NHS
Harrogate and District
NHS Foundation Trust

**The meeting of the Board of Directors held in public will take place on**
**Wednesday 30 May 2018**
**Boardroom, Harrogate District Hospital, HG2 7SX**
**Start: 9.00am Finish: 12.30pm**

| AGENDA | | | |
|---|---|---|---|
| **Item No.** | **Item** | **Lead** | **Paper No.** |
| **9.00am – 10.30am** | | | |
| **-** | **Patient Story** | Mrs A Schofield, Chairman | - |
| **1.0** | **Welcome and Apologies for Absence**<br>*To receive any apologies for absence:* | Mrs A Schofield, Chairman | - |
| **2.0** | **Declarations of Interest and Register of Interests**<br>*To declare any interests relevant to the agenda and to receive any changes to the register of interests* | Mrs A Schofield, Chairman | 2.0 |
| **3.0** | **Minutes of the Board of Directors meetings held on 25 April 2018**<br>*To review and approve the minutes* | Mrs A Schofield, Chairman | 3.0 |
| **4.0** | **Review Action Log and Matters Arising**<br>*To provide updates on progress of actions* | Mrs A Schofield, Chairman | 4.0 |
| **Overview by the Chairman** | | Mrs A Schofield, Chairman | - |
| **5.0** | **Arrangements for conducting Board business - discussion paper**<br>*To be agreed* | Mrs A Schofield, Chairman | 5.0 |
| **6.0** | **Report by the Chief Executive Including the Integrated Board Report**<br>*To receive the report for comment* | Dr R Tolcher, Chief Executive | 6.0a<br>6.0b |
| **7.0** | **Report by the Finance Director**<br>*To receive the report for comment* | Mr J Coulter, Deputy Chief Executive/ Finance Director | 7.0 |
| **10.30am – 11.40am** | | | |
| **Break** | | | |
| **11.40am – 12.30pm** | | | |
| **8.0** | **Report from the Chief Operating Officer**<br>*To receive the report for comment* | Mr R Harrison, Chief Operating Officer | 8.0 |
| **9.0** | **Report by the Director of Workforce and Organisational Development**<br>*To receive the report for comment* | Mr P Marshall, Director of Workforce & Organisational Development | 9.0 |

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| **10.0** | **Report from the Chief Nurse**<br>*To receive the report for comment* | Mrs J Foster, Chief Nurse | 10.0 |
| **10.1** | **Annual Patient Experience and Complaints Report**<br>*To receive the report for comment* | Mrs J Foster, Chief Nurse | 10.1 |
| **11.0** | **Report from the Medical Director**<br>*To receive the report for comment* | Dr D Scullion, Medical Director | 11.0 |
| **11.1** | **Guardian of Safe Working Hours Quarterly Report**<br>*To receive the report for comment* | Dr D Scullion, Medical Director | 11.1 |
| **11.2** | **Learning from Deaths Report**<br>*To receive the report for comment* | Dr D Scullion, Medical Director | 11.2 |
| **11.3** | **NHS Resolution: Safer Maternity Incentive Scheme**<br>*To receive the report for comment* | Dr K Johnson, Clinical Director | 11.3 |
| **12.0** | **Oral Reports from Directorates**<br>*12.1 Planned and Surgical Care*<br>*12.2 Children's and County Wide Community Care*<br>*12.3 Long Term and Unscheduled Care* | Dr K Johnson, Clinical Director<br>Dr N Lyth, Clinical Director<br>Mr A Alldred, Clinical Director | -<br>-<br>- |
| **13.0** | **Committee Chair Reports**<br>*13.1 To receive the reports from the Quality Committee meeting held 2 May 2018 and the Quality Committee's Annual Report 2017/18.*<br>*13.2 To receive the report from the Audit Committee meetings held on 3 May 2018 and 17 May 2018 and the Audit Committee's Annual Report 2017/18.*<br>*13.3 To receive the Finance Committee's Annual Report 2017/18.* | Mrs L Webster, Quality Committee Chair<br>Mr C Thompson, Audit Committee Chair<br>Mrs M Taylor, Finance Committee Chair | 13.1a<br>13.1b<br>13.2a<br>13.2b<br>13.3 |
| **14.0** | **Council of Governors minutes of the meeting held 3 February 2018**<br>*To receive and note the minutes* | Mrs A Schofield, Chairman | 14.0 |
| **15.0** | **Other matters relating to compliance with the Trust's Licence or other exceptional items to report, including issues reported to the Regulators**<br>*To receive an update on any matters of compliance* | Mrs A Schofield, Chairman | - |
| **16.0** | **Any other relevant business**<br>*By permission of the Chairman* | Mrs A Schofield, Chairman | - |
| | **Board Evaluation** | Mrs A Schofield, Chairman | - |
| **Confidential Motion – the Chairman to move:**<br>*Members of the public and representatives of the press to be excluded from the remainder of the meeting due to the confidential nature of business to be transacted, publicly on which would be prejudicial to the public interest.* | | | |

Harrogate and District
NHS Foundation Trust

## BOARD OF DIRECTORS – REGISTERED DECLARED INTERESTS

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

The register is maintained by the Company Secretary and was last updated in May 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<br>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.<br>2. Harrogate Ambassador on behalf of Harrogate Convention Centre |
| 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 |

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| Mr Richard Stiff | Non-Executive Director | 1. Director of /50% owner Richard Stiff Consulting Limited<br>2. Director of NCER CIC<br>3. Director and Trustee of TCV (The Conservation Volunteers)<br>4. Governor of Selby College |
| Mrs Maureen Taylor | Non-Executive Director | None |
| Mr Christopher Thompson | Non-Executive Director | 1. Director of Harrogate Healthcare Facilities Management Limited (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)<br>2. Director – Neville Holt Opera<br>3. Member – Council of the University of York<br>4. Chair – Audit Yorkshire Consortium |
| Dr Ros Tolcher | Chief Executive | 1. Specialist Adviser to the Care Quality Commission<br>2. Member of NHS Employers Policy Board (Vice Chair).<br>3. Harrogate Ambassador on behalf of Harrogate Convention Centre |
| Mr Ian Ward | Non-Executive Director | 1. Non-Executive Director of :<br>• Charter Court Financial Services Limited,<br>• Charter Court Financial Services Group Limited,<br>• Exact Mortgage Experts Limited,<br>• Broadlands Finance Limited<br>• Charter Mortgages Limited.<br>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.<br>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.<br>3. Member, Leeds Kirkgate Market Management Board |
| Mrs Lesley Webster | Non-Executive Director | None |
| **Deputy Directors** | | |
| Dr David Earl | Deputy Medical Director | 1. Private anaesthetic work at BMI Duchy hospital |
| Dr Claire Hall | Deputy Medical Director | 1. Trustee, St Michael's Hospice Harrogate |

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|---|---|---|
| Mrs Joanne Harrison | Deputy Director of W & OD | None |
| Mr Jordan McKie | Deputy Director of Finance | 1. Familial relationship with NMU Ltd, a company providing services to the NHS |
| Mrs Alison Mayfield | Deputy Chief Nurse | None |
| Mr Paul Nicholas | Deputy Director of Performance and Informatics | None |

Harrogate and District
NHS Foundation Trust

**Report Status: Open**

**BOARD OF DIRECTORS MEETING**

Minutes of the Board of Directors' meeting held in public on
Wednesday 25 April 2018 at 9.00am in the Meeting Room at Kingswood Surgery,
Wetherby Road, Harrogate, HG2 7SA

**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
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
Mrs Lesley Webster, Non-Executive Director

**In attendance:**
Mr Andrew Alldred, Clinical Director for Long Term and Unscheduled Care
Mr Richard Chillery, Operations Director for Children's and County Wide Community Services (representing Dr Lyth)
Dr Kat Johnson, Clinical Director, Planned and Surgical Care
Mrs Katherine Roberts, Company Secretary (minutes)

**Patient Story**

Mrs Schofield welcomed Mr W to the meeting. Mr W shared his experience of having a heart attack and being treated at Harrogate District Hospital Accident and Emergency department in January 2018. He described the symptoms he had experienced, including gum pain, indigestion and low level pain in his arms.

Mr W said he had received excellent care following his cardiac arrest and was transferred very quickly to Leeds Teaching Hospitals Trust and had critical surgery within 2 hours of arriving at the Accident and Emergency department in Harrogate. He confirmed that following his initial treatment, Harrogate District Hospital had provided a good standard of follow up care.

Dr Tolcher thanked Mr W for sharing his experience with the Board. She said it was important to celebrate a patient story in which things had gone very well. Strong team working within the emergency room was clear and Mr W had been transferred very quickly.

Two clinicians who had treated Mr W joined the meeting; the Board expressed their thanks to them and the rest of the Emergency Department team.

Dr Scullion noted that systems of a cardiac arrest were often not well known by members of the public. He reflected that the organisation of cardiac services across the NHS was a real success story for the health service.

Dr Tolcher concluded by observing that it was important for the Board to receive patient stories which highlighted outstanding care. There was evidence that stretching to be the very best rather than focusing on what was not good supported continuous improvement.

**1.0 Welcome and Apologies for Absence**

Mrs Schofield welcomed observers to the meeting, this included Mr Tim Franklin (CQC), Tony Doveston (Public Governor), Rosemary Marsh (Public Governor), Daniel Scott (Staff Governor) and Paul Widdowfield (Communications & Marketing Manager).

She noted that apologies had been received from Dr Natalie Lyth, Clinical Director, Children's and County Wide Community Services and Mr Ian Ward, Non-Executive Director. It was confirmed a quorum was present at the meeting.

**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 (HHFM). 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 HHFM.

**3.0 Minutes of the meetings of the Board of Directors on 28 March 2018**

The draft minutes of the meeting held on 28 March 2018 were approved with one amendment; minute 6.6 should read 'Mr McLean' (not Ms McLean).

**APPROVED:**
**The Board of Directors approved the minutes of the meeting held on 28 March 2018 as an accurate record of proceedings.**

**4.0 Review of Action Log and Matters Arising**

4.1 Completed actions were noted. In addition it was confirmed actions 46, 66, 72 and 90 were complete.

4.2 Mr Harrison reported actions 76 and 81 would be completed during May 2018.

4.3 There were no other matters arising.

**APPROVED:**
**The Board of Directors noted completed actions and received an update on actions and agreed to close actions 46, 66, 72 and 90.**

**Overview by the Chairman**

Mrs Schofield noted a number of items:

- Two new Non-Executive Director appointments would be recommended to the Council of Governors for approval in May 2018;
- The Trust had welcomed staff delivering 0-19 Children's Services in Stockton-On-Tees;
- A successful Medicine for Members event regarding infection prevention and control had taken place; and
- Due to patient confidentiality concerns the Board had received a patient story during the private section of the meeting on 28 March 2018. The story related to support provided to a patient with learning disabilities which had enabled them to receive care that they were anxious about.

Mr Schofield noted this would be the first meeting of a new financial year, which was expected to present very significant challenges. The Board would need to keep a forensic eye on performance.

Dr Tolcher confirmed she had no additional urgent matters to report to the Board.

**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 explained that that Trust's financial position had changed following circulation of the Board reports: this was the result of communications from NHS Improvement. She noted that the Trust had made an operating loss in month twelve, and reflected that this was the first time the Trust had made a deficit in the month of March. This was due in part to a shortfall in income from elective work because, despite a reduction in extreme levels of non elective activity bed occupancy had remained high following demand earlier in the winter., but The Trust had therefore struggled with the Emergency Department four hour target and referral to treatment targets. She confirmed that patient safety had not been compromised, but there had been a negative impact on patient experience.

5.3 Reflecting on the 2017/18 financial year she commented it had been a hard year. Overall the Trust had achieved twelve month targets for the A&E 4 hour standard, referral to treatment, 62 day cancer and diagnostic wait measures. Therefore the Trust's relative performance remained strong when compared nationally. However absolute performance was not as good as previous years; patients had experienced longer waits and there had been more months when the Emergency Department target had not been achieved. She assured the Board that the Executive Team were determined, had a relentless focus on care quality and would seek to correct things that were within the Trust's gift.

5.4 During the year there had been some notable successes including the new Sterile Services Department, redevelopment of the Endoscopy suite (due to open in early June), the establishment of HHFM, being awarded new contracts for 0-19 Children's Services and very positive staff survey results.

5.5 Dr Tolcher said she thought the year ahead (2018/19) would be difficult. The Trust

would have to work hard to sustain performance and ensure that the workforce felt valued in the face of increasing pressures.

5.6 Highlighting other items from her report, Dr Tolcher said the Board would consider a draft of the West Yorkshire and Harrogate (WY&H) Health and Care Partnership Memorandum of Understanding in the private section of the meeting.

5.7 Mrs Schofield queried whether length of stay during March 2018 had been affected by delayed transfers of care (DTOC) or whether patients were not medically fit to be discharged. Mr Harrison said the level of DTOCs was stable; there had been a longer stay per medical episode and increased occupancy following a high level of non-elective activity during February 2018. Mr Harrison explained that a number of actions to support the Trust's response to winter demand had been saturated during March 2018. Mr Alldred outlined actions being taken to support timely discharge of patients, however acknowledged it remained a challenge for the Trust. He noted that recent bed modelling forecast increased demand in 2018/19, the Trust's ability to manage the bed base effectively and ensure timely outflow of patients would be imperative.

5.8 Following a question from Ms Robson, Mr Harrison explained patients discharged to Hampden House were placed there for a limited number of days, which was agreed per patient and communicated in a letter to the patient. Patients were managed by the supported discharge service.

5.9 Mr Thompson asked what Dr Tolcher felt would be the potential benefit of changes in the structure of NHS Improvement and NHS England. She said she expected it would support closer working and some devolution of regulation to WY&H level.

5.10 The new model of partnership working in Harrogate was noted. Dr Tolcher provided additional detail about the new model and supporting governance groups.

5.11 Mrs Schofield sought additional information about the two patient deaths as a result of influenza. Dr Scullion confirmed Dr Jenny Child (Director of Infection Prevention and Control) was confident the influenza was hospital acquired and a review of case notes would be undertaken to identify any learning. Mr Alldred confirmed the Trust was following new national guidance regarding influenza vaccination for patients and staff. Consideration was being given to vaccinating people known to be vulnerable to influenza at the time of admission.

**APPROVED:**
**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; and**
- **Endorsed use of the Trust's seal and agreement of a licence as detailed in the report.**

**6.0 Integrated Board Report**

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

6.2 Following a question from Ms Robson, Mr Harrison explained there had been an increase in referrals which had resulted in operational pressure on achievement of the

breast two week wait target. The Trust was reviewing the radiology model to try and increase the flow of patients. He provided reassurance that although the two week target had not been achieved, the majority of patients were still seen within two weeks and those who had not been seen had attended appointments within three weeks. Dr Johnson explained a change to the general surgery on call rota would support the increase in demand for the breast clinic.

6.3 Reflecting on the overall trend that patients were waiting longer for treatment, Mrs Webster asked what the Trust planned to do differently to stop the trend. Dr Tolcher said there had to be realism about the operational plan, although performance was not expected to decline significantly patients would continue to wait longer. There would not be a significant improvement unless the Trust received additional funding or there was a reduction in rates of referral and demand. Mr Coulter noted the 2018/19 plan did not include achievement of referral to treatment targets during the year.

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

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

**7.0 Finance Report including Financial Recovery Plan and CIP update**

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

7.2 The position included within the finance report circulated was a year-end surplus of £100k. This included £2.4m of sustainability and transformation monies. If these monies were removed the Trust ended the year £4.5 away from plan.

7.3 Mr Coulter explained that late on Friday 20 April 2018 the Trust had received a letter from NHS Improvement which had altered the Trust's financial position. NHS Improvement had awarded an additional £1m to the Trust. This income was expected to be received in June or July 2018, and would assist the Trust's cash position.

7.4 Mr Coulter highlighted a number of financial successes during the year; establishment of HHFM and the award of new 0-19 Children's Services contracts. However the year had included many challenges including spending on temporary workforce, activity had been behind plan and cost improvement plan (CIP) performance had been £2m behind target.

7.5 Mrs Taylor confirmed the Finance Committee would review the final year end position and identify any learning for the Trust. She noted critical links to ward staffing levels, and commented that despite the ward establishment review it appeared there were too many staff on wards. Dr Tolcher agreed and said this was being discussed by the executive directors. Mrs Foster explained the Trust was part of an NHS Improvement collaborative project to review the use of additional staffing to provide enhanced care for patients who were assessed to need one to one care. A small number of wards were piloting a review of these patients every 24 hours. Mrs Webster expressed caution regarding staffing in light of an increase in falls and pressure ulcers during some parts of 2017/18. Dr Tolcher agreed but noted a number of wards appeared to be operating over staff establishment.

7.6 Following a question from Ms Robson, Mr Marshall said the Trust was seeking to maximise potential income from the apprenticeship levy to support training schemes. He

noted that during 2017/18 the Trust had paid £600k to the levy but had only drawn down £30k.

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

**8.0 Business Planning Update – Operational Plan 2018/19**

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

8.2 Mr Coulter reported the Trust had received a letter from NHS Improvement on 24 April 2018. The letter offered to reduce the 2018/19 control total to £0, however if this was achieved the Trust would only receive three quarters of the sustainability and transformation (S&T) funding previously offered. He recommended that the Board accept this offer.

