p>																					

Finance and Efficiency - March 2018

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 5.7% below plan in the month of March and 3.4% below plan for the full year. 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 9.4% below plan in the month of March and 8.3% below plan for the full year. 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 4.2% below plan in the month of March but 3.2% above plan for the full year.
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 3.1% above plan in the month of March and 2.0% above plan for the full year.

Operational Performance - March 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation																														
<div>NHS Improvement Single Oversight Framework</div> <div>✓</div>	<p>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.</p>	<table><thead><tr><th>Standard</th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th><th>YTD</th></tr></thead><tbody><tr><td>RTT incomplete pathways</td><td>93.8%</td><td>92.3%</td><td>91.9%</td><td>90.5%</td><td>92.1%</td></tr><tr><td>A&E 4-hour standard</td><td>96.7%</td><td>96.0%</td><td>94.9%</td><td>92.1%</td><td>95.0%</td></tr><tr><td>Cancer - 62 days</td><td>86.1%</td><td>88.9%</td><td>90.5%</td><td>90.2%</td><td>88.9%</td></tr><tr><td>Diagnostic waits</td><td>99.8%</td><td>99.6%</td><td>99.7%</td><td>99.4%</td><td>99.6%</td></tr></tbody></table>	Standard	Q1	Q2	Q3	Q4	YTD	RTT incomplete pathways	93.8%	92.3%	91.9%	90.5%	92.1%	A&E 4-hour standard	96.7%	96.0%	94.9%	92.1%	95.0%	Cancer - 62 days	86.1%	88.9%	90.5%	90.2%	88.9%	Diagnostic waits	99.8%	99.6%	99.7%	99.4%	99.6%	<p>In Quarter 4, 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. However the Trust achieved all 4 standards for the overall year 2017/18.</p>
Standard	Q1	Q2	Q3	Q4	YTD																												
RTT incomplete pathways	93.8%	92.3%	91.9%	90.5%	92.1%																												
A&E 4-hour standard	96.7%	96.0%	94.9%	92.1%	95.0%																												
Cancer - 62 days	86.1%	88.9%	90.5%	90.2%	88.9%																												
Diagnostic waits	99.8%	99.6%	99.7%	99.4%	99.6%																												
<div>RTT Incomplete pathways performance</div> <div>✓</div>	<p>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.</p> <p>A high percentage is good.</p>		<p>Performance was at 90.2% in March, an improvement on last month but remaining below the minimum standard of 92%. At specialty level, Trauma & Orthopaedics and Ophthalmology were below the 92% standard. Performance for the year 2017/18 was 92.1%.</p> <p>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.</p>																														
<div>A&E 4 hour standard</div> <div>✓</div>	<p>Percentage of patients spending less than 4 hours in Accident & Emergency (A&E). The operational standard is 95%.</p> <p>The data includes all A&E Departments, including Minor Injury Units (MIUs). A high percentage is good.</p>		<p>HDFT's Trust level performance for March was 92.6%, a deterioration on last month and remaining below the required 95% standard. This includes data for the Emergency Department at Harrogate and Ripon MIU. Performance for Harrogate ED was at 91.3%.</p> <p>The Trust's performance for 2017/18 overall is 95.1%.</p>																														
<div>Cancer - 14 days maximum wait from urgent GP referral for suspected cancer referrals</div> <div>✓</div>	<p>Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%. A high percentage is good.</p>		<p>Delivery at expected levels. This standard was achieved for all quarters of 2017/18.</p>																														

Operational Performance - March 2018

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.		<p>Provisional performance for March was at 89.5%, an improvement on last month but remaining below the 93% standard. This means that the standard was not achieved for Quarter 4 with performance for the quarter at 89.4%.</p> <p>The Clinical Directorates continue to work together to manage the volume of referrals received and match this with appropriate clinic capacity. The aim for the service is to have its own stand-alone breast screening unit, a joint project with York Hospital. In the meantime, options are being identified for an interim unit to improve both patient experience and hospital performance.</p>
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.		<p>Delivery at expected levels. This standard was achieved for all quarters of 2017/18.</p>
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.		<p>Delivery at expected levels. This standard was achieved for all quarters of 2017/18.</p>
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.		<p>Delivery at expected levels. This standard was achieved for all quarters of 2017/18.</p>



Operational Performance - March 2018

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.		<p>Provisional performance for March is above the required 85% standard at 89.7% with 5.5 accountable breaches. Of the 11 tumour sites, 3 had performance below 85% in March - haematological (2 breaches), lung (2.5) and upper gastrointestinal (0.5). One patient waited over 104 days in March. The main reason for the delay was a complex diagnostic pathway.</p> <p>This standard was achieved for all quarters of 2017/18.</p>
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.		<p>Delivery at expected levels. This standard was achieved for all quarters of 2017/18.</p>
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.		<p>Delivery at expected levels. This standard was achieved for all quarters of 2017/18.</p>
Children's Services - 10-14 day new birth visit 	<p>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.</p> <p>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.</p>		<p>In February, the validated performance position is that 95% of babies were recorded on Systmone as having had a new birth visit within 14 days of birth.</p> <p>The data is reported a month in arrears so that the validated position can be shared.</p>

Operational Performance - March 2018

Indicator name / data quality assessment	Description	Trend chart	Interpretation
Children's Services - 2.5 year review 	<p>The percentage of children who had a 2.5 year review. A high percentage is good.</p> <p>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.</p>	<p>The chart displays the percentage of children who had a 2.5 year review over time. The Y-axis represents the percentage from 60% to 100%. The X-axis shows dates from April 2016 to February 2018. Four data series are plotted: Darlington (blue line with diamonds), Co. Durham (red line with squares), Middlesbrough (green line with triangles), and North Yorkshire (purple line with circles). Middlesbrough consistently shows the highest percentage, often reaching 100%. Darlington and Co. Durham also show high percentages, generally above 90%. North Yorkshire shows a lower percentage, starting around 70% and rising to around 95% by February 2018.</p>	<p>In February, the validated performance position is that 99% of children were recorded on Systmone as having had a 2.5 year review.</p> <p>The data is reported a month in arrears so that the validated position can be shared.</p>

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 	<p>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.</p> <p>The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc.</p> <p>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.</p>

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 $\geq 97\%$, Green if $\geq 95\%$ 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 $\geq 50\%$ 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)	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	Complaints	No. complaints, split by criteria	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 - all	Incidents split by grade (hosp and community)	Green if none reported in current month; Red if 1 or more never event or comprehensive reported in the current month.	
Quality	Incidents - comprehensive 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 latest month \geq latest published national average, Red if $<$ latest published national average.	Comparison with national average performance.
Quality	Friends & Family Test (FFT) - Patients	% recommend, % not recommend - combined score for all services currently doing patient FFT	Green if latest month overall staffing $\geq 100\%$, amber if between 95% and 100%, red if below 95%.	The Trusts aims for 100% staffing overall.
Quality	Safer staffing levels	RN and CSW - day and night overall fill rates at trust level	Annual rolling total - 90% green. Amber between 70% and 90%, red $< 70\%$.	Locally agreed target level based on historic local and NHS performance
Quality	Staff appraisal rate	Latest position on no. staff who had an appraisal within the last 12 months	Blue if latest month $\geq 95\%$; 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	Mandatory training rate	Latest position on the % staff trained for each mandatory training requirement	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 sickness rate	Staff sickness rate	Green if remaining static or decreasing, amber if increasing but below 15%, red if above 15%.	Based on evidence from Times Top 100 Employers
Quality	Staff turnover	Staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts.	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	Readmissions	No. emergency readmissions (following elective or non-elective admission) within 30 days.		
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	Green = $\geq 85\%$, Amber = between 75% and 85%, Red = $< 75\%$	A utilisation rate of around 85% is often viewed as optimal.
Finance and efficiency	Theatre utilisation	% of theatre time utilised for elective operating sessions		

Section	Indicator	Further detail	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%
Finance and efficiency	Outpatient DNA rate	% first OP appointments DNA'd	Contractual requirement
Finance and efficiency	Outpatient new to follow up ratio	No. follow up appointments per new appointment.	Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%.
Finance and efficiency	Day case rate	% elective admissions that are day case	Green if on plan, amber <1% behind plan, red >1% behind plan
Finance and efficiency	Surplus / deficit and variance to plan	Monthly Surplus/Deficit (£'000s)	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.
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
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.
Finance and efficiency	Outpatient activity against plan (new and follow up)	Includes all outpatient attendances - new and follow-up, consultant and non-consultant led.	Locally agreed targets.
Finance and efficiency	Elective activity against plan	Includes inpatient and day case activity	Locally agreed targets.
Finance and efficiency	Non-elective activity against plan		Locally agreed targets.
Finance and efficiency	Emergency Department attendances against plan	Excludes planned followup attendances.	Green if on or above plan in month, amber if below plan by < 3%, red if below plan by > 3%.
Operational Performance	NHS Improvement governance rating	Trust performance on Monitor's risk assessment framework.	As per defined governance rating
Operational Performance	RTT Incomplete pathways performance	% incomplete pathways within 18 weeks	Green if latest month >=92%, Red if latest month <92%.
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%
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%.
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%.
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%.
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%.
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%.
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%.
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%.
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%.
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%.
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%.

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

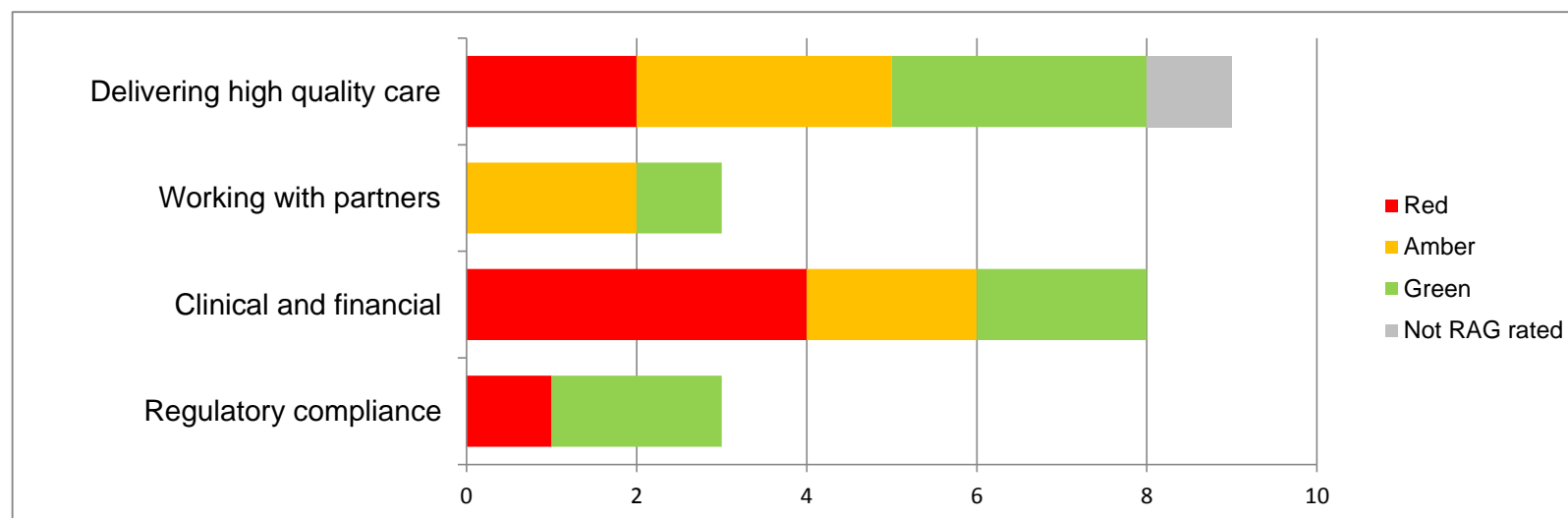
Date of Meeting:	25 April 2018	Agenda item:	5.1								
Report to:	Board of Directors										
Title:	Strategic KPIs Report										
Sponsoring Director:	Dr Ros Tolcher, Chief Executive										
Author(s):	Ms Rachel McDonald, Head of Performance & Analysis Mrs Samantha McLachlan, Assistant Planning Manager										
Report Purpose:	<table border="1"> <tr> <td>Decision</td> <td></td> <td>Discussion/ Consultation</td> <td>✓</td> <td>Assurance</td> <td>✓</td> <td>Information</td> <td>✓</td> </tr> </table>			Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓
Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓				
Executive Summary:	<p>The Board of Directors are asked to note that:</p> <ul style="list-style-type: none"> • There is continued positive external validation of the Trust's performance; • The Trust achieved its trajectory for 2017/18 for the patient FFT survey. However results in the staff survey were less positive than last year; • Further work is needed to understand our current incident reporting ratio of high/low risk incidents. The latest published data shows a small improvement but the Trust remains in the bottom 25% of Trusts nationally; • The Trust's financial performance was behind plan in 2017/18 and is a significant challenge for the next 3 years; • Delivery of the IT Strategy milestones via the WebV project is progressing and the project is on track with 3 modules now live; • More action to undertake over the next year in terms of catchment population and out of Harrogate activity, as part of local and West Yorkshire STP discussions. 										
Related Trust Objectives											
<table border="1"> <tr> <td>To deliver high quality care</td> <td>✓</td> <td>To work with partners to deliver integrated care:</td> <td>✓</td> <td>To ensure clinical and financial sustainability:</td> <td>✓</td> </tr> </table>				To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓		
To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓						
Key implications											
Risk Assessment:	Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF 4: risk of a lack of interoperable systems across New Care Models partners; BAF 9: risk of a failure to deliver the operational plan; BAF 10: risk of a breach of the terms of the NHS Provider licence; BAF 16: risk to delivery of integrated care models.										
Legal / regulatory:	None identified.										
Resource:	Not applicable.										
Impact Assessment:	Not applicable.										
Conflicts of Interest:	None identified.										
Reference documents:	None.										
Assurance:	Report reviewed monthly at Senior Management Team in Operational Delivery Group.										
Action Required by the Board of Directors:											
The Board of Directors are asked to receive and note the content of the report.											

Strategic Key Performance Indicators

March 2018

Key issues to note:

1. There is continued positive external validation of the Trust's performance;
2. The Trust achieved its trajectory for 2017/18 for the patient FFT survey. However results in the staff survey were less positive than last year.
3. Further work is needed to understand our current incident reporting ratio of high/low risk incidents. The latest published data shows a small improvement but the Trust remains in the bottom 25% of Trusts nationally;
4. The Trust's financial performance was behind plan in 2017/18 and is a significant challenge for the next 3 years.
5. Delivery of the IT Strategy milestones via the WebV project is progressing and the project is on track with 3 modules now live;
6. More action to undertake over the next year in terms of catchment population and out of Harrogate activity, as part of local and West Yorkshire STP discussions.



Board of Directors Strategic KPIs report - March 2018

Delivering high quality care

Patient safety

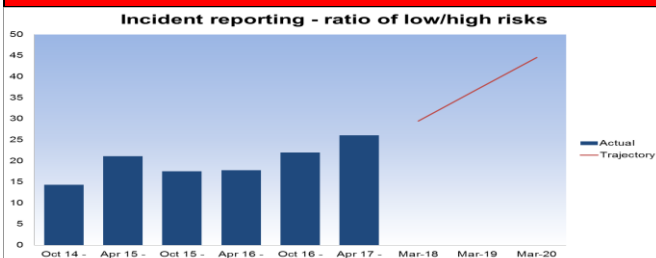
1. Emergency admissions receiving senior reviews within 14 hours of admission to hospital



All emergency admissions should receive a clinical assessment by a senior clinician as soon as possible, but at the latest within 14 hours of admission to hospital. Trusts should be achieving this for 100% of patients by 2019.

The latest results opposite came from the last case note reviews undertaken in September 2017. The overall proportion of patients seen and assessed by a suitable senior clinician within 14 hours of emergency admission was 61%, (broken down as 59% weekdays and 66% on weekends), remaining below both the most recently published National and North England averages.

2. Reporting culture - Ratio of high/low risks.

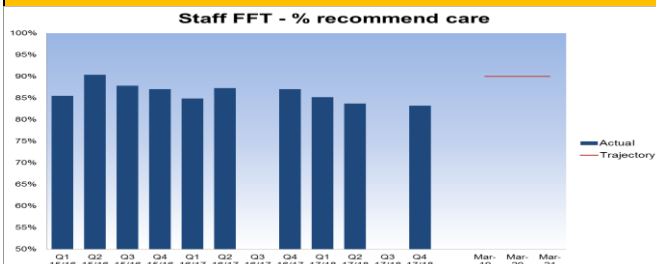


A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture.

The latest published national data (for the period April to September 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 local reporting ratio for the same period was 26, an improvement on the last publication. However the Trust remains in the bottom 25% nationally. HDFT aspires to be in line with the national average by March 2018, within the top 25% of Acute Trusts by March 2019 and within the top 10% of Acute Trusts by March 2020.

Patient experience

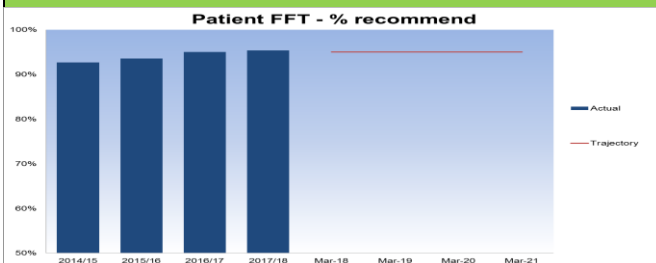
3. Friends & Family Test (FFT) - Staff - % recommend as a place to receive care



The Staff Friends and Family Test (FFT) gives staff the opportunity to give feedback on the organisation they work in. The chart shows the trend in the percentage of staff that would recommend HDFT as a place to receive care. A high percentage is good.

HDFT's score of 83% for Q4 2017/18 placed us in the middle 50% of Trusts. HDFT's aim is to achieve and maintain 90% of staff recommending the Trust as a place to receive care from March 2019 onwards.

4. Friends & Family Test (FFT) - Patients - % recommend



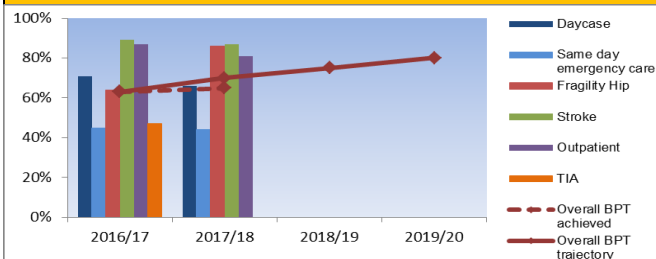
The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of hospital and community services including inpatients, day cases, outpatients, maternity services, the emergency department, some therapy services, district nursing, community podiatry and GP OOH. A high percentage is good.

During 2017/18, 95.4% of patients surveyed by HDFT would recommend our services. HDFT's aim is to maintain 95% of patients recommending the Trust as a place to receive care.

Delivering high quality care

Patient outcomes

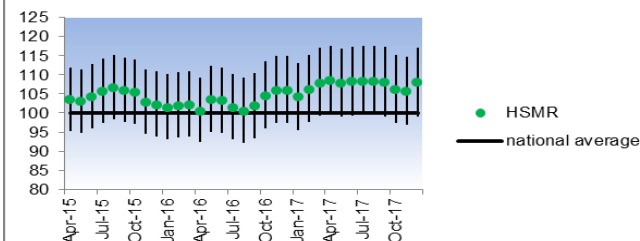
5. Proportion of Best Practice Tariff achieved



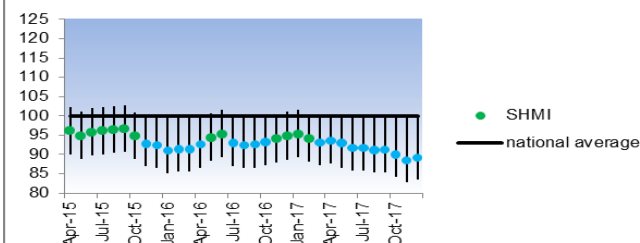
The chart opposite compares year to date (to Feb-18) achievement for both the overall and each key area of Best Practice Tariffs against the previous year. Overall achievement is 65% in 2017/18 to date, compared to 63% in 2016/17, this increase is caused by the better achievement in BPT for Fragility Hips.

A trajectory of achieving 80% of total possible BPT income by March 2020 is proposed.

6. HSMR and SHMI indicator



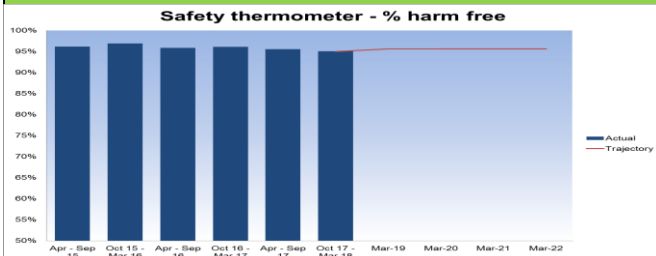
The Hospital Standardised Mortality Ratio (HSMR) looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care. A low figure is good. HDFT's HSMR was 107.9 for the rolling 12 months ending December 2017, an increase on recent months but remaining within expected levels.



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 was 89.1 for the rolling 12 months ending December 2017, below expected levels.

The Trust aims to maintain within expected levels for both metrics over the next 5 years.

7. Safety Thermometer

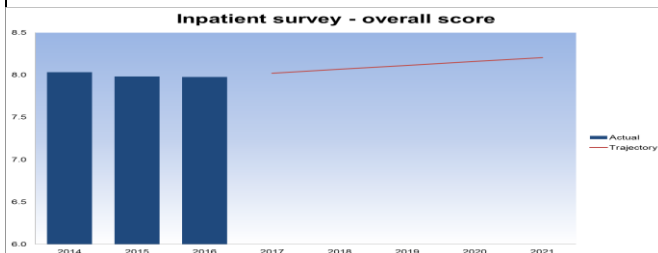


Measures the percentage of patients receiving harm free care (defined as the absence of pressure ulcers, harm from a fall, urine infection in patients with a catheter and new VTE) in the Safety Thermometer audits conducted once a month. The data includes hospital and community teams. A high score is 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 reported for HDFT for the period Oct-17 to Mar-18 was 95.1%. HDFT's aim is to continue to maintain 95% harm free care and to maintain 95.6% harm free consistently by March 2019, based on the average harm free % of outstanding CQC acute providers.

Delivering high quality care

8, 9 & 10. Patient surveys



There is no update of this metric since the previous report.
The national **adult inpatient survey** for 2016 was published in May 2017. HDFT's overall score of 8.0 placed us 18th out of 149 participating Trusts.

The proposed trajectory is to achieve an overall score of 8.2 by 2021, in line with the highest overall score reported by an Acute (Non-Specialist) Trust in the 2016 survey.



There is no update of this metric since the previous report.
The national **cancer patient survey** 2016 was published in July 2017. HDFT came joint 4th out of the 148 Trusts who took part in the survey achieving an average score of 80.4. This placed us joint 1st for non-specialist Acute Trusts.

The proposed trajectory is to maintain our score of 80.4.



There is no update of this metric since the previous report.
The national **A&E patient survey** 2016 was published in October 2017. The survey is conducted every two years. In the latest survey, HDFT came joint 1st out of the 137 Trusts who took part in the survey achieving an average score of 8.2.

The proposed trajectory is to maintain our score of 8.2.

11. Staff survey - overall engagement score



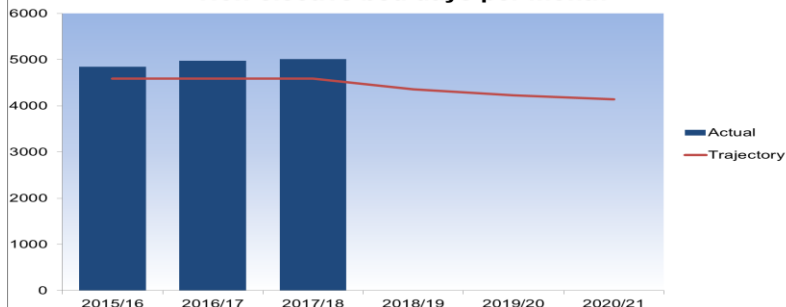
The national staff survey is carried out annually. Results are presented in a variety of key areas including a measure of overall staff engagement. In 2017, HDFT scored 3.83 for staff engagement (with their work, their team and their Trust), below the trajectory of 3.92 which we had achieved in 2016. Possible scores range from 1 to 5, with 5 indicating that staff are highly engaged. The Trust scored "above average" when compared to other similar Trusts, which is the highest ranking possible.

The trajectory is to achieve a score of 4.03 by 2021.

Working with Partners

12. Non-elective bed days

Non-elective bed days per month



The charts shows the number of non-elective (emergency) bed days at HDFT for patients aged 18+, per month per 100,000 population. The chart only includes the local HARD CCG area. A lower figure is preferable. The trajectory was set in 2016/17 and based on allowing for demographic growth and reducing by the non-elective reductions identified in the Value Proposition. Average non-elective bed days increased in 2017/18 and are above this trajectory.

The Trust carried out an analysis to model the likely bed capacity needed over the next 5 years and this was shared with the board and external partners in March 2018. This is informing our planning and discussions with partners in the local health community.

13. Delivery of IT strategy in line with agreed milestones

No. of WebV Modules Deployed



The Strategy aims to provide a robust scalable IT infrastructure that delivers information where staff need it; robust governance arrangements; high quality information management; training and development of IT skills in staff; efficient project management and procurement; and collaborative working with other NHS organisations.

In August 2016, the Trust signed a memorandum of agreement for a two year proof of concept with North Lincolnshire and Goole Foundation Trust (NLG) to deploy the WebV EPR system. This supports the delivery of the Trust's strategy of an integrated electronic patient record system which will enable the organisation to be paperlite, provide clinicians with clinical decision tools and enable the sharing of information not just to HDFT staff but to the wider community.