8.3 Mr Coulter highlighted details included with the operational plan regarding estates planning. He confirmed there would be further amendments to this section of the plan to outline principles the Trust would follow but include less detail about specific amendments to the Trust's estate.

8.4 The Board acknowledged a letter sent to all NHS Trusts by NHS Improvement expressing concern that operational plans were not realistic. It was agreed that the plan was transparent about risks the Trust would face during 2018/19 to achieve the operational plan.

8.5 The Board agreed to accept the offer from NHS Improvement and agree to a revised control total of £0 during 2018/19.

8.6 Mr Thompson reflected on forecast population changes (an increase in the number of older people) alongside the strategic key performance indicators (falling catchment population and number of births) and the significant challenge this would present for the Trust. Mr Coulter noted the Trust's place in service sustainability across WY&H, with other providers relying on capacity Harrogate could offer.

8.7 Mrs Webster queried whether the cost improvement plan target for 2018/19 would be achievable. Mr Coulter acknowledged the cost improvement plan target was high, but explained it had been increased as a result of underachievement during 2017/18.

8.8 Following a question from Mrs Taylor it was confirmed the activity planning included within the plan had been shared with HaRD CCG.

8.9 Mr Coulter noted amendments would be made to the operational plan to reflect comments received from members of the Board, and to reflect the revised control total for 2018/19.

8.10 The Board approved the submission of the Operational Plan for 2018/19 and the Self Certification document.

**APPROVED:**
**The Board of Directors:**
- **Approve the submission of the Operational Plan for 2018/19, including the**

**Control Total requirement and the Self Certification document.**

## 9.0 Bi-annual review of Strategic KPIs

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

9.2 Dr Tolcher highlighted performance against the catchment population target and noted how important this was for the organisation. She also noted performance against the surplus per occupied bed days and reflected that during 2017/18 bed based care had been a deficit position. Future success would depend on mitigating this, and there would therefore be a renewed focus on length stay and the workforce associated with the bed base. It would be imperative that the Trust addressed any inefficiency in the use of beds.

9.3 Mr Alldred provided reassurance about the work underway to support this, including discharge processes, the Emergency Department and staffing levels.

9.4 Mr Harrison reflected that relationships with partners were increasingly positive. For example, the Accident and Emergency Delivery Board had committed to a focus on making a step change in discharge.

9.5 Mr Thompson asked a question about the best practice tariff, commenting that the Trust had not moved forward as far as was planned. Mr Harrison and Dr Johnson noted that investment in infrastructure would be required in order to achieve a step change in performance against the best practice tariff.

**9.6 ACTION: Briefing session for the Board at a future strategy day regarding the best practice tariff.**

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

- **Received and noted the content of the report**

## 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 noted progress to support resilience of the oncology service. A locum Consultant Oncologist had been appointed and the Trust had received short term support from Leeds Teaching Hospitals Trusts for urology oncology services. There had been positive conversations with Leeds Teaching Hospitals Trusts and York Teaching Hospital Foundation Trust regarding the longer term sustainability of the service.

10.3 The Board agreed to delegate authority to Dr Tolcher and Mr Harrison to approve an information return on behalf of the Trust to NHS Digital regarding data security.

10.4 Mrs Taylor asked whether activity during April 2018 suggested any cause for concern against planned activity during month and any implications this may have for the 2018/19 plan. Mr Harrison explained activity levels were positive. However he had concerns about the level of non elective activity during February and March 2018 and the continued implications for the Trust's bed occupancy during April 2018. He emphasised the importance of the Trust delivering a reduction in medical beds in order to deliver the elective activity plan. In addition he highlighted the workforce risks outlined in the

2018/19 plan and the imperative of delivering the new endoscopy suite in June 2018 and achieving planned substantive recruitment for posts in the new unit.

10.5 Mr Thompson sought further information about a decline in performance against patient-led assessment of environment for dementia care. Mr Harrison explained that in order to improve performance the Trust would need to make significant changes across the hospital site, for example to flooring. Dr Tolcher added that the concerns highlighted by the patient-led assessment of environment for dementia care had been risk assessed and it had been determined that they had not contributed to an increased level of falls.

10.6 Mr Harrison noted a short term staffing issue which had impacted on the anaesthetics register. Dr Johnson said the anaesthetic consultant team had been flexible and supported resilience of the service and expressed her thanks to them.

**10.7 ACTION: Following a question from Mr Robson, Mr Harrison agreed to consider how to report future accident and emergency performance in light of revised national targets.**

**APPROVED:**
**The Board of Directors:**
- **Received and noted the contents of the report.**
- **Agreed to delegate authority to Dr Tolcher and Mr Harrison to approve an information return on behalf of the Trust to NHS Digital regarding data security**

**11.0 Report by the Director of Workforce and Organisational Development**

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

11.2 Mr Marshall highlighted good performance on consultant job planning, and noted progress on developing a medical bank across WYAAT which would have aligned rates of pay.

**APPROVED:**
**The Board of Directors:**
- **Noted items included within the report.**

**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 activity to support nurse recruitment, a 10% reduction in the number of complaints received by the Trust when compared with the same period in 2017. She noted demand on the community care teams had reduced as had the number of staff vacancies.

**12.2 ACTION: Mrs Foster to add percentage figures to analysis of staffing on adult in-patient wards in order to assist the context of the report.**

**12.3 ACTION: Mrs Foster to schedule director inspections for 2018/19.**

12.4 With regards to data about 'care hours per patient day', Ms Robson asked how many hours a patient should receive. Mrs Foster reported there was no national guidance, although the Trust's figures were slightly higher than average. Mr Coulter noted

the data was included within the model hospital data report.

**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 he 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 2017/18; and**
- **Noted HDFT is participating in NHS Improvement Collaborative to improve Enhanced Care.**

## 13.0 Report from the Medical Director

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

13.2 Dr Scullion noted there was no additional information to report regarding TARN (Trauma Audit Research Network) data. He explained that the Trust received a small number of major trauma patients and noted concerns about the data quality used to prepare TARN data, this was due to varied interpretations of 'trauma' deaths. Following a report which suggested the Trust was an outlier based on TARN data Dr Scullion had asked the lead consultant to undertake a further review and in addition the Trust's Trauma Steering Group would review all TARN cases.

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

- **Received and noted the report.**

## 14.0 Annual Efficiency Programme Quality Impact Assessment

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

14.2 Mrs Foster explained the quality impact assessment process continued throughout the year. Dr Scullion and Mrs Foster received details of the quality impact assessment screening undertaken for all cost improvement plans. Dr Scullion noted that they relied upon assurance from the directorates about the impact assessments undertaken.

14.3 She noted that the Trust's Internal Auditors had recently reviewed the impact assessment process and reached a finding of limited assurance. It had been recommended that the Trust should develop more evidence of the ongoing scrutiny which took place. An action plan to respond to the recommendation had been developed and was being implemented.

14.4 Dr Tolcher noted that she had requested that a post project evaluation of cost improvement plan impact assessments undertaken during 2017/18 was completed. This evaluation would consider the assumed, and actual, impact of cost improvement plan schemes on care quality.

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

- **Noted the findings in relation to the quality impact assessment process for the current efficiency programme.**
- **Noted the level of assurance currently available.**
- **Noted and support the work that is still required to strengthen the process**

**15.0 Oral Reports from Directorates**

**15.1 Planned and Surgical Care Directorate**

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

- A peer review of critical care had highlighted some areas of concern. As a result a new anaesthetic rota had been recommended. In addition the review had recommended a supernumerary coordinator would be appointed. The recommendations were being considered.
- The Trust was in the process of completing a maternity self-assessment for NHS Resolution, this would be reported to the Board in May 2018.
- As a result of issues within the general surgery team the directorate was developing additional support for junior staff out of hours.

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

15.2.1 Mr Chillery provided a verbal update from the Children's and County Wide Community Services Directorate:

- The new 0-19 Children's Service had successfully mobilised in Stockton-On-Tees. The commissioners were reported to be very happy with progress. Implementation plans for mobilisation of services in Gateshead and Sunderland from 1 July 2018 were ongoing.
- The contract for 0-19 Children's Service in County Durham had been extended until 2020.
- A new Head of Safeguarding had been appointed and would commence in post in early July 2018.
- As reported in previous months medical staffing within paediatrics remained a challenge.
- A CQC peer review of the Woodlands Ward had been successful.
- The directorate had engaged commissioners regarding a proposed contract review of specialised children services. It was hoped this would address a significant increase in demand for the services.

**15.3 Long Term and Unscheduled Care Directorate**

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

- The directorate had reflected on the national staff survey results and identified a number of areas for improvement. The resilience of staff would be a focus.
- The Trust had drafted an initial impact assessment of the GP Out of Hours service provided for Hambleton, Richmondshire and Whitby CCG.
- The directorate had seen high levels of medical outliers; a resulting 'hot spot' review had been completed to support improved management of medical

outliers.

- It was reported Ms Kath Banfield had been appointed as the new Head of Nursing for the Long Term and Unscheduled Care Directorate.

**16.0 Committee Chair Reports**

Mrs Schofield welcomed reports from the Board's committees.

**16.1 Report from the Quality Committee meeting held on 4 April 2018**

16.1.1 Mrs Webster reported the Quality Committee had considered and agreed on the quality priorities for 2018//19. In addition the committee had reviewed a draft of the 2017/18 Quality Accounts.

**16.2 Report from the Finance Committee meeting held on 12 April 2018**

16.2.1 Mrs Taylor presented a report from the Finance Committee on 12 April 2018. The report had been circulated in advance of the meeting and was taken as read.

16.2.2 Mrs Taylor noted the committee had reviewed financial risks on the board assurance framework, received an update on the private patient business case and considered the results of the committee's effectiveness survey.

16.2.3 Mrs Taylor explained proposed amendments to the Finance Committee's terms of reference for approval.

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

- **Approved the Finance Committee's terms of reference.**

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

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

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

There were no other items of business.

**19.0 Board Evaluation**

Members of the Board said they felt the right topics had been discussed and appropriate time had been allocated to each item. Mr Harrison said there had been appropriate challenge to the 2018/19 operational plan. Dr Tolcher reflected there had been a good balance in discussion between strategy and operational issues.

**20.0 Confidential Motion**

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

The Board agreed the motion unanimously. The meeting closed at 12.30pm.

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# HDFT Board of Directors Actions Schedule
# Action Log
# May 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 |
|---|---|---|---|---|---|
| 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 | |
| 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 rom April 2018. | Mrs J Foster, Chief Nurse | May 2018 | |
| 91 | April 2018 (minute 9.6) | Briefing session for the Board at a future strategy day regarding the best practice tariff | Mrs Katherine Roberts, Company Secretary / Mrs Angela Schofield, Chairman | June 2018 | |
| 92 | April (minute 10.7) | Mr Harrison agreed to consider how to report future accident and emergency performance in light of revised national targets. | Mr Harrison, Chief Operating Officer | June 2018 | |
| 93 | April (minute 12.2) | Mrs Foster to add percentage figures to analysis of staffing on adult in-Patient Wards in order to | Mrs J Foster, Chief Nurse | June 2018 | |

| | | | | | |
|---|---|---|---|---|---|
| | | assist the context of the report. | | | |
| 94 | April (minute 12.3) | Mrs Foster to schedule director inspections for 2018/19 | Mrs J Foster, Chief Nurse | June 2018 | |

Harrogate and District
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|---|---|---|---|
| **Date of Meeting:** | 30 May 2018 | **Agenda item:** | 5.0 |
| **Report to:** | Board of Directors | | |
| **Title:** | Arrangements for Conducting Board Business | | |
| **Sponsoring Director:** | Angela Schofield, Chairman | | |
| **Author(s):** | Angela Schofield, Chairman | | |

**Report Purpose:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Decision** | ✓ | **Discussion/ Consultation** | ✓ | **Assurance** | ✓ | **Information** | |

**Executive Summary:**

- Consideration to change to programme for board meetings
- Assurance regarding public accountability

**Related Trust Objectives**

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

**Key implications**

| | |
|---|---|
| **Risk Assessment:** | There could be a risk of reduced reporting to members and members of the public. This will be addressed through new arrangements for briefing members of the Council of Governors. |
| **Legal / regulatory:** | None identified. |
| **Resource:** | None identified. |
| **Impact Assessment:** | Not applicable |
| **Conflicts of Interest:** | None identified |
| **Reference documents:** | Paper attached |
| **Assurance:** | The Board of Directors |

**Action Required by the Board of Directors:**

It is recommended that the Board consider and approve the proposals contained within the report, to commence in August 2018 when the first informal Board workshop would take place.

It is also proposed that the Board would review this arrangement for conducting board business in May 2019

## Introduction

Some informal discussions have taken place between Board members and Governors about whether we are maximising the effectiveness of Board time and this has led to consideration of the frequency of Board meetings. We currently have 10 Board meetings a year with an in-public session scheduled for 9am to 12.30pm and a confidential session scheduled for 1.00pm to 2.30pm approx. The Board also has occasional "strategy away days" where time is spent on getting to grips with issues relating to future plans. A number of Board members have commented that the style of working in the away days is more effective than formal Board meetings as there is more time to probe issues and contribute to a debate which draws on the expertise of all Board members.

## Proposal

This has led to consideration of restructuring the conduct of Board business around six in-public Board meetings followed by a private meeting and six informal Board workshops. This pattern has been adopted by a number of NHS trusts.

The months when the in-public meetings would take place would be May, July, September, November, January and March. Informal workshops would take place in April, June, August, October, December and February.

The in-public meeting days would follow a similar format to the current position. It is proposed that the informal workshops should generally be arranged as follows:

- Consideration of any urgent matters which would normally be raised in a confidential board meeting
- Exception report on the Integrated Board Report and Board Assurance Framework
- Focus on a major strategic issue
- Meeting with a Trust service
- Board members to visit a Trust service.

This could be flexible according to the needs at the time.

The Trust's Finance Sub-Committee has amended its terms of reference to scrutinize the financial performance of the trust so this will ensure that this is given thorough consideration monthly.

## Public Accountability

It is essential for the Board to consider whether this change would have a significant impact on our accountability to members of the Trust and members of the public. Due consideration has been given to the importance of this to ensure that the Trust preserves a high level of public confidence. There are a number of ways in which this will be assured:

- The Integrated Board Report which is produced every month and is scrutinized by the Board at every meeting would still be available on the Trust's web site. This is also reviewed in depth by the Senior Management Team and Board sub-committees.
- The informal workshops will not be constituted to take decisions which would otherwise have been taken in public. Any such decisions will be taken at an in-public Board meeting.
- The Chairman and Chief Executive, with other Board members as appropriate, will provide a briefing to the Council of Governors soon after every informal Board workshop.

**Views of the Council of Governors**

This matter has been discussed informally with Governors and in the private session of the May 2018 Council of Governors' meeting. Generally the Governors support the proposal to try a different approach and I am grateful to them for their comments and suggestions. The issue of the potential of reduced accountability to the public was raised and, hopefully, this has been addressed in this proposal. A suggestion was made by one Governor to restructure the business into eight in-public meetings rather than six. The assurance was given to Governors that they would be fully briefed on issues considered in the informal workshops and that the new arrangement would be reviewed.

**Recommendation**

The Board is requested to approve this proposal, to commence in August 2018 when the first informal Board workshop would take place. It is proposed that the Board would review this arrangement for conducting board business in May 2019.

Angela Schofield
Chairman
May 2018

Harrogate and District NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Date of Meeting:** | 30 May 2018 | **Agenda item:** | 6.0a |
| **Report to:** | Board of Directors | | |
| **Title:** | Report from the Chief Executive | | |
| **Sponsoring Director:** | Dr Ros Tolcher, Chief Executive | | |
| **Author(s):** | Dr Ros Tolcher, Chief Executive | | |
| **Report Purpose:** | **Decision** [ ] **Discussion/ Consultation** [✓] **Assurance** [✓] **Information** [✓] | | |
| **Executive Summary:** | • An announcement regarding the West Yorkshire and Harrogate HCP joining the ICS development programme is thought to be imminent<br>• Operational and financial performance in Month one is slightly below the planned position.<br>• Healthy Child Services in North Yorkshire, in partnership North Yorkshire Council prevention services have been awarded Stage 2 Baby Friendly accreditation | | |

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

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

**Action Required by the Board of Directors:**

- 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. MATTERS RELATING TO QUALITY, PATIENT EXPERIENCE AND PERFORMANCE

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

Demand has settled to a more seasonal norm in the last few weeks although the Trust continues to have a relatively high rate of patients with a length of stay in excess of 7 and 21 days and high numbers of ED attendances. Operational performance fell short of the planned level of attainment in April, for a number of reasons.

As reported in prior months Board reports, achieving the 18 week RTT target remains challenging. The Trust did however achieve an improved position in April compared to the last two months. Performance on the A&E 4 hour standard also increased to 94.1% but remains a little below the 95% target. Both standards should continue to improve over the remainder of Q1.

The positon in respect of cancer pathways is more challenging and may not be corrected within the quarter. Delays in the 62 day pathway relate to complex cases and patient choice. Delays in the 14 day symptomatic breast pathway are due to high volumes. The great majority of patients are however seen within 15 days and there is no evidence of adverse clinical impact on individual patients. Breach analysis continues in all cases.

After two successive months of an improved safety thermometer score the rate of harm free care dropped to 93.1% in April. This change was due to a relatively high number of 'old' pressure ulcers reported by Community Care Teams (CCT). An 'old' pressure ulcer is one which is found at the first point of contact and does not therefore represent a lapse in the care provided by the CCT although it may have been avoidable by earlier intervention.

## 2. FINANCIAL POSITION

### 2.1 Financial performance

The Trust reported a deficit position of £2,303k for April. Although this was in line with the plan agreed with NHS Improvement based on a breakeven control total, it is behind the internally set stretch target, which was a deficit of £1,526k. Further work is therefore required to reduce the run rate.

As in previous months, the main drivers of the adverse position are the additional costs of bank, agency and locum staffing, and some shortfall in CIP attainment. Elective income is slightly above plan but day case and non-elective income are slightly below plan. Phasing of assumed levels of elective and non-elective activity is being reviewed in the light of the Aligned Incentive Contract and roll out of the new Endoscopy Unit. The reported position which shows elective and out-patient activity as 4-5% less than planned is therefore subject to change.

Of particular concern is the escalation in the cost of medical locums. This is attributed to the number of hours contracted being higher than previously and while work continues to try and fill gaps it is foreseeable that this level of expenditure will continue in the medium term. Spending on additional ward staffing has not fallen relative to the reduction in non-elective admissions. There has been some improvement in this position and further work is underway to contain expenditure while sustaining safe staffing.

The Trust aims to have less than 3% of the total pay bill on agency staff. Actual agency expenditure in April was 4.3% of the pay bill, which is the highest level the Trust has incurred. The actions in this area are discussed in the later reports.

The Trust reported a rating of 3 in April in line with the annual plan submitted to NHS Improvement. This is a slightly weaker 3 as a result of agency spend performance mentioned above.

### 2.2 NHS Improvement

An additional review meeting took place with NHSI on 11 May with particular focus on assurance in respect of CIPs and winter planning. NHSI is supportive of the Trust's approach and suggested that a stronger 'best case' could be developed.

A review of ward staffing is to be conducted, with support from NHSI. NHSI will also be undertaking a financial diagnostic of a number of trusts, including HDFT.

## 3. STRATEGIC UPDATE

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

### 3.1 Accountable Care System developments

As noted at previous Board meetings, the West Yorkshire and Harrogate HCP is working towards endorsement as an ICS (Integrated Care System). A Memorandum of Understanding (MoU) for the partnership, a financial strategy and a place-based approach to regulation and oversight have all been developed.

An expression of interest was submitted in February and at the time of writing a decision from NHS England and NHS Improvement is thought to be imminent. If successful, the WYH would join the national development programme in shadow form. Becoming part of the ICS development programme would enable further progress on integration of health and care services for the 2.6m population served by the WYH Partnership. It also secures greater financial backing in terms of access to national transformation funding and capital funds.

A further verbal update will be provided at the Board meeting.

## 4. WORKING IN PARTNERSHIP

### 4.1 Harrogate System Leadership Executive Group (formerly the Harrogate Health Transformation Board (HHTB)

Positive progress continues in respect of partnership working in the Harrogate 'place'. The Harrogate System Leadership Executive has now replaced the HHTB. Two sub groups report to the HSLG, one overseeing operational delivery of adult health and care services, and the other overseeing the redesign of services in line with commissioner's indicative proposal for integrate services.

## 5. SENIOR MANAGEMENT TEAM (SMT) MEETING

The SMT met on 23 May 2018. The following key areas are for noting:

- The SMT focused primarily on Month 1 financial and operational performance. The underlying issues in respect of income shortfall and overspends were reviewed and mitigations/controls discussed. Actions to improve the run rate include control of above establishment rostering and improved oversight of CIP delivery and budget controls.

- A new SMT subgroup, the Cost Improvement Oversight Group will be introduced from June, with the remit to oversee and drive delivery of the full CIP programme.
- Drivers of adverse operational performance were discussed and assurances given on the mitigating actions in hand. It was noted that the positon in respect of cancer pathways remains challenging and may not be corrected within the quarter. There is no evidence of adverse clinical impact on individual patients and careful breach analysis continues.
- An update on the private patient strategy was received. Income from the PPU grew significantly in Q4. The dedicated website is now live; the Medical Advisory Committee chair and vice chair have been appointed.
- The Healthy Child Services in North Yorkshire, in partnership North Yorkshire County Council prevention services have been awarded Stage 2 Baby Friendly accreditation.
- Work within the Maternal Neonatal Safety Collaboration has commenced. The Trust will focus on readmissions and smoking cessation in pregnancy.
- The Community Service Joint Management team is working well.
- An update on the medical outliers hot spot action plan was received. New arrangements will be put in place in Q1/Q2 prior to the next winter surge.
- A report on Post Project Evaluations was received. Timeliness of reports needs to be improved. A key theme from reports to date is that benefits realisation plans tended to be overoptimistic when they are reliant upon recruitment. More prudent assumptions about new capacity have been made in 2018/19 plans.
- A report on a recent 'phishing' exercise was received. This was designed to test the Trust's resilience against a potential cyber-attack. Key actions were agreed. Further tests will be conducted.

## 6. COMMUNICATIONS RECEIVED AND ACTED UPON OR TO NOTE

### 6.1 National Breast Screening Incident

The Trust is responding to an announcement by Public Health England (PHE) in early May 2018 that up to 309,000 women nationally (aged between 70 and 79) would be offered the opportunity for a catch-up NHS breast screening test this year. The decision follows analysis by PHE dating back to 2009, which found that a number of routine invitations for a final test had not been sent out to women, between their 68$^{th}$ and 71$^{st}$ birthday. The total number of older women affected since 2009 is estimated to be approximately 450,000. Further details are included within the Medical Directors Report.

### 6.2 Calderdale and Huddersfield Foundation Trust Configuration

The Secretary of State for Health and Social Care has published the findings of the Independent Reconfiguration Panel advice on a referral regarding proposed changes to services provided by Calderdale and Huddersfield NHS Foundation Trust (CHFT). The Trust, which is part of WYAAT, currently provides hospital services at Calderdale Royal Hospital in Halifax and Huddersfield Royal Infirmary. The Independent Reconfiguration Panel determined that proposals were not in the best interests of the people of Calderdale and Greater Huddersfield.

### 6.3 Reports on Learning Disabilities and Mental Health Provision

Three significant reports were published in early May with a focus on mental health and learning disabilities:

1. A joint report by the Health and Social Care Select Committee and the Education Select Committee on the Government's Green Paper on mental health: failing a generation – The Committees welcomed the publication but said it *"lacks ambition*

*and will provide no help to the majority of those children who desperately need it".* The Committees were disappointed that there are no substantive plans to deal with the transition from CAMHS to adult mental health services. The funding for the Green Paper's proposals is not guaranteed and is contingent on an unspecified level of success and adequate funding being made available beyond 2020/21.

2. The Learning Disabilities Mortality Review (LeDeR) Programme; annual report by the Healthcare Quality Improvement Partnership, on behalf of NHS England. The LeDeR programme was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives.
   1,311 deaths were notified to the LeDeR programme (1 July 2016 – 30 November 2017). Of the 103 cases reviewed, 13% of people's health had been adversely affected by one or more of the following:

   a. delays in care or treatment;
   b. gaps in service provision;
   c. organisational dysfunction; or,
   d. neglect or abuse.

   It was recommended that providers should:

   - Clearly identify people requiring the provision of reasonable adjustments, record the adjustments that are required, and regularly audit their provision;
   - Provide mandatory learning disability awareness training to all staff, delivered in conjunction with people with learning disabilities and their families; and
   - Strengthen their governance in relation to adherence to the MCA, and provide training and audit compliance 'on the ground' so that professionals fully appreciate the requirements of the Act in relation to their own role.

3. The interim report of the Independent Review of the Mental Health Act 1983 (MHA). The review is being chaired by Professor Sir Simon Wessely and was commissioned by the Department of Health and Social Care in October 2017. The report confirms that there is a need to look at a wide range of options for reforming the MHA, but helpfully acknowledges that the Act cannot be considered in isolation from the operational and practical context in which it operates. The final report of the review is due to be published in autumn 2018.

The Trust continues to take steps to ensure that people living with mental health problems or learning disability experience high quality care and appropriate adjustments to meet their needs. Additional training and support in mental health and learning disabilities is now available.

### 6.4 Freedom to Speak Up (FTSU)

NHS Improvement has published guidance for Foundation Trust Boards about Freedom to Speak Up, and also a supporting self-assessment tool. The guide sets out NHS Improvement's expectations of boards in relation to Freedom to Speak Up. These include:

- Leaders are knowledgeable about FTSU;
- Leaders have a structured approach to FTSU;

- Leaders actively shape the speaking up culture;
- Leaders are clear about their role and responsibilities;
- Leaders are confident that wider concerns are identified and managed a variety of forms;
- Leaders engage with all relevant stakeholders; and
- Leaders are focused on learning and continual improvement.

The Trust's Freedom to Speak Up Guardian (Dr Sylvia Wood), the Company Secretary (Mrs Katherine Roberts), the Chief Operating Officer (Mr Robert Harrison) and a Non Executive Director (Mrs Maureen Taylor) will complete an initial appraisal of the self-assessment tool. This self-assessment will be shared with the Board for discussion in summer 2018.

## 7. BOARD ASSURANCE AND CORPORATE RISK

### 7.1 Board Assurance Framework (BAF)

No new risks have been added to the BAF this month. Five risks are currently assessed as having achieved their target risk score. The strategic risks are as summarized as follows:

| Ref | Description | Risk score | Progress score | Target risk score reached |
|---|---|---|---|---|
| **BAF 1** | Risk of a lack of medical, nursing and clinical staff | *Red 12 ↔* | *Unchanged at 1* | |
| **BAF 2** | Risk of a high level of frailty in the local population | *Amber 8 ↔* | *Unchanged at 1* | ✓ |
| **BAF 3** | Risk of a failure to learn from feedback and Incidents | *Amber 9 ↔* | *Unchanged at 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 | *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 | *Red 12* | *Improved to 2* | |
| **BAF 17** | Risk to senior leadership capacity | *Amber 9 ↔* | *Unchanged at 1* | |

### 7.2 Corporate Risk Register (CRR)

The CRR was reviewed at the monthly meeting of the Corporate Risk Review Group on 11 May 2018. The Corporate Risk Register contains 12 risks.

## Corporate Risk Register Summary

| 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* | |
| **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* | |
| **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* | *Sep-18* | *Target date extended* |
| **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* | |
| **CR24** | Risk to patient safety, quality, experience, reputation, staff wellbeing due to reduced capacity in the Community Care teams (CCTs). | 15 | ↔ | *3* | *Mar-19* | |
| **CR25** | Risk to quality of care due to lack of capcity in the acute and community services to meet anticipated increased urgent care demand | 4 | ↓ | *1* | *Apr-18* | *Closed* |
| **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 | 6 | ↓ | *tbc* | *tbc* | *Closed* |

*Progress key*

*1 = fully on plan across all actions*

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

*3 = actions defined - work started but behind plan*

*4 = actions defined but largely behind plan*

*5 = actions not yet fully defined*

### Risks added to the corporate risk register

None

### Risks removed from corporate risk register

CR25 - Risk to quality of care due to lack of capacity in the acute and community services to meet anticipated increased urgent care demand

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

### 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:

- Deed of surrender of lease at Church Lane Surgery in Boroughbridge.
- Deeds of novation transferring contracts from the Trust to Harrogate Healthcare Facilities Management (HHFM):

    - Henderson Biomedical Ltd
    - Feastfield Medical Centre
    - Beech House Surgery
    - ACP Environmental
    - Dr Moss and Partners
    - Church Avenue Medical Group
    - Scobie Vending Services Ltd
    - Record UK Ltd

In addition the following licenses were approved:

- The Norton Children's Centre licence was signed this month. It expires 31/03/20 when the Children's Service Contract will be re-tendered.
- Three Bowel Screening Licences completed for Armley, East Leeds and Parkside clinics. All licences are for 12 months.

**Dr Ros Tolcher**
**Chief Executive**
**May 2018**

Harrogate and District
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Date of Meeting:** | 30 May 2018 | **Agenda item:** | 6.0b |
| **Report to:** | Board of Directors | | |
| **Title:** | Integrated Board Report | | |
| **Sponsoring Director:** | Dr Ros Tolcher, Chief Executive | | |
| **Author(s):** | Ms Rachel McDonald, Head of Performance & Analysis | | |

**Report Purpose:**

| Decision | | Discussion/ Consultation | ✓ | Assurance | ✓ | Information | ✓ |
|---|---|---|---|---|---|---|---|

**Executive Summary:**

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

- The Trust reported a deficit of £2.3m in April. This is in line with the plan submitted to NHS Improvement, but is behind the £1.5m deficit plan the Trust has internally.
- In April, HDFT's performance was below the required level for 4 key operational performance metrics within the Single Oversight Framework - 18 weeks, cancer 62 days, A&E 4-hour standard and diagnostic waiting times.
- Dementia screening performance is included in the Single Oversight Framework for the first time this month. The Trust was above the required 90% for all 3 parts of the standard.
- Two cancer waiting times standard were not achieved in April, the 2 week wait standard for breast symptomatic patients and the 62 day referral to treatment standard.
- There was 1 hospital acquired C. diff case reported in April. The Trust's trajectory for 2018/19 is a maximum of 11 avoidable hospital acquired cases.
- Elective and outpatient activity was below plan in April, although outpatient activity is an improved position on recent months.

**Related Trust Objectives**

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

**Key implications**

| | |
|---|---|
| **Risk Assessment:** | Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF 4: risk of a lack of interoperable systems across New Care Models partners; BAF 9: risk of a failure to deliver the operational plan; BAF 10: risk of a breach of the terms of the NHS Provider licence; BAF 16: risk to delivery of integrated care models. |
| **Legal / regulatory:** | None identified. |
| **Resource:** | Not applicable. |
| **Impact Assessment:** | Not applicable. |
| **Conflicts of Interest:** | None identified. |
| **Reference documents:** | None. |
| **Assurance:** | Report reviewed monthly at Senior Management Team and the 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 - April 2018

## Key points this month

1. The Trust reported a deficit of £2.3m in April. This is in line with the plan submitted to NHS Improvement, however, it is behind the £1.5m deficit plan the Trust has internally. Key drivers for the variance to plan include ward staffing costs, income and performance against the cost improvement programme.

2. In April, HDFT's performance was below the required level for 4 key operational performance metrics within the Single Oversight Framework - 18 weeks, cancer 62 days, A&E 4-hour standard and diagnostic waiting times.

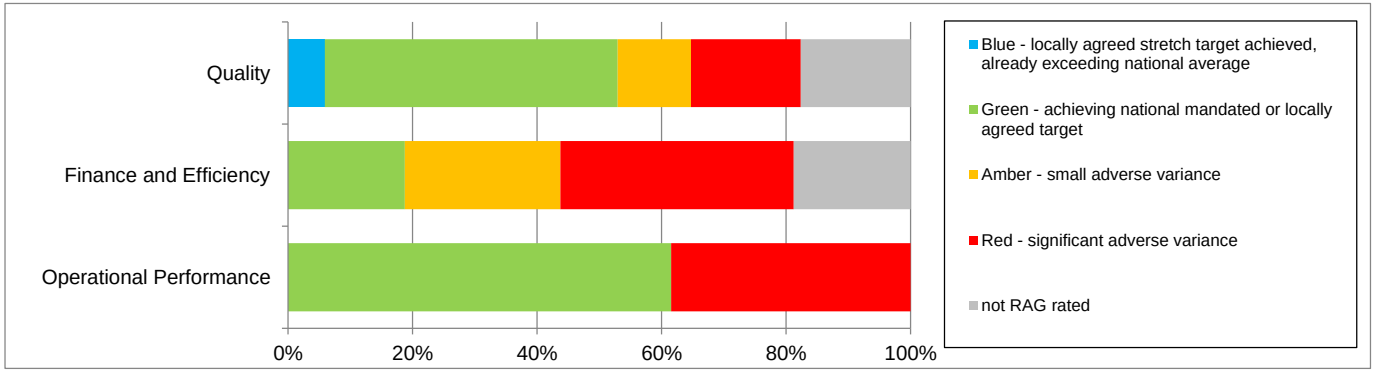
3. Dementia screening performance is included in the Single Oversight Framework for the first time this month. The Trust was above the required 90% for all 3 parts of the standard.

4. Two cancer waiting times standard were not achieved in April, the 2 week wait standard for breast symptomatic patients and the 62 day referral to treatment standard.

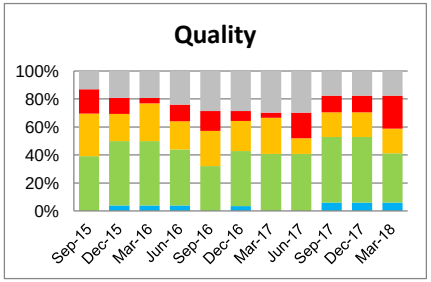
5. There was 1 hospital acquired C. diff case reported in April. The Trust's trajectory for 2018/19 is a maximum of 11 avoidable hospital acquired cases.

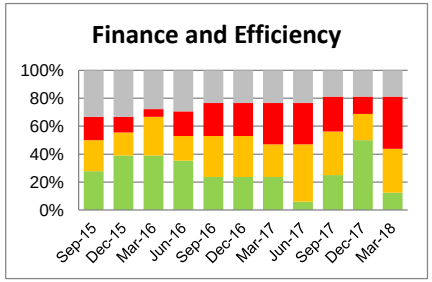
6. Elective and outpatient activity was below plan in April, although outpatient activity is an improved position on recent months.