To date, 3 WebV modules are live with more modules due for delivery in 2018/19.

14. Patient satisfaction of new models of care - Adult Community Services Friends and Family Test

Patient FFT - community services - % recommend

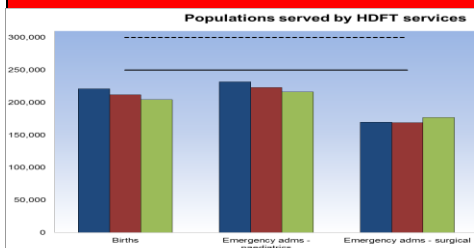


The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. The data presented is for community services, including district nursing, community podiatry and GP OOH. A high percentage is good.

In 2017/18, HDFT reported that 94.5% of patients surveyed would recommend our community services. This is an improvement on 2016/17 but places us below the latest national average of 96%. The trajectory is to achieve 96% by March 2022. It should be noted that the number of patients surveyed represents a small proportion of the community based contacts that we deliver in a year.

Clinical and financial sustainability

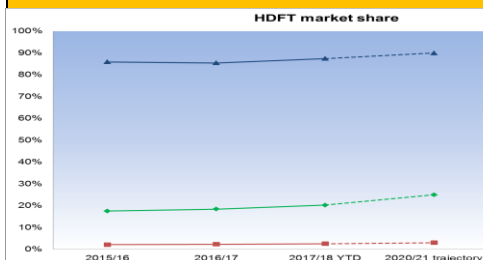
15. Sufficient catchment population for key specialities of maternity, paediatrics and emergency surgery



The chart shows estimated catchment populations served by HDFT services in recent years for maternity, paediatrics and emergency surgery, along with target population sizes. A target catchment population of 300,000 for emergency surgery and 250,000 for paediatrics and maternity services by March 2021 is proposed.

As can be seen from the chart, the catchment populations for births and paediatrics have reduced in 2017/18 to date but the emergency surgery catchment population has increased.

16. Increased share of HaRD CCG, Leeds North CCG and Leeds West CCG referrals

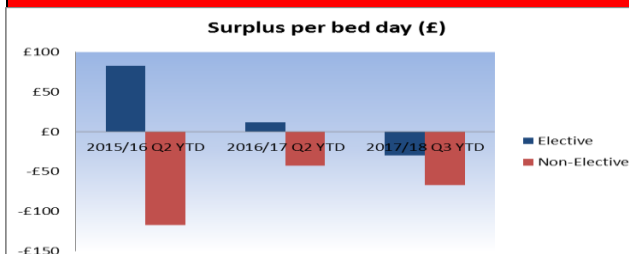


The chart shows the proportion of first outpatient attendances from each locality that are seen at HDFT. The data is sourced from the HED (Healthcare Evaluation Data) benchmarking system and only includes specialties for which HDFT run services.

HDFT's market share in 2017/18 to date is 87% in HaRD CCG, 20% in Leeds North CCG and 3% in Leeds West CCG, a slight increase on the previous year.

The chart also shows the aspirational market shares for 2020/21.

17. Surplus/deficit per occupied bed days

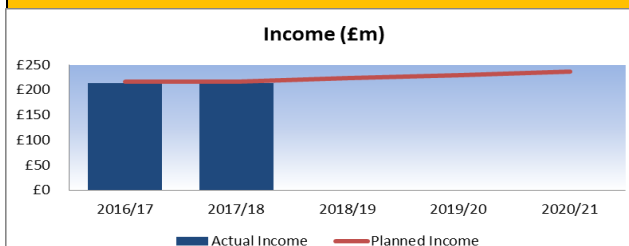


The chart outlines the current surplus per occupied bed day for elective and non-elective activity, utilising information from the service line reporting system.

Movements between years are influenced by a number of items which include movements in tariff prices, performance against elective activity plan and prior year position, move to daycase from elective work (daycase income and activity excluded) and higher levels of non elective bed occupancy.

The key driver for the deterioration in 2017/18 is our underlying financial performance in year. An improvement trajectory of a 3% year on year improvement is proposed.

18. Income



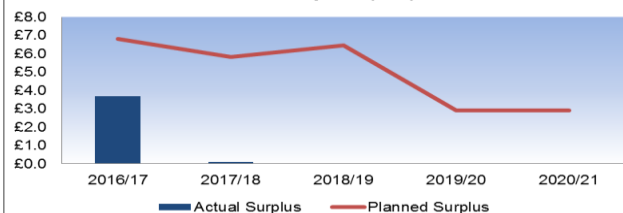
The chart opposite shows the income achievement in 2016/17 and 2017/18, excluding S&T funding.

The trajectory is to increase income by £5m year on year for the next 5 years. The business development success in relation to the new children's services contracts and the improving private patient position mean that in 2018/19, we will be above trajectory.

19. I&E surplus/deficit

Clinical and financial sustainability

I&E Surplus (£m)



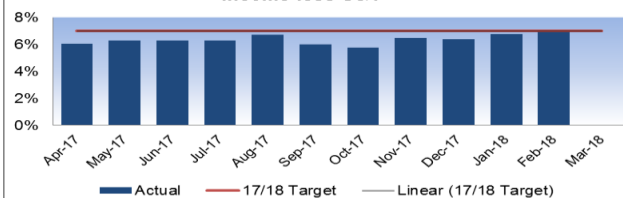
This chart shows the I&E Surplus achievement in 2016/17 and 2017/18. Figures for 2016/17 and 2017/18 include S&T funding. Planned figures for 2019/20 onwards do not include S&T funding.

Achievement of this metric is key to our sustainability and is a key priority for 2018/19.

The trajectory is to increase surplus by 1% per annum.

20. Carter management costs

Carter management costs - Overhead as a % of income less S&T

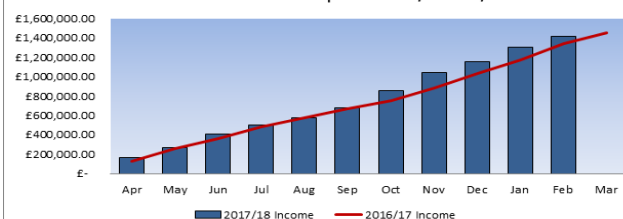


This indicator highlights the Hospital Management Overheads using 2016/17 data. This chart shows that in 2016/17, the Trust operated its management costs below the 2017/18 target of 7%. Information in relation to the Carter management costs for 2017/18 is being collated as part of the year end accounts process and will be available shortly.

The trajectory is to achieve 6% by March 2018.

21. Private income

Cumulative Income Apr to Feb 2016/17 v2017/18

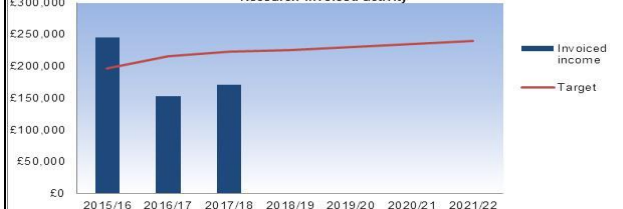


The Private Healthcare position is showing a positive increase in income for 2017/18. As of September 2017 the FOT was at £1.36m against a target of £1.45m. As of the end of February 2018 the FOT for the year has changed to £1.54m which is above plan.

There is work currently underway to strengthen the Harrogate Harlow Private Health brand for 2018/19 with new services being developed and brought on board, the target for 2018/19 is set at £1.7m.

22. Research income

Research Invoiced activity



The Research and Development Strategy proposed a 2% year on year growth. This has not been achieved. This is due to the reduced number of available and appropriate trials to undertake within the Trust. All current commercial trials are above target. The research department have several initiatives to market and attract increased commercial activity within the Trust.

Regulatory Compliance

23. NHS Improvement Single Oversight Framework - Use of Resources Metric

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

From 1st October 2016, NHS Improvement introduced the Single Oversight Framework. As part of this a "Use of Resource" metric was introduced to replace the previous Financial Sustainability Risk Rating. This is the product of five elements which are rated between 1 (best) to 4.

The Trust reported a rating of 3 in March as a result of the variance to plan reported above. The element related to the variance to plan is a 4, automatically triggering an overall position of 3.

24. NHS Improvement Single Oversight Framework - Operational Performance Metrics

Standard	Q1	Q2	Q3	Q4	YTD
RTT incomplete pathways	93.8%	92.3%	91.9%	90.5%	92.1%
A&E 4-hour standard	96.7%	96.0%	94.9%	92.1%	95.0%
Cancer - 62 days	86.1%	88.9%	90.5%	90.2%	88.9%
Diagnostic waits	99.8%	99.6%	99.7%	99.4%	99.6%

From October 2016, NHS Improvement will use a variety of information to assess a Trust's governance risk rating, including CQC information, access and outcomes metrics, third party reports and quality governance metrics. The table to the left shows how the Trust is performing against the national performance standards in the "operational performance metrics" section.

In Quarter 4, 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. However the Trust achieved all 4 standards for the overall year 2017/18.

25. CQC Inspection Rating

Ratings

Overall rating for this trust

Good 

Are services at this trust safe?

Requires improvement 

Are services at this trust effective?

Good 

Are services at this trust caring?

Outstanding 

Are services at this trust responsive?

Good 

Are services at this trust well-led?

Good 

There is no update of this metric since the previous report.

CQC monitor, inspect and regulate health and social care services to make sure they meet fundamental standards of quality and safety and publish their findings. HDFT was last inspected by CQC in February 2016. Overall, HDFT was given a "good" rating in the inspection report published by CQC in July 2016. A further breakdown of the rating is provided in the table to the left.

Following publication of the report, the Trust agreed an action plan with CQC and HARD CCG to address the small number of issues identified during the inspection. Actions are now being progressed in preparation for a likely re-inspection in the coming year. The Trust aims to maintain a rating of good or outstanding overall in the next inspection.

Strategic KPIs report - list of indicators - March 2018

Section	Indicator	Rationale	Goal / ambition	Scope	BAF Indicator Link
Delivering high quality care - patient safety	1. Emergency admissions receiving senior reviews within 14 hours of admission to hospital	This indicator is one of the national 7-day working clinical standards. Delays to both consultant reviews and a lack of on-going senior involvement in patient care have been linked to poor outcomes in patients. Timely reviews are linked to better outcomes.	100% achievement by March 2019, in line with the nationally proposed improvement trajectory.	Acute Services	BAF #2
	2. Reporting culture - Ratio of high/low risks	A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture. HDFT currently performs worse than the national average on this metric.	The national average based on the 2016/17 benchmark report is a ratio of 37. HDFT aspires to achieve this level by March 2018, with a further improvement to a level equivalent to the top 25% of Acute Trusts by March 2020 (a ratio of 68).	Trust wide	BAF #3, BAF #13
Delivering high quality care - patient experience	3. Friends & Family Test (FFT) - Staff - % recommend as a place to receive care. A high rate of approval demonstrates a high level of confidence in care quality amongst staff	The Staff Friends and Family Test (FFT) gives staff the opportunity to give feedback on the organisation they work in. A high rate of approval reflects a high level of confidence in the quality of care being provided.	% recommend = 90% by March 2019 and then maintain this performance. Current national figures: average = 79%, upper decile = 92%, upper quartile = 87%, HDFT = 87%.	Trust wide	BAF #1, BAF #13
	4. Friends & Family Test (FFT) - Patients. A high level of approval is evidence of a positive experience of care from patient/service user perspective	The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. A high level of approval reflects a high level of satisfaction with care received.	% recommend = 95% by March 2018 and then maintain this performance. Current national average is: 94%, HDFT is 94.6%.	Trust wide	BAF #1, BAF #2, BAF #13
Delivering high quality care - patient outcomes	5. Proportion of Best Practice Tariff achieved	Best practice tariffs (BPTs) are designed to incentivise pathways which reduce unexplained variation in quality and promote best practice. Achievement of BPTs is a measurable proxy indicator aimed at assessing the proportion of care that the Trust is delivering in line with best practice.	Achievement of 80% of total possible BPT income by March 2020.	Acute Services	BAF #13
	6. HSMR and SHMI indicators.	The Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Mortality Index (SHMI) look at in-hospital mortality standardised against various criteria including age, sex and comorbidities. Mortality is a nationally recognised outcome indicator and sometimes seen as an overall indicators of care quality for acute care	Maintain within expected range.	Acute Services	BAF #1, BAF #2, BAF #13
	7. Safety Thermometer	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. Whilst there is no nationally defined target for this measure, a score of 95% or above is considered best practice.	Maintain 95% harm free care and achieve 95.6% harm free by March 2019 - based on average harm free % of outstanding CQC acute providers. Review performance as a 6-month rolling average position.	Acute and adult community services	BAF #1, BAF #2, BAF #13
	8. Inpatient survey	National survey of inpatients conducted annually.	Achieve an overall score of 8.2 by 2021 (in line with the highest overall score reported by an Acute (Non-Specialist) Trust in the 2016 survey).	Acute Services	BAF #1, BAF #2, BAF #3, BAF #13
	9. Cancer patient survey	National survey of cancer patients conducted annually.	tbc	Acute Services	BAF #1, BAF #13
	10. A&E patient survey	National survey of patients attending A&E which is conducted every 2-3 years.	tbc	Acute Services	BAF #1, BAF #13

Strategic KPIs report - list of indicators - March 2018

Section	Indicator	Rationale	Goal / ambition	Scope	BAF Indicator Link
	11. Staff survey	The national NHS staff survey is conducted annually. Results are presented in 32 key areas known as 'Key Findings' as well as a measure of overall Staff Engagement. High levels of staff engagement are positively associated with positive clinical outcomes.	Maintain overall engagement score (weighted) for 2017 and achieve overall engagement score (weighted) of 4.03 by 2021, in line with the highest score in 2016 for Combined Acute and Community Trusts.	Trust wide	BAF #1, BAF #3, BAF #13
Working with partners	12. Non-elective bed days	The indicator looks at the number of non-elective (emergency) bed days at HDFT for patients aged 18+, per month per 100,000 population. There is a shared local ambition to reduce reliance on bed based care where clinically appropriate. Preventing avoidable admissions and reducing acute LOS can only be achieved through partnership working and delivery of integrated care.	tbc	Trust wide	BAF #2, BAF #14
	13. Delivery of IT strategy in line with agreed milestones	The IT strategy aims to provide a robust scalable IT infrastructure that delivers information where staff need it; robust governance arrangements; high quality information management; training and development of IT skills in staff; efficient project management and procurement; and collaborative working with other NHS organisations. An element of the strategy is access to a shared record for all clinicians involved in a patient's care which is a critical success factor for delivering integrated care.	Paperlite by 2020. Delivery of implementation of WebV modules as set out in IT strategy.	Trust wide	BAF #16
	14. Patient satisfaction of new models of care - Adult Community Services Friends and Family Test	The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. This metric is used to monitor the impact of system-wide transformation programmes on the experience of patients using our adult community services.	Current national average is: 96%, HDFT is 93.6%. % recommend 95% by March 2019 and 96% by March 2022.	Community Services	BAF #1, BAF #13, BAF #14
	15. Sufficient catchment population for key specialties of maternity, paediatrics and emergency surgery	To achieve clinical and financial sustainability, the Trust needs a catchment population which will generate sufficient activity/income to cover the baseline cost/fixed cost of providing the service. Growth beyond the fixed cost base delivers a growing margin and hence growing the catchment population becomes progressively more valuable.	A target catchment population of 300,000 for emergency surgery and 250,000 for paediatrics and maternity services by March 2021.	Acute Services	BAF #5, BAF #17
Clinical and financial	16. Increased share of HaRD CCG, Leeds North CCG and Leeds West CCG referrals	This indicator assesses the Trust's progress against its strategic objective of continuing to expand secondary care services into Leeds.	HARD CCG - 90% applicable market share, Leeds North CCG - 25% market share, Leeds West CCG - 3% market share - by 2020/21.	Acute Services	BAF #5, BAF #15, BAF #17
	17. Surplus per occupied bed days	This reflects operational efficiency and productivity for in patient areas	3% improvement year on year.	Acute Services	BAF #2, BAF #5
	18. Income	A driver of financial sustainability	Increase of £5m per year next 5 years.	Trust wide	BAF #9, BAF #17
	19. I&E surplus	An indicator of current and future sustainability.	1% per annum	Trust wide	BAF #9, BAF #12, BAF #17
	20. Carter management costs	This indicator assesses the hospital management overheads in comparison to other organisations.	Achieve 6% by March 2018 and then maintain.	Trust wide	BAF #1, BAF #9, BAF #17
	21. Private income	Exploring opportunities to increase the income received from delivery of private patient care was identified as one element of maintaining clinical and financial sustainability. PPI generates a higher contribution than NHS tariff based income. Growth in private income as a % of overall revenue will strengthen bottom line indicators	tbc	Acute Services	BAF #9

Strategic KPIs report - list of indicators - March 2018

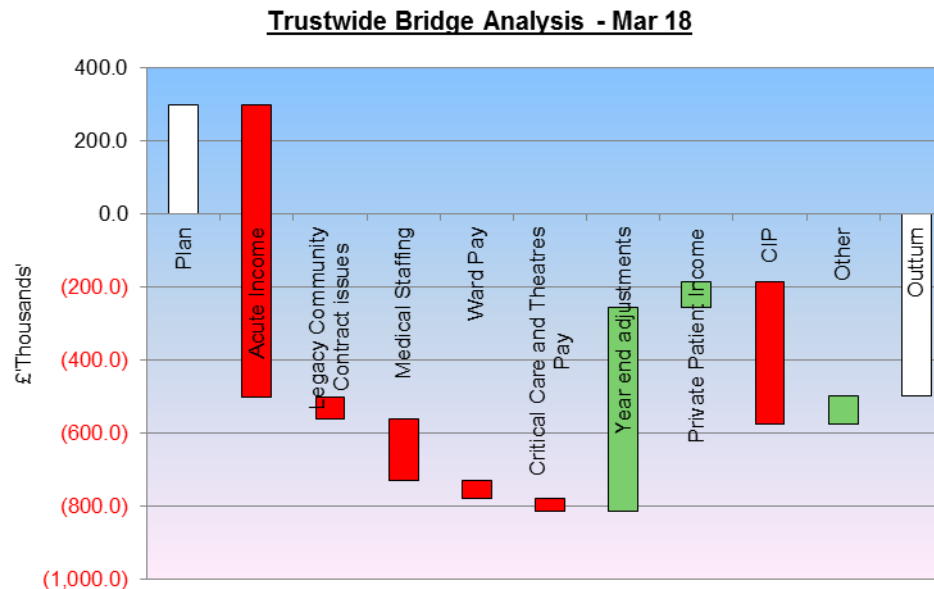
Section	Indicator	Rationale	Goal / ambition	Scope	BAF Indicator Link
	22. Research income	As set out in the Research & Development strategy, the Trust intends to maintain its current income from commercial research activity and NIHR income to support research staff to 2019. high levels of engagement in R&D are associated with positive clinical outcomes.	3% growth in 2017/18 and 2% growth year on year in subsequent years.	Trust wide	
Regulatory compliance	23. NHS Improvement Financial Risk Rating	As part of NHS Improvement's Single Oversight Framework, the Use of Resource Metric is used to assess an organisation's financial sustainability. This is the product of five elements which are rated between 1 (best) to 4.	To achieve a financial risk rating of 1.	Trust wide	BAF #10
	24. NHS Improvement Single Oversight Framework	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. This metric reviews how the Trust is performing against the national performance standards in the "operational performance metrics" section.	To achieve a green rating overall each quarter.	Trust wide	BAF #10, BAF #12
	25. CQC Inspection Rating	CQC monitor, inspect and regulate health and social care services to make sure they meet fundamental standards of quality and safety and publish their findings. HDFT was last inspected by CQC in February 2016 and was given a "good" rating overall.	To maintain a rating of good or outstanding overall in the next inspection.	Trust wide	BAF #1,BAF #2, BAF#3, BAF #13, BAF #14

Date of Meeting:	25 April 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:	<table border="1"> <tr> <td>Decision</td> <td></td> <td>Discussion/ Consultation</td> <td>✓</td> <td>Assurance</td> <td>✓</td> <td>Information</td> <td>✓</td> </tr> </table>			Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓
Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓				
Executive Summary:	<ul style="list-style-type: none"> The Trust's financial position for 2017/18 is currently being finalised, however, it is expected that the final position pre impairments will be a surplus of £0.1m; significantly behind the planned surplus position of £5.9m. In terms of Use of Resource Ratings, the Trust position for 2017/18 is a 3. Cash continues to be a concern as a result of the financial position. 										
Related Trust Objectives											
<table border="1"> <tr> <td>To deliver high quality care</td> <td>✓</td> <td>To work with partners to deliver integrated care:</td> <td>✓</td> <td>To ensure clinical and financial sustainability:</td> <td>✓</td> </tr> </table>				To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓		
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.											

March 2018 Financial Position

Financial Performance

- An in month deficit of £0.3m was reported in March, £0.8m adverse of plan. This position excludes Sustainability and Transformation, which the Trust will not receive in quarter 4, and the impact of the finalised position with HaRD CCG for 2016/17. The drivers for this in month position are outlined below.



- The Trust financial position for 2017/18 is currently being finalised, however, it is expected that the final position pre impairments will be a surplus of £0.1m, significantly behind the planned surplus position of £5.9m.
- This considerable adverse variance to plan has resulted in significant pressure on the Trusts resources as a result of the subsequent availability of cash to support capital developments.
- These figures include Sustainability and Transformation Funding of £2.45m. Without this the Trust would have reported a deficit position of £2.4m, £4.5m behind plan. The underlying position represents a notable pressure to the new financial year and highlights the pressures faced by the Trust currently.

March 2018 Financial Position

Financial Performance Cont.

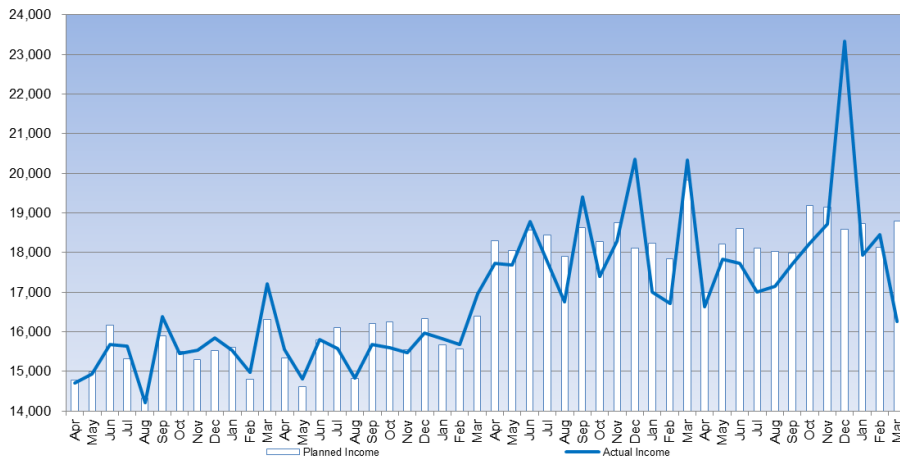
- As outlined on page 1 of the report, Sustainability and Transformation funding was not achieved in quarter 4, resulting in an impact to I&E of £1.3m. The impact of not receiving this cash adds further pressure to the cash position moving into 2018/19.
- In terms of Use of Resource Ratings, the Trust position for 2017/18 is a 3. This is the result of the variance to plan rated as a 4 (see below) which automatically triggers an overall rating of 3. The plan for 2017/18 was to end the year with a rating of 1.

Element	Plan	Actual
Capital Service Cover	1	2
Liquidity	1	1
I&E Margin	1	3
I&E Variance From Plan		4
Agency	1	1
UoR Rating	1	3

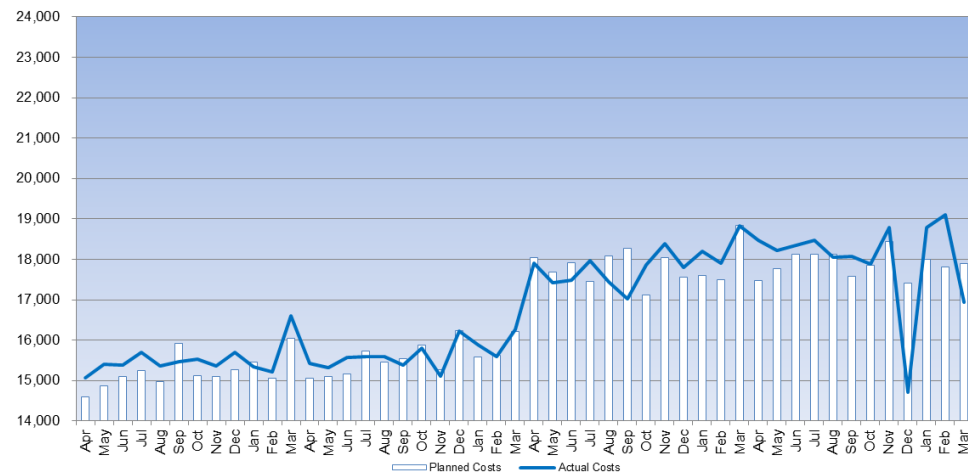
- As mentioned in previous reports, cash continues to be a significant risk and is resulting in limited resource availability for capital. The Trust ended 2017/18 with a cash balance of £5.4m. This appears to be a positive position, however, this total includes –
 - Prepayments of £1.8m
 - An additional £2m of payments that were not anticipated until 2018/19 but were received following work by the finance team to expedite receipt of income.
- It should also be noted that during 2017/18 the average payment time of invoices has increased by a week during 2017/18, an issue that has been discussed at the finance committee.
- Improvements to the cash position, and therefore financial resilience of the Trust, remain a significant priority moving into 2018/19. This position has been carefully managed during the last few years but is now causing issues in relation to resource availability as a result of continued adverse I&E variances.
- The detailed financial position is being submitted within the accounts and will be reviewed as part of this process.

2017/18 Run Charts

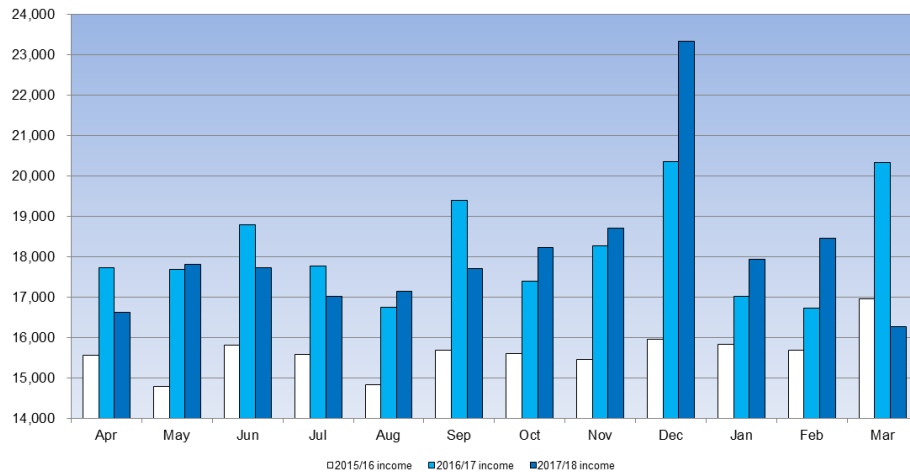
Planned and Actual Income Apr 2014 - Mar 2018



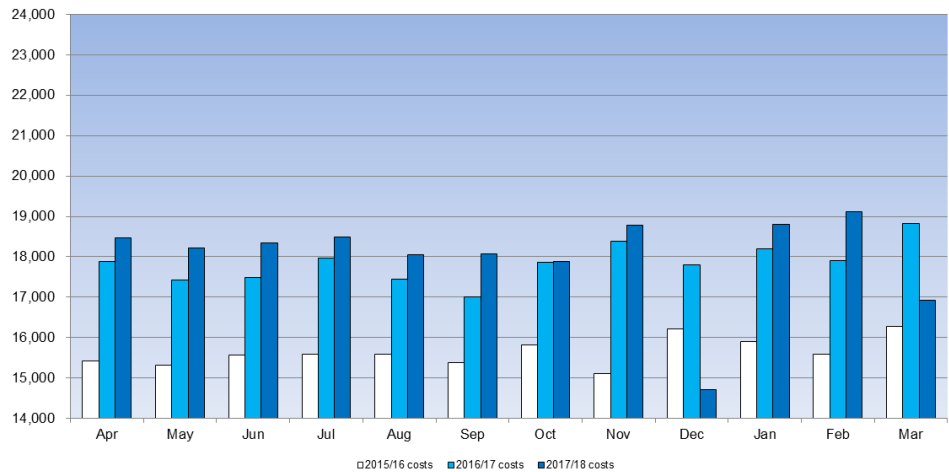
Planned and Actual Costs Apr 2014 - Mar 2018



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



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



NOTE - Following discussion with Audit, the CGS benefit outlined in December as a income benefit has been accounted for in March as a benefit to expenditure, hence the significant movement in month which has an overall nil impact. This has been agreed with our external auditors.

2017/18 Activity Information

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

Activity type	Feb-18				Mar-18				Mar-18 YTD			
	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	7543	7778	7931	-4.9%	7836	8167	8312	-5.7%	96368	97611	98459	-1.2%
Follow-up outpatients	14316	17132	14539	-1.5%	15307	16379	15283	0.2%	186925	192666	187271	2.8%
Elective inpatients	274	336	303	-9.7%	294	294	328	-10.4%	3470	3962	3675	-7.3%
Elective day cases	2401	2712	2650	-9.4%	2611	2840	2768	-5.7%	29063	31525	29847	-4.7%
Non-electives	1799	1670	1670	7.7%	1787	1865	1865	-4.2%	22436	21734	21734	3.2%
A&E attendances	3705	3721	3721	-0.4%	4249	4120	4120	3.1%	49470	48507	48507	1.9%

Surgical consultant-led new outpatient activity was above plan in March with General Surgery and Urology significantly over plan. However when taking into account nurse led activity, outpatient procedures and ward attenders, new outpatient activity was below plan overall.

Day cases were below plan in March – in particular in gastroenterology, ophthalmology and orthopaedics. General surgery day case activity has increased and was on plan for the month of March. Urology day case activity was above plan.

Despite an increase in inpatient activity from January and February, March was below plan, with Trauma & Orthopaedics 20 patients below plan. Thirteen patients were cancelled (with ten of these being orthopaedic) as no beds were available, and 11 were cancelled due to a lack of theatre time. There was also an impact through March of Anaesthetic cover, mainly due to two leavers and one staff member on long term sick. Significant cover has been provided internally, however there remained some impact with ten patients cancelled due to this. The Anaesthetic clinical lead is working with the management team regarding ongoing cover arrangements. Although the elective inpatient activity was below plan, a great deal of time and effort was undertaken in order to maintain theatre lists whilst the bed pressures were ongoing through March, with decisions made on a daily basis in relation to the cancellation of elective inpatient work.

The number of medical patients on surgical wards remained high through the month of March and Swaledale ward remained open and EADU worked around inpatients being admitted. Littondale SAU remained closed for the majority of the month due to the beds being required for admissions.

Date of Meeting:	25 April 2018	Agenda item:	6.1								
Report to:	Board of Directors										
Title:	Operational Plan - Draft										
Sponsoring Director:	Jonathan Coulter, Deputy Chief Executive / Finance Director										
Author(s):	Angie Gillet, Deputy Director of Planning and Business Development										
Report Purpose:	<table border="1"> <tr> <td>Decision</td> <td>✓</td> <td>Discussion/ Consultation</td> <td>✓</td> <td>Assurance</td> <td>✓</td> <td>Information</td> <td>✓</td> </tr> </table>			Decision	✓	Discussion/ Consultation	✓	Assurance	✓	Information	✓
Decision	✓	Discussion/ Consultation	✓	Assurance	✓	Information	✓				
Executive Summary:	<ul style="list-style-type: none"> The attached paper outlines the Operational Plan for 2018/19. 										
Related Trust Objectives											
<table border="1"> <tr> <td>To deliver high quality care</td> <td>✓</td> <td>To work with partners to deliver integrated care:</td> <td>✓</td> <td>To ensure clinical and financial sustainability:</td> <td>✓</td> </tr> </table>				To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓		
To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓						
Key implications											
Risk Assessment:	The planning document outlines the Workforce, Performance, Quality and Financial Risks that the Trust faces in 2018/19										
Legal / regulatory:	The final version of this document will be submitted to NHS Improvement with the Self Certification Submission										
Resource:	The plan outlines the resource requirements planned for the Trust in 2018/19.										
Impact Assessment:	Quality Impact Assessments are being undertaken and a paper will be reviewed at Board.										
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 approve the submission of the Operational Plan for 2018/19, including the Control Total requirement and the Self Certification outlined in Appendix B.

You matter most

Operational Plan 2018/19

DRAFT

Final Draft
April 18



1. Introduction

Harrogate and District NHS Foundation Trust (HDFT) has developed the Operational Plan for 2018/19 which builds on the two year plan submitted to NHSI in December 2016. It highlights in detail the plans for 2018/19.

2. Overview

The Trust is the principal provider of hospital services to the population of Harrogate and Rural District and North East and West Leeds. This represents a catchment population in excess of 250,000 which is still increasing in relation to North and West Leeds. In addition, the organisation now also serves a wider population, including Harrogate and Rural District, of approximately 600,000 across North Yorkshire as it provides a range of specialist Community Services including a wide range of community-based services for both adults and children.

For adult services we provide to a population covering the Harrogate and District locality as well as some services covering the whole of North Yorkshire. In relation to children's services we are the principal provider of 0-19 Children's services in North Yorkshire, the Middlesbrough, Darlington and Durham localities, making the Trust the largest provider of Children's services in the country. The Trust has recently successfully secured three new contracts for 0-19 children's services in Stockton, Sunderland, and Gateshead. We therefore will be providing services to a catchment population in the North East of 1,365,000.

Following a comprehensive inspection the Care Quality Commission (CQC) in early 2016 the Trust has been rated as 'Good' overall and 'Outstanding' in the 'Caring' domain, overall and separately for hospital-based and community services.

We are currently delivering the Emergency Department (ED) standard, cancer standards and 18 week standards. With regard to the delivery of our financial plan, whilst we have consistently delivered a surplus every year for over 12 years, we did not achieve the control total in 2017/18. We are planning to achieve the control total in 2018/19 and are working with local Commissioners and across the Health & Care Partnership to deliver care consistently within the resources that are available to the organisation, local Place, and wider system.

Staff engagement is strong and the results from the 2017 National Staff Survey confirmed that the Trust's overall Staff Engagement score was 3.8 which ranked 'above average'. The results from our Q2 Staff Friends and Family test survey showed that 83.7% of the staff who responded would be likely or extremely likely to recommend HDFT to their family and friends if they needed care or treatment and that 64.7% would recommend HDFT as a place to work. The Trust's results are higher than the SFFT national average, which were reported as 80% and 63% respectively. Our patients also regard the services we provide very positively as reported through national and local staff survey results.

Our strategy continues to be to deliver high quality care, work with our partners to deliver integrated care and ensure we continue to be clinically and financially sustainable. We monitor delivery of our strategy through the use of strategic Key Performance Indicators (KPIs) that we report to the Board on a regular basis. Details of these indicators are attached at **Appendix A**.

3. Strategic Context

3.1 Strategic Vision

As part of the development of the Operational Plan for 2018/19, we have taken the opportunity to review our strategic vision to ensure it continues to support the delivery of the key deliverables of the Next steps on the NHS Five Year Forward View.

We have held a series of strategy days with our Board of Directors and Senior Management Team to discuss our strategy to ensure we continue to be a sustainable organisation, both clinically and financially, delivering high quality services.

Our Vision continues to be to achieve Excellence Every Time for our patients and service users, with our Mission statement to be an exceptional provider of healthcare for the benefit of our communities, our staff and our partners. In order to achieve our Mission and Vision we have set out three key strategic objectives:-

- ▲ To deliver high quality care
- ▲ To work with our partners to deliver integrated care
- ▲ To ensure clinical and financial sustainability

In order to deliver our Vision we recognise the need to work with our partners across the patch including:-

- ▲ West Yorkshire and Harrogate Health and Care Partnership (HCP)
- ▲ West Yorkshire Association of Acute Trusts (WYAAT)
- ▲ Clinical Alliances with York Teaching Hospitals NHS Foundation Trust (YTHT) and Leeds Teaching Hospitals NHS Trust (LTHT)
- ▲ Harrogate PLACE
- ▲ Local Provider collaboration with other providers including Tess Esk and Wear Valley NHS Foundation Trust (TEWV) North Yorkshire County Council (NYCC), and the local GP Federation

3.2 National Context

The Trust continues to take forward the implementation of the Next steps of the Five Year Forward View and the 2018/19 deliverables of

- ▲ Cancer services
- ▲ Urgent and Emergency Care
- ▲ Maternity Services
- ▲ Learning Disabilities
- ▲ Supporting our partners in Mental Health and Primary care and
- ▲ Supporting the delivery of the national priority in relation to financial improvement and our contribution to improving the financial sustainability of the NHS

We will continue to ensure that these deliverables are achieved in 2018/19.

3.3 Local Context

West Yorkshire and Harrogate Health and Care Partnership

The Trust is part of the West Yorkshire and Harrogate Health and Care Partnership (HCP) which is built up from the work of the six health and care economies in West Yorkshire and Harrogate. As part of the HCP our vision for West Yorkshire and Harrogate is for everyone to have the best possible outcomes for their health and wellbeing.

Closer partnership working is at the very core of our HCP and HDFT continues to be actively engaged with our partners across the region.

A Memorandum of Understanding has been developed to strengthen joint working arrangements across the Partnership and to support the next stage of development. It builds on our existing partnership arrangements to establish more robust mutual accountability and break down barriers between each separate organisation.

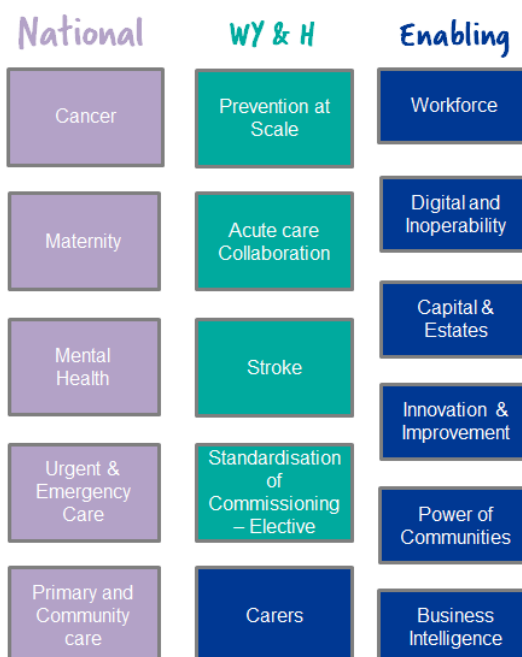
The Partnership has attracted additional funding for cancer diagnostics, diabetes and a new child and adolescent mental health unit as well as developing a strategic case for

change for stroke from prevention to after care and are identifying and treating people at high risk of having a stroke.

We will continue to work with our partners in the HCP to identify initiatives for funding which support our Vision. In particular we are taking forward a number of key initiatives in relation to:

- ▲ Urgent and Emergency Care services
- ▲ Stroke Care
- ▲ Acute Hospital collaboration

The West Yorkshire and Harrogate HCP is submitting an application to become an Integrated Care System (ICS) which will enable the members of the group to work collaboratively to deliver services that are clinically and financially sustainable. Through this system we will jointly have greater access to capital and transformation funding in the future. Work will continue in the coming months to progress our application.



West Yorkshire Association of Acute Trusts (WYAAT)

Complementing and working closely with the HCP is the West Yorkshire Association of Acute Trusts, which is an innovative collaboration bringing together the NHS Trusts who deliver acute hospital services across West Yorkshire and Harrogate. HDFT is an active member of this network.

The WYAAT has a joint work programme focussed around four clear work streams:

- ▲ Specialist services – a review of the way some of the specialist services are delivered and whether these could be provided in a better way.
- ▲ Clinical standardisation and networks – looking to standardise the way we work across trusts to reduce variation and duplication.
- ▲ Clinical support – reviewing pathology, radiology and pharmacy systems and processes to identify benefits of working together and in the same ways.
- ▲ Corporate services – looking at our back office functions to share learning and identify any benefits of bringing together ways of working, teams and services.

Within the WYATT programme, HDFT is focusing on a number of initiatives across a range of different areas. It is recognised that in order to remain a sustainable organisation, the Trust needs to work in partnership with other provider trusts to deliver new models of working and financial efficiencies. In addition there may be occasions when there is a need to provide support to other WYAAT Trusts that impacts upon the Trust position but improves the quality, performance or safety of the collective. Equally there may be occasions when the Trust benefits from support in this way from other WYAAT Trusts.

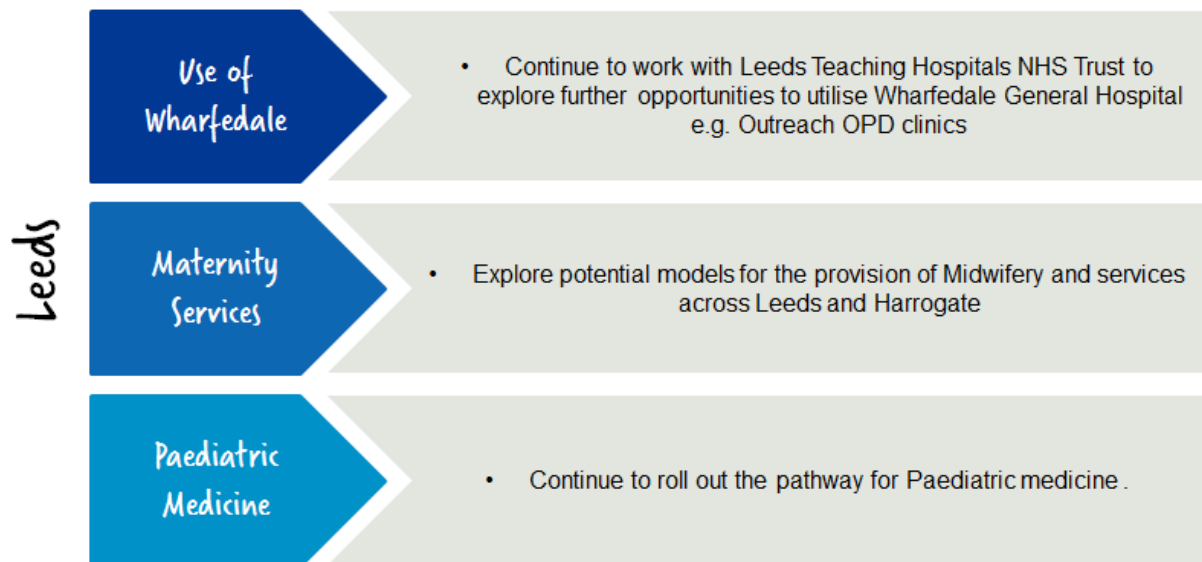
A summary of the key work streams being taken forward is detailed below

Elective orthopaedics	<ul style="list-style-type: none"> Exploring the potential to develop an elective care centre at HDF to support the delivery of elective orthopaedic activity across the HCP with a view to repatriating NHS work from the private sector
Pathology services	<ul style="list-style-type: none"> Working in collaboration with Airedale Foundation Trust develop a joint managed service
Pharmacy	<ul style="list-style-type: none"> Development of a central supply chain accessible by all WYATT members
IM&T	<ul style="list-style-type: none"> Development of a common email solution Strategic review of Microsoft licencing and a collaborative strategy for cyber security
Procurement	<ul style="list-style-type: none"> Work plan developed across Trusts to deliver efficiencies in procurement
Workforce	<ul style="list-style-type: none"> Development of collaborative bank to support recruitment and the reduction agency spend
Estates	<ul style="list-style-type: none"> Establishment of a separate SPV at HDFT

Clinical Alliances

With regard to alliances with our neighbouring Provider Trusts, HDFT has well established clinical alliances with York Teaching Hospitals NHS Foundation Trust (YTHFT) and Leeds Teaching Hospitals NHS Trust (LTHFT). We will continue to work together to explore opportunities for greater collaboration across key specialties.

York	Stroke Services	<ul style="list-style-type: none"> Work with neighbouring Provider Trusts to agree the future model for Stroke Services. Discussion to continue with York Teaching Hospitals NHS Foundation Trust (YTHFT) to implement the preferred option in relation to the provision of the HASU element of the pathway
	Cardiology	<ul style="list-style-type: none"> Develop clinical alliance with YTHFT for cardiology services with a view to enhancing the services at Harrogate making them more suitable in the longer term
	Gastroenterology	<ul style="list-style-type: none"> Explore the potential for a clinical alliance for gastroenterology services to provide sustainable services across both Provider organisations Implement a robust on-call rota for Upper GI Services.
	Breast Screening	<ul style="list-style-type: none"> Work with YTHFT to develop a business case for the provision of a new breast screening facility in the Harrogate locality to replace the mobile service currently in operations



Harrogate PLACE

We are working closely with Harrogate and Rural District CCG to ensure that as a Local Health Economy we can continue to provide high quality services within the agreed financial resources. Both organisations recognise the level of financial challenge that this presents but are fully committed to working together to meet this objective. Discussions have been ongoing regarding the development of an aligned incentive contract (AIC) ensuring that we live within our agreed level of resources. A contract variation has been signed to this effect, and a governance model is being developed to ensure that we have the necessary framework in place.

A statement of principles has been agreed with HaRD CCG.as follows: -

- ▲ Sustainability of both HaRD CCG and HDFT, both financially and clinically
- ▲ A reduction in the cost of healthcare provision for the Harrogate population
- ▲ Delivery of the best possible outcomes within the resources available – delivery of value for money
- ▲ Maximising the resource that is available to the Harrogate system, including provider and commissioner sustainability funds
- ▲ A commitment that any potential changes in service or pathway provision that increase costs will be jointly discussed before any resource commitment is made
- ▲ A Joint effort to repatriate Harrogate activity that is currently delivered out of area or transfer patient activity from other CCGs into Harrogate where this is beneficial to do so
- ▲ Efficiency in the contracting process and a focus of available staffing support resources on delivering the clinical changes required

Supporting the AIC for acute hospital work is the development of a Provider collaborative model for care outside of hospital.

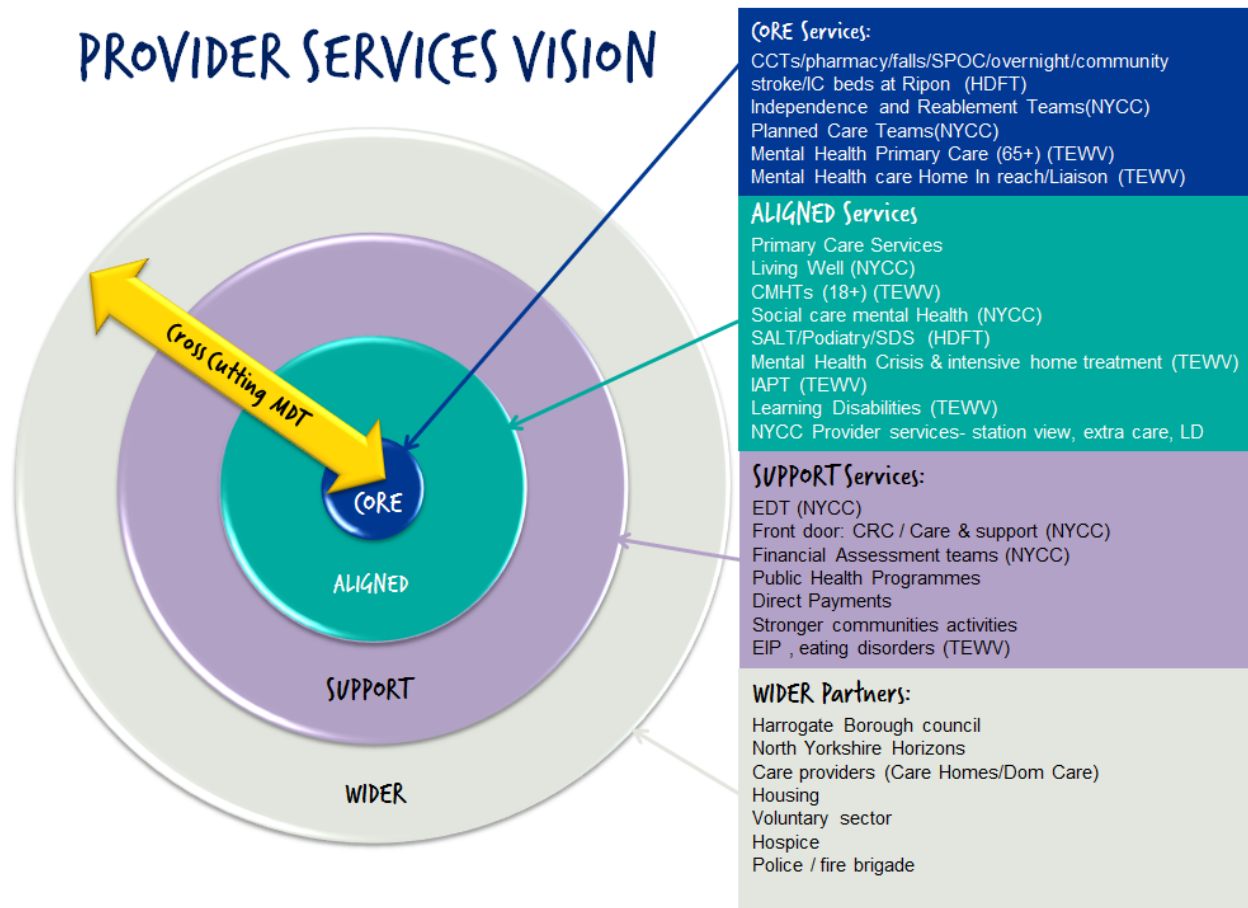
Provider collaborative

HDFT is a member of the Provider collaborative which includes representatives from TEWV, NYCC and the GP Federation. The Provider Services Vision aspires to

- ▲ **Have the Person and community at centre** and designed around needs and assets/strengths based approach

- ▲ **Support and champion** our community services, managers and staff
- ▲ Be **realistic and ambitious** in exploring how we can work together
- ▲ Make **joint working and leadership** the norm rather than an exception or an initiative
- ▲ **Recognise and address** the very real pressures of service delivery in and around Harrogate and the surrounding areas
- ▲ Achieve Successful **collaboration** whilst maintaining our own organisational identity

The Vision for Provider services can be summarised as



HDFT will continue to work with partner organisations to support delivery of integrated primary and community care across the local health community in 2018/19.

Development of Children's Services

HDFT is now the largest Provider of Children's services in the country following the successfully securing contracts across the North East of England, the most recent in Stockton, Gateshead and Sunderland. This has resulted in the ability to manage services at scale with the opportunity to implement transformational work and shared learning across contracts. Work will continue in 2018/19 build on the implementation of our delivery model across the new contracts in Stockton, Gateshead and Sunderland as well as continue to engage with our Commissioners for our other 0-19 Children's services contracts to continue to deliver high quality services.