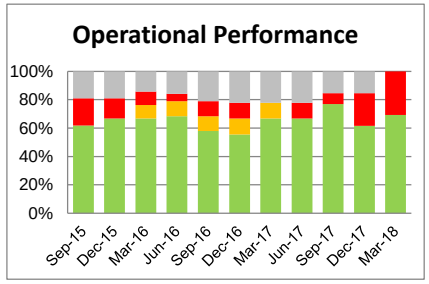
## Summary of indicators - current month



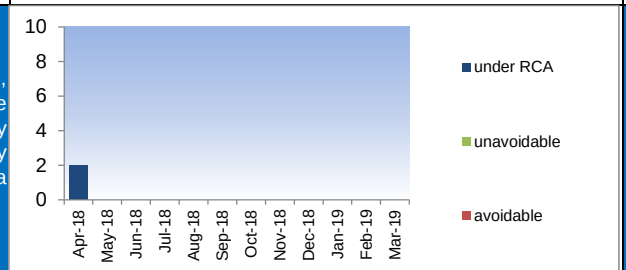
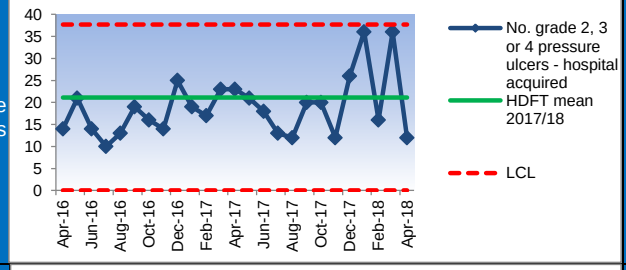
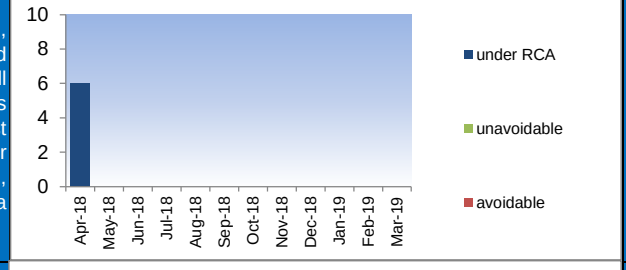
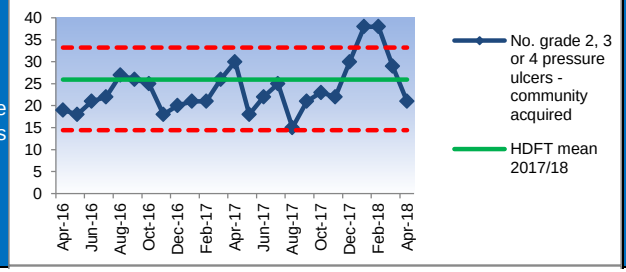

## Summary of indicators - recent trends



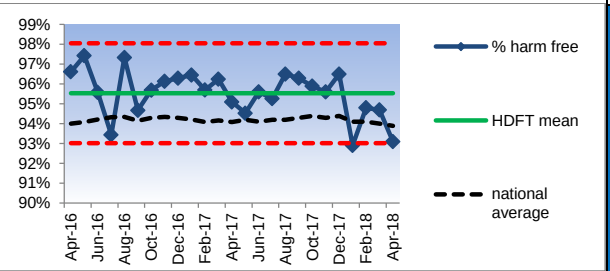
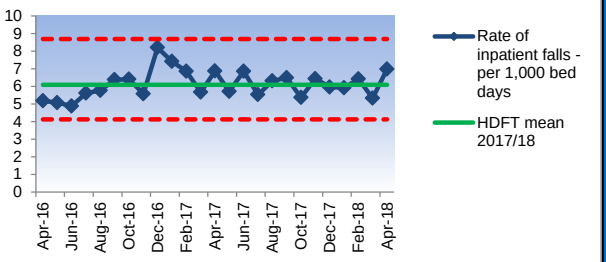
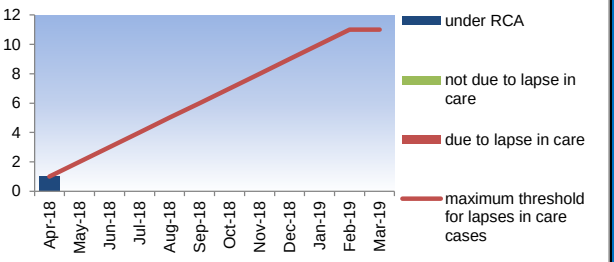
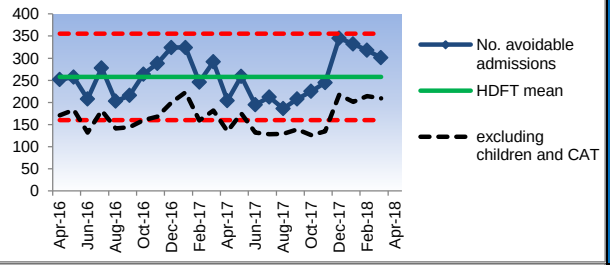



## Quality - April 2018

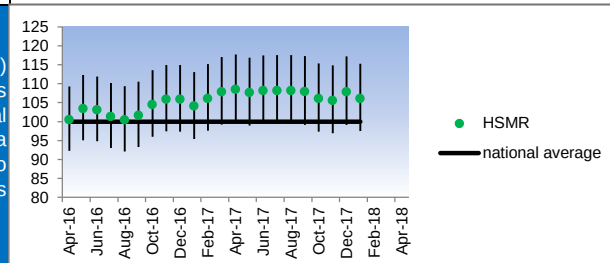
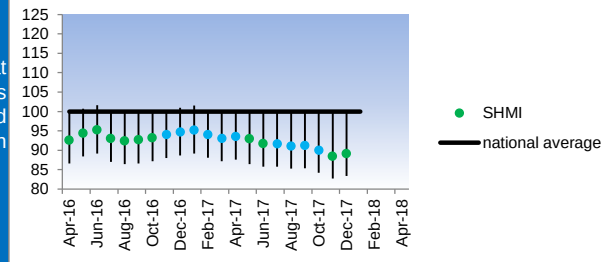
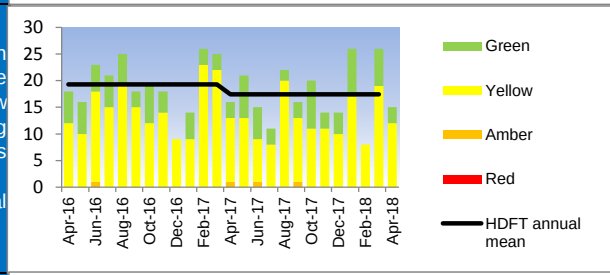
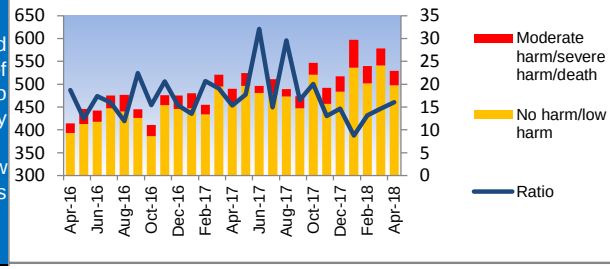
| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| Pressure ulcers - hospital acquired | The chart shows the cumulative number of category 3, category 4 or unstageable hospital acquired pressure ulcers in 2018/19. The Trust has set a local trajectory for 2018/19 to reduce the number of avoidable category 3, category 4 or unstageable pressure ulcers. The data includes hospital teams only. |  | There were 2 hospital acquired unstageable or category 3 pressure ulcers reported in April. This compares to an average of 5 per month reported in 2017/18.<br><br>Both April cases are still under root cause analysis (RCA). |
| | The chart includes category 2, 3 and 4 and unstageable hospital acquired pressure ulcers. The data includes hospital teams only. |  | The number of hospital acquired category 2-4 (or unstageable) pressure ulcers reported in April was 12, a significant decrease on last month and below the average per month reported in 2017/18. |
| Pressure ulcers - community acquired | The chart shows the cumulative number of category 3, category 4 or unstageable community acquired pressure ulcers in 2018/19. 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 2018/19 to reduce the number of avoidable category 3, category 4 or unstageable pressure ulcers. The data includes community teams only. |  | There were 6 community acquired category 3, category 4 (or unstageable) pressure ulcers reported in April, a reduction on last month. This compares to an average of 12 per month reported in 2017/18.<br><br>All April cases are still under root cause analysis (RCA). |
| | The chart includes category 2, 3 and 4 and unstageable community acquired pressure ulcers. The data includes community teams only. |  | The number of community acquired category 2-4 (or unstageable) pressure ulcers reported in April was 21 cases, a reduction on last month and below the average per month reported in 2017/18. |

# Quality - April 2018

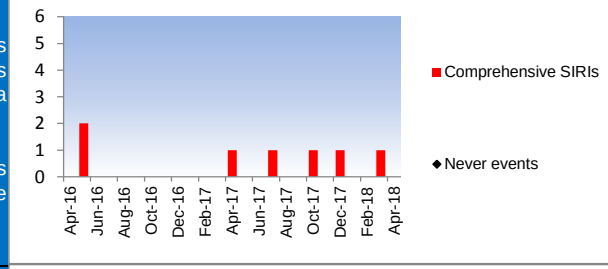
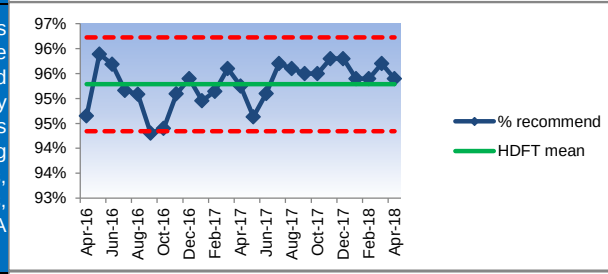
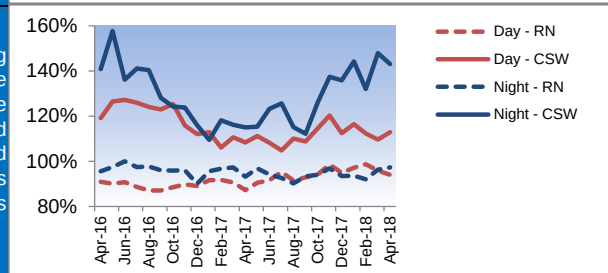
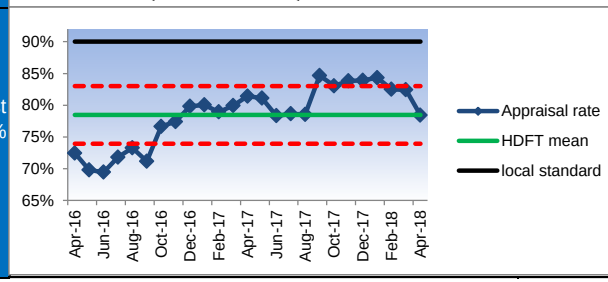
| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Safety Thermometer - harm free care** ✓ | Measures the percentage of patients receiving harm free care (defined as the absence of pressure ulcers, harm from a fall, urine infection in patients 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 April was 93.1%, remaining below 95% and a reduction on last month. The majority of harms reported this month were old pressure ulcers reported by the community teams. |
| **Falls** ✓ | The number of inpatient falls expressed as a rate per 1,000 bed days. The data includes falls causing harm and those not causing harm. A low rate is good. |  | The rate of inpatient falls was 6.97 per 1,000 bed days in April, an increase on last month and above the average HDFT rate for 2017/18. There were 3 falls resulting in a fracture in April (2 last month). |
| **Infection control** ✓ | The chart shows the cumulative number of hospital apportioned C. difficile cases during 2018/19. HDFT's C. difficile trajectory for 2018/19 is 11 cases, a reduction of 1 on last year's trajectory. Cases where a lapse in care has been deemed to have occurred would count towards this. Hospital apportioned MRSA cases will be reported on an exception basis. HDFT has a trajectory of 0 MRSA cases for 2018/19. The last reported case of hospital acquired MRSA at HDFT was in Oct-12. |  | There was 1 case of hospital apportioned C. difficile reported in April. Root cause analysis (RCA) is in progress for this case. RCAs have now concluded for all 2017/18 cases. For 6 cases, the outcome was that no lapse of care had occurred. For 1 case, a lapse of care was deemed to have occurred which related to antibiotic prescribing for a patient with a previous history of C.difficile.<br><br>No hospital apportioned MRSA cases have been reported in 2018/19 to date. |
| **Avoidable admissions** ✓ | The chart shows the number of avoidable emergency admissions to HDFT as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require a hospital admission. Conditions include pneumonia and urinary tract infections in adults and respiratory conditions in children. |  | Provisional data indicates that there were 301 avoidable admissions in March, a decrease on recent months. However this month's figure is above the level reported in March last year (292).<br><br>Adult admissions (excluding CAT attendances) also decreased this month to 209, compared to 214 last month. |

# Quality - April 2018

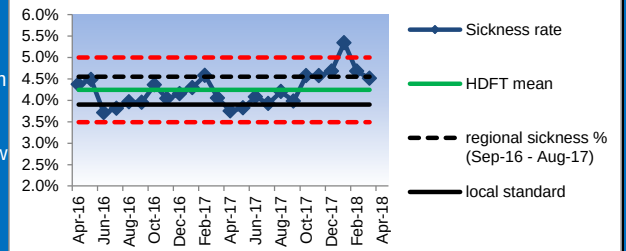
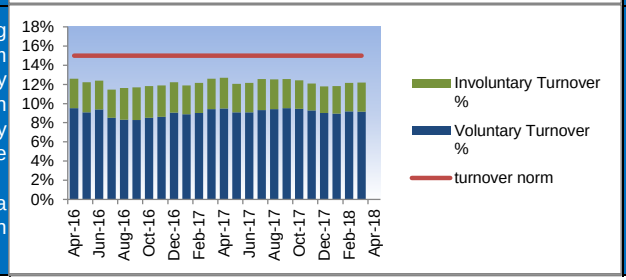
Harrogate and District NHS Foundation Trust

| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Mortality - HSMR** ✓ | The Hospital Standardised Mortality Ratio (HSMR) looks at the mortality rates for 56 common diagnosis groups that account for around 80% of in-hospital deaths and standardises against various criteria including age, sex and comorbidities. The measure also makes an adjustment for palliative care. A low figure is good. |  | HDFT's HSMR for the rolling 12 months ending January 2018 was 106.1, a decrease on last month and remaining within expected levels. At specialty level, two specialties have a higher than expected standardised mortality rate (Geriatric Medicine and Trauma & Orthopaedics).<br><br>The latest HSMR data on HED includes the period to end February 2018 but reflective of the data position as at mid-March when the Trust was only partly coded for the month of February. As detailed in last month's report, we will therefore report the HSMR a month in arrears with the HED publications to ensure that it reflects a fully coded position for HDFT. |
| **Mortality - SHMI** ✓ | The Summary Hospital Mortality Index (SHMI) looks at the mortality rates for all diagnoses and standardises against various criteria including age, sex and comorbidities. The measure does not make an adjustment for palliative care. A low figure is good. |  | *There is no update of this data available this month due to a delay in the data being released by NHS Digital.*<br>HDFT's SHMI increased to 89.1 for the rolling 12 months ending December 2017 but remains below expected levels.<br><br>At specialty level, four specialties (Respiratory Medicine, Gastroenterology, Geriatric Medicine and one small volume surgical specialty) continue to have a standardised mortality rate above expected levels. |
| **Complaints** ✓ | The number of complaints received by the Trust, shown by month of receipt of complaint. The criteria define the severity/grading of the complaint with green and yellow signifying less serious issues, amber signifying potentially significant issues and red for complaints related to serious adverse incidents.<br>The data includes complaints relating to both hospital and community services. |  | 15 complaints were received in April which is below the average for 2017/18. 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. The most common reasons for complaints were communication and attitude of staff. |
| **Incidents - all** ✓ | The chart shows the number of incidents reported within the Trust each month. It includes all categories of incidents, including those that were categorised as "no harm". The data includes hospital and community services.<br>A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture |  | The latest published national data (for the period Apr - Sep 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 16, 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. |