The key initiatives identified in our Operational Plan for 2018/19 support the delivery of the National priorities in the Next steps on the NHS Five Year Forward View. We will continue to work closely with our partners across the West Yorkshire HCP and our local PLACE to achieve these objectives and support the implementation of our local strategy. Our plan sets out the priorities to be delivered over the next twelve months.

4. Capacity to Deliver Our Strategy

4.1. Activity

Activity and capacity plans have been developed together and from the bottom up, using a combination of historical activity, Office for National Statistics (ONS) population estimates and change in age profile to forecast activity by commissioner, specialty and point of delivery.

Clinical Directorates have worked closely with lead clinicians to understand and take into account changes in medical practice and infrastructure that will impact on activity in 2018/19. Activity has been formally signed off at specialty level following meetings with the Chief Operating Officer and the senior directorate teams.

Activity plans have been through a number of iterations, with meetings held with each clinical directorate team to ensure activity forecasts are fully understood and additional capacity is in place, where required, to fully deliver the plan. The plan has been phased over the year using an intelligent phasing approach looking at historical trends in both activity and financial terms.

Historically, our activity and capacity assessments have been an accurate forecast for planning purposes. We recognise that we will need to take into account our assessment of HaRD CCG QiPP plans when they are developed, and if necessary utilise any resultant capacity with neighbouring Commissioners in line with our West Yorkshire and Harrogate HCP.

Elective inpatient, elective day case and outpatient activity plans have been agreed with the Clinical Directorates at specialty and sub-specialty level and have been based on a factor for demographic growth plus additional activity identified within specific business plans and service developments proposed for the coming five years. In particular, we will be providing a new endoscopy unit at Harrogate District Hospital which will result in us being able to bring back Harrogate patients being treated at Wharfedale Hospital in Leeds, and filling their slots with patients from Leeds. We have engaged in planning with HaRD CCG involving the Clinical Board for focused areas of work and with a view to managing elective activity across a range of targeted specialties. This work will be factored into our plan, and will result in the continued shift in the use of our elective capacity from Harrogate to Leeds patients, in line with our Business Development Strategy, clinical alliance with LTHT and our HCP. HaRD CCG has the ambition to significantly reduce elective and non-elective activity but tangible plans to achieve this are at an early stage of development. This introduces a greater element of risk to activity assumptions for 2018/19 than in prior years.

For non-elective admissions, year on year historical growth and ONS population estimates for the local area for 2015 to 2020 were reviewed. These showed that for our local commissioning area (HaRD CCG), there would be a small overall population growth (around 1%) in the next five years but with a significant increase over the same period for the over 65 years age group (around 9%).

The plan covers the detail of the activity of the hospital, but clearly the Trust also provides a range of community services across North Yorkshire and in relation to Children's Services the North East, County Durham, Darlington and Middlesbrough. This will be extended to include Stockton, Gateshead and Sunderland in 2018/19. As part of our planning process we also assess the demand and capacity requirements needed for our community services.

In summary, the 2018/19 plan at **Trust** level is:

	2017/18 outturn estimate	2018/19 Plan	
POD	Activity	Activity	% growth
First OP - cons led	61,590	64,096	4.1%
First OP - non-cons led	28,933	29,132	0.7%
FU OP - cons led	116,566	122,899	5.4%
FU OP - non-cons led	66,769	69,793	4.5%
Ward attenders - new	5,874	5,395	-8.2%
Ward attenders - FU	3,652	3,204	-12.3%
Elective inpatient	3,471	3,581	3.2%
Elective day case	29,070	32,885	13.1%
Non-elective	22,434	22,656	1.0%

4.1. Capacity to Deliver

18 weeks delivery. The Trust achieved the 18 week standard in 2017/18 at Trust level only. The plan in 2018/19 is to hold the March 2018 performance to the end of 2018/19 which is a delivery of 90% against this standard. The highest risk areas are trauma and orthopaedics and ophthalmology. The Trust does not expect to have any breaches of the 52 week RTT standard.

Waiting list. Plans are in place to maintain the waiting list size at the same size as March 2018. This based upon delivering the activity and referrals within the plan.

Bed capacity to ensure operational resilience. During 2017/18, the non-elective medical activity was 8.5% above plan. This has resulted in more sustained period of increase of medical patients in inpatients beds.

If we assume current LOS and a 2.3% growth on 2017/18 outturn it has been modelled that demand for medical beds will outstrip capacity for 6 months of 2018/19 and there would be only two months when the medical bed base could be reduced (based on 100% occupancy).

Best practice would suggest bed occupancy should be maintained at 85% but given our small bed base 90% would allow us to manage acute and elective flow effectively. The modelling shows we would not be able to deliver 90% occupancy for any month in 2018-19.

The average LOS across Medicine for 2017/18 was 6 days. To remain within funded capacity which is 172 beds per month we would need to achieve an average LOS of 5.6 days.

To support this, the Trust has agreed to the following transformation projects for 2018-19:

- ▲ Integrated Discharge Hub
- ▲ Clinical criteria for discharge
- ▲ Tomorrows Ward – (continuation of SAFER, more efficient processes & technology (WebV initiatives)
- ▲ Supportive discharge service expansion and development and implementation of Virtual Ward for elderly patients
- ▲ Development of a Surgical / Medical Joint Assessment Unit located close to A&E

Cancer. Our plan is to deliver the 62 day standard of 85% for the year.

ED performance. Achievement of the 4-hour standard has continued to be challenging but the Trust has met requirement in 2017/18. Historically we have consistently achieved this

target, however the delivery is becoming more difficult. Our submitted trajectories reflect the risk to delivery, with current plans delivering a performance in the month of March 2019 of 92.7%.

4.2. Workforce

4.2.1. Approach to Workforce Planning with Clinical Engagement

The Trust recognises that to deliver high quality services, it needs the appropriate skilled workforce. We have continued to strengthen workforce development and planning in parallel with clinical engagement to determine how services and clinical pathways can be provided more efficiently and innovatively. This is facilitated by the Health Education England's (HEE) annual workforce planning tool. The clinical directorates also produce annual business plans which contain their workforce plans and inform the annual workforce planning process including determining expansion, contraction and new roles for education commissioning.

The Trust will regularly review the workforce plan against actual delivery for key staff groups that present the biggest workforce challenges. This information will also be triangulated alongside the financial costs and projections. The aim of this work is to ensure that we have the right workforce numbers in established posts and that the cost of the workforce is in line with established budgets. This will be monitored through the Workforce Efficiency Group (WEG) on a monthly/quarterly basis. Key staff groups include:

- ▲ Medical and Dental staff – Consultant, career grades and Doctors in Training, across all specialities
- ▲ Nursing and midwifery – inpatient wards, theatres, Adult community and Children's services
- ▲ Support to Clinical Staff – support to nursing staff and allied health professionals

Key performance indicators will also be monitored to support action planning and the identification of emerging areas, which will include:

- ▲ Vacancy rates
- ▲ Cost of agency staff and total shifts
- ▲ Cost of agency above and below NHS cap
- ▲ Total agency shifts
- ▲ Labour Turnover
- ▲ Sickness
- ▲ Safer staffing
- ▲ Rostering efficiency

The overall aim of this is to embed workforce planning into day to day operational discussions. This process will support the Trust to identify emerging trends as well monitoring variances from plan and adjust action plans accordingly.

The table below shows a summary of the workforce plan by staff group.

Staff group	Establishment 17/18	Forecast outturn at 31/03/2018 (WTE)	Plan at 31/03/2019 (WTE)	Supporting narrative
Medical and Dental	To be completed	317.5	345.9	The increase for this staff group based upon substantive recruitment plans to vacant posts within the establishment, with subsequent reduction in bank agency usage.
Registered Nursing, Midwifery	To be completed	1141.6	1415.7	The increase is based on the TUPE transfer of new children

Health Visiting Staff				services contracts as well as recruitment to established vac posts, , with subsequent reduction in bank agency usage.
All Scientific Therapeutic Technical Staff	To be completed	449.3	458.7	
Support to Clinical Staff	To be completed	969.1	1086.8	This increase is based on recruitment to established vac posts, with subsequent reduction in bank agency usage.
Qualified Ambulance	To be completed	2	2	
Others	To be completed	0	7	
NHS Infrastructure Support	To be completed	484.3	559.5	The increase in infrastructure increase in posts in line with the new contracts.
All staff		3363.7	3875.6	

The West Yorkshire and Harrogate STP continues to be supported by a Local Workforce Action Board (LWAB). The LWAB has established a workforce programme built on the requirements of the STP workforce priority areas. These include a focus on; the primary care and public health workforce, the registered and non-registered workforce, prevention at scale and flexibility and resilience. The Trust has a representative on the North Local Education and Training Board which supports our workforce planning intentions.

The West Yorkshire Association of Acute Trusts (WYAAT) has continued work on the four key workforce priorities. Workshops have been held to inform the development of a business case for the implementation of internal and collaborative banks, options have been considered in relation to collaboration between Occupational Health functions, the West Yorkshire and Harrogate Excellence Centre has been established to make the best use of the apprenticeship levy and the Yorkshire and Humber streamlining workstream has been established to take forward National and Regional learning to deliver consistency and efficiency between organisations. In order to secure a future pipeline of Registered Nurses the Trust has developed an innovative three year BSC programme in adult nursing with the universities of York, Bradford and Leeds Beckett. This will provide a potential pipeline of 55 registered nurses from 2020/21 onwards who will be contracted to remain with the Trust for a minimum of two years.


4.2.2. Local Clinical Strategy and Workforce Impact

Following the end of the Vanguard Programme as at 31 March 2018, a Provider Collaborative is being established. The purpose of this collaborative is to review, implement and embed the lessons learnt from the Vanguard Programme, which will be shared with the Harrogate Health Transformation Board (HHTB) in due course.

The 'Harrogate place' systems Shadow Board Programme will enable aspirant directors from across the Trust and external partners to develop their skills and experience as part of their continuous professional development, with members of this collaborative forming some of the delegates to support joint working and the required cultural and behavioural shifts.

The Trust has commenced the implementation phase of the Clinical Workforce Strategy for delivery over the next five years. The mission of the strategy is to have an efficient, productive, skilled and resilient workforce, providing high quality sustainable health and care. Further details are contained within the Clinical Workforce Strategy.

The key strategic goals for this strategy are;

-  **Growing our Capacity** – develop a sustainable, high quality, competent workforce

- ▲ **Staff Engagement** – create an engaged and motivated workforce and a performance improvement culture; to be an employer and provider of choice
- ▲ **Productivity & Efficiency** – create a sustainable, permanent workforce; improve staff retention and resilience

Each Clinical Directorate has identified its own workforce priorities for the next two years and a programme for delivery. Good progress has been made on the development of our capability through the introduction and expansion of new roles; Advanced Clinical Practitioners, Associate Nurses, Assistant Practitioners, Apprenticeships for Health Care Assistant roles and the placements of Physician Associates. As well as the preceptorship programme for years 1 and 2 to ease the transition into registered roles and aid recruitment and retention of Registered Nurses. Additionally improvements have been made in relation to productivity and efficiency through the introduction of a Master Vend model for locum medical staff and a direct engagement platform. Work in 18/19 will particularly focus on staff engagement referencing the Staff Survey results for 2017 and the Staff Friends and Family Test to develop the staff engagement plan for the year ahead.

4.2.3. Local Workforce Transformation Programmes

The Trust's Clinical Transformation Board has four work streams; including Workforce. Under the Workforce Transformation Programme there are two key work streams:

- ▲ Clinical Workforce Strategy
- ▲ Workforce Redesign and Reward

The aim of these two work streams is to deliver a high quality, productive workforce and recognise that engagement and culture need to be combined with specific redesign and reward initiatives to support the Trust to retain its position as an employer of choice in the local area.

In terms of specific productivity improvements, the following initiatives will provide benefits in 2018-19:

- ▲ Continued roll out of Health and Wellbeing interventions to support reductions in sickness absence for the reasons of Stress Anxiety and Depression and Musculoskeletal conditions Review skill mix and local terms and conditions of employment
- ▲ Ensuring all senior medical staff employed in the Trust have a Job Plan with clear objectives identified
- ▲ Continued use of Oceans Blue software to drive compliance and efficiency in the use of our staff rosters
- ▲ Embed the Master Vend and Direct Engagement platform for medical locums Development of an internal bank for medical staff with potential to develop into a collaborative bank across the STP
- ▲ Focus on the apprenticeship levy and solutions to support long term retention of both existing and trainee staff

4.2.4. Build Leadership Capability

Capable leadership is undoubtedly one of the most important factors in creating and maintaining an organization which achieves outstanding and sustainable results. Building clinical leadership capability to enable people to meet future challenge is important, as leaders will then champion learning and capability development in others to support the change management process. To support this agenda some of the deliverables are:

- ▲ The continued roll out of the leadership development strategy and its associated work plan including talent management.

- ▲ To self-assess against the sixth generation Investors in People standard and develop and implement associated programmes of work to enable achievement of this standard in 2020.
- ▲ All newly appointed leaders to attend The Pathway to Management Programme on joining the Trust, or being promoted into a leadership role
- ▲ The Healthcare Leadership Model, a behavioural competency framework to demonstrate and support individuals in understanding “what good looks like” and how to identify where they are within the framework. The model becoming the norm and part of our culture through increased use of self-assessment, 360 degree feedback and group feedback. The RCN Clinical Leadership Programme to support Band 6 and Band 7 clinical staff develop and grow in their leadership role.

4.2.5. Use of E-rostering and Reduction in Reliance on Agency Staffing

The Trust has fully rolled out and implemented e-rostering across all identified areas, using an IT solution named Rosterpro.

The Trust is continuing to work with Oceans Blue to assist with a review of the efficiency of rostering arrangements across inpatient ward areas including Emergency Department and Intensive Therapy Unit (ITU). Significant progress has been made to date with this work and improve rostering practice across the Trust to ensure that efficiencies are delivered, through effective deployment of staff across the Trust. Rostering KPI's have been incorporated into the bi-weekly Workforce Efficiency Group meeting which are reviewed on a monthly basis.

One of the WYAAT priorities is the development of internal staff banks for medical staff in the first instance. This will reduce reliance on expensive agency staff across the West Yorkshire and Harrogate system.

The Trust continues to work in partnership with HEE to develop the Global Health Exchange programme, predicated on the principle of Earn, Learn and Return. This programme sets out to develop an ethically and financially sustainable approach to international recruitment across the NHS. Our first cohort of GHE staff joined the Trust in 2017/18 and we look forward to welcoming further cohorts with the aim of reducing reliance of Agency Nursing staff.

4.2.6. Alignment with Local Education and Training Board plans

The Chief Executive HDFT is the chair of the West Yorkshire and Harrogate LWAB. The Trust's Director of Workforce and Organisational Development is also a Board member of the LWAB as well as the newly established Local Education and Training Board LWAB for the North of England.

At a local level we continue to review existing roles as well as develop and implement new roles. The Trust has recently recruited its' second cohort of Advanced Clinical Practitioners (ACP's), with our first cohort now working in a fully embedded way within consultant led teams.

We have worked with the Local Education and Training Boards (LETB) and Skills for Health to develop our strategy for employing apprentices, specifically the use of apprentices in Health Care Assistant roles. It is our intention to launch our bands 1-4 career development pathway and bridge into nurse training. To support the achievement of this we are focused on building our relationships with local schools and colleges through the use of Health Ambassadors and work placements. This work will continue to be developed and implemented in 2018-19.

4.2.7. Balancing of agency rules with the achievement of appropriate staffing levels

We are fully committed to providing safe staffing levels as part of our drive to deliver high quality care to our patients. However, we recognise the importance of controlling agency spend and will ensure that this is achieved without compromising safety. We have implemented and embedded our approach to the NHS Improvement Agency Cap rates. The Trust has implemented the capped

rates along with an escalation process should there be a need to pay beyond current Agency cap for patient safety reasons.

HDFT continues to manage agency spend within the agency ceiling set, although this remains a continued challenge.

We are also engaging with our existing workforce to establish alternate methods of maintaining safe and effective services i.e. acting up/down protocols for medical staff and we will ensure that we have effective internal controls to maintain visibility of both risks and of opportunities for improved rate control. We also utilise our new Master Vend model of locum procurement and Direct Engagement to ensure we prioritise our control of medical locum spend through effective negotiation with agencies and where necessary individual locums. HDFT is also part of the WYAAT where we are working with other providers across the region to share best practices and undertake a shared approach to the implementation of agency caps.

In addition to controlling agency spend; the following initiatives are also in place:

- ▲ Utilising international recruitment to achieve the appropriate substantive staffing levels
- ▲ A recruitment and retention package for the Emergency Department which includes CESR programme as well as a recruitment and retention premia
- ▲ Investment in new roles such as Advanced Care Practitioners and exploring opportunities for Physician Associates in response to current and anticipated service demands and workforce supply issues.
- ▲ Review of the Trust's undergraduate nursing commissions is also taking place with a view to facilitating recruitment from the existing workforce and the local population
- ▲ Review our contractual arrangements for 18-19 with NHS professionals (our supplier of bank nurses)
- ▲ Actively work with HEE (Yorkshire and the Humber) to minimise the number of vacancies or gaps that the Trust experiences following regional Doctors in Training recruitment processes
- ▲ Appointment of further Medical Training Initiative and Clinical Fellow posts to support a number of specialities and to strengthen our arrangements for the provision of services out of hours.
- ▲ Establishment of an Executive Director level committee to oversee and control expenditure on our temporary workforce (Workforce Efficiency Group).

4.2.8. Workforce risk areas review

As indicated in section 6, the Trust has well established Quality Governance processes in place which receives an integrated Board report each month that triangulates workforce indicators such as sickness, agency usage and appraisal rates with quality and efficiency indicators. In addition the Trust has a Workforce and OD steering group which meets on a monthly basis with full directorate representation.

The key risks are highlighted below:

Risks	Mitigation
Recruitment and retention of staff due to rates of pay offered via national terms and conditions of service (Agenda for Change)	Evidence submitted by NHS Employers and NHS Providers to inform the national pay review bodies. The Trust has representatives attending the national pay review body meetings for Agenda for Change staff and Doctors and Dentists. Consideration of local terms and conditions.
Labour Market conditions and difficulties recruiting Registered Nurses, Medical staff including Doctors in Training and SAS Doctors.	All medical locums booked via the Master Vend model other than in exceptional circumstances. The Trust has also implemented the NHSI agency cap process with a clear escalation protocol, including Chief Executive oversight where appropriate. ACP programme has also been implemented with the first cohort completing training in 2017 and a second cohort commencing training in January 2018. LETB encouraged to commission additional training posts such as ACPs to reskill mix the workforce to become less reliant on medical rota. Local recruitment campaigns held for nurse





	recruitment including: open days, social media campaigns, University careers events. We have also developed the Global Health Exchange model with HEE and part of the pilot group of providers to secure registered nurses from India.
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4.3. Capital Infrastructure

The Trust recognises that to support the delivery of our activity and implementation of our workforce strategy, the appropriate physical infrastructure is required. Harrogate and District NHS Foundation Trust has therefore undertaken a review of its capital strategy which has focussed on the key developments in the short term to meet current service pressures, as well as considering the longer term estates strategy for the site over the next 5 - 10 years

The Trust continues to face significant challenges in continuing to deliver high quality standards in emergency and urgent care, placing additional pressures on our bed capacity. We have undertaken a bed modelling exercise to ascertain the bed capacity that will be required in the organisation between 2018/19 and 2026/27. We are acutely aware that given current trends and the demographic pressures, the organisation needs to find solutions that ensure we continue to successfully deliver our ED performance standards, improve the patient flow, improve productivity and enhance the overall experience for patients. Our focus has therefore been to consider the options for the redevelopment of the District Hospital site and our future site strategy to address these current pressures both in relation to service need and building infrastructure.

The redevelopment of the site will be phased as follows: -

-  Creation of an Ambulatory care unit and provision of an additional main theatre
-  Provision of an Urgent Care Centre at the front of the site
-  Redevelopment of the Obstetric Unit to include a Midwifery Led facility
-  Provision of an Elective Centre to the rear of the hospital in the Briary Wing

Phase 1a: Creation of an Ambulatory care unit and

Phase1b: Provision of an additional main theatre

The development of an ambulatory care unit would be a short stay assessment facility for medical and surgical patients. The new unit will enable patients to be seen, assessed and treated, reducing the need for admission to a ward and improving patient flow.




The Trust is currently in the process of building a new endoscopy facility which is due to be operational from July 2018. The existing endoscopy facility, which will be vacated, is located at the front of the hospital, near to the emergency department and would be an appropriate location to accommodate a new ambulatory care facility, as it would be in close proximity to ED and diagnostic services.

Initial feasibility work has been undertaken and notional costs developed for the unit with the next stage in the planning process to develop a full business case. Planning work is due to commence in April 2018, with a new facility fully operational by October 2019.

In relation to the provision of an additional theatre, the Trust recognises the need to provided capacity in the short term in addition to the potential development of an elective care centre in the future. Work will commence in April 2018 to develop a business case for a sixth main theatre. It is anticipated that this will be operational in 2020.

Phase 2: Provision of an Urgent Care Centre

Whilst the provision of an Ambulatory Care unit will assist in addressing some of the short term service pressures, the Trust recognises the need to develop an Urgent Care solution that meets the needs of the local health economy in the longer term. The provision of a facility of this nature is in line with the National Urgent Care Strategy and will enable the Harrogate locality to deliver urgent care in line with the new approach to provide

-  A community/emergency care hub
-  Greater integration with Primary Care and Mental Health Providers
-  Improved patient flow

Based on this model, the existing ED department would be extended to provide an Urgent Care Centre, including the provision of improved diagnostic facilities for a second CT scanner and MRI which will provide additional resilience. As part of this project it will be necessary to relocate the existing orthopaedic department to new facilities on the hospital site. Without the creation of this centre the Trust will be unable to continue to meet the ED performance standards and deliver improvements in urgent care, resulting in patient delays in ED, inappropriate emergency admissions, and further pressure on the inpatient beds.

Phase 3: Redevelopment of the Obstetric Unit to include Midwifery led facility

The provision of an Urgent Care Centre that brings services together will release capacity elsewhere on the site that can be adapted to support the introduction of a Midwifery Led Obstetric Unit in line with the delivery of the Better Births agenda. As part of the clinical alliance discussions with Leeds Teaching Hospitals Trust, it is acknowledged that the introduction of a unit of this nature would provide capacity in the wider locality, ensure future clinical sustainability and give women a choice in the type of unit they wish to access.

Phase 4: Provision of an Elective Centre

The redesign of the front of the hospital site to focus on urgent care will present the Trust with the opportunity to reconfigure facilities elsewhere on the site, with a view to creating an elective care facility, including wards and theatre capacity that can support the delivery of elective activity for the locality and the wider health and care partnership. Through the protection of our elective care capacity it will be possible to repatriate NHS elective work from the private sector which supports the wider health and care partnership strategy to deliver NHS work within the NHS and improve financial and clinical sustainability for the partnership as a whole.

The Harrogate Hospital site is landlocked with limited capacity for expansion. It is anticipated that Tees Esk and Wear Valley Mental Health NHS Foundation Trust (who are currently occupying Trust facilities in the Briary Wing at the rear of the hospital site), will be relocating to alternative premises. No date has been confirmed, but is anticipated that it will be within the next 2-3 years. The vacation of this accommodation will create the site flexibility to enable the strategic changes outlined above to be facilitated.

The value of the full site redevelopment has been estimated at over £60m, but clearly further work is required to establish the priorities within the strategic plan and align funding availability with the strategic programme.

Discussions will continue with our partners in the HCP to consider our capital proposals and funding availability over the next 5 years. We will continue to contribute to the development of the HCP estate strategy and develop our proposals further for consideration as part of the HCP capital bidding process.

Whilst our longer term capital strategy is in the process of being determined, the Trust recognises the need to address the short term requirements in relation to the replacement of medical and scientific equipment, backlog maintenance management, and the implementation of our IT strategy.

Business as usual investment, such as replacement equipment, will be supported using internally generated cash reducing the amount of reactive expenditure which is required however, it is recognised that capital funding is at a premium. Discussions have taken place with the Clinical Directorates to agree the Capital priorities for 2018/19 subject to the availability of resources. Building infrastructure investment to manage backlog maintenance will be discussed with our subsidiary company Harrogate Healthcare Facilities Management Ltd, and the contract varied in line with the agreed investment programme.

A number of schemes have been identified subject to delivery of the financial plan which will create the necessary internally generated cash to allow investment during 2018/19. The schemes can be summarised as follows: -

Completion of existing schemes	New commitments
Endoscopy (inc equipment)	IT allocation
Nuclear medicine scanner	Estate (via HHFM)
	Woodlands ward minor alterations
	Medical records storage

In addition, the Hospital Charity will continue to explore opportunities for fundraising for items of medical and scientific equipment, in particular the upgrading of the existing Cath Laboratory in the Heart Centre and additional diagnostic capacity (CT scanner initially).

As part of WYAAT and the STP we have also been successful in relation to a bid to deliver Scan for Safety, and this investment profile is being developed.

In relation to the Community Estate, the Trust is continuing to explore opportunities to rationalise the number of properties occupied across Harrogate and North Yorkshire, in conjunction with our partners including NHS Property Services (NHSPS) and the Local Authority. The ultimate aim is to reduce the estate footprint across the patch.

4.5 IT Strategy

The IM&T strategy describes a vision and framework for a robust scalable IT infrastructure that delivers information where staff need it, robust governance arrangements, high quality information management, training and development of IT skills in staff, efficient project management and procurement and collaborative working with other NHS organisations. The key deliverable at the centre of the strategy is the implementation of an Electronic Patient Record (EPR) called WebV in support of a paperless or paper-lite environment by 2020. Introducing a clinical solution that delivers real-time information is a fundamental part of the strategy.

The WebV Electronic Patient Record (EPR) system developed by North Lincolnshire and Goole NHS Foundation Trust is currently being delivered. To date three modules have been deployed and continue to be rolled out. In 2018/19 a further 6 modules will begin delivery and roll out and local development of WebV by HDFT staff will also commence. The Trust is part way through the delivery of a replacement PACS system called EI and is due to go live later this year and a number of other clinical IT systems have and are being delivered. Additionally, the Trust continues to replace its server infrastructure moving towards a virtual server platform and has recently delivered a public Wi-Fi service for patients and relatives. Due to recent cyber-attacks across the NHS, work has focussed on ensuring the Trust is fully prepared for any such attacks in future and is delivering a number of technical and policy changes in support of this work.





5. Quality Planning

5.1. Approach to Quality Governance and Quality Improvement

Our executive lead for quality is the Chief Nurse, supported by the Medical Director, who is the executive lead for patient safety and the Director of Workforce and Organisational Development.



The organisation wide improvement approach to maintaining a good CQC rating, and achieving an outstanding rating in the future, includes promoting our values and behaviours, and having a clear focus on improving quality in all that we do. We closely monitor quality performance metrics, and focus our clinical and internal audit plan on priority areas, monitoring implementation of action plans to ensure improvement prior to further evaluation by re-audit. We monitor and act on staff feedback using the staff Friends and Family test (FFT) and national Staff Survey, and patient feedback using the patient FFT, compliments, comments, concerns and complaints. We have established processes for investigating and learning from errors and incidents, and promote a robust safety culture which is monitored using a suite of metrics. There are regular unannounced Director inspections to assess compliance against a clear framework, and patient safety visits that encourage staff engagement with the Board in relation to patient safety.

The key quality governance structures and processes at ward and department level are the Quality of Care Teams. These are planned multidisciplinary meetings with defined standards which include:

-  Promotion of quality improvement including in relation to Trust and directorate initiatives;
-  Review of key performance indicators and the departmental risk register;
-  Review of complaints, incidents and audits, and monitoring of progress with action plans to deliver learning and change in service delivery;
-  Celebrating success and innovation.

There is an expectation that information from these meetings is shared with the wider team and reported within the directorate governance structure. Within clinical directorates and across the Trust, there is a framework of groups and committees with appropriate representation, focused on progressing work relating to specific aspects of quality, quality improvement and innovation. These report by exception to directorate boards, steering groups or the Clinical Transformation Board that all report into the Senior Management Team (SMT). The latter is chaired by the Chief Executive who provides a summary report to the Board. The SMT monitor quality and integrated dashboards, and agree Trust wide quality priorities each year, taking into account local and national performance and initiatives. There is a lead appointed for each quality priority with improvement targets, work plans and metrics agreed and monitored by the Quality Committee. Assurance and progress in relation to clinical audit and internal audit are monitored by Quality Committee and Audit Committee respectively. Together with the quality and integrated dashboards, and specific reports from the executive leads, the Board is kept informed about quality and quality improvement.

Our Innovation and Improvement Strategy details the building of quality improvement capacity and capability in the Trust to implement and sustain change. Every quality improvement project or intervention delivered has clear targets set from the outset. Measures are used to indicate whether the changes made have actually secured an improvement in quality. The development and delivery of our Quality Charter is the key vehicle for building quality improvement capacity within the organisation and has been developed as part of our commitment to:

-  Reward and recognise our colleagues who carry out improvement activities
-  Celebrate the everyday successes that our colleagues achieve

The Charter has been built on four 'joining' elements and we have set specific actions for each of these:

1. Setting our ambition for quality and safety
2. Promoting staff engagement
3. Providing assurance on care quality
4. Supporting a positive culture

The Quality of Care Champions scheme is being delivered as part of the Charter. It is open to all employees, regardless of job role. This scheme recognises and rewards colleagues who undertake training and deliver quality improvement work. It facilitates personal and professional development by providing a structured framework for progression from "preparing" (bronze level) to "excellence" (platinum) through "delivering" (silver) and "teaching" (gold) levels. Quality of Care Champions, no matter what level they are working at, will receive a certificate and pin badge in recognition of their knowledge and achievements in quality improvement. Other elements of the Charter include Making a Difference awards, Team of the Month, Quality Conference and quality campaigns. A Quality of Care Team scheme is about to be launched, whereby a team can be accredited for developing a vision for improvement, a team culture to achieve that and then for sustaining and sharing high quality.

6.2 Summary of the Quality Improvement Plan





Our quality improvement plans in relation to local and national initiatives include:

National and local clinical audits

HDFT has an annual programme of clinical audit which incorporates a balance of both national and local priorities. The Trust participates in relevant audits within the National Clinical Audit and Patient Outcomes Programme (NCAPOP). We review our performance from all local and national audits we undertake using either locally produced or national benchmarking reports respectively, to identify areas of good practice and where improvements can be made.

The four priority standards for seven day hospital services

To support the delivery of high quality urgent and emergency care every day as identified in the Five Year Forward View, 10 clinical standards were developed by the NHS Services, Seven Days a Week Forum led by Professor Sir Bruce Keogh. From these four were identified as a priority:

-  Time to Consultant Review
-  Access to Diagnostics
-  Access to Consultant-directed interventions
-  On-going review

There are three phases to the implementation of these standards nationally, which commence with the five specialist service areas (vascular; stroke; major trauma; heart attack; children's critical care) in 2017. There are then two further phases to reach the ambition of >95% of the population being covered by hospitals meeting the four priority standards.

HDFT has not been identified as a phase one site; however HDFT, as part of the West Yorkshire Urgent and Emergency Care Network, is working with the rest of West Yorkshire and will be developing a local strategy to Emergency Care Network, is working with the rest of West Yorkshire and will be developing a local strategy to develop services to support the standards. The Trust is utilising the benchmarking data which is being produced from the national seven day service audit to identify the key areas of focus along with the gap analysis work which has already been completed.

Safe staffing and care hours per patient day

HDFT ensures safe nurse staffing of inpatient areas through implementing recommendations of the safe staffing guidance issued from the National Quality Board and monthly monitoring of actual versus planned staffing levels by the Board. We plan to review the expected staffing guidance from NHS Improvement for other nurse staff groups when available. HDFT is also improving roster practices and will review our performance in relation to care hours per patient day with the aim of ensuring we have the right staff, in the right place at the right time.

Improving the quality of mortality review and serious incident investigation and subsequent learning and action

The Trust has developed and implemented a Learning from Deaths Policy to standardise an approach to reviewing the care provided to patients who die, with the aim of identifying learning that will contribute to our quality governance and quality improvement work. Quarterly reports have been provided to the Board of Directors from December 2017 to include detail of the process, any identified learning and any actions to be taken to ensure improvement in the care provided.

Any serious incidents (SIs) will continue to be subject to a root cause analysis and learning review. Comprehensive SIs will have a team assigned, including a trained senior investigator, Non-executive Director, and staff and patient support officers, to undertake a detailed review and to prioritise subsequent learning and action.

Infection prevention and control










The Trust has an established Healthcare Associated Infection (HCAI) Improvement Plan which evolves in response to national and local initiatives and issues. The Infection and Prevention and Control (IPC) Committee structure supports ongoing review and implementation of this plan, as well as devolved responsibility for HCAI to directorate management and clinical teams. Over the next two years the focus will be on assurance that action plans arising from root cause analysis investigations are implemented.

The Hospital and Community IPC Teams will continue to lead the Trust and also the North Yorkshire CCGs in a whole health economy approach to respond to HCAI challenges including *C. difficile*, staphylococcal bacteraemia and the anticipated new initiative requiring reduction of Gram negative bacteraemia cases.

The North Yorkshire TB Team will work towards implementation of the 2016 NICE guidelines with a particular emphasis on screening of “at risk” groups and individuals for latent TB infection.







Other initiatives included in the quality improvement plan are detailed below:

Initiative	Plans
Falls	<p>Our priority is to continue to work towards effective falls prevention in hospital and to reduce the number of falls and the level of harmful falls of people in our care. This will be achieved by:</p> <ul style="list-style-type: none"> ▲ Actively participating in national inpatient falls audits and incorporating key recommendations into our patient care. ▲ Focusing on training our workforce of clinicians, therapists and support teams by raising awareness of how to reduce falls in older people. ▲ Increasing clinic capacity for the multidisciplinary falls clinic by developing a specialised advanced care practitioner. ▲ Prioritising protocols of care and management of patients who have fallen in hospital, by improving guidance and documentation used by doctors and nursing teams. ▲ Promoting safety huddles which encourage doctors, nurses, therapists and support teams to work together to reduce inpatient falls. ▲ Regularly review and implement technology when and where appropriate. ▲ To introduce a review and pathway for older people, at risk of falls, seen within the Emergency Department. ▲ Continue to liaise closely with GPs, community and voluntary groups to support and promote their evidence based community exercise programmes; and raise awareness of older people of the positive impacts that exercise, in a social environment, can have on their levels of confidence, stability and mobility and ultimately result in the reduction of falls in older people.

Sepsis	 Continue the progress already made on screening patients for sepsis, ensuring that patients with severe sepsis are rapidly identified and intravenous antibiotics administered as a priority.  Continue to ensure full implementation of a sepsis module on our electronic observation and escalation system Patienttrack to facilitate this.  Embedding sepsis screening and management using UK Sepsis Trust tools in the GP Out of Hours Service.
Pressure Ulcers	 Continue to support a “zero tolerance” approach to avoidable pressure ulcer development in people who are receiving nursing care, which will be supported by our pressure ulcer prevention strategies including training and investigation processes
End of life care	 Introduce our end of life strategy, continuing to focus on supporting staff to provide person centred high quality care at end of life across the organisation, developing metrics that can be monitored, providing transparency and assurance.
Patient Experience	 Focus on ensuring frontline staff are empowered to proactively seek out dissatisfaction, resolving minor problems informally as quickly as possible. The Patient Experience Team will continue to promote the resolution of issues with clinical teams efficiently, and ensure patient feedback is used to identify opportunities to improve patient care.
Anti- microbial resistance	 Continue to focus on antimicrobial stewardship (AMS) using regular audit to monitor prescribing trends and identify areas for development. We will continue to engage prescribers through education, awareness events and the sharing of individual Consultant prescribing data. Targeted AMS ward rounds will continue with emphasis on reduction of broad spectrum antibiotic use. The laboratory will make changes to the reporting order of antibiotic susceptibilities to encourage use of narrow spectrum agents. Local antibiotic resistance data will be shared annually.
Mental health standards (Early Intervention in Psychosis and IAPT)	 Although HDFT does not provide mental health services, we will support a place-based ambition to achieve 60% of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral by 2021. There is also an ambition to improve the proportion of people referred to Improving Access to Psychological Therapies (IAPT) starting treatment within specified timeframes, and having an effective response to treatment.
Actions from the Better Births review	 Following review of the Better Births Review we will consider developing community hubs, whilst implementing small teams of community midwives, aligned with a named Consultant, to improve continuity. We are reviewing the impact of transitional care on Pannal Ward on staffing and resources, and also reviewing the provision of a midwife led care facility. Business cases to be developed for a specialist perinatal mental health midwife to meet the national recommendations and to deliver training for all midwives and obstetric staff, and also to support the purchase of the Birthrate Plus® acuity tool. Electronic maternity records will be part of the planned Trust wide implementation.

National CQUINs

The Trust will continue to prioritise the requirements of the 2017-19 national CQUIN schemes, these being:

-  Improving staff health and well-being
-  Supporting proactive and safe discharge
-  Reducing the impact of serious infections
-  Improving services for people with mental health needs who present to ED
-  E-referrals, and preventing ill health by risky behaviours – alcohol and tobacco
-  Advice and guidance

Local quality priorities will continue to be agreed with stakeholders each year, and plans and subsequent progress and results will be reported in the Trust's Quality Account. The quality priorities for 2018-19 are to:

1. Ensure effective learning from incidents, complaints and good practice;
2. Reduce morbidity and mortality related to sepsis;
3. Improve discharge processes;
4. Increase patient and public participation in the development of services;
5. Promote safer births, with a specific focus on reducing stillbirths.

We have engaged with local stakeholders to consider progress with previous priorities, consider other local and national priorities including the West Yorkshire and Harrogate STP, and agree these specific areas for quality improvement during 2018-19. Work in relation to previous quality priorities will continue.

We will be supporting individual and community resilience, and will continue to implement our New Care Model: What Matters to Us, whilst evaluating outcomes to ensure it delivers the

right place-based solution of integrated care. We will be taking a system approach to reducing demand and variation in elective care and are using Right Care methodology, the Elective Care Rapid Testing Programme (100 day challenge) to work on clinical thresholds. We will continue to support the establishment of a referral management service with clinical review, and develop our Out of Hospital Strategy. There will be a focus on self-care, prevention and early intervention, and the promotion of evidence based lifestyle prevention services, including the roll out of a diabetes prevention programme during 2018/19. These areas of focus are in line with our STP.

Summary of Quality Impact Assessment Process (QIA)

Efficiency plans are developed within the directorates as a result of engagement with frontline clinical and non-clinical staff. Screening is undertaken using a Trust template to identify any impact on quality against the three core quality domains (safety, effectiveness and experience), as well as impact on equality.

Any scheme with a moderate or significant impact at screening requires a detailed impact assessment if it is to be taken forward. At this stage risk and opportunity scores for quality and equality, mitigating actions and specific metrics for monitoring impact will be identified. When necessary additional information will be prepared which may include baseline data covering an appropriate period to capture seasonal variations, and engagement with staff and service users. Each directorate Board is required to approve schemes to be progressed following impact screening and assessment, and these will then be subject to challenge and scrutiny by the Medical Director and Chief Nurse.

Further work is planned to ensure service developments and service transformation are also subject to the same impact assessment, and that any potential cumulative impact of several schemes on a particular pathway, service, team or professional group is considered.

The quality dashboard and integrated board report contain metrics that reflect safety, effectiveness and experience but other key performance indicators aligned to specific schemes will be developed to facilitate early sight of potential impact on the quality of care when necessary. A summary of the schemes, impact assessment process and any relevant key performance indicators is reported to the Board.

Summary of Triangulation of Quality with Workforce and Finance

The Trust will continue to triangulate intelligence in relation to quality, performance, workforce and finance, using this to monitor and improve the quality of care and enhance productively. The Integrated Board Report includes key indicators for each and is reviewed monthly at SMT, the Quality Committee and the Board of Directors.

Quality	Workforce	Efficiency	Finance
Safety Thermometer performance	Safer staffing levels	Readmission rates	Cash balance
Incident data relating to pressure ulcers and falls	Staff FFT	Length of stay	CIP achievement
C. Difficile data	Appraisal	Theatre utilization	Capital spend
Mortality	Mandatory training	Delayed transfer of care	Agency spend in relation to pay spend
Complaints	Sickness	Outpatient DNA rate and New to follow up ration	NHS improvement financial performance assessment
Patient FFT	Staff turnover rates	Day case rate	
Maternity Specific Indicators			

6. Financial Planning

6.1. Overall Financial Challenge

In line with all NHS Providers, there are significant financial challenges to be faced in 2018/19, with key drivers being the availability of appropriate workforce and the management of urgent care. As a local Harrogate health community, we are currently spending more on healthcare than is available, with the CCG recording a deficit in 2017/18 and forecasting a deficit into 2018/19 plans. We are working collectively across the system to manage financial risk, including the agreement of an Aligned Incentive Contract, in order to create a framework for the necessary difficult decisions and prioritisation that will have to take place through the year.

The priority of the Trust and the Harrogate system is to deliver financial sustainability for both organisations and principles have been agreed to this effect. This recognises that the best way of meeting the overall significant financial challenges is to work collaboratively to reduce the costs of healthcare for the local population.

6.2. Financial Performance for 2017/18

The Trust financial position for 2017/18 is a surplus of £0.1m before impairments, significantly behind the planned surplus position of £5.9m.

This considerable adverse variance to plan has resulted in significant pressure on the Trust's resources as a result of the subsequent availability of cash to support capital developments.

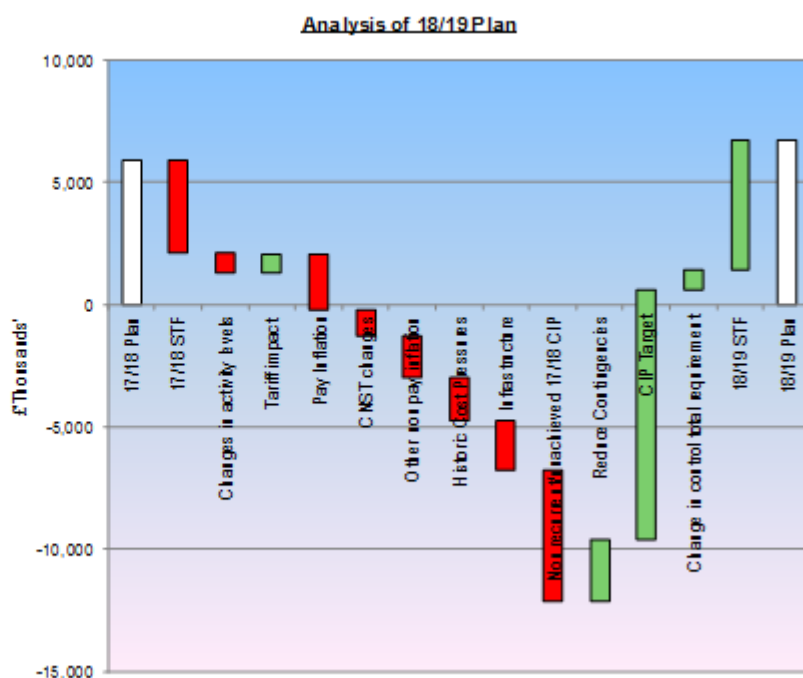
These figures include Sustainability and Transformation Funding of £2.45m. Without this the Trust would have reported a deficit position of £2.4m, £4.5m behind plan. The underlying position represents a notable pressure to the new financial year and highlights the pressures faced by the Trust currently.

6.3. 2018/19 Planning Assumptions

The financial assumptions for the 2018/19 plan are outlined below.

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



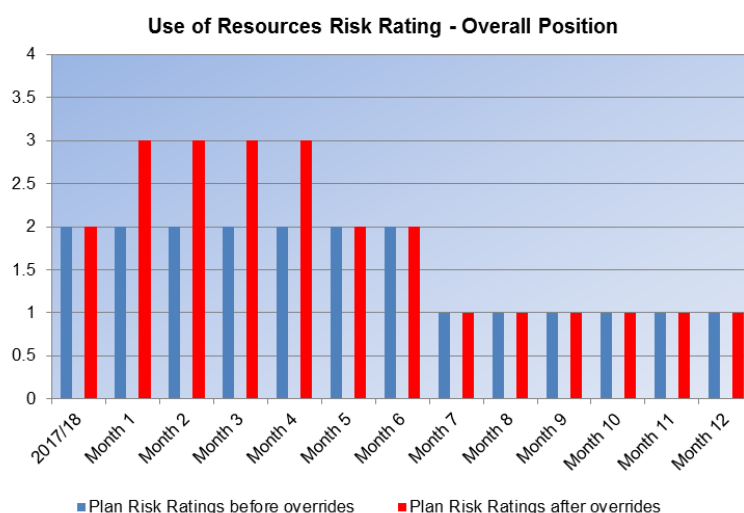
This plan has been robustly developed across the directorates, investing in the areas where the Trust has pressures. In turn, this provides a challenging Cost Improvement (CIP) target, which is needed to provide the cash for capital resources for the Trust, as well as meeting the control requirements set by NHS Improvement.

Key assumptions that feed into plan are –

- ▲ A reduction in planned activity levels to reflect a prudent approach to planning for 2018/19. These plans still equate to more activity than 2017/18 outturn, however, the above is a plan to plan summary. An appropriate level of infrastructure has been added to the plan to support this additional activity above outturn.
- ▲ At present pay expenditure assumptions are based on a 1% pay award and will need to be updated when the pay settlement is finalised.
- ▲ Funding for historic pressures and non pay inflation has been reviewed and finalised within the above.
- ▲ Non recurrent and unachieved CIP plans from 2017/18 cause a significant pressure moving into the new financial year, effectively doubling the Trust's saving requirement.
- ▲ As a result of the prudent planning outlined above, the level of contingency the Trust holds has been reduced.
- ▲ Finally, as a result of the above a CIP requirement of £10.2m is required for 2018/19. This is likely to rise by £500k as a result of the 2017/18 outturn position and its subsequent impact on 2018/19's control total.

6.4. Use of Resources Rating

The Trust is planning to have a Use of Resource Rating of 1 by the end of the financial year. This plan is outlined in more detail in the graph below.



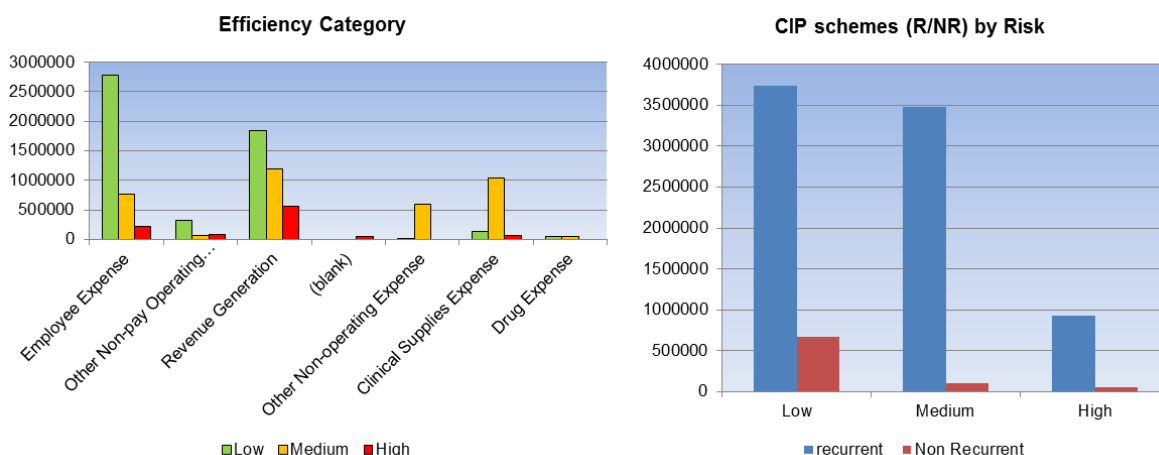
As with actual performance in 2017/18, the phasing of the plan during the first part of the year reflects the anticipated challenges of 2018/19 as the Trust seeks to address the underlying adverse position. This is expected to improve from September onwards.

6.5. Cost Improvement Programme

A CIP of £10.2m has been agreed, with the potential for this to increase dependent upon the control total adjustment as described in section 6.3 above.

The current position is as follows:

Summary	Target	Actioned	Low	Medium	High	Total	Total %age	Risk Adjust	Risk Adj %age
Corporate Services	10,201,000	835,200	5,142,783	3,707,031	999,669	10,684,683	105%	8,886,403	87%
% age of target			50%	36%	10%				



The programme has been risk assessed, and Quality Impact Assessments undertaken.

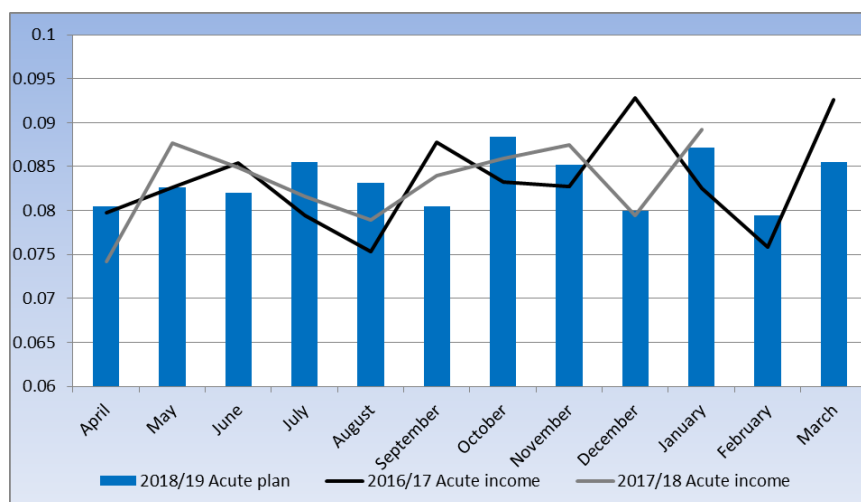
6.6. Risk

There are a number of financial risks that are being managed as part of the plan as well as a challenging CIP target to deliver as outlined above. The two key risks are the availability of workforce and the management of urgent care activity, particularly during winter. No winter funding has been assumed within the plan and this will need to be managed through the governance arrangements relating to our AIC and the A&E delivery board.

Mitigations for these financial risks relate to delivery of our approved clinical workforce strategy, managing capacity within the level of staff that we are confident we can employ, reducing the urgent care hospital activity/length of stay, and utilising any transformation funding that results from becoming part of an Integrated Care System across West Yorkshire and Harrogate. This funding would be used at local place to change the systems and processes in relation to capacity and flow (to enable the Trust to stay within a bed base that is staffed and affordable), and support the clinical workforce transition into future years.

6.7. Cash

In 2018/19, the Trusts ability to move forward capital schemes will be predicated on the availability of cash as a result of the above surplus. As well as provide for capital, there is an element of ensuring the Trusts resilience and therefore improving the cash balance is vital. The profile for cash is outlined below.



This profile assumes an extremely modest level of capital expenditure in cash terms other than the carry forwards from 2017/18. There is also no change in the receivables position, however payables has a modest improvement to reflect the recovery of the delay in payments up to month 12.