# Quality - April 2018

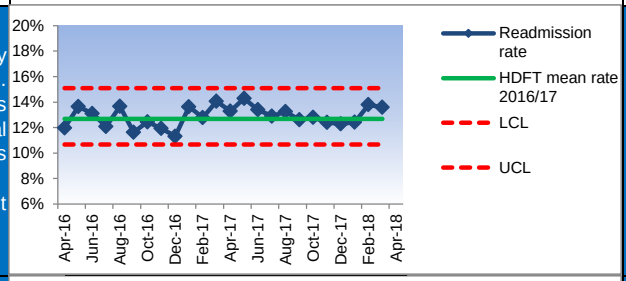
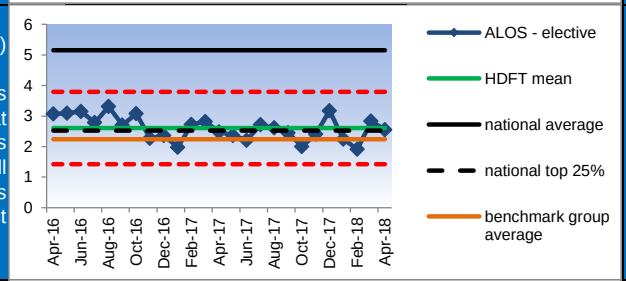
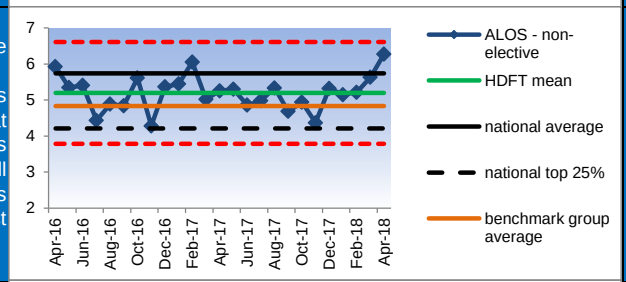
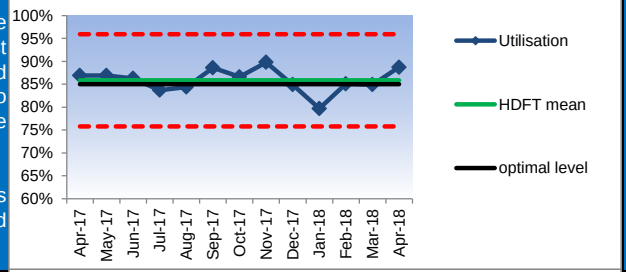
| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Incidents - SIRIs and never events** ✓ | The chart shows the number of Serious Incidents Requiring Investigation (SIRIs) and Never Events reported within the Trust each month. The data includes hospital and community services.<br><br>Only comprehensive SIRIs are included in this indicator, as concise SIRIs are reported within the presure ulcer / falls indicators above. |  | There were no comprehensive SIRIs and no Never Events reported in April. In 2017/18, there were 5 comprehensive SIRIs and no Never Events reported. |
| **Friends & Family Test (FFT) - Patients** ✓ | The Patient Friends and Family Test (FFT) gives patients and service users the opportunity to give feedback. They are asked whether they would recommend the service to friends and family if they required similar care or treatment. This indicator covers a number of hospital and community services including inpatients, day cases, outpatients, maternity services, the emergency department, some therapy services, district nursing, community podiatry and GP OOH. A high percentage is good. |  | 95.4% of patients surveyed in April would recommend our services, in line with recent months and remaining above the latest published national average (93%).<br><br>Around 2,300 patients responded to the survey this month. This is lower than the normal monthly average of around 4,000 responses but significantly more than last month and is due to a problem with the automated phone call surveys which was rectified in mid-April. |
| **Safer staffing levels** ✓ | Trusts are required to publish information about staffing levels for registered nurses/midwives (RN) and care support workers (CSW) for each inpatient ward. The chart shows the overall fill rate at HDFT for RN and CSW for day and night shifts. The fill rate is calculated by comparing planned staffing with actual levels achieved. A ward level breakdown of this data is published on the Trust website. |  | Overall staffing compared to planned was at 105% in April, 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. |
| **Staff appraisal rates** ✓ | The chart shows the staff appraisal rate over the most recent rolling 12 months. The Trusts aims to have 90% of staff appraised. A high percentage is good. |  | The appraisal rate in April was 78.4%. 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 are being produced to demonstrate progress and monitor progress. |

# Quality - April 2018

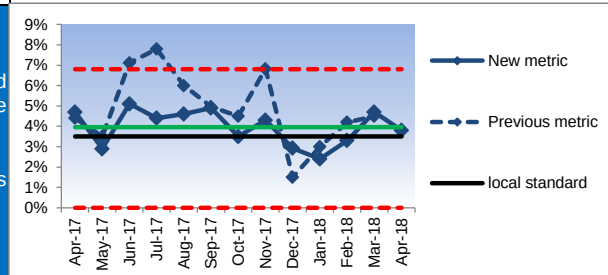
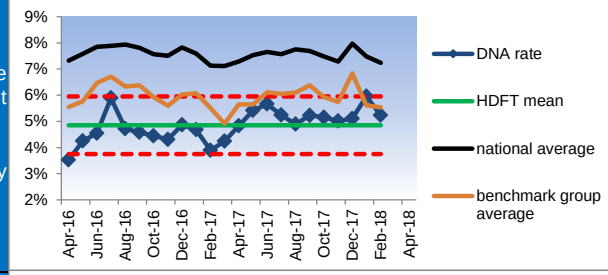
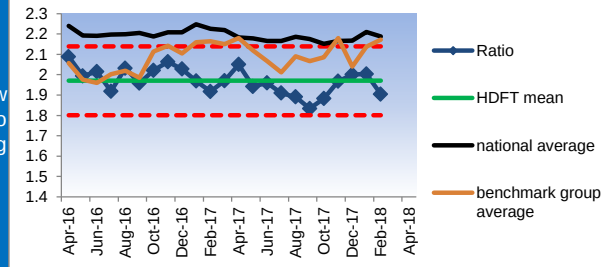
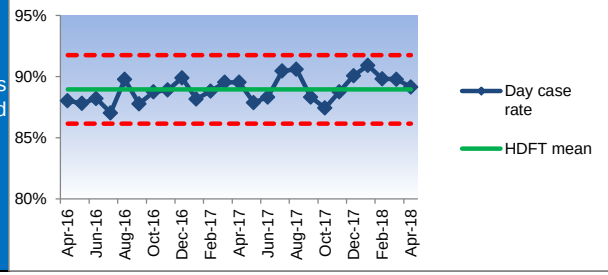
| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Mandatory training rates** ✓ | The table shows the most recent training rates for all mandatory elements for substantive staff. | See table below | The data shown is for the end of April and excludes the Harrogate Healthcare Facilities Management (HHFM) staff who transferred into the new organisation on the 1st March 2018 and the Stockton Childrens Services staff who TUPE transferred in to the Trust on 1st April 2018. The overall training rate for mandatory elements for substantive staff is 89%. |
| **Sickness rates** ✓ | Staff sickness rate - includes short and long term sickness.<br><br>The Trust has set a threshold of 3.9%. A low percentage is good. |  | Sickness absence reduced again in March to 4.51% from 4.68% 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** ✓ | The chart shows the staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. The turnover figures include both voluntary and involuntary turnover. Voluntary turnover is when an employee chooses to leave the Trust and involuntary turnover is when the employee unwillingly leaves the Trust.<br>Data from the Times Top 100 Employers indicated a turnover rate norm of 15%, i.e. the level at which organisations should be concerned. |  | Labour turnover remains static at 12%. An engagement plan focusing on Care Support Workers and Registered Nursing retention is being developed. Support will be sought from the Director Team, to undertake focus groups within inpatient ward areas and theatres in the first instance with a phased roll out plan across other key areas. |

| Competence Name | % Completed |
|---|---|
| Equality, Diversity and Human Rights - Level 1 | 89 |
| Fire Safety Awareness | 75 |
| Infection Prevention & Control (Including Hand Hygiene) 1 | 99 |
| Infection Prevention & Control (Including Hand Hygiene) 2 | 79 |
| Data Security Awareness | 93 |
| Preventing Radicalisation - Level 1 and 2 (December 2015) | 97 |
| Safeguarding Adults Awareness Elearning (Dec 2015) | 97 |
| Safeguarding Children & Young People Level 1 - Introduction eLearning | 94 |

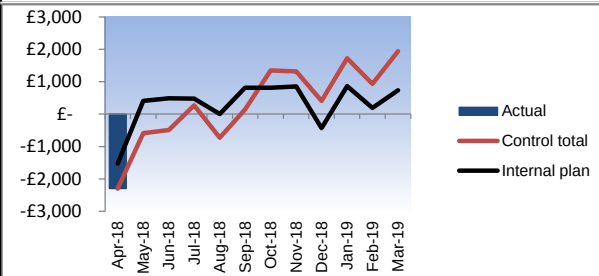
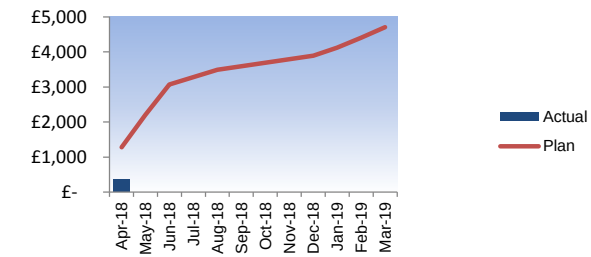
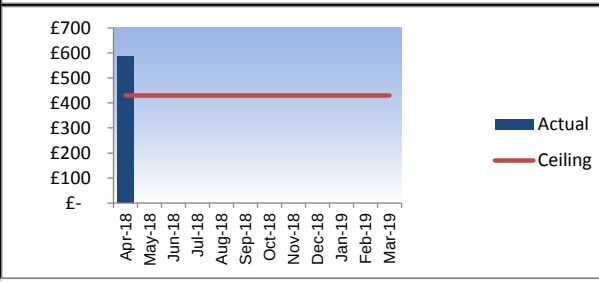
# Finance and Efficiency - April 2018

| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Readmissions**  | % of patients readmitted to hospital as an emergency within 30 days of discharge (PbR exclusions applied). To ensure that we are not discharging patients inappropriately early and to assess our overall surgical success rates, we monitor the numbers of patients readmitted. A low number is good performance.<br>This data is reported a month behind so that any recent readmissions are captured in the data. |  | The number of emergency readmissions (after PbR exclusions are applied) in March was 243. This equates to 13.6% when expressed as a percentage of all emergency admissions, a small decrease on last month but above the HDFT average rate for 2017/18. |
| **Length of stay - elective**  | Average length of stay in days for elective (waiting list) patients. The data excludes day case patients.<br>A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay. |  | HDFT's average elective length of stay for April was 2.6 days. This is a decrease on last month. The Trust remains in the middle 50% of Trusts nationally in the most recently available benchmarking data. |
| **Length of stay - non-elective**  | Average length of stay in days for non-elective (emergency) patients.<br>A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay. |  | HDFT's average non-elective length of stay for April was 6.3 days. This is an increase on last month and significantly above the average for HDFT. A number of medical specialties showed an increase in length of stay and a small number of very long stay patients were discharged this month which has impacted upon the overall average length of stay.<br><br>The Trust remains in the middle 50% of Trusts nationally when compared to the most recently available benchmarking data. |
| **Theatre utilisation**  | The percentage of time utilised during elective theatre sessions (i.e. those planned in advance for waiting list patients). The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc.<br><br>A higher utilisation rate is good as it demonstrates effective use of resources. A utilisation rate of around 85% is often viewed as optimal. |  | Elective theatre utilisation was at 88.7% in April, an increase on recent months and above 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. |

# Finance and Efficiency - April 2018

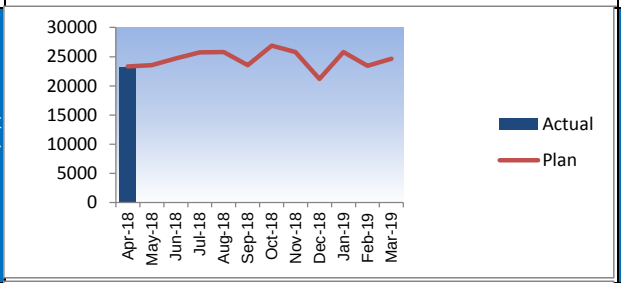
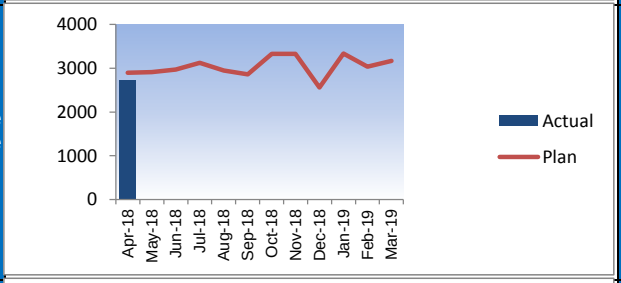
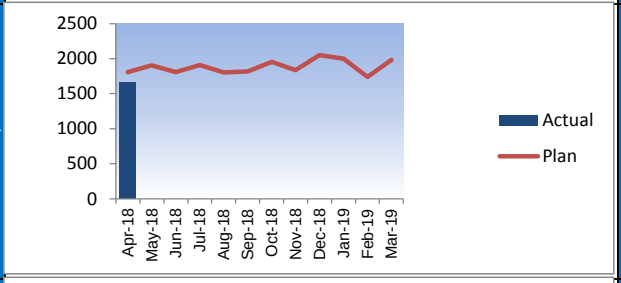
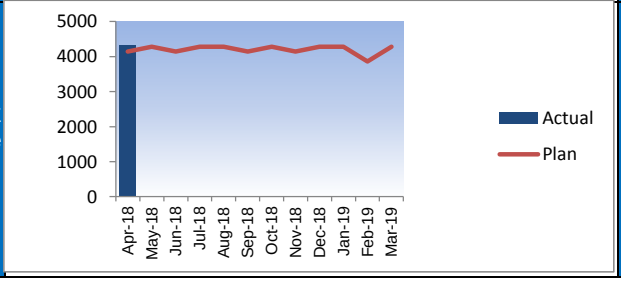
| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Delayed transfers of care** ✓ | The proportion of bed days lost due to being occupied by patients who are medically fit for discharge but are still in hospital. A low rate is preferable.<br><br>The maximum threshold shown on the chart (3.5%) has been agreed with HARD CCG. |  | In April, 3.8% of bed days were lost due to delayed transfers of care, above the local standard of 3.5%.<br>From this month, this metric will be calculated as the total bed days lost during the month due to a delayed transfer, expressed as a percentage of total bed days. This is a more robust metric as it looks at the proportion of bed days lost across the whole of the month rather the snapshot position reported on previously. It is also in line with the published metric used by NHS England. The chart calcluates both metrics for each month of 2017/18. As can be seen, there is a reasonable degree of correlation between the two metrics. |
| **Outpatient DNA rate** ✓ | Percentage of new outpatient attendances where the patient does not attend their appointment, without notifying the trust in advance.<br><br>A low percentage is good. Patient DNAs will usually result in an unused clinic slot. |  | HDFT's DNA rate decreased to 5.2% in January. This is in now below the benchmarked group of trusts and the national average. |
| **Outpatient new to follow up ratio** ✓ | The number of follow-up appointments per new appointment. A lower ratio is preferable. A high ratio could indicate that unnecessary follow ups are taking place. |  | Reducing the number of follow ups is a major part of HARD CCG's financial recovery plan. HDFT's new to follow up ratio was 1.90 in February, a reduction on last month and remaining below both the national and benchmark group average. |
| **Day case rate** ✓ | The proportion of elective (waiting list) procedures carried out as a day case procedure, i.e. the patient did not stay overnight.<br><br>A higher day case rate is preferable. |  | The day case rate was 89.1% in April, a minor reduction on last month. The average day case rate for 2017/18 overall was 89.3%. |

# Finance and Efficiency - April 2018

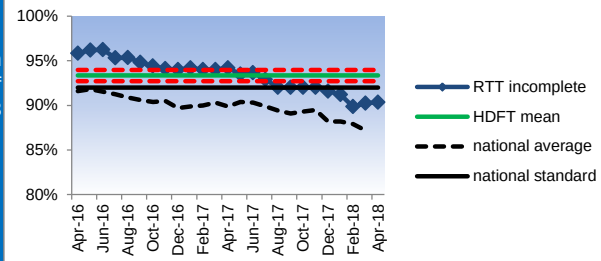
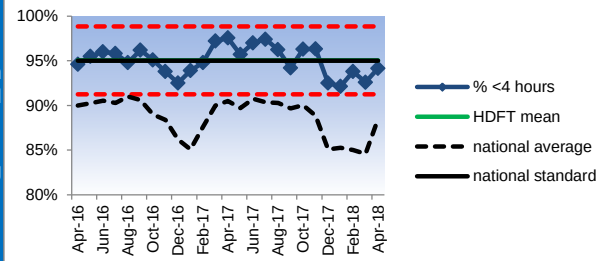
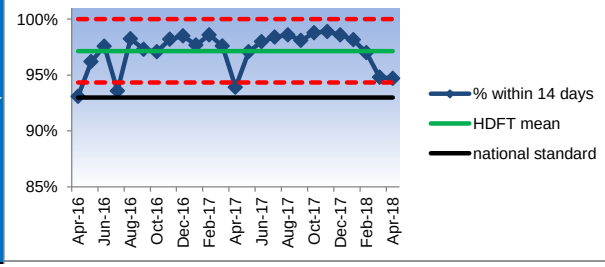
| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Surplus / deficit and variance to plan** | Monthly Surplus/Deficit (£'000s). In some months, a deficit is planned for. This indicator reports positive or adverse variance against the planned position for the month. |  | The Trust reported a deficit of £2.3m in April. This is in line with the plan submitted to NHS Improvement, however, it is behind the £1.5m deficit plan the Trust has internally. Key drivers for the variance to plan include ward staffing costs, income and performance against the cost improvement programme. |
| **NHS Improvement Single Oversight Framework - Use of Resource Metric** | From 1st October 2016, NHS Improvement introduced the Single Oversight Framework. As part of this this, Use of Resource Metric was introduced to replace the previous Financial Sustainability Risk Rating. This is the product of five elements which are rated between 1 (best) to 4. | **Element** / **Plan** / **Actual**<br>Capital Service Cover: 4 / 4<br>Liquidity: 1 / 1<br>I&E Margin: 4 / 4<br>I&E Variance From Plan: 1 / 1<br>Agency: 1 / 2<br>**Financial Sustainability Risk Rating: 3 / 3** | The Trust reported a rating of 3 in April which is in line with the annual plan submitted to NHS Improvement. This is a slightly weaker 3 as a result of agency spend performance mentioned below. |
| **Capital spend** | Cumulative Capital Expenditure by month (£'000s) |  | Capital Expenditure in April was lower than plan. However the programme overall is being managed tightly within the resources available. |
| **Agency spend in relation to pay spend** | Expenditure in relation to Agency staff on a monthly basis as a percentage of total pay bill. The Trust aims to have less than 3% of the total pay bill on agency staff. |  | At 4.3% of the pay bill, actual agency expenditure in April was at the highest level since the introduction of the agency ceiling. This is the second occasion this has occurred in the past 3 months. The actions in this area are discussed in the later reports. |