6.8. Control Total 2018/19

The planning process has been geared around delivery of the control total and subsequent receipt of S&T funding. The Board has committed to delivering the control total, but at the point of completing this plan, we are awaiting final confirmation of the Control Total for 2018/19 from NHSI. – *to be updated upon receipt of letter from NHSI*

7. Membership and Elections

Harrogate and District NHS Foundation Trust continues to develop a representative and vibrant membership of over 18,000 people, offering innovative and active engagement across the organisation.

The Council of Governors is an integral part of the Trust and ensures that we are accountable to the community we serve. Governors have key responsibilities and, through their work to represent the interests of the members and the general public, strengthen and enhance the Trust's Vision and strategic objectives.

The Trust's Membership Development Strategy guides the drive to encourage a wider and more diverse membership which focusses on quality engagement and promotes the different ways in which we can listen to our service users, across the population we serve, our staff, and the many stakeholders across health and social care. Members have been invited to attend a stakeholder event to discuss our Equality Delivery System (EDS2) grading and subsequent actions. We continue to publicise the public Board of Director meetings, public Council of Governors' meetings and the Annual Members' meeting and we continue to engage with our younger members through our innovative and award winning Education Liaison and Work Experience programmes. During 2018 we will review and refresh our Membership Development Strategy.

The establishment of the Trust's new Youth Forum during 2017 has proved a highly successful way to actively engage with young people in decision making and give them the opportunity to influence future service development.

Over the coming year the Governor Working Group for Membership Development and Communications will continue to focus on membership recruitment and engagement in areas which are under-represented. We hope to promote membership to the wider public and service

users in partnership with our community staff and continue to work with key stakeholders and members to reach more people with protected characteristics.

We continue to promote Governor Elections and encourage people to join our Council of Governors to help shape the Trust as we move forward. We use a wide variety of Governor recruitment methods including: prospective Governor sessions held in both Harrogate District Hospital and out in the community, press releases, stakeholder communications and social media. We have commenced electronic voting, in addition to the traditional postal system, and our plans over the next 12 months will continue to focus on promoting this efficient and cost-effective method with our members.

The 'Rest of England' constituency aims to reflect the Trust's growing footprint and we will continue to promote membership in line with service delivery.

The Trust provides a local induction programme and ongoing training and development opportunities for all Governors to equip them with the skills required to undertake their role and meet their responsibilities as set out in the Health and Social Care Act 2012. These include: access to an on-line Governor Resource File, formal induction, departmental tours, introduction to a mentor, invites to educational and network briefings, internal training workshops and encouragement to attend Regional Governor Forums and external training and development provided by NHS Providers.

Appendix 1: Strategic KPIs

Details to be added

Date of Meeting:	25 April 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:	<table border="1"> <tr> <td>Decision</td> <td>✓</td> <td>Discussion/ Consultation</td> <td>✓</td> <td>Assurance</td> <td>✓</td> <td>Information</td> <td>✓</td> </tr> </table>			Decision	✓	Discussion/ Consultation	✓	Assurance	✓	Information	✓
Decision	✓	Discussion/ Consultation	✓	Assurance	✓	Information	✓				
Executive Summary:	<ul style="list-style-type: none"> • With the exception of the 2WW standard for breast symptomatic patients, all cancer waiting times standards were achieved for each quarter of 2017/18. • All three headline national standards were delivered for the 2017/18 financial year. • Elective and outpatient activity did not reach the recovery plan. A&E and NEL activity exceed plan for the year. • The new Stockton-on-Tees children's contract was successfully mobilised from 1 April with positive feedback from the new staff. 										
Related Trust Objectives											
<table border="1"> <tr> <td>To deliver high quality care</td> <td>✓</td> <td>To work with partners to deliver integrated care:</td> <td>✓</td> <td>To ensure clinical and financial sustainability:</td> <td>✓</td> </tr> </table>				To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓		
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 9: risk of a failure to deliver the operational plan; BAF 10: risk of a breach of the terms of the NHS Provider licence;										
Legal / regulatory:	None										
Resource:	None identified.										
Impact Assessment:	Not applicable.										
Conflicts of Interest:											
Reference documents:											
Assurance:											
Action Required by the Board of Directors:											
<p>It is recommended that the Board/Committee:</p> <ul style="list-style-type: none"> • <i>Note items included in the report.</i> 											

1.0 OUTTURN FOR RTT, A&E, AND CANCER 62 DAYS 2017/18

The table below sets out the achievement of all three headline national standards for the full year position. Although throughout the year there have been fluctuations in performance and a decline in performance towards the end of the year for two of the measures, the overall achievement of these headline performance measures for our patients is very positive and our staff should be commended for achieving this.

Performance Indicator Description	Q1	Q2	Q3	Q4	YTD
RTT - incomplete - % in 18 weeks	93.8%	92.3%	91.9%	90.4%	92.1%
All Cancers: 62 Day Target	86.0%	88.9%	90.5%	90.3%	88.9%
Trust total - Total time in A&E - % within 4 hours	96.7%	96.0%	94.9%	92.8%	95.2%

2.0 SERVICE ACTIVITY

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

Activity type	Feb-18				Mar-18				Mar-18 YTD			
	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	7543	7778	7931	-4.9%	7836	8167	8312	-5.7%	96368	97611	98459	-2.1%
Follow-up outpatients	14316	17132	14539	-1.5%	15307	16379	15283	0.2%	186925	192666	187271	-0.2%
Elective inpatients	274	336	303	-9.7%	294	294	328	-10.4%	3470	3962	3675	-5.6%
Elective day cases	2401	2712	2650	-9.4%	2611	2840	2768	-5.7%	29063	31525	29847	-2.6%
Non-electives	1799	1670	1670	7.7%	1787	1865	1865	-4.2%	22436	21734	21734	3.2%
A&E attendances	3705	3721	3721	-0.4%	4249	4120	4120	3.1%	49470	48507	48507	2.0%

Surgical consultant-led new outpatient activity was above plan in March with General Surgery and Urology significantly over plan. However when taking into account nurse led activity, outpatient procedures and ward attenders, new outpatient activity was below plan overall.

Day cases were below plan in March – in particular in gastroenterology, ophthalmology and orthopaedics. General surgery day case activity has increased and was on plan for the month of March. Urology day case activity was above plan.

Despite an increase in inpatient activity from January and February, March was below plan, with Trauma & Orthopaedics 20 patients below plan. Thirteen patients were cancelled (with ten of these being orthopaedic) as no beds were available, and 11 were cancelled due to a lack of theatre time. There was also an impact through March of Anaesthetic cover, mainly due to two leavers and one staff member on long term sick. Significant cover has been provided internally, however there remained some impact with ten patients cancelled due to this. The Anaesthetic clinical lead is working with the management team regarding ongoing cover arrangements. Although the elective inpatient activity was below plan, a great deal of time and effort was undertaken in order to maintain theatre lists whilst the bed pressures were ongoing through March, with decisions made on a daily basis in relation to the cancellation of elective inpatient work.

The number of medical patients on surgical wards remained high through the month of March and Swaledale ward remained open and EADU worked around inpatients being admitted. Littondale SAU remained closed for the majority of the month due to the beds being required for admissions.

Nurse staffing in Ophthalmology remains very challenging with the risk being escalated to the Corporate risk register. Accelerated training is being undertaken for DSU staff to take a

greater role in theatre lists and helping with the pre-assessment of Ophthalmology patients. Three Care Support Workers have started and a member of staff is back from long term sick leave, so this will ease some pressure moving forwards.

Both the General Surgery and Orthopaedic Consultant posts were advertised at the end of March with both attracting interest. Interviews are at the end of May and the beginning of June respectively.

3.0 CHILDREN'S SERVICES

Medical staffing within HDFT paediatric services remains challenging, which is primarily due to the 3.5 vacancies at the middle grade level. It is hoped an international medic, who has been recruited, will start at the end of April however, they will require a period of induction before starting on the on-call rota. There is a rolling programme of recruitment but with minimal success, in part due to national shortages, but the Directorate will be progressing with their CESR programme which seeks to provide a medium to longer term solution. The current situation means that paediatric consultants are acting down into middle grade roles when required.

The Directorate has successfully mobilised the new Stockton-on-Tees children's contract from 1 April and the feedback from the new staff regarding the engagement and mobilisation process within HDFT has been excellent.

4.0 CANCER SERVICES

Oncology Service

The risk around Oncology provision reported in the last Board update has reduced temporarily as a locum Oncologist has been appointed in early April. Furthermore agreement has been reached for all Cancer of Unknown Primary patients to be managed through the MDT in York for the foreseeable future; this is an important agreement to ensure appropriate leadership of clinical management plans during the period when HDFT do not have a full time substantive Oncologist in place. A meeting has taken place with both Leeds and York Trusts to develop a longer term sustainability plan for the medical staffing requirements on the HDH site. This Board will be updated as this plan develops.

Performance

Performance against the 14 day standard for breast symptomatic patients was below the required 93% standard for the second consecutive month in March with 89.5% of patients seen after day 14. Consequently the standard was not delivered for Quarter 4 (89.4%). However for 2017/18 overall, 94.4% of patients were seen within 14 days.

Trust performance for the 62 day standard was above 85% for the eighth consecutive month in March with 89.9% of patients treated within 62 days. Performance for the quarter and financial year was at 90.3% and 88.9% respectively. All other applicable standards were achieved for the month and quarter, and all standards were achieved for the financial year.

Inter-Provider Transfer (IPT) performance

As stated above, 62-day performance for March with the current allocation rules is at 89.9%. A total of 15 patients were treated at tertiary centres in the month following a 2WW referral to Harrogate. Of these, ten were transferred by day 38 (66.7%). For the year-to-date, 59.4% of patients were transferred before day 38.

The rules for re-allocation of treatments and breaches have now been clarified and disseminated by the national team, and collection of IPT data in the new national Cancer Waiting Times database will commence in July. Overall, the Trust supports the reasoning and implementation of the new rules, and it is felt that these will result in a fairer distribution of provider accountability.

Shadow reporting of the 62 day standard shows that when the national re-allocation rules are applied, performance would have been 0.3% lower for March, 0.6% lower for the quarter, and 0.3% lower for the year. However, performance but would have remained above 85% at 88.7%.

For 2017/18, the sites where shadow performance is over 3% lower than standard reporting are: Head and Neck, Lung, and 'Other' (usually cancers of unknown primary (CUP)).

The table below illustrate HDFT's actual reported performance, and performance when re-allocation rules are applied.

ACTUAL performance	Q2	Oct-17	Nov-17	Dec-17	Q3	Jan-18	Feb-18	Mar-18	Q4	YTD
Total	180.0	67.5	61.0	46.0	174.5	44.0	51.0	54.5	149.5	669.5
Within 62 days	160.0	62.0	53.5	42.5	158.0	39.5	46.5	49.0	135.0	595.5
Outside 62 days	20.0	5.5	7.5	3.5	16.5	4.5	4.5	5.5	14.5	74.0
Performance	88.9%	91.9%	87.7%	92.4%	90.5%	89.8%	91.2%	89.9%	90.3%	88.9%
Re-allocation (NATIONAL)	Q2	Oct-17	Nov-17	Dec-17	Q3	Jan-18	Feb-18	Mar-18	Q4	YTD
Total	177.0	67.0	61.0	45.5	173.5	43.0	50.0	53.0	146.0	658.5
Within 62 days	156.5	62.0	53.5	43.0	158.5	37.5	46.0	47.5	131.0	584.0
Outside 62 days	20.5	5.0	7.5	2.5	15.0	5.5	4.0	5.5	15.0	74.5
Performance	88.4%	92.5%	87.7%	94.5%	91.4%	87.2%	92.0%	89.6%	89.7%	88.7%
Difference (National/Actual)	Q2	Oct-17	Nov-17	Dec-17	Q3	Jan-18	Feb-18	Mar-18	Q4	YTD
Total	-3.0	-0.5	0.0	-0.5	-1.0	-1.0	-1.0	-1.5	-3.5	-11.0
Within 62 days	-3.5	0.0	0.0	0.5	0.5	-2.0	-0.5	-1.5	-4.0	-11.5
Outside 62 days	0.5	-0.5	0.0	-1.0	-1.5	1.0	-0.5	0.0	0.5	0.5
% difference	-0.5%	0.7%	0.0%	2.1%	0.8%	-2.6%	0.8%	-0.3%	-0.6%	-0.3%
IPTs (actual patients) SENT	Q2	Oct-17	Nov-17	Dec-17	Q3	Jan-18	Feb-18	Mar-18	Q4	YTD
Total	50	12	13	8	33	10	12	15	37	170
Within 38 days	30	6	12	6	24	6	7	10	23	101
Outside 38 days	20	6	1	2	9	4	5	5	14	69
Performance	60.0%	50.0%	92.3%	75.0%	72.7%	60.0%	58.3%	66.7%	62.2%	59.4%

5.0 CQC INSIGHT FOR ACUTE NHS TRUSTS – MONTHLY UPDATE

CQC published the latest Insight packs for all Trusts on 16 March 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.

The headline composite indicator score is composed of 12 specific indicators where performance is highly correlated to inspection ratings. The latest HDFT composite score is similar to other acute trusts that were more likely to be rated as requires improvement, and the score remains within the middle 50% of acute trusts. The indicators with a declining performance are:

- Staff flu vaccination uptake (based on the change from Sept 15 – Feb 16 to Sept 16 – Feb 17);
- Patient-led assessment of environment for dementia care (%) (based on the change from Feb 16 – June 16 to March 17 – June 17).

There are currently no active outliers for maternity and one 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. This is under review by the regional CQC team and followed up at engagement meetings.

Of the 77 Trustwide 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%)

62 indicators have been compared to data from 12 months previous, of which 4 (6%) have shown an improvement and 2 (3%) have shown a decline:

- 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 - 2 (3%)
 - Flu vaccination uptake
 - Patient-led assessment of environment for dementia care

Inpatient response rate for FFT has been removed from the indicators listed as showing a decline.

Date of Meeting:	25 April 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:	<table border="1"> <tr> <td>Decision</td> <td></td> <td>Discussion/ Consultation</td> <td>✓</td> <td>Assurance</td> <td>✓</td> <td>Information</td> <td>✓</td> </tr> </table>			Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓
Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓				
Executive Summary:	<ul style="list-style-type: none"> Trust response to the national Call for Action on tackling bullying at work Progress regarding the 2018 Staff Appraisal Window New approach for Flu Vaccination Programme 2018-19 										
Related Trust Objectives											
<table border="1"> <tr> <td>To deliver high quality care</td> <td>✓</td> <td>To work with partners to deliver integrated care:</td> <td>✓</td> <td>To ensure clinical and financial sustainability:</td> <td>✓</td> </tr> </table>				To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓		
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: <ul style="list-style-type: none"> Note the content of the report and comment as required 											

a) Sickness Absence

The overall sickness absence rate across the Trust for February 2018 has decreased from 5.36% in January to 4.68% in February which is 0.78% above the overall Trust target of 3.90%. In comparison with February 2017, when the sickness absence rate was 4.59%, this is higher by 0.09% in 2018. We have seen consecutively over the last three months (December, January and February) that the top reason for absence across all four Directorates was due to cold and flu.

There has been a reduction in sickness absence within all of the Directorates:

- Children's and Countywide Care - has moved from 5.05% to 4.93% which is an overall decrease of 0.12% in February.
- Corporate Services - has seen a decrease of 0.6% moving from 3.94% to 3.34% in February.
- Long Term and Unscheduled Care - has seen a decrease from 5.69% to 4.59% which is a 1.1% decrease in February.
- Planned and Surgical Care - has seen a decrease of 0.81% moving from 6.26% to 5.45%.

The action over the coming months is to focus on short-term sickness management across the Trust, specifically ensuring that the short-term absence process is implemented across departments. To support with this a short-term absence 'crib sheet' has been developed, there will be regular attendance at management meetings to review short term absence cases in detail and developing management plans where appropriate. In addition, there will be a focus on ensuring all absences related to sickness are supported by a return to work interview.

b) Tackling Bullying – a Call to Action

The 'Tackling Bullying in the NHS; a collective call to action' (December 2016)' sets out the ambition for a measurable improvement of the national staff survey results by 2020.

The national NHS staff survey has repeatedly shown that about a quarter of NHS staff feel bullied by their managers, subordinates or colleagues. This is clearly unacceptable and impacts not only on staff health and well-being but patient care and outcomes. The NHS has an opportunity to improve the experience of staff by tackling bullying and creating positive cultures. Leaders across the NHS are committed to making a difference by promoting supportive cultures where staff can flourish and problem behaviours such as bullying are tackled. The NHS Social Partnership Forum (SPF) is leading this initiative and wants to encourage and support organisations to take further action by asking them to explore their cultures in partnership with staff, commit to positive action and track progress.

In response to the Collective Call to Action we are delivering a number of initiatives to help us explore the cultures and understand the nature and extent of the problems. Firstly we will be re-launching the Managing Workplace Relationships roadshows which will take place during weeks commencing 16 and 27 of April. These will be hosted by representatives from Human Resources, Bullying and Harassment Advisors, the Freedom to Speak up Guardian and the Health and Wellbeing Service.

Following this a series of proactive interviews will be held in May. Departments for the proactive interviews are being identified through engagement with Directorate Boards and HR

Business Partners, along with analysis of our staff survey data. Analysis from the roadshows, staff survey and proactive interview feedback will provide us with a baseline assessment of the nature and extent of the problem. Following the analysis, goals will be set identifying what needs to change, with clear timescales for delivery.

We hope to achieve a positive change in our Staff Survey Results by 2020 in relation to the key finding 26 (% staff that have personally experienced harassment, bullying or abuse from staff in the last twelve months.) The 2016 results for HDFT was 22% (national average 24%) and the 2017 results for HDFT was 21% (national average 24%).

In addition the Trust has reported progress to the Local Workforce Action Board (LWAB) which is working in partnership with the Social Partnership Forum with the aim of creating 'positive workplace cultures and reduce bullying by sharing and working together' as the very definition of the type of collaboration and partnership working will be needed if it is to make West Yorkshire & Harrogate both a healthy place to live and a great place to work.

c) BREXIT Action Plan

The Trust is developing a set of themed updates to send to all staff on a quarterly basis, starting from April 2018, addressing the implications of Brexit for staff. These updates will be used to reassure staff and provide details of the support offered by the Trust. They will be produced for all staff, on the understanding that all staff are interested, and potentially affected. In some instances a further communication will be required, aimed specifically at European Union (EU) staff. This will detail support options and employee engagement options for both the wider workforce and another communication targeted at EU staff specifically. The latter will provide more information that could be beneficial to those staff. A paper giving more detail is attached as an appendix to this paper.

It is expected that there will be formal communications, closer to the date of Brexit, issued by the Home Office. This will directly influence the type and content of future Trust communications. Meanwhile it is intended to open, and keep open, channels of communication with all staff but with an emphasis on ensuring that those staff from the EU are alerted to the current and changing national position.

d) Appraisal window 2018

Following from the success of the innovative 'appraisal window' in 2017 for Agenda for Change staff, which increased the appraisal rate from 85% to 90%, it has been agreed that a similar 'window' approach will operate in 2018. Some 84.6% of appraisal completed in 2017-18 were completed during the six-month window and the aspiration is to increase the percentage completed in this period to exceed the 90% total achieved last year.

The 2018 'appraisal window' opened on 1 April and will run until 30 September. Support will be given to both managers and staff to increase the number of appraisals completed, including the 'appraisal on a page' which was used for the first time in 2017.

e) CQUIN Update

The 2017-18 CQUIN report for Improving Staff Health and Wellbeing has now been completed. This required the achievement of a 5% improvement in two out of three NHS National Staff Survey questions on health and well-being, musculoskeletal and stress, using the 2015 and 2016 results as a baseline.

Despite a significant number of interventions, including a range of mental health initiatives, the SHU Wellness programme, a re-launch of the Trust's health and wellbeing offer to staff, and a

range of personal resilience training opportunities, the Trust has not met the CQUIN for 2017-18, based on the required parameters. The 2018-19 CQUIN is based on a percentage point increase from the results of the 2016 NHS National Staff Survey to those in the 2018 Survey. The proposed approach to continuing to improve the health and wellbeing of Trust staff will be brought to SMT in May. The interventions are likely to include more personal resilience training, a musculo-skeletal 'fast track' pilot and proposals to engage with staff about 'back to basics' interventions at departmental level to support their wellbeing.

f) Job Planning

MARCH 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	12	12	100.00%	0	0.00%	0	0.00%	0	84.62%	
LT & UC	55	46	83.63%	8	14.55%	1	1.81%	1	81.03%	
P & SC	69	49	71.01%	17	24.64%	3	4.34%	0	73.53%	
Total	136	107	78.68%	25	18.38%	4	2.94%	0	78.03%	

MARCH 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	33%	
LT & UC	12	5	41.67%	7	58.33%	0	0.00%	0	50.00%	
P & SC	36	14	38.88%	7	19.44%	15	41.66%	0	40.63%	
Total	54	21	38.89%	18	33.33%	15	27.78%	0	42.00%	

Excludes locums, maternity leave, bank; new starters u/6 months	Change from previous month (current JPs)	Improved		No change		Worse				
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The March job planning figures (shown above) show that for Consultant job plans there has been a welcome reversal of the downward trend of the previous two months but, with the exception of the CCCC Directorate, the position for SAS doctors continues to deteriorate. There is no doubt that the pressure on Clinical Leads and General Managers has restricted the time available to complete Job Plans but a major effort is needed now to move the overall percentage figures to above 80%. The expected improvement in LTUC, following the job planning 'summit' on 27 March, has not yet been realised. The job planning summit with PSC was postponed for operational reasons and took place on 19 April.

The Job Planning Group meets on 16 April and will be discussing future arrangements for job planning using the NHS Improvement guidance and a revitalised Job Planning Policy.

g) eLearning Super Users

A need has been identified within the Trust to provide staff with further training around the eLearning system held within the Electronic Staff Record. The system has become quite complex and generated an increase in the number of queries received by the Learning & Development (L&D) team in recent months.

At present, there are a range of guides on the Trust intranet detailing specific guidance for accessing the system, locating courses and playing eLearning content. The L&D team understands that many members of staff are only allocated short periods of time to complete their eLearning during working hours and struggle to find and play the correct eLearning content in ESR without seeking additional help and these guides do not always contain the information they require.

The L&D team receives a lot of the same queries from staff about the eLearning system which could be reduced if each department had a single point of contact that would be able to effectively disseminate guidance and help with Frequently Asked Questions amongst their teams. Some departments already have one or two staff members who are more familiar with the system and happy to offer their help to colleagues who struggle to play their eLearning. Introducing training for eLearning 'super users' should encourage more members of staff who would like to take up this role in their department to undertake additional training to help them assist their colleagues with common eLearning queries.

By training super users, staff will be able to access the support they need in their own departments and reduce the time spent needing to seek support directly from L&D. In return, the L&D team will be able to provide a better level of service for all staff and continue to make improvements to the training provided and our use of ESR. A support system of eLearning super users will also hopefully grow the knowledge base of staff and provide a good foundation for building in further self-service functions for a more independent workforce.

A trial has been put in place to evaluate the effectiveness of this approach before it is rolled-out across the Trust.

h) Flu Vaccination Programme

The Trust achieved a significant increase in healthcare worker flu vaccination uptake over the past winter, reporting 60.4% uptake by end of February. Both hospital and community areas showed an increased uptake, with the community sector showing a greater increase:

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

However, uptake fell short of the 70% target for 2017/18. The 2018/19 target, linked to Year 2 of the associated CQUIN, is 75%.

Directorate involvement in the planning and implementation of a successful flu vaccination campaign will be key, and the Occupational Health Manager will be seeking nominations from Operational Directors for Directorate representation on the Flu Steering Group and inviting them to both 'own' the flu vaccination target for their areas and consider what will help them to achieve 75% uptake within their Directorates next winter, in order that campaign planning may take account of and respond to local needs, as far as possible.

In planning for the 2018-19 programme a number of initiatives are under consideration. These include wider opportunities for community staff to be vaccinated and recruitment of trained ward and departmental vaccinators to ensure that as large a number of healthcare staff as possible are able to take up the opportunity, and increase patient safety.

With the 60.4% uptake, the Trust achieved 50% of the available CQUIN payment for 2017/18, but with concerted effort from all concerned it is hoped to achieve vaccination uptake of 75% or more to secure the full payment for 2018/19.

A decision has already been made to follow the recent recommendations of the Joint Committee for Vaccination and Immunisation regarding which type of flu vaccine is most effective for different groups. In line with these recommendations, an order has already been placed for 3,000 doses of quadrivalent inactivated flu vaccine for healthcare workers (aged under 65) and 100 doses of a new adjuvant trivalent inactivated flu vaccine for those staff aged 65 or over. However, this compliance with the recent recommendations has resulted in

a doubling of our expenditure on flu vaccine compared to 2017/18 with resulting cost pressures.

i) WYAAT workforce up-date

1. Promotion of the role of Operating Department Practitioner

I arranged and attended a meeting of representatives from WYAAT, the University of Huddersfield and a regional schools liaison officer, in my capacity as the Registered Workforce Lead for the West Yorkshire and Harrogate Local Workforce Action Board.

By way of context for the meeting, I informed the meeting that I had been in dialogue for some time now with the University of Huddersfield regarding the future supply of the Operating Department Practice workforce. I had asked the University what would be required to support the West Yorkshire and Harrogate HCP to achieve a position of future surplus as far as the availability of registered ODPs in WYAAT was concerned. I highlighted the number of undergraduate placements that would be required within each of the WYAAT providers in order for this ambition to be achieved.

I confirmed that I had submitted a bid to the LWAB for funding to support the future recruitment into difficult to fill areas and advised that ODPs was the first priority given the current vacancy rate, turnover levels and spiralling bank and agency costs. This bid was approved.

I welcomed a social media/recruitment advertising company to the meeting who have been tasked with developing a brand and campaign to achieve the ambition referenced above. I noted some of the materials already in existence such as an ODP career video made by the University of Huddersfield, as well as stressing the need for some of the materials to be readily available to schools and colleges in the WYAAT area. An up-date on this work will be provided to the Board of Directors over the coming months.

2. Collaborative bank

At the Executive Time Out for WYAAT, Chris Mannion and I gave a presentation on the work done to date to establish internal medical staff bank rates of pay. Our project was strongly supported by all of those present and we were asked to take this to the next stage. As part of the consultation regarding this work, we were asked to attend a meeting at Quarry House with NHSI. Following this meeting NHSI have raised two specific issues which we are in the process of exploring in consultation with NHSI. It is readily apparent that there are no other Trusts across the Country seeking to do a similar piece of work on the geographical scale which we are trying to achieve across WYAAT. NHSI are keen to support us with this work as this could become a model to be shared.

3. Streamlining

A bid was presented to LWAB in April by Joanne Harrison, Deputy Director of Workforce and OD to request the implementation of a Project Manager role to support the delivery of the National Streamlining agenda across WYAAT. The purpose of this work is to improve workforce mobility across the NHS in the first instance with a link into social care and release efficiencies in terms of time and costs of recruitment. This paper was supported by the LWAB with funding approved for a two year fixed term contract to take this agenda forward across the LWAB and wider areas.

P Marshall, Director of Workforce and Organisational Development

April 2018

Appendix: BREXIT Communications Plan 2018

Appendix to 8.0 Workforce and Organisational
Development paper dated 18 April 2018

Harrogate and District NHS Foundation Trust

2018 Brexit Communications Plan

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Two Plans:

This communication plan sets out two plans- a business as usual plan and a reactive plan.

The Business as usual plan:

The first plan refers to a set of themed updates to send to all staff on a quarterly basis, starting from April 2018. These updates will be used to reassure staff and provide details of the support offered by the Trust.

These communications will be aimed at the following groups:

This communication shall be produced for all staff, on the understanding that all staff are interested, and potentially affected. In some instances a further communication will be required, aimed specifically at EU staff (more information below).

Ownership of these updates will be held by:

Due to the Employee Relation focus of this update ownership sits within the Human Resources bracket. Communications should be produced by HR, and sent out by the Communications and Marketing Team. Staff questions arising from the update should be forwarded to a Brexit Email inbox, and answered by the HR team.

Signature:

This communication should receive a Director Signature before being sent out. Ideally this would come from the Director most appropriate to the theme of the communication This will demonstrate the seriousness with which HDFT takes the matter.

Transmission

Communications should be transmitted by Email in the first instance. The recommendation is that an all user staff bulletin be sent out. The all user Email shall explain the purpose of the communication, and then attach a copy of the update. Line managers should also feed this communication to staffing groups who do not use Email.

Themes

Planned communications shall initially be focussed around the following themes; immigration arrangements, support options, employee engagement, and Trust plans to prepare for Brexit.

Additional Communication

Planned communications around support options and employee engagement will necessitate two communications, a broad communication to all staff and another

communication targeted at EU staff specifically. The latter will provide more information that could be beneficial to those staff. Line managers should feed this second communication to EU staff who do not use Email

Business as usual process flow chart



Reactive plan:

Under this plan the proposal would be that an update be sent out after major developments in the EU negotiations that effect HDFT as an organisation, or HDFT staff. The aim would be for a communication to go out within one day of a major announcement taking place, so as to provide assurances to HDFT staff. An item should also be displayed on the front page of the intranet, taking the shape of a hyperlink that directs the viewer to the communication.

Major Announcement

The term 'major' here refers to confirmed agreements arising from the negotiations which will directly impact the NHS or our workers. One prominent example of this type of update would be the recent agreement on the status of EU workers currently living in the UK. Due to substantial conjecture around the Brexit negotiations and the prevalence of different proposals it is suggested that HDFT should keep to this definition of major so as to avoid confusing colleagues.

The communications will be aimed at the following staff groups:

This communication shall be produced for all staff, on the understanding that all staff are interested, and potentially affected.

Ownership and sign off for this update shall be held by:

Communications should be produced by HR, and sent out by the Communications and Marketing Team. Staff questions arising from the update should be forwarded to a Brexit Email inbox, and answered by the HR team. Alternatively, questions can be fed back through line managers or individuals can ring the Operational HR Department.

Signature:

This communication should receive a Director Signature before being sent out. This will demonstrate the seriousness with which HDFT takes the matter.

Branding:

Communications should be branded in the typical HDFT format for HDFT staff and the new HHFM branding should be used for HHFM staff.

Transmission:

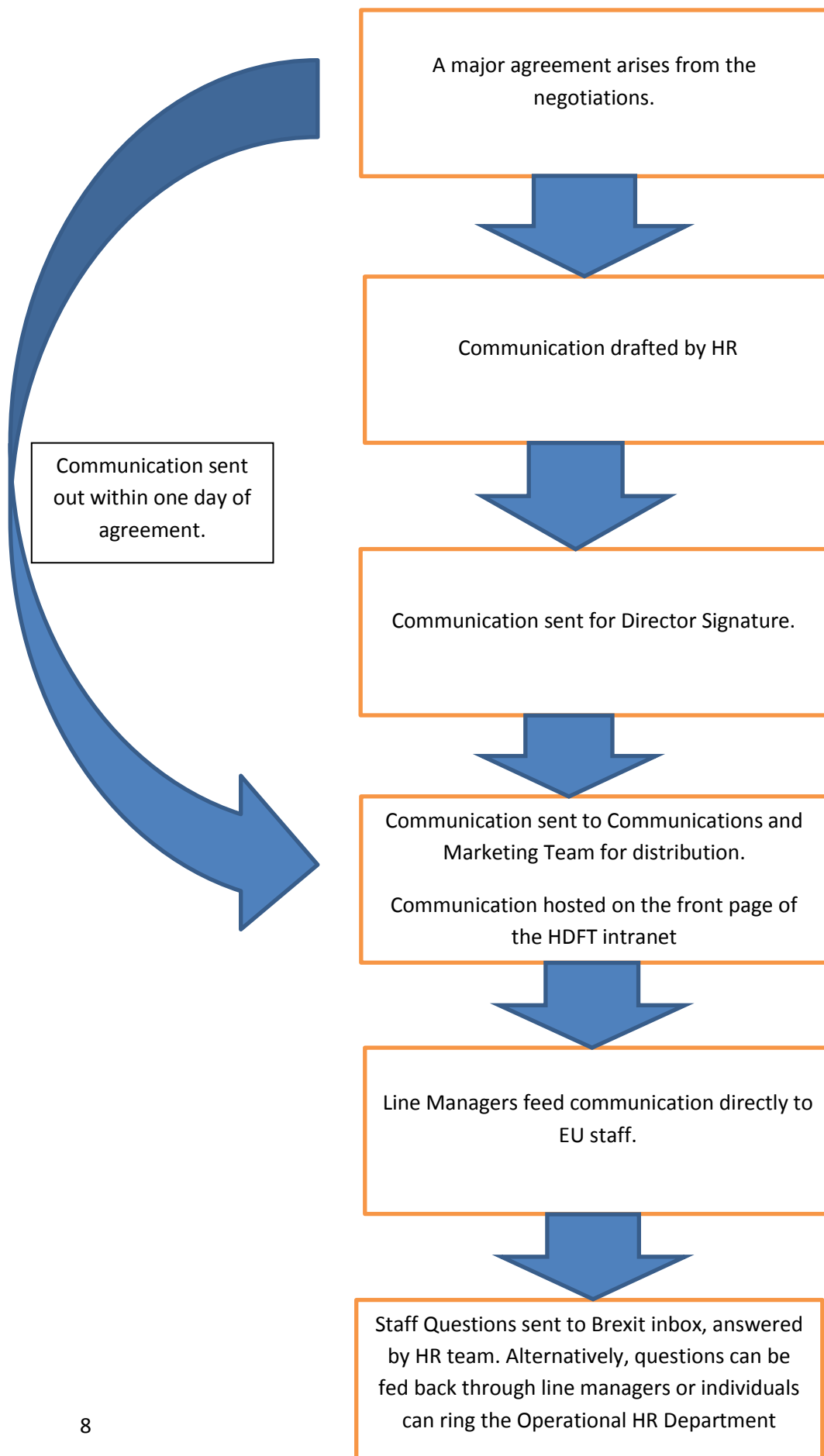
Communications should be transmitted by Email in the first instance. The recommendation is that an all user staff bulletin be sent out. The all user Email shall explain the purpose of the communication, and then attach a copy of the update. Line managers should also feed this communication to their staffing groups as soon as possible.

Further information required:

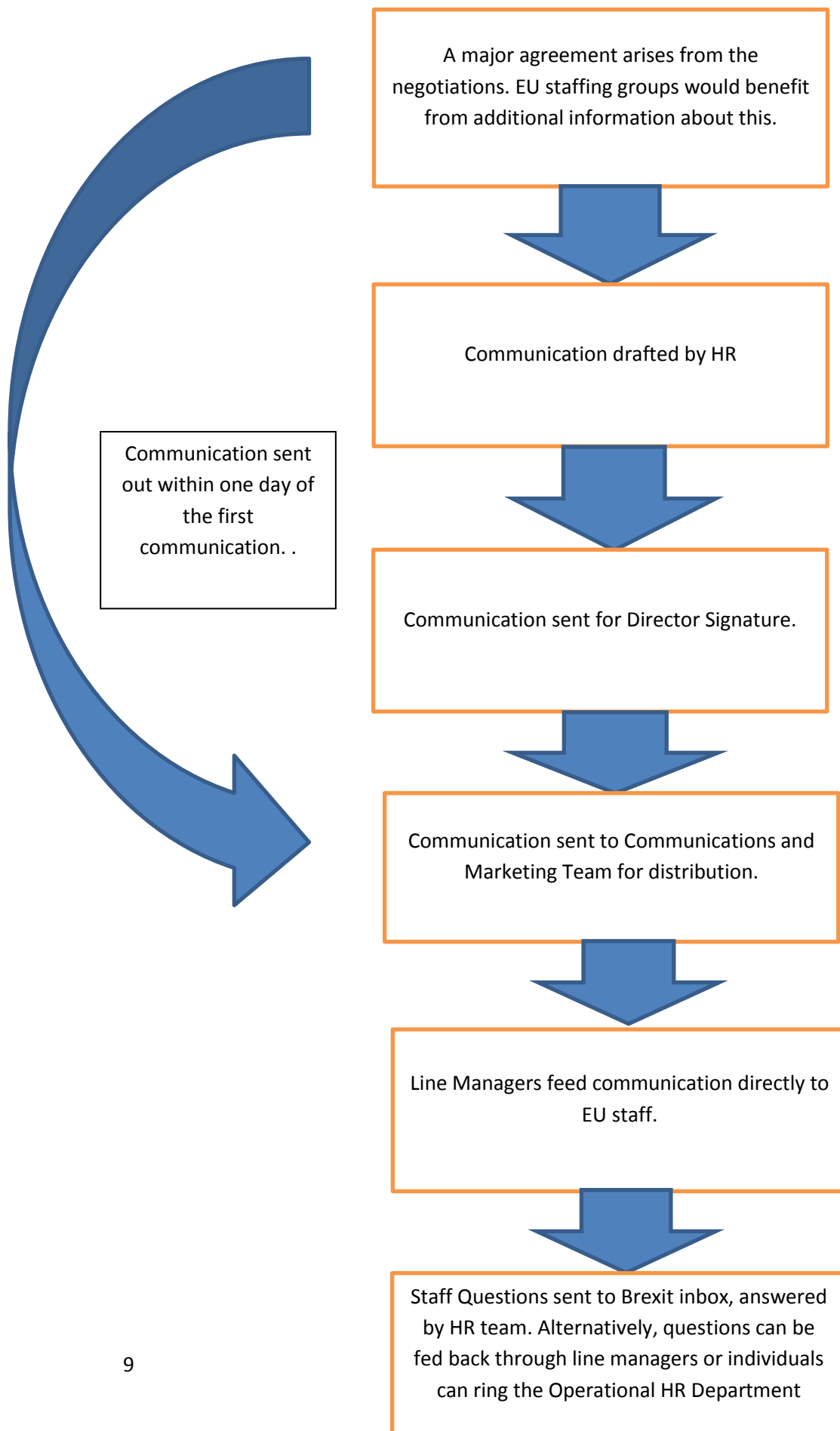
Additionally, with reactive communications it may be appropriate to send out an additional communication, solely to EU Staff. This will be needed in cases, such as when the details of

the immigration arrangements are revealed, where EU staff could benefit from additional information. This should be sent within one day of the original communication. Line managers should also feed this communication to their EU staffing groups as soon as possible.

Reactive Plan Process:



Reactive Plan Additional Communication:



Summary Table

Date	Theme	Audience	Director Signature	Medium
19/04/18	Support Options for all staff	All Staff	Phillip Marshall	Email and line manager interaction.
20/04/18	Support Options for EU staff	EU Staff Targeted	Phillip Marshall	Email and Line Manager interaction to engage EU staff.
02/07/18	Immigration Arrangements	All Staff	Phillip Marshall	Email and line manager interaction.
01/10/18	Engagement with all Staff around Brexit	All Staff	Phillip Marshall	Email and line manager interaction.
02/10/18	Engagement with EU Staff around Brexit	EU Staff Targeted	Phillip Marshall	Email and Line Manager Interaction to engage EU staff.
03/12/18	HDFT Brexit plans and discussions	All Staff	Dr Ros Tolcher	Email and Line Manager Interaction
Reactive Plan (issue pertains to Brexit and effects all staff)	Unknown	All Staff	Most Appropriate Director	Email and Line Manager interaction.
Reactive plan additional communication (issue pertains to Brexit and effects EU staff disproportionately)	Unknown	EU Staff Targeted	Most Appropriate Director	Email and Line Manager interaction to engage EU staff.

Date of Meeting:	25 April 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:	<table border="1"> <tr> <td>Decision</td> <td></td> <td>Discussion/ Consultation</td> <td>✓</td> <td>Assurance</td> <td>✓</td> <td>Information</td> <td>✓</td> </tr> </table>			Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓
Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓				
Executive Summary:	<ul style="list-style-type: none"> 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 has reduced. The number of hospital acquired pressure ulcers, categories 2-3 and unstageable has increased in 2018. The proportion of category 3 and unstageable pressure ulcers deemed to be avoidable has reduced in the community. The total numbers of in-patient falls in 2017/18 remains about the same compared to 2016/17. The number of complaints received in 2017/18 is the 10% lower than 2016/17. HDFT is participating in the NHSI Collaborative to improve Enhanced Care. 										
Related Trust Objectives											
<table border="1"> <tr> <td>To deliver high quality care</td> <td>✓</td> <td>To work with partners to deliver integrated care:</td> <td>✓</td> <td>To ensure clinical and financial sustainability:</td> <td>✓</td> </tr> </table>				To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓		
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:											
<ul style="list-style-type: none"> 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 community acquired pressure ulcers in month Note the work around falls reduction Be assured about the monitoring of care provided by the CCT's Note the number of complaints in 2017/18 Note HDFT is participating in NHSi Collaborative to improve Enhanced Care. 											

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 toward zero vacancies. Services and departments are continuously recruiting and the next Trustwide event is planned for 1 May 2018.
- 1.2 The Trust has welcomed 33 newly qualified nurses between September 2017 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. We are looking to develop a cohort of nurses for Theatres.
- 1.4 Long Term and Unscheduled Care (LTUC) currently has **14.91** RN Band 5 vacancies across their inpatient areas. They have **10** Care Support Worker (CSW) vacancies.
- 1.5 Planned and Surgical Care has **11.93** RN Band 5 vacancies across their in-patient areas with **0** CSW vacancies.
- 1.6 In Main Theatres there are **11.59** 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.

1.10 Current Situation on Adult In-Patient Wards

Ward	Registered Nurses			CSW's		
	Est.	Vac.	%	Est.	Vac.	%
Acute Admissions Unit	23.27	0.83	3.6	13.93	1.63	11.7
Byland	16.11	3.26	19.1	22.88	0	0
Clinical Assessment Team	25.03	6.51	26	16.5	1.84	11.2
Granby	12.47	0	0	12.5	3	24
Jervaulx	16.11	1.76	10.3	22.88	0.19	0.9
Lascelles	10.76	0	0	10.68	0	0
Oakdale	25.05	2.55	10.2	15.32	0.32	2
Trinity	11.01	0	0	13.27	3	22
Total	139.81	14.91	10.5	127.96	9.98	8
Farndale	13.92	4.39	32	16.32	0	0
Wensleydale	16.74	1.97	12	11.51	0	0
Littondale	18.17	0.73	4	13.44	0	0
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	0
Total	109.19	11.93	11	62.55	0	0

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	6.97
Adult Community Nurses (CCT's)	0.43
Main Theatres	11.59
Day Surgery	3.11
Maternity Unit	1.88
Woodlands	2
SCBU	0.64

1.11 Is the situation improving?

The nursing vacancy situation remains about the same as last month for the in-patient areas of LTUC and has improved for the in-patient areas of PSC.

In March 2018 the Band 5 vacancies in the Emergency Department have increased. The Band 5 vacancies in Main Theatres remain the same.

Vacancies in the Community, Maternity and Paediatrics have improved in March 2018.

2. Unannounced Directors' Inspections 2017-2018

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

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

Date of inspection	Ward/Dept. visited	Risk Rating
21/04/17	Trinity	Green
12/05/17	Granby	Green
18/05/17	Wensleydale	Green
01/06/17	Selby MIU	Green
16/06/17	ITU	Green
16/06/17	Littondale	Green
21/11/17	AMU	Red
19/12/17	AMU	Green
19/12/17	Granby	Red
24/01/18	Oakdale	Green
14/02/18	CATT	Red
28/02/18	CATT	Green
01/03/18	Emergency Department	Green

2.3 Granby – Red due to cannula compliance, subsequent visits show they are making progress but this is still an issue.

3. Patient Safety Visits

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

Date	Area
25/04/17	Littondale
23/04/17	Granby
06/06/17	Byland
21/06/17	Pharmacy
27/06/17	Main Out-Patients Dept
06/07/17	Endoscopy
28/07/17	General Office
10/08/17	Main Theatres
22/08/17	Oakdale
02/11/17	Elective Assessment and Discharge Unit
10/11/17	Lascelles
21/12/17	Heart Centre
16/01/18	CSSD
30/01/18	Medical Records
09/02/18	Site Services (Portering)
06/03/18	Clinical Site Management Team
27/03/18	Community Children's Services – Sedgefield Locality

3.2 There are no patient safety visits planned for April and May 2018. The formats of the patient safety visits and directors inspections are currently under review. The aim is to develop a framework for visits that continues to support engagement between staff and members of the Trust Board and helps to ensure the Trust is CQC ready.

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.

In January 2018 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 Community Care Teams (CCTs). The numbers in February 2018 remained about the same. March 2018 has seen a reduction in category 3 and unstageable pressure ulcers across all the CCTs. As last month, the proportion of category 3 and unstageable pressure ulcers deemed to be avoidable has reduced.

January 2018 also saw a rise in hospital acquired pressure ulcers categories 2-3 and unstageable. I was pleased to report the number of hospital acquired pressure ulcers categories 2-3 and unstageable was significantly lower in February 2018 however there has been an increase in March 2018.

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 or March 2018.

5. Falls

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

Due to the increased total number of falls year to date (YTD) and an increased number of falls with fractures, the Board has asked the Quality Committee to review the workstream regarding the prevention and management of falls. The Quality Committee received a position paper at December's meeting and was assured about the work in place to prevent and manage in-hospital falls. The Chief Nurse met with the Matrons and Ward Managers to discuss the falls situation on Tuesday 5 December 2017 and agreed a number of immediate actions.

Since December 2017 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.

The total number of falls in March 2018 is **57** compared to **57** in March 2017.

The total number of falls in 2017/18 in **701** compared to **693** in 2016/17. The total number of falls with moderate harm including fractures is **21** in 2017/18 compared to **15** in 2016/17.

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 since December to date.

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 formal complaints.

In January 2018 I reported an increase in January in the number of category 3 and unstageable pressure ulcers, particularly in Harrogate North and South CCTs and that one formal complaint had been received. The number of category 3 and unstageable pressure ulcers remain about the same in February 2018. In March 2018 the number of category 3 and unstageable pressure ulcers has reduced across all the Community Care Teams. There have been no End of Care Life issues and no complaints received regarding the Community Care Teams in February or March 2018.

Patient Experience

7. Complaints

7.1 The number of complaints received in March 2018 is 26. Of the 26 complaints received in March 2018, 19 have been graded Yellow and seven Green.

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

Total number of complaints by month for 2017/18 compared to 2016/17 and 2015/16													
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
2017/18	16	20	16	11	22	16	20	14	14	26	8	26	209
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 formal complaints received in 2017/18 is **209**. The total number of formal complaints received in 2016/17 was **232**. The number of formal complaints received in 2017/18 is 10% lower than in 2016/17.

8 NHSI Collaborative for Improving Enhanced Care

8.1 On 11 April 2018, HDFT representatives joined the launch of the NHSi Collaborative for Enhanced Care. This is a 90 day programme which has the aim of improving the quality of enhanced care by improving the experience for patients receiving enhanced care and the experience of staff providing enhanced care. The programme also aims to reduce the cost of providing enhanced care.

I will update the Board as the project progresses.

Appendix One

Actual versus planned nurse staffing - Inpatient areas

The table below summarises the average fill rate on each ward during **March 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 March was **7.66** care hours per patient per day.

Ward name	Mar-2018						
	Day		Night		Care hours per patient day (CHPPD)		
	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	98.5%	119.8%	97.2%	205.4%	4.15	3.64	7.79
Byland	108.9%	94.4%	81.3%	148.4%	2.58	3.79	6.37
CATT	91.7%	109.7%	83.9%	127.4%	3.72	2.70	6.42
Farndale	83.6%	96.8%	100.0%	161.3%	2.90	3.69	6.59
Granby	109.9%	165.3%	100.0%	129.0%	2.98	3.61	6.59
Harlow	130.6%	146.8%	104.8%	-	4.22	2.82	7.04
ITU/HDU	106.9%	-	112.9%	-	23.63	1.57	25.19
Jervaulx	104.5%	92.5%	81.9%	144.1%	2.51	3.71	6.22
Lascelles	102.2%	91.6%	100.0%	96.8%	4.18	3.51	7.69
Littondale	93.2%	135.5%	97.8%	138.7%	3.35	2.43	5.78
Maternity Wards	97.5%	95.1%	100.1%	80.6%	17.37	4.72	22.09
Nidderdale	97.1%	102.8%	97.8%	209.7%	3.50	2.88	6.38
Oakdale	90.8%	137.6%	91.9%	167.7%	4.10	3.64	7.75
SCBU	92.3%	40.0%	93.5%	-	15.67	1.78	17.45
Trinity	125.6%	75.8%	100.0%	100.0%	3.19	2.94	6.13
Wensleydale	90.9%	148.4%	100.0%	153.2%	3.04	2.99	6.03
Woodlands	67.2%	95.2%	86.0%	112.9%	9.74	3.78	13.52
Trust total	97.4%	109.6%	96.2%	147.9%	4.39	3.27	7.66

Key

Red = < 90%

Blue = >110%

ED	102%	173%	89%	119%			
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Further information to support the March data

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

On Harlow Suite the increase in RN and care staff hours above plan was to support the opening of additional escalation beds as required in March.

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 March; 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 March this is reflected on the wards; AMU, Byland, CATT, Farndale, Granby, Littondale, Nidderdale Oakdale, and Wensleydale.

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

The staffing complement for the children's ward, Woodlands, is designed to reflect varying levels of occupancy. The day and night time RN hours are less than planned in March 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 was to support the opening of additional beds to support winter pressures.

Date of Meeting:	25 April 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:	<table border="1"> <tr> <td>Decision</td> <td></td> <td>Discussion/ Consultation</td> <td>✓</td> <td>Assurance</td> <td>✓</td> <td>Information</td> <td>✓</td> </tr> </table>			Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓
Decision		Discussion/ Consultation	✓	Assurance	✓	Information	✓				
Executive Summary:	<ul style="list-style-type: none"> • Mortality update; both the HSMR and SHMI have increased in the latest published update. • Sexual safety on Mental Health wards; Communication has been received from the CQC. • West Yorkshire and Harrogate Cancer Alliance has been allocated £13m of cancer transformation funding. • A new team of NHS safety investigators has been established. 										
Related Trust Objectives											
<table border="1"> <tr> <td>To deliver high quality care</td> <td>✓</td> <td>To work with partners to deliver integrated care:</td> <td>✓</td> <td>To ensure clinical and financial sustainability:</td> <td>✓</td> </tr> </table>				To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓		
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:											
<ul style="list-style-type: none"> • It is recommended that the Board receives and notes the report. 											

1. Mortality update

Hospital Eposodic Data (HED) has published updates of HSMR and SHMI. Both have increased this month.

Our HSMR for the rolling 12 months ending December 2017 is 107.9 (105.6 last month), however this is still within expected levels. At specialty level, two specialties have a higher than expected standardised mortality rate – Geriatric Medicine and Respiratory Medicine.

Our SHMI has increased to 89.1 (88.4 last month) for the rolling 12 months ending December 2017, but remains below expected levels. 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.

Please note that the latest HSMR on HED includes data up to the end of January 2018. However as we were only partly coded for January when they ran the extract, we will continue to report HSMR a month in arrears for the Integrated Board Report etc. as per last month.

No new mortality sub-specialty alerts have been received.