## Finance and Efficiency - April 2018

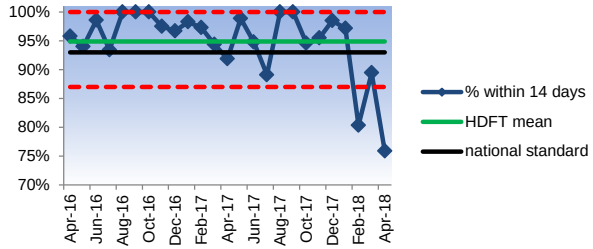
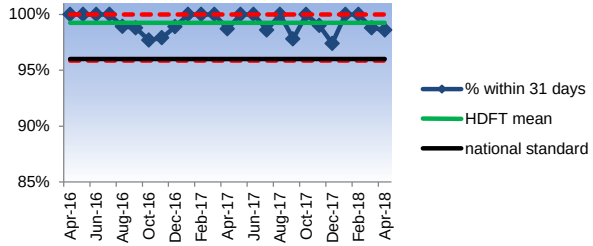
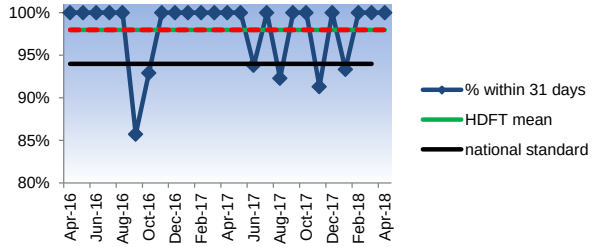
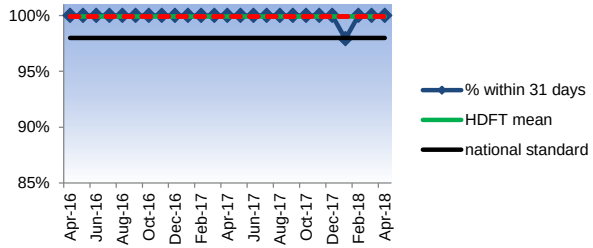
Harrogate and District NHS Foundation Trust

| 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 0.7% below plan in April. The phasing of this year's plan is currently being reviewed and finalised with the Clinical Directorates. As a result, there may be some minor changes in the month on month plan figures in next month's report, although the overall plan figure for the year will remain unchanged. 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 5.5% below plan in April. The phasing of this year's plan is currently being reviewed and finalised with the Clinical Directorates. As a result, there may be some minor changes in the month on month plan figures in next month's report, although the overall plan figure for the year will remain unchanged. 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 8.0% below plan in April. The phasing of this year's plan is currently being reviewed and finalised with the Clinical Directorates. As a result, there may be some minor changes in the month on month plan figures in next month's report, although the overall plan figure for the year will remain unchanged. |
| **A&E activity against plan** ✓ | The chart shows the position against plan for A&E attendances at Harrogate Emergency Department. The data excludes planned follow-up attendances at A&E. |  | A&E attendances were 4.2% above plan in April. |

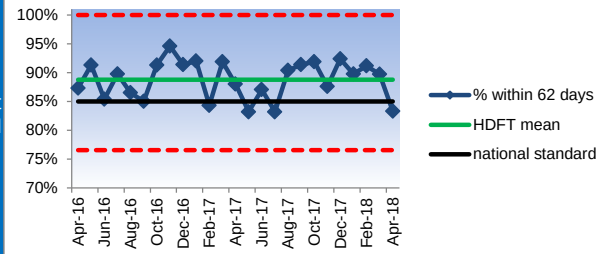
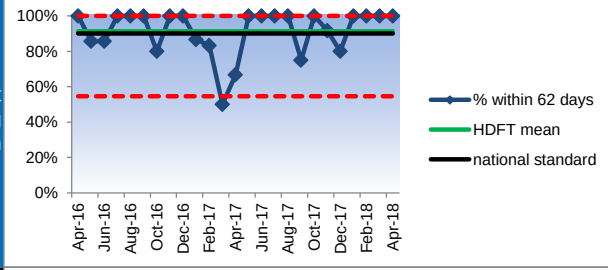
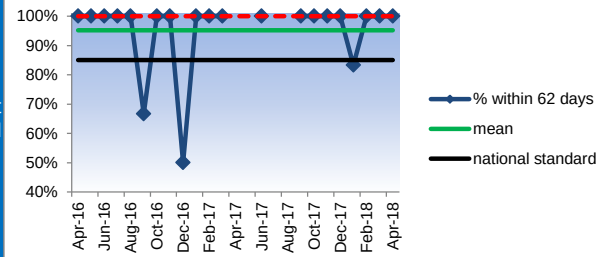
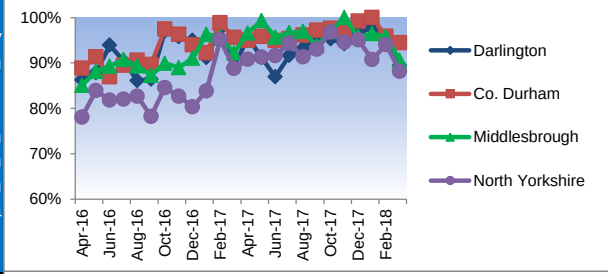
# Operational Performance - April 2018

<table>
<tr><th>Indicator name / data quality assessment</th><th>Description</th><th>Trend chart</th><th>Interpretation</th></tr>
<tr>
<td>NHS Improvement Single Oversight Framework</td>
<td>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. From 1st April 2018, dementia screening perfromance forms part of this assessment.</td>
<td>
<table>
<tr><th>Standard</th><th>Q1 to date</th><th>Q2</th><th>Q3</th><th>Q4</th><th>YTD</th></tr>
<tr><td>RTT incomplete pathways</td><td>90.3%</td><td></td><td></td><td></td><td>90.3%</td></tr>
<tr><td>A&E 4-hour standard</td><td>94.1%</td><td></td><td></td><td></td><td>94.1%</td></tr>
<tr><td>Cancer - 62 days</td><td>81.8%</td><td></td><td></td><td></td><td>81.8%</td></tr>
<tr><td>Diagnostic waits</td><td>97.5%</td><td></td><td></td><td></td><td>97.5%</td></tr>
<tr><td>Dementia screening - Step 1</td><td>98.1%</td><td></td><td></td><td></td><td>98.1%</td></tr>
<tr><td>Dementia screening - Step 2</td><td>92.9%</td><td></td><td></td><td></td><td>92.9%</td></tr>
<tr><td>Dementia screening - Step 3</td><td>100.0%</td><td></td><td></td><td></td><td>100.0%</td></tr>
</table>
</td>
<td>In April, HDFT's performance was below the required level for 4 of the operational performance metrics, as detailed below and in this month's Chief Operating Officer's report.<br><br>The diagnostic waiting times standard was below the required 99% due to a significant number of patients who were waiting over 6 weeks at the end of April, predominantly in ultrasound. The majority of these patients were seen in early May and a significantly improved position is anticipated for end May.</td>
</tr>
<tr>
<td>RTT Incomplete pathways performance</td>
<td>Percentage of incomplete pathways waiting less than 18 weeks. The national standard is that 92% of incomplete pathways should be waiting less than 18 weeks.<br><br>A high percentage is good.</td>
<td> 
</td>
<td>Performance was at 90.3% in April, an improvement on last month but remaining below the minimum standard of 92%. At specialty level, General Surgery, Trauma & Orthopaedics and Ophthalmology were below the 92% standard.<br><br>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.</td>
</tr>
<tr>
<td>A&E 4 hour standard</td>
<td>Percentage of patients spending less than 4 hours in Accident & Emergency (A&E). The operational standard is 95%.<br><br>The data includes all A&E Departments, including Minor Injury Units (MIUs). A high percentage is good.</td>
<td> 
</td>
<td>HDFT's Trust level performance for April was 94.1%, an improvement on last month but remaining below the required 95% standard. This includes data for the Emergency Department at Harrogate and Ripon MIU. Performance for Harrogate ED was at 93.1%.</td>
</tr>
<tr>
<td>Cancer - 14 days maximum wait from urgent GP referral for suspected cancer referrals</td>
<td>Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%. A high percentage is good.</td>
<td> 
</td>
<td>Provisional performance for April was at 94.7%. This is above the 93% but lower than the HDFT historical average.</td>
</tr>
</table>

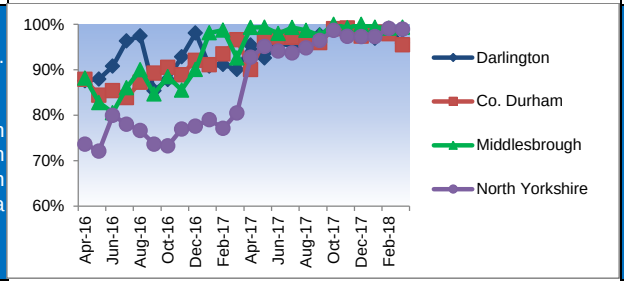
# Operational Performance - April 2018

| 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. |  | Provisional performance for April was at 75.9%, a deterioration on last month and remaining below the 93% standard.<br><br>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. |
| **Cancer - 31 days maximum wait from diagnosis to treatment for all cancers** ✓ | Percentage of cancer patients starting first treatment within 31 days of diagnosis. The operational standard is 96%. A high percentage is good. |  | Delivery at expected levels. |
| **Cancer - 31 day wait for second or subsequent treatment: Surgery** ✓ | Percentage of cancer patients starting subsequent surgical treatment within 31 days. The operational standard is 94%. A high percentage is good. |  | Delivery at expected levels. |
| **Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug** ✓ | Percentage of cancer patients starting subsequent drug treatment within 31 days. The operational standard is 98%. A high percentage is good. |  | Delivery at expected levels. |

# Operational Performance - April 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. |  | Provisional performance for April was below the required 85% standard at 83.3% with 8 accountable breaches. Of the 11 tumour sites, 6 had performance below 85% in April - breast (2 breaches), colorectal (2), head and neck (0.5), lung (1), sarcoma (0.5) and upper gastrointestinal (0.5). 3 patients waited over 104 days in April. The main reasons for the delays were clinically complex pathways and patient choice. |
| **Cancer - 62 day wait for first treatment from consultant screening service referral** ✓ | Percentage of cancer patients starting first treatment within 62 days of referral from a consultant screening service. The operational standard is 90%. A high percentage is good. |  | Delivery at expected levels. |
| **Cancer - 62 day wait for first treatment from consultant upgrade** ✓ | Percentage of cancer patients starting first treatment within 62 days of consultant upgrade. The operational standard is 85%. A high percentage is good. |  | Delivery at expected levels. |
| **Children's Services - 10-14 day new birth visit** ✓ | The percentage of babies who had a new birth visit by the Health Visiting team within 14 days of birth. A high percentage is good.<br><br>Data shown is for the 0-5 Health Visiting Service in North Yorkshire and the Healthy Child Programme in Darlington, Co. Durham and Middlesbrough. A high percentage is good. The contract does not specify a required level. |  | In March, the validated performance position is that 91% of babies were recorded on Systmone as having had a new birth visit within 14 days of birth.<br><br>The data is reported a month in arrears so that the validated position can be shared. |

# Operational Performance - April 2018

| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Children's Services - 2.5 year review** ✓ | The percentage of children who had a 2.5 year review. A high percentage is good.<br><br>Data shown is for the 0-5 Health Visiting Service in North Yorkshire and the Healthy Child Programme in Darlington, Co. Durham and Middlesbrough. A high percentage is good. The contract does not specify a required level. |  | In March, the validated performance position is that 97% of children were recorded on Systmone as having had a 2.5 year review.<br><br>The data is reported a month in arrears so that the validated position can be shared. |

# Data Quality - Exception Report

Harrogate and District NHS Foundation Trust

| Report section | Indicator | Data quality rating | Further information |
|---|---|---|---|
| Quality | Pressure ulcers - community acquired - grades 2, 3 or 4 | **Amber**  | The observed increase in reported cases over the last two years may be partly due to improvements in incident reporting during the period. |
| Finance and efficiency | Theatre utilisation | **Amber**  | This metric has been aligned with the new theatre utilisation dashboard from December 2017. Further metrics from the new dashboard are being considered for inclusion in this report from April 2018.<br><br>The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc.<br><br>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. |

Harrogate and District NHS Foundation Trust

**Indicator traffic light criteria**

| Section | Indicator | Further detail | Traffic light criteria | Rationale/source of traffic light criteria |
|---|---|---|---|---|
| **Quality** | **Pressure ulcers - hospital acquired** | No. category 3 and category 4 avoidable hospital acquired pressure ulcers | tbc | tbc |
| **Quality** | **Pressure ulcers - community acquired** | No. category 3 and category 4 community acquired pressure ulcers | tbc | tbc |
| **Quality** | **Safety thermometer - harm free care** | % harm free | Blue if latest month >=97%, Green if >=95% but <97%, red if latest month <95% | National best practice guidance suggests that 95% is the standard that Trusts should achieve. In addition, HDFT have set a local stretch target of 97%. |
| **Quality** | **Falls** | IP falls per 1,000 bed days | Blue if YTD position is a reduction of >=50% of HDFT average for 2016/17, Green if YTD position is a reduction of between 20% and 50% of HDFT average for 2016/17, Amber if YTD position is a reduction of up to 20% of HDFT average for 2016/17, Red if YTD position is on or above HDFT average for 2016/17. | Locally agreed improvement trajectory based on comparison with HDFT performance last year. |
| **Quality** | **Infection control** | No. hospital acquired C.diff cases | Green if below trajectory YTD, Amber if above trajectory YTD, Red if above trajectory at end year or more than 10% above trajectory in year. | NHS England, NHS Improvement and contractual requirement |
| **Quality** | **Avoidable admissions** | The number of avoidable emergency admissions to HDFT as per the national definition. | tbc | tbc |
| **Quality** | **Mortality - HSMR** | Hospital Standardised Mortality Ratio (HSMR) | Blue = better than expected (95% confidence interval), Green = as expected, Amber = worse than expected (95% confidence interval), Red = worse than expected (99% confidence interval). | Comparison with national average performance. |
| **Quality** | **Mortality - SHMI** | Summary Hospital Mortality Index (SHMI) | | |
| **Quality** | **Complaints** | No. complaints, split by criteria | Blue if no. complaints in latest month is below LCL, Green if below HDFT average for 2017/18, Amber if on or above HDFT average for 2017/18, Red if above UCL. In addition, Red if a new red rated complaint received in latest month. | Locally agreed improvement trajectory based on comparison with HDFT performance last year. |
| **Quality** | **Incidents - all** | Incidents split by grade (hosp and community) | Blue if latest month ratio places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25% | Comparison of HDFT performance against most recently published national average ratio of low to high incidents. |
| **Quality** | **Incidents - complrehensive SIRIs and never events** | The number of comprehensive SIRIs and the number of never events reported in the year to date. The indicator includes hospital and community data. | Green if none reported in current month; Red if 1 or more never event or comprehensive reported in the current month. | |
| **Quality** | **Friends & Family Test (FFT) - Patients** | % recommend, % not recommend - combined score for all services currently doing patient FFT | Green if latest month >= latest published national average, Red if < latest published national average. | Comparison with national average performance. |
| **Quality** | **Safer staffing levels** | RN and CSW - day and night overall fill rates at trust level | Green if latest month overall staffing >=100%, amber if between 95% and 100%, red if below 95%. | The Trusts aims for 100% staffing overall. |
| **Quality** | **Staff appraisal rate** | Latest position on no. staff who had an appraisal within the last 12 months | Annual rolling total - 90% green. Amber between 70% and 90%, red<70%. | Locally agreed target level based on historic local and NHS performance |
| **Quality** | **Mandatory training rate** | Latest position on the % staff trained for each mandatory training requirement | Blue if latest month >=95%; Green if latest month 75%-95% overall, amber if between 50% and 75%, red if below 50%. | Locally agreed target level - no national comparative information available until February 2016 |
| **Quality** | **Staff sickness rate** | Staff sickness rate | Green if <3.9% , amber if between 3.9% and regional average, Red if > regional average. | HDFT Employment Policy requirement. Rates compared at a regional level also |
| **Quality** | **Staff turnover** | Staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. | Green if remaining static or decreasing, amber if increasing but below 15%, red if above 15%. | Based on evidence from Times Top 100 Employers |
| **Finance and efficiency** | **Readmissions** | No. emergency readmissions (following elective or non-elective admission) within 30 days. | Blue if latest month rate < LCL, Green if latest month rate < HDFT average for 2016/17, Amber if latest month rate > HDFT average for 2016/17 but below UCL, red if latest month rate > UCL. | Locally agreed improvement trajectory based on comparison with HDFT performance last year. |
| **Finance and efficiency** | **Length of stay - elective** | Average LOS for elective patients | Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%. | Comparison with performance of other acute trusts. |
| **Finance and efficiency** | **Length of stay - non-elective** | Average LOS for non-elective patients | | |
| **Finance and efficiency** | **Theatre utilisation** | % of theatre time utilised for elective operating sessions | Green = >=85%, Amber = between 75% and 85%, Red = <75% | A utilisation rate of around 85% is often viewed as optimal. |