The crude death rate decreased to 1.27% in March (1.33% in February) – this is the same level as the crude death rate last March. The rolling 12 months crude death rate remains at 1.17%.

The Trust recently received an enquiry from the Health Service Journal to provide comment on the recent publication of TARN (Trauma Audit Research Network) data for the period 2014-2017. Total eligible cases are 572. The published data on the TARN website suggests an excess of 2.6 deaths per 100 patients (range -4.77 to -0.38) over the data collection period. This data has now been published in HSJ. I will give a verbal update on this matter at Board. It is worth mentioning that cases of serious blunt and penetrating trauma are transported directly to the Major Trauma Centre in Leeds in the vast majority of cases.

Going forwards the intention will be to examine the data closely with a view to understanding possible reasons for variance. This is likely to involve looking closely at a sample of case notes. I would stress at this stage that there are a number of possible reasons for this, some interconnected. It should not, at this stage, be seen as a marker for sub-standard care.

2. Sexual Safety on Mental Health Wards

A recent communication has been received from the CQC. A prior report had highlighted the potential for incidents of sexual harassment and sexual violence.

This risk is heightened by the propensity for mixed sex accommodation on some mental health wards. The report focused on the responsibility of staff to ensure that vulnerable patients are kept safe from such abuse.

I am not aware of any such incidents in the Trust, but will be liaising with Risk Management and our Mental Health Service provider partner to ensure this is the case and that not only are reporting processes robust, but proactive measures are in place to minimise the risk to patients under our care.

3. West Yorkshire and Harrogate Cancer Alliance update

The Alliance has been allocated £13million of cancer transformation funding. Draw down of this funded allocation will be linked to a system-wide performance against the 62 day urgent referral to treatment standard (threshold 85%). The current system-wide performance has already accrued a penalty against draw down of funds, but there is an opportunity to make up some or all of this potential loss. The Alliance core team is now leading work to prioritise projects from our previously agreed transformation bids for continuation in 2018/2019. This is expected to reflect the latest NHS Planning Guidance (including the 62 day standard); implementation of lung, prostate and colorectal pathways and rollout of the stratified breast follow-up pathway.

The ongoing major workforce issues are, in most areas, directly impactful on cancer performance. Examples include:

- Histopathology
- Diagnostic radiology
- Gastroenterology
- Oncology

A task and finish group, accountable to the Cancer Alliance Board, has been set up to identify and prioritise workforce planning gaps in cancer care delivery. This will look at, amongst other things, innovative ways of working, upskilling, deferred retirement and shared provider contracts.

A multi-agency Tobacco Advisory Board has been set up with an ambition to reduce the numbers of smokers across the STP from 330,000 to 125,000 by 2020.

4. Safety update

In part arising directly from a number of high profile national cases and the CQC report on investigation of deaths in the NHS, a new team of NHS safety investigators has been formed called the Healthcare Safety Investigation Branch (HSIB). They have a paper which is currently out to consultation regarding a new process for independent high level investigations when serious lapses of care occur. The Trust will respond to this consultation document.

The HSIB will begin by embarking upon a new independent process for maternity investigations following direction from the Secretary of State for Health and Social Care. They will independently investigate intrapartum stillbirth, early neonatal deaths and severe brain injuries after 37 weeks gestation. Once in place, and the referral criteria are met, this investigation will replace that normally undertaken by the host Trust. Shared learning will result.

As yet the Trust has not been the subject of any such investigation.

5. Workforce update

Health Education England in Yorkshire and the Humber is continuing to do all it can to ensure that medical trainee numbers support future workforce requirements. The need for further medical training post adjustments has been widely discussed, and the principles and priorities agreed with Local Education Providers (LEPs) recently formally communicated with in relation to the plans for 2018.

There is additional capacity identified in ST training posts in Emergency Medicine as a result of the expansion and natural progression of the CT3 training grade. This is welcome news and the Trust has been offered an additional single training post, the start date as yet undefined. The funding of the post lies solely with the provider Trust.

Date of Meeting:	25 April 2018	Agenda item:	11.0								
Report to:	Board of Directors										
Title:	Annual Efficiency Programme Quality Impact Assessment										
Sponsoring Director:	Dr D Scullion, Medical Director and Mrs J Foster, Chief Nurse										
Author(s):	Dr Sylvia Wood, Deputy Director of Governance										
Report Purpose:	<table border="1"> <tr> <td>Decision</td> <td>✓</td> <td>Discussion/ Consultation</td> <td>✓</td> <td>Assurance</td> <td>✓</td> <td>Information</td> <td>✓</td> </tr> </table>			Decision	✓	Discussion/ Consultation	✓	Assurance	✓	Information	✓
Decision	✓	Discussion/ Consultation	✓	Assurance	✓	Information	✓				
Executive Summary:	The annual efficiency programme should be fully assessed for the impact of individual schemes on quality prior to agreement and implementation, and there should be clear methods in place for detecting any emerging decline in quality.										
Related Trust Objectives											
<table border="1"> <tr> <td>To deliver high quality care</td> <td>✓</td> <td>To work with partners to deliver integrated care:</td> <td>✓</td> <td>To ensure clinical and financial sustainability:</td> <td>✓</td> </tr> </table>				To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓		
To deliver high quality care	✓	To work with partners to deliver integrated care:	✓	To ensure clinical and financial sustainability:	✓						
Key implications											
Risk Assessment:	Without a robust impact assessment process there is a risk to the quality or equality of services when schemes are introduced to deliver efficiencies.										
Legal / regulatory:	The CQC well-led domain has a prompt (W5.6) about how the impact on quality and sustainability is assessed and monitored when considering developments to services or efficiency changes.										
Resource:	None identified.										
Impact Assessment:	Not applicable.										
Conflicts of Interest:	None identified.										
Reference documents:	None.										
Assurance:	This paper identifies the current assurance in relation to the annual efficiency programme quality impact assessment										
Action Required by the Board of Directors:											
<ul style="list-style-type: none"> Note the findings in relation to the quality impact assessment process for the current efficiency programme. Note the level of assurance currently available. Note and support the work that is still required to strengthen the process. 											

“The need for a formal process of ‘quality impact assessments (QIA) over cost improvement plans’ has been in place for some time and came about as a direct result of the criticism of the board of Mid Staffs.

The need for more robust assessment on the impact on quality of proposed savings plans or indeed any service change comes at a time when the financial efficiency requirement remains high. Indeed, the overall value and proportion of turnover of trust cost improvement plans (CIPs) is higher than that historically achieved and in all cases the quick wins and ‘low hanging fruit’ have long since been removed. CIPs are increasingly more challenging to identify and deliver and tend to be more transformational (and therefore impactful) than previously. The need for a formal quality impact assessment process is essential in a system as complex and interdependent as the NHS, where decisions in one part of the service can impact upon another with many co-dependencies that are not always easy to predict or assess”.

[Good Practice: Quality Impact Assessment \(NHS Providers 2015\)](#)

The last report to the Board of Directors regarding the impact assessment process for annual efficiency programme was in October 2017 and related to the efficiency programme for 2017/18. The report noted that in 2016 the documentation relating to the assessment of risk to quality of CIPs in 2015/16 and 2016/17 was updated, with some work undertaken to strengthen the process which aimed to include:

- Impact assessment of transformation schemes and service development proposals as well as CIPs;
- Equality impact assessment as well as quality impact assessment.

Quality assurance of both screening and assessment stages are required at Directorate Board level, and then at corporate level by the Medical Director and Chief Nurse. More detail including further review of risk, opportunity, mitigation, details of metrics to enable monitoring of impact, or consultation with staff or other stakeholders may be requested at this stage prior to a decision being made on implementation.

In October 2017 there was evidence of some effective impact assessment being undertaken in relation to the efficiency programme, with the majority of proposed schemes implemented with appropriate monitoring of impact on quality, and a small number of schemes rejected as likely to cause a significant negative impact. However further work was needed to refine the documentation, develop guidance for staff undertaking impact assessments, extend impact assessments from being largely focused on the efficiency programme to become part of all significant service change, service development, business planning and transformation, and to ensure a supported roll-out for this process to develop cultural ‘buy-in’. This work has not yet happened.

Evidence of impact assessments by directorate for 2018/19

Children and Countywide Community Services Directorate

Jill Foster, Chief Nurse (CN) and Dr David Scullion, Medical Director (MD) have received all available impact screening and outcomes. At the time of writing, there is impact assessment screening available for 19/23 schemes.

Three of the 23 schemes need a more detailed work up before progression within the directorate.

One scheme has had a detailed impact assessment completed and this requires discussion with the Chief Nurse/Medical Director.

There is summary documentation available of the Children and County wide Community Directorate impact assessment screening.

Planned and Surgical Care Directorate

Jill Foster, Chief Nurse and Dr David Scullion, Medical Director have received all available impact screening and outcomes. At the time of writing, there is impact assessment screening available for 38/43 schemes.

Four of the 43 schemes need a more detailed work up before progression within the directorate.

One scheme has had a detailed impact assessment completed. This is a bed reduction scheme planned for May – October 2018 in Planned and Surgical Care. The CN and MD received the detailed impact assessment and the CN met with Jonny Hammond, Operational Director to discuss the scheme. The scheme will go ahead with the following expectations. The directorate will monitor on a monthly basis

- Vacancy and sickness rates
- Use of unplanned, non-substantive staff
- ED Target
- RTT Targets
- Complaints /concerns
- Number of beds that stay closed on a daily basis
- Staff engagement/ satisfaction
- There will auditable evidence the effects of the bed closures are monitored through the directorates' governance framework and discussed at the directorates Board.
- The Directorate will continue to recruit registered nurses

There is summary documentation available of the Planned and Surgical Care Directorate impact assessment screening.

Long Term and Unscheduled Care Directorate

Jill Foster, Chief Nurse and Dr David Scullion, Medical Director have received all available impact screening and outcomes. At the time of writing, there is impact assessment screening available for 34/51 schemes.

17 of the schemes need a more detailed work up before progression with the directorate.

There are no schemes which require a detailed impact assessment.

There is summary documentation available of the Long Term and Unscheduled Care Directorate impact assessment screening.

Corporate Directorate

Alison Mayfield, Deputy Chief Nurse and Sylvia Wood, Deputy Director Governance have reviewed all available impact assessment screening processes and outcomes. At the time of writing, there is impact assessment screening available for 17/23 schemes.

No detailed impact assessments were required as the identified risk during screening for all of these schemes was minimal. One scheme is not being progressed by the relevant corporate function despite being marked as no impact. There is summary documentation available of the corporate directorate impact assessment screening.

Summary

The impact assessment process for the annual efficiency programme has been undertaken which provides some assurance that current cost improvement schemes have been assessed for impact on quality and equality.

However the previously identified work needed to refine the documentation and strengthen the process has not yet happened. There has been a recent Internal Audit on quality impact assessment and actions to address the recommendations are being developed.

Board Committee report to the Board of Directors

Committee Name:	Quality Committee (QC)
Committee Chair:	Mrs L.A. Webster
Date of last meeting:	4 April 2018
Date of Board meeting for which this report is prepared	25 April 2018

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

Hot Spots and Financial Recovery Plan Discussion:

There were no areas for debate in this section and the standing item related to the Financial Recovery Plan has been removed.

Board Request for QC to seek assurance:

EColi - QC has received the Infection Prevention & Control report on this for some time and has debated the relevance for this continued scrutiny by QC. The same report is reviewed at SMT each month, QC agreed that SMT is the correct group to escalate concerns and QC considers this action closed.

Reports Received:

- First draft of the Quality Account reviewed, the Quality Priorities for the FY18/19 were received.
- Staff Friends and Family Test and Staff Survey – annual report.
- Quality Charter Annual Report.
- Clinical Audit Plan/Report – Q3.
- Clinical Effectiveness & Audit Programme - Year End Update. In addition the draft Audit Programme for FY18/19 was approved.
- External Reports – additional assurance was received in relation to the planned improvements for Paediatric Diabetes clinic services.
- Management of Controlled Drugs annual report noted

Other Items

- **Complaints** – Assurance gained in respect of timescales for dealing with complaints. Additional assurance being sought with respect to the quality of complaints handling.
- **Quality Dashboard** – the new format dashboard will be available during Quarter 1.

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

None

Matters for decision

None

Action Required by Board of Directors: None

Board Committee report to the Board of Directors

Committee Name:	Finance Committee
Committee Chair:	Maureen Taylor
Date of last meeting:	12 April 2018
Date of Board meeting for which this report is prepared	25 April 2018

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

1. The committee received an update on the latest financial position for 2017/18. Mr Coulter confirmed that the control total had not been met but that the provisional outturn position indicates the Trust will achieve a break-even position.
2. The cash position has improved due to some cash receipts at year end, some of which are payments in advance. However, there are still a large number of outstanding debts and the committee discussed whether these were disputed or remain unpaid due to our commissioner's financial constraints.
3. Capital programme spend in 2017/18 was estimated to be £12.4m (subject to accounts closedown) against a plan of £16.1m. Draft plans for 2018/19 were discussed. Design work will commence on three major schemes but they cannot proceed without identification of external funding. Design costs could therefore become abortive.
4. The Financial Sustainability Risk Rating for the year end is likely to be 3.
5. The updated Operational Plan was discussed. Figures remain largely unchanged from the previous version. Some £8m has been added to budgets in 2018/19 to reflect cost pressures. Pay costs above staffing structure have not been reflected in the budget. Also £600k of Community team costs have still to be resolved during discussions on the aligned incentive contract.
6. CIP delivery has been phased in 2018/19 financial year to give the maximum opportunity to earn the available S&T funding. Internally, Directorates will be managed to a tighter timeline.
7. Mr Coulter updated the committee on progress made with the aligned incentive contract with HaRD CCG. Governance processes are being worked through and there is still work to do on setting triggers.
8. Mr McKie updated the meeting on the Model Hospital and Service Line

Reporting. NHS Improvement will be speaking to clinical leads on the Model Hospital on 19th April. Monthly reports are now produced on Service Line Reporting.

9. Mr Coulter presented a paper on the financial risks in the BAF. Based on a signed contract variation and progress with the aligned incentive contract, the risk of misaligned plans has been reduced from 12 to 8. Risks on failure to deliver operational plan and external funding constraints remain at 12.
10. The Committee received an update on the Private Patients business case. Significant progress has been made with limited resources. Work is continuing on a number of aspects including governance structure and infrastructure. The main constraint looking forward is theatre capacity and bed availability and the Board may wish to receive proposals on these areas in due course.
11. It was noted that the results from the Finance Committee Effectiveness survey were very positive.
12. The Finance Committee Annual Report for 2017/18 was agreed.
13. Finance Committee Terms of Reference were reviewed and changes agreed. The updated version showing changes is attached.

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

- Outstanding debts from 2017/18 continue to impact on the Trust's cash position.

Matters for decision

Action Required by Board of Directors: The Board of Directors is asked to approve the updated Terms of Reference for Finance Committee.



Terms of Reference

Finance Committee

1. **Accountable to:** Board of Directors

2. Purpose of the group

The Finance Committee is a committee of the Board of Directors of Harrogate and District NHS Foundation Trust, with oversight of the development and delivery of the financial plan of the organization.

3. Responsibilities

The key responsibilities of the group are:

Scrutiny and Efficiency

- To support the Board in scrutinising financial performance, operational activity levels and workforce assumptions (excluding performance against operational standards).
- Scrutiny of the annual Cost Improvement Programme and review the impact on the Trust.
- To scrutinise the Trust budget prior to approval by the Board.
- To scrutinise and ensure appropriate due diligence is undertaken in relation to any significant transactions as defined by NHS Improvement or as directed by the Board of Directors.
- To carry out detailed reviews of financial risks within the Board Assurance Framework.

Financial Strategy

- To scrutinise the development of the Trust's financial and commercial strategy, both revenue and capital.
- To scrutinise the assumptions and methodology used in developing the financial strategy, including activity modelling and efficiency assumptions.
- To ensure that the annual financial plan is consistent with the Trust's strategy.
- To review the capital programme in line with the financial plan.
- To recommend to the Board the financial plan for submission to NHS Improvement.

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Financial Performance

- To review the activity plans in line with the financial planning, operational activity and workforce assumptions.
- To review the quarterly financial performance before submission to Monitor / NHS Improvement.
- To assess the impact of financial performance on the Financial Services Risk Rating.
- To overseeing the implementation of benchmarking initiatives including service line reporting.
- To review service line information, profitability of service lines and the impact of activity delivery on financial performance.

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~~— To undertake any relevant matter as requested by the Board of Directors~~

- ~~To scrutinise the development of the Trust's financial and commercial strategy, both revenue and capital.~~
- ~~To scrutinise the assumptions and methodology used in developing the financial strategy, including activity modelling and efficiency assumptions.~~
- ~~To recommend to the Board the financial plan for submission to Monitor/NHS Improvement.~~
- ~~To scrutinise and ensure appropriate due diligence is undertaken in relation to any significant transactions as defined by Monitor / NHS Improvement~~
- ~~To scrutinise the annual Cost improvement Programme and review the impact on the Trust.~~
- ~~To ensure that annual financial plan is consistent with financial strategy.~~
- ~~To scrutinise the Trust budget prior to approval by the Board.~~
- ~~To review the capital programme in line with the financial plan.~~
- ~~To review the activity plans in line with the financial planning assumptions.~~
- ~~To review quarterly financial performance before submission to Monitor / NHS Improvement~~
- ~~To assess the impact of financial performance on the Financial Services Risk Rating~~
- ~~Oversee implementation of service line reporting.~~
- ~~To review service line information, profitability of service lines and the impact of activity delivery on financial performance~~

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- To undertake 'deep dive' reviews of appropriate sections of the Board Assurance Framework

- To undertake any relevant matter as requested by the Board of Directors

4. Audit Committee

The Audit Committee will maintain full oversight of the Annual Accounts process and also Treasury Management policy, as well as areas such as Standing Financial Instructions (SFIs) which are part of the Trust's system of control.

5. Membership

The ~~core~~ membership comprises:

- Non-Executive Director (Mrs Maureen Taylor) (Chair)
- Non-Executive Director (Mr Ian Ward)
- Non-Executive Director (Mrs Lesley Webster)
- Director of Finance
- Chief Operating Officer

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Title	Deputy	Attend:	Formatted Table
Mrs Maureen Taylor, Non-Executive Director (Chair)	n/a	Full	
Mr Ian Ward, Non-Executive Director		Full	
Mr Chris Thompson, Non-Executive Director		Observer	
Mrs Lesley Webster, Non-Executive Director		Full	
Mr Jonathan Coulter, Director of Finance		Full	
Mr Robert Harrison, Chief Operating Officer		Full	
Mr Paul Nicholas, Deputy Director of Performance and Informatics		Full	
Mr Jordan McKie, Deputy Director of Finance		Full	
Mrs Catherine Gibson — Corporate PA (Admin support)		Full	

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Ad hoc attendance may be by invitation of the Chair.

The Non-Executive Director who serves as Chair of the Audit Committee will be standing observer to the Audit Committee.

The Deputy Director of Performance and Informatics, Deputy Director of Finance and Company Secretary will be in attendance at meetings of the Finance Committee.

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6. Quorum

Quorum will be 3 members of the Committee, with at least 2 Non-Executive and 1 Executive Director at each meeting.

7. Administrative support

Administrative support to the Finance Committee will be provided by the Corporate Support team. Admin support will be provided by Mrs Catherine Gibson, Corporate PA

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8. Frequency of meetings

The Committee will meet 6 times per year.

~~For 2016/17 these meetings will be in April, June, September, October, December and February.~~

Additional meetings may be scheduled if necessary and agreed by the Chair of the Committee.

Minutes will be reported to the Board of Directors and copied to the Audit Committee.

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9. Date terms of reference approved

DRAFT April 2018

HARROGATE AND DISTRICT NHS FOUNDATION TRUST GLOSSARY OF ABBREVIATIONS

A

A&E	<i>Accident and Emergency</i>
AfC / A4C	<i>Agenda for Change</i>
AHPs	<i>Allied Health Professionals</i>
AIC	<i>Aligned Incentive Contract</i>
AMM	<i>Annual Members' Meeting</i>
AMU	<i>Acute Medical Unit</i>
AQP	<i>Any Qualified Provider</i>

B

BAF	<i>Board Assurance Framework</i>
BME	<i>Black and Minority Ethnic</i>
BoD	<i>Board of Directors</i>

C

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

D

Datix	<i>National Software Programme for Risk Management</i>
DBS	<i>Disclosure and Barring Service</i>
DNA	<i>Did not attend</i>

DoH	<i>Department of Health</i>
DoLS	<i>Deprivation of Liberty Safeguards</i>
Dr Foster	<i>Provides health information and NHS performance data to the public</i>
DSU	<i>Day Surgery Unit</i>
DToC	<i>Delayed Transfer of Care</i>

E

E&D	<i>Equality and Diversity</i>
eNEWS	<i>National Early Warning Score</i>
ENT	<i>Ear, Nose and Throat</i>
EOLC	<i>End of Life Care</i>
ERCP	<i>Endoscopic Retrograde Cholangiopancreatography</i>
ESR	<i>Electronic Staff Record</i>
EU	<i>European Union</i>
EWTD	<i>European Working Time Directive</i>

F

FAQ	<i>Frequently Asked Questions</i>
FFT	<i>Friends and Family Test</i>
FC	<i>Finance Committee</i>
FOI	<i>Freedom of Information</i>
FT	<i>NHS Foundation Trusts</i>
FY DR	<i>Foundation Year doctor</i>

G

GIRFT	<i>Get it Right First Time</i>
GPOOH	<i>GP Out of Hours</i>
GWG MD&C	<i>Governor Working Group – Membership Development and Communications</i>
GWG V&E	<i>Governor Working Group – Volunteering and Education</i>

H

H@N	<i>Hospital at Night</i>
HaRD CCG	<i>Harrogate and Rural District Clinical Commissioning Group</i>
HaRCVS	<i>Harrogate and Ripon Centres for Voluntary Service</i>
HBC	<i>Harrogate Borough Council</i>
HCP	<i>Health and Care Partnership</i>
HDFT	<i>Harrogate and District NHS Foundation Trust</i>
HDU	<i>High Dependency Unit</i>
HED	<i>Hospital Episodic Data</i>
HEE	<i>Health Education England</i>
HFMA	<i>Healthcare Financial Management Association</i>
HHFM	<i>Harrogate Healthcare Facilities Management Ltd</i>
HR	<i>Human Resources</i>
HSIB	<i>Healthcare Safety Investigation Branch</i>
HSE	<i>Health & Safety Executive</i>
HSMR	<i>Hospital Standardised Mortality Ratios</i>

I

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

K

KPI	<i>Key Performance Indicator</i>
KSF	<i>Knowledge & Skills Framework</i>

L

L&D	<i>Learning & Development</i>
LAS DR	<i>Locally acquired for service doctor</i>
LAT DR	<i>Locally acquired for training doctor</i>
LCFS	<i>Local Counter Fraud Specialist</i>
LEPs	<i>Local Education Providers</i>
LMC	<i>Local Medical Council</i>
LNC	<i>Local Negotiating Committee</i>
LoS	<i>Length of Stay</i>
LPEG	<i>Learning from Patient Experience Group</i>
LSCB	<i>Local Safeguarding Children Board</i>
LTUC	<i>Long Term and Unscheduled Care Directorate</i>
LWAB	<i>Local Workforce Action Board</i>

M

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

N

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

O

OD	<i>Organisational Development</i>
ODG	<i>Operational Delivery Group</i>
ODP	<i>Operating Department Practitioner</i>
OPEL	<i>Operational Pressures Escalation Levels</i>
OSCE	<i>The Objective Structured Clinical Examination</i>

P

PACS	<i>Picture Archiving and Communications System – the digital storage of x-rays</i>
PbR	<i>Payment by Results</i>
PEAT	<i>Patient Environment Action Team</i>
PET	<i>Patient Experience Team</i>
PET SCAN	<i>Position emission tomography scanning system</i>
PHSO	<i>Parliamentary and Health Service Ombudsman</i>
PMO	<i>Project Management Office</i>
PROM	<i>Patient Recorded Outcomes Measures</i>
PSC	<i>Planned and Surgical Care Directorate</i>
PST	<i>Patient Safety Thermometer</i>
PSV	<i>Patient Safety Visits</i>
PVG	<i>Patient Voice Group</i>

Q

QC	<i>Quality Committee</i>
QIA	<i>Quality Impact Assessment</i>
QIPP	<i>The Quality, Innovation, Productivity and Prevention Programme</i>
QPR	<i>Quarterly Performance Review</i>

R

RCA	<i>Route Cause Analysis</i>
RN	<i>Registered Nurse</i>
RTT	<i>Referral to Treatment. The current RTT Target is 18 weeks.</i>

S

SALT	<i>Speech and Language Therapy</i>
SAS DR	<i>Speciality and Associate specialist doctors</i>
SCBU	<i>Special Care Baby Unit</i>
SHMI	<i>Summary Hospital Mortality Indicator</i>
SHU	<i>Sheffield Hallam University</i>
SI	<i>Serious Incident</i>
SID	<i>Senior Independent Director</i>
SIRI	<i>Serious Incidents Requiring Investigation</i>
SLA	<i>Service Level Agreement</i>
SMR	<i>Standardised Mortality rate – see Mortality Rate</i>
SMT	<i>Senior Management Team</i>
SPF	<i>Social Partnership Forum</i>
SpR	<i>Specialist Registrar – medical staff grade below consultant</i>
ST DR	<i>Specialist trainee doctors</i>

STEIS *Strategic Executive Information System*
STP *Sustainability and Transformation Plan/Partnerships*

T

TARN *Trauma Audit Research Network*
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 Thromboembolism*

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>

April 2018

Corporate/Misc/Glossary of Abbreviations April 2018