| Section | Indicator | Further detail | Traffic light criteria | Rationale/source of traffic light criteria |
|---|---|---|---|---|
| Finance and efficiency | Delayed transfers of care | % acute beds occupied by patients whose transfer is delayed - snapshot on last Thursday of the month. | Red if latest month >3.5%, Green <=3.5% | Contractual requirement |
| Finance and efficiency | Outpatient DNA rate | % first OP appointments DNA'd | Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%. | Comparison with performance of other acute trusts. |
| Finance and efficiency | Outpatient new to follow up ratio | No. follow up appointments per new appointment. | | |
| Finance and efficiency | Day case rate | % elective admissions that are day case | | |
| Finance and efficiency | Surplus / deficit and variance to plan | Monthly Surplus/Deficit (£'000s) | Green if on plan, amber <1% behind plan, red >1% behind plan | Locally agreed targets. |
| Finance and efficiency | NHS Improvement Financial Performance Assessment | An overall rating is calculated ranging from 4 (no concerns) to 1 (significant concerns). This indicator monitors our position against plan. | Green if rating =4 or 3 and in line with our planned rating, amber if rating = 3, 2 or 1 and not in line with our planned rating. | as defined by NHS Improvement |
| Finance and efficiency | Capital spend | Cumulative capital expenditure | Green if on plan or <10% below, amber if between 10% and 25% below plan, red if >25% below plan | Locally agreed targets. |
| Finance and efficiency | Agency spend in relation to pay spend | Expenditure in relation to Agency staff on a monthly basis (£'s). | Green if <1% of pay bill, amber if between 1% and 3% of pay bill, red if >3% of pay bill. | Locally agreed targets. |
| Finance and efficiency | Outpatient activity against plan (new and follow up) | Includes all outpatient attendances - new and follow-up, consultant and non-consultant led. | Green if on or above plan in month, amber if below plan by < 3%, red if below plan by > 3%. | Locally agreed targets. |
| Finance and efficiency | Elective activity against plan | Includes inpatient and day case activity | | Locally agreed targets. |
| Finance and efficiency | Non-elective activity against plan | | | Locally agreed targets. |
| Finance and efficiency | Emergency Department attendances against plan | Excludes planned followup attendances. | | Locally agreed targets. |
| Operational Performance | NHS Improvement governance rating | Trust performance on Monitor's risk assessment framework. | As per defined governance rating | as defined by NHS Improvement |
| Operational Performance | RTT Incomplete pathways performance | % incomplete pathways within 18 weeks | Green if latest month >=92%, Red if latest month <92%. | NHS England |
| Operational Performance | A&E 4 hour standard | % patients spending 4 hours or less in A&E. | Blue if latest month >=97%, Green if >=95% but <97%, red if latest month <95% | NHS England, NHS Improvement and contractual requirement of 95% and a locally agreed stretch target of 97%. |
| Operational Performance | Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals | % urgent GP referrals for suspected cancer seen within 14 days. | Green if latest month >=93%, Red if latest month <93%. | NHS England, NHS Improvement and contractual requirement |
| Operational Performance | Cancer - 14 days maximum wait from GP referral for symptomatic breast patients | % GP referrals for breast symptomatic patients seen within 14 days. | Green if latest month >=93%, Red if latest month <93%. | NHS England, NHS Improvement and contractual requirement |
| Operational Performance | Cancer - 31 days maximum wait from diagnosis to treatment for all cancers | % cancer patients starting first treatment within 31 days of diagnosis | Green if latest month >=96%, Red if latest month <96%. | NHS England, NHS Improvement and contractual requirement |
| Operational Performance | Cancer - 31 day wait for second or subsequent treatment: Surgery | % cancer patients starting subsequent surgical treatment within 31 days | Green if latest month >=94%, Red if latest month <94%. | NHS England, NHS Improvement and contractual requirement |
| Operational Performance | Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug | % cancer patients starting subsequent anti-cancer drug treatment within 31 days | Green if latest month >=96%, Red if latest month <96%. | NHS England, NHS Improvement and contractual requirement |
| Operational Performance | Cancer - 62 day wait for first treatment from urgent GP referral to treatment | % cancer patients starting first treatment within 62 days of urgent GP referral | Green if latest month >=85%, Red if latest month <85%. | NHS England, NHS Improvement and contractual requirement |
| Operational Performance | Cancer - 62 day wait for first treatment from consultant screening service referral | % cancer patients starting first treatment within 62 days of referral from a consultant screening service | Green if latest month >=90%, Red if latest month <90%. | NHS England, NHS Improvement and contractual requirement |
| Operational Performance | Cancer - 62 day wait for first treatment from consultant upgrade | % cancer patients starting first treatment within 62 days of consultant upgrade | Green if latest month >=85%, Red if latest month <85%. | NHS England, NHS Improvement and contractual requirement |
| Operational Performance | Children's Services - 10-14 day new birth visit | % new born visit within 14 days of birth | Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%. | Contractual requirement |
| Operational Performance | Children's Services - 2.5 year review | % children who had a 2 and a half year review | Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%. | Contractual requirement |

**Data quality assessment**

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

Harrogate and District
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Date of Meeting:** | 30 May 2018 | **Agenda item:** | 7.0 |
| **Report to:** | Board of Directors | | |
| **Title:** | Finance Report | | |
| **Sponsoring Director:** | Jonathan Coulter<br>Deputy Chief Executive / Finance Director | | |
| **Author(s):** | Finance Department | | |
| **Report Purpose:** | **Decision** [ ] **Discussion/ Consultation** [✓] **Assurance** [✓] **Information** [✓] | | |
| **Executive Summary:** | • The Trust financial performance in April 2018 was a deficit of £2,303k. Despite being in line with the control total, this is £777k adverse to plan.<br>• Key drivers for this variance relate to Acute Clinical Income, Ward and Medical Staffing pay expenditure and CIP performance.<br>• Cash continues to be a concern for the Trust. The position for April was £651k behind plan. | | |

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

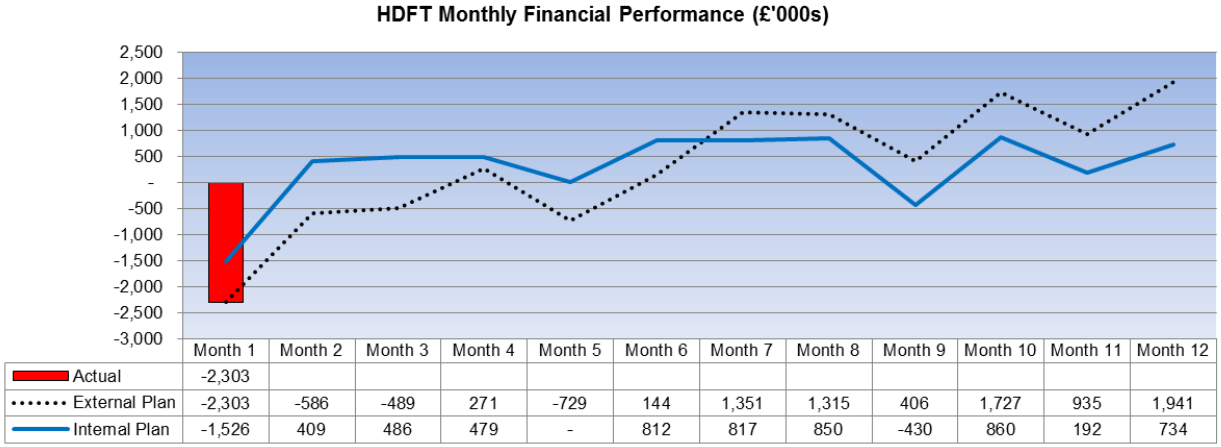
| **Key implications** | |
|---|---|
| **Risk Assessment:** | The paper outlines the financial risks facing the Trust and the mitigations being put in place to resolve these in terms of revenue and cash. |
| **Legal / regulatory:** | None directly identified. |
| **Resource:** | The document outlines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

| **Action Required by the Board of Directors:** |
|---|
| The Board of Directors is asked to note the contents of this report and the actions that are being progressed to achieve the financial plan. |

# April 2018 Financial Position

**Financial Performance**

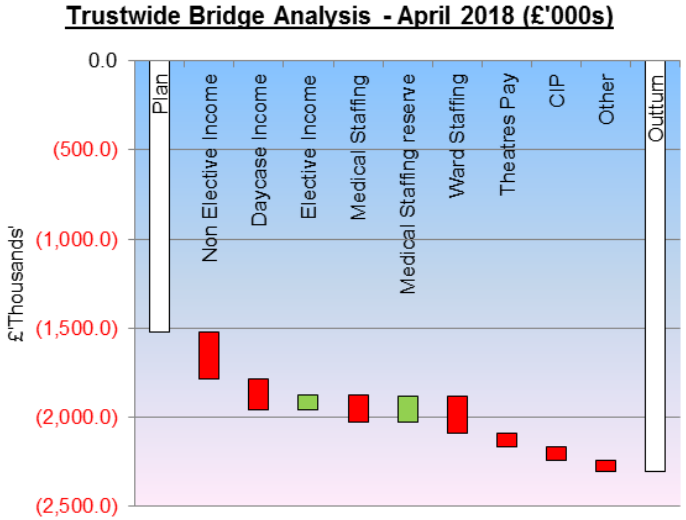
- The Trust reported a deficit position of £2,303k for April. Although this was balanced to the control total plan set with NHS Improvement, it is behind the plan set internally to deliver the 2018/19 plan, which was deficit of £1,526k. This is highlighted in the graph below.




| | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Month 7 | Month 8 | Month 9 | Month 10 | Month 11 | Month 12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | -2,303 | | | | | | | | | | | |
| External Plan | -2,303 | -586 | -489 | 271 | -729 | 144 | 1,351 | 1,315 | 406 | 1,727 | 935 | 1,941 |
| Internal Plan | -1,526 | 409 | 486 | 479 | - | 812 | 817 | 850 | -430 | 860 | 192 | 734 |

- The drivers for this position are highlighted in the diagram on the right, with associated values below. Income, Workforce and CIP are discussed in more detail later in the report.

| | £'000s |
|---|---|
| **Plan** | **(1,526.000)** |
| Non Elective Income | (259.000) |
| Daycase Income | (175.649) |
| Elective Income | 83.000 |
| Medical Staffing | (148.417) |
| Medical Staffing reserve | 140.000 |
| Ward Staffing | (206.630) |
| Theatres Pay | (72.967) |
| CIP | (80.442) |
| Other | (56.895) |
| **Actual** | **(2,303.000)** |



# April 2018 Financial Position

**Financial Performance Cont.**

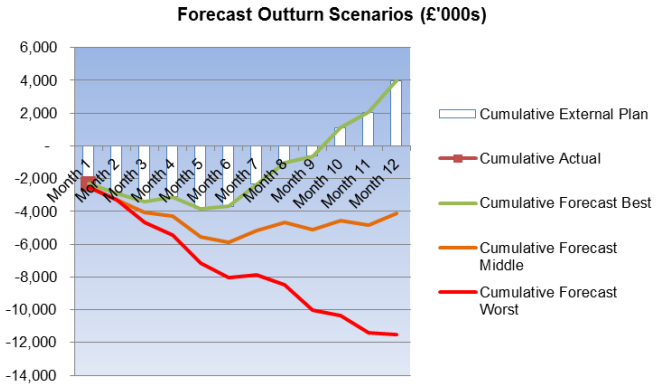
- The following headline messages were discussed in more detail at SMT –
  - ***Non-elective activity is down but costs have gone up***
  - ***We have breached the agency ceiling in April***
  - ***Our wards have significantly overspent, with significant agency spend and employment above establishment***
  - ***CIP delivery is not at 100% as at the end of April***
- More detailed actions were discussed, however, the following outcomes were agreed as part of the SMT discussion –
  - Reinforced message in relation to living within establishment, including enhanced care. This includes actions which have already started around new risk assessments and a focus on discharge of long stay patients.
  - Participation in NHS Improvement ward staffing review and enhanced care review, as well as review of the FLIP business case to ensure cost neutral impact.
  - Review of future agency bookings and the potential to implement/fast track more cost effective alternatives.
  - Work with partners to ensure a consistent approach across the wider system for agency usage.
  - Focus on delivery of activity. Early indications are an improvement in May but need to ensure this is consistent and sustainable.
  - In relation to CIP, a need to ensure 100% of plans in place following risk adjustment. Arrangements in relation to the delivery and oversight of this programme have changed to support this.

# April 2018 Financial Position

**Forecast outturn**

- The following forecast outturn scenarios outline the financial impact of the risks currently faced by the Trust. This has been discussed in detail with NHSI.

| | Best Case £m | Medium Case £m | Worse case £m | comment |
|---|---|---|---|---|
| Plan | 4.0 | 4.0 | 4.0 | |
| Ward staffing pressures | | -1.0 | -1.5 | current cost pressure |
| CIP delivery | | -0.9 | -3.2 | medium - risk adj, worse - national expectation |
| Income risk | | -1.0 | -2.0 | substitution of HaRD CCG activity |
| historic issues | | | -2.8 | |
| S&T funding impact | | -4.0 | -4.0 | impact of adjustments |
| sub-total | 4.0 | -2.9 | -9.5 | |
| winter costs | | -0.9 | -1.5 | with no mitigation |
| pay award funding - calculation | | -0.3 | -0.3 | only 90% funded |
| pay award funding - HHFM | | | -0.2 | funding doesn't flow for HHFM staff |
| TOTAL | 4.0 | -4.1 | -11.5 | |

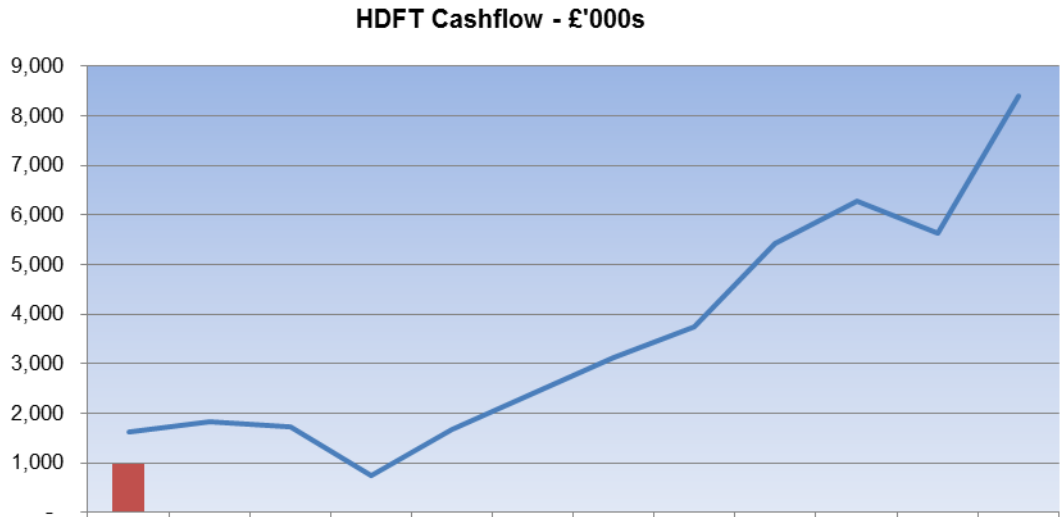



- NHS Improvement will be visiting in June to review the Trusts financial planning and governance processes. The outcome of this is proposed to be discussed at Finance Committee and reported back to the Board once feedback is received.

# April 2018 Financial Position

**Cash and Capital resource**

- Cash remains a significant risk for the Trust, with a need to establish some recovery and resilience while providing resource for a limited capital programme. The cash position at the end of April was £976k, which continued to be behind plan as outlined below.




| | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Month 7 | Month 8 | Month 9 | Month 10 | Month 11 | Month 12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | 976 | | | | | | | | | | | |
| Plan | 1,627 | 1,837 | 1,719 | 750 | 1,660 | 2,389 | 3,108 | 3,735 | 5,424 | 6,270 | 5,617 | 8,398 |

- It should be noted this position does not include the cash position of HHFM.

- Subsequently this position, driven by the Trusts I&E performance further limits capital resources available. Expenditure is only being committed where vital, and the impact is being carefully managed.

# April 2018 Financial Position

**Income and Activity**

- As outlined on page 1, there are some significant variances relating to income in month 1. The key areas are –
  - Non elective **£259k adverse** to plan. This variance is being driven by activity, with the variance to plan being 8% for activity and income. The level of admissions in month was the lowest level since 2015/16.
  - Daycase income **£176k adverse** to plan. There is a mix of activity and casemix issues here, with the variances at specialty level more exaggerated than the Trust wide position. Currently activity variance Trustwide is 5.5%, however, the income variance is 10%.
  - Elective income **£83k favourable** to plan. Following the rebasing of the activity plans it is positive to be in a favourable position for elective income. This is anticipated to continue in May.
- The current coded position for outpatients required an estimate to be made for outpatient procedures. This equates to approx. £100k.
- The current income position for the top 5 commissioners based on annual contract values is highlighted in the table below. This equates to 82% of the Trust's planned income.

| Commissioner | Annual Plan (£'s) | April Plan (£'s) | April Actual (£'s) | Variance (£'s) | Variance (%) |
|---|---|---|---|---|---|
| HaRD CCG | 105,781,900 | 8,515,183 | 8,263,723 | - 251,460 | -2.95% |
| Leeds CCGs | 27,719,800 | 2,215,400 | 2,059,091 | - 156,309 | -7.06% |
| Durham Council | 11,249,000 | 937,416 | 941,775 | 4,359 | 0.47% |
| NHS England - Spec Comm | 8,602,900 | 697,916 | 807,817 | 109,901 | 15.75% |
| North Yorkshire County Council | 7,915,600 | 659,633 | 648,190 | - 11,443 | -1.73% |

# April 2018 Financial Position

## Workforce

- The Trust reported an adverse pay variance of £155k, including costs related to HHFM. This is summarised in the tables below.

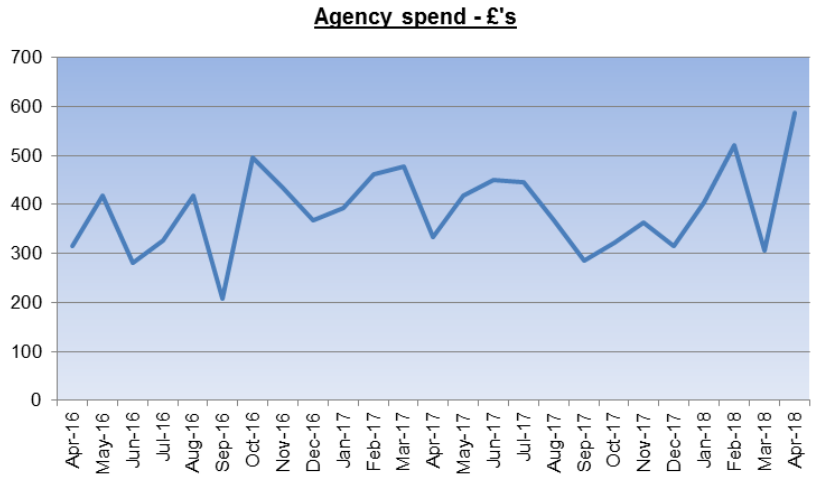
| | CHILDRENS AND COUNTY WIDE COMMUNITY CARE | | | CORPORATE SERVICES | | | LONG TERM AND UNSCHEDULED CARE | | | PLANNED AND SURGICAL CARE | | | Trust wide | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | April Budget | April Spend | April Variance | April Budget | April Spend | April Variance | April Budget | April Spend | April Variance | April Budget | April Spend | April Variance | April Budget | April Spend | April Variance |
| AGENCY | 2,000 | 19,332 | 17,332 | 1,316 | 17,350 | 16,034 | 40,665 | 161,191 | 120,526 | 41,666 | 247,818 | 206,152 | 85,647 | 445,690 | 360,043 |
| BANK | 6,091 | 20,179 | 14,088 | 100 | 1,340 | 1,240 | 40,383 | 118,831 | 78,448 | 19,333 | 56,347 | 37,014 | 65,907 | 196,697 | 130,790 |
| LOCUM | - | 10,151 | 10,151 | | | - | 38,100 | 339,902 | 301,802 | 14,341 | 127,281 | 112,940 | 52,441 | 477,334 | 424,893 |
| PERMANENT | 3,280,021 | 3,128,520 | - 151,501 | 1,057,963 | 1,033,308 | - 24,655 | 4,446,580 | 4,072,817 | - 373,764 | 3,838,059 | 3,626,811 | - 211,248 | 12,622,623 | 11,861,456 | - 761,167 |
| **Total** | **3,288,112** | **3,178,182** | **- 109,930** | **1,059,379** | **1,051,998** | **- 7,381** | **4,565,728** | **4,692,740** | **127,012** | **3,913,399** | **4,058,257** | **144,858** | **12,826,618** | **12,981,177** | **154,559** |

Note - the below excludes contingency funding

| | April Budget £ | April Actual £ | April Variance £ | April Variance % |
|---|---|---|---|---|
| Adult Community Services | 353,503 | 391,055 | 37,552 | 11% |
| Children's - all staff | 1,872,673 | 1,844,413 | - 28,260 | -2% |
| Medical Staffing | 2,936,546 | 3,084,963 | 148,417 | 5% |
| RN - wards | 1,273,393 | 1,331,414 | 58,021 | 5% |
| Theatres and Day Surgery | 384,272 | 457,239 | 72,967 | 19% |
| HCA - Wards | 483,340 | 631,949 | 148,609 | 31% |
| Other | 5,968,330 | 5,864,369 | - 103,961 | -2% |
| **Grand Total** | **13,272,057** | **13,605,402** | **333,345** | 3% |

| | April Budget WTE | April Contracted WTE | April Variance WTE | April Variance % |
|---|---|---|---|---|
| Adult Community Services | 124.78 | 129.55 | 4.77 | 4% |
| Children's - all staff | 604.78 | 601.64 | - 3.14 | -1% |
| Medical Staffing | 333.56 | 318.57 | - 14.99 | -4% |
| RN - wards | 355.98 | 331.38 | - 24.60 | -7% |
| Theatres and Day Surgery | 128.32 | 105.20 | - 23.12 | -18% |
| HCA - Wards | 201.48 | 200.46 | - 1.02 | -1% |
| Other | 1,959.50 | 1,809.84 | - 149.66 | -8% |
| **Grand Total** | **3,708.40** | **3,496.64** | **- 211.76** | -6% |

» Accompanying this, the Trusts agency expenditure hit its highest level since the introduction of the agency caps in 2016. This is the 2nd time this has occurred in the past 3 months.

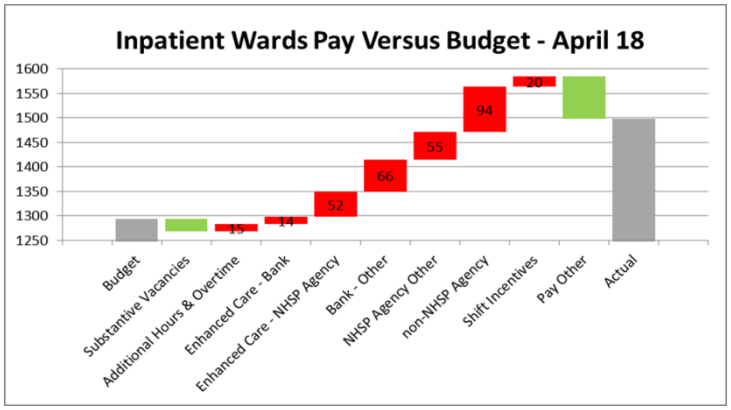


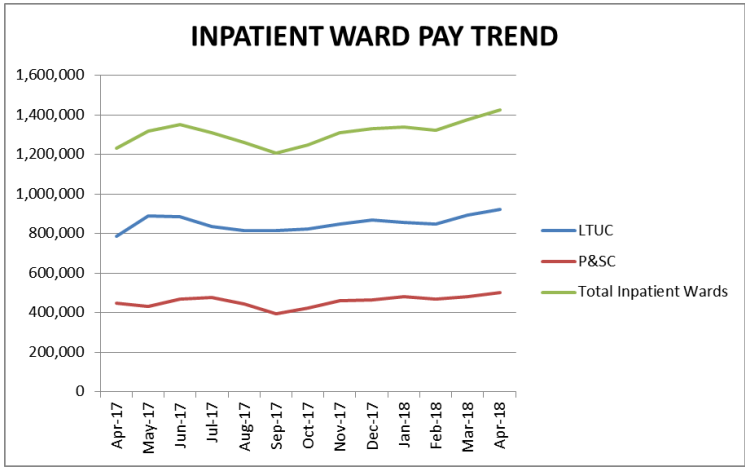

- Since month end discussions at the Workforce Efficiency Group have focused on the drivers for the key variances, as well as the actions to address the impact of these. This is discussed in more detail on the following pages.

# April 2018 Financial Position

**Workforce continued – Ward Nursing and Healthcare Assistants**

- The information below outlines the severity of the overspend in this area during April. Given the severity of the level of overspend immediate actions have been implemented.

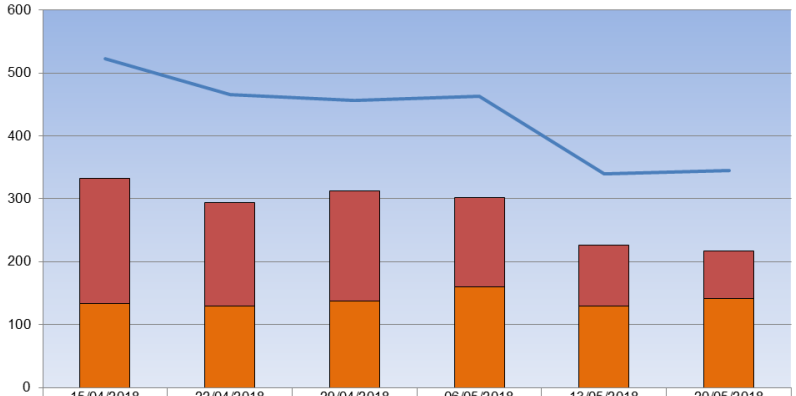



- Initial impacts have been seen with bank and agency requests reducing, as highlighted below. It is too soon to see what financial impact this will have on the underlying run rate and will need to be closely monitored over the coming weeks.

- As described on page 2, there are a number of short, medium and long term actions in place to address this.

**Weekly bank and agency shifts - wards**

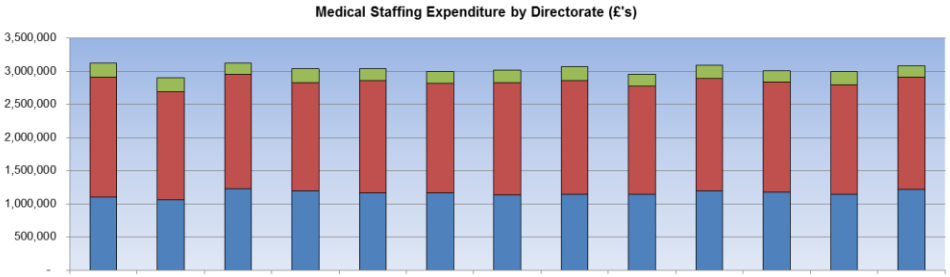



| | 15/04/2018 | 22/04/2018 | 29/04/2018 | 06/05/2018 | 13/05/2018 | 20/05/2018 |
|---|---|---|---|---|---|---|
| Agency Fill | 200 | 165 | 175 | 142 | 97 | 75 |
| Bank Fill | 133 | 129 | 137 | 160 | 129 | 142 |
| Shift Requests | 522 | 466 | 456 | 463 | 340 | 345 |

# April 2018 Financial Position

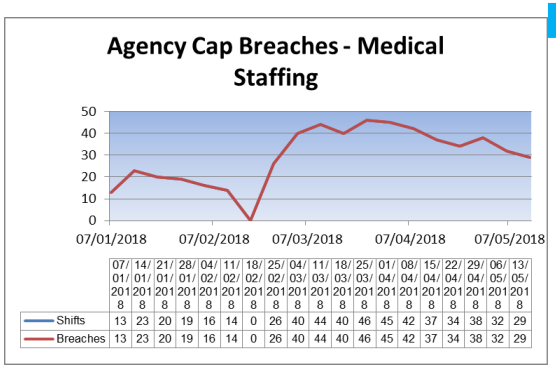
**Workforce Continued – Medical Staffing**

- The Workforce Efficiency Group also discussed the expenditure in relation to medical staffing. Although the Trust holds a contingency for some of this cost the graph outlines the overall cost to the Trust and within each directorate.



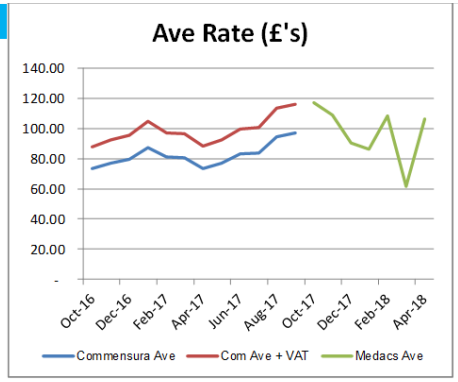

| | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CCCC | 211,247 | 214,427 | 170,390 | 209,059 | 187,524 | 177,393 | 195,259 | 200,879 | 180,620 | 195,958 | 174,070 | 194,042 | 176,204 |
| PSC | 1,803,494 | 1,630,952 | 1,726,082 | 1,633,597 | 1,685,466 | 1,650,030 | 1,689,954 | 1,724,940 | 1,631,794 | 1,701,881 | 1,660,424 | 1,658,554 | 1,688,596 |
| LTUC | 1,104,895 | 1,055,314 | 1,229,188 | 1,197,442 | 1,169,901 | 1,167,664 | 1,136,320 | 1,139,869 | 1,146,812 | 1,193,275 | 1,174,639 | 1,141,343 | 1,220,163 |

- The graphs below outline the performance against the agency cap, as well as the average hourly rate paid to agencies and the hours filled.

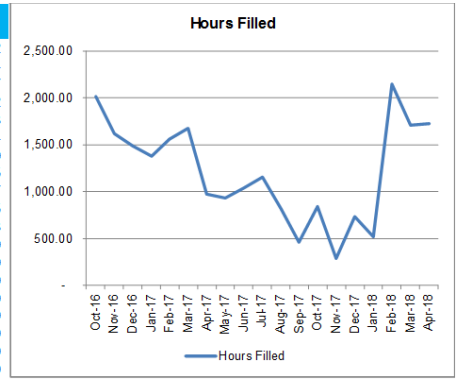



| | 07/01/2018 | 14/01/2018 | 21/01/2018 | 28/01/2018 | 04/02/2018 | 11/02/2018 | 18/02/2018 | 25/02/2018 | 04/03/2018 | 11/03/2018 | 18/03/2018 | 25/03/2018 | 01/04/2018 | 08/04/2018 | 15/04/2018 | 22/04/2018 | 29/04/2018 | 06/05/2018 | 13/05/2018 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Shifts | 13 | 23 | 20 | 19 | 16 | 14 | 0 | 26 | 40 | 44 | 40 | 46 | 45 | 42 | 37 | 34 | 38 | 32 | 29 |
| Breaches | 13 | 23 | 20 | 19 | 16 | 14 | 0 | 26 | 40 | 44 | 40 | 46 | 45 | 42 | 37 | 34 | 38 | 32 | 29 |

| Month | Commensura Ave | Com Ave + VAT | Medacs Ave |
|---|---|---|---|
| Oct-16 | 73.28 | 87.94 | |
| Nov-16 | 76.80 | 92.16 | |
| Dec-16 | 79.73 | 95.67 | |
| Jan-17 | 87.08 | 104.49 | |
| Feb-17 | 80.84 | 97.01 | |
| Mar-17 | 80.35 | 96.42 | |
| Apr-17 | 73.53 | 88.23 | |
| May-17 | 77.03 | 92.43 | |
| Jun-17 | 82.90 | 99.48 | |
| Jul-17 | 83.73 | 100.47 | |
| Aug-17 | 94.39 | 113.27 | |
| Sep-17 | 96.83 | 116.20 | |
| Oct-17 | | | 116.97 |
| Nov-17 | | | 108.74 |
| Dec-17 | | | 90.07 |
| Jan-18 | | | 86.36 |
| Feb-18 | | | 108.42 |
| Mar-18 | | | 61.64 |
| Apr-18 | | | 106.21 |




| Month | Hours Filled |
|---|---|
| Oct-16 | 2,012.92 |
| Nov-16 | 1,617.74 |
| Dec-16 | 1,481.67 |
| Jan-17 | 1,375.42 |
| Feb-17 | 1,559.43 |
| Mar-17 | 1,673.24 |
| Apr-17 | 971.50 |
| May-17 | 932.25 |
| Jun-17 | 1,035.67 |
| Jul-17 | 1,155.75 |
| Aug-17 | 818.83 |
| Sep-17 | 462.00 |
| Oct-17 | 838.00 |
| Nov-17 | 286.00 |
| Dec-17 | 737.00 |
| Jan-18 | 516.50 |
| Feb-18 | 2,148.50 |
| Mar-18 | 1,706.00 |
| Apr-18 | 1,724.50 |




- As outlined in the information, all agency bookings are currently above the agency cap. However, as the second graph outlines the current rates paid per hour are comparable to those previously paid.

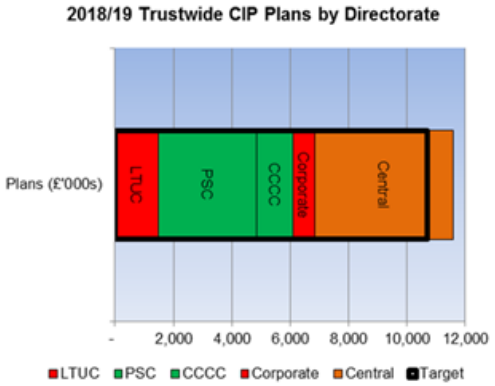
- The key driver for premium expenditure has been the number of hours filled, as per the final graph. This increase in early 2018 is being investigated further with actions to address demand to be agreed.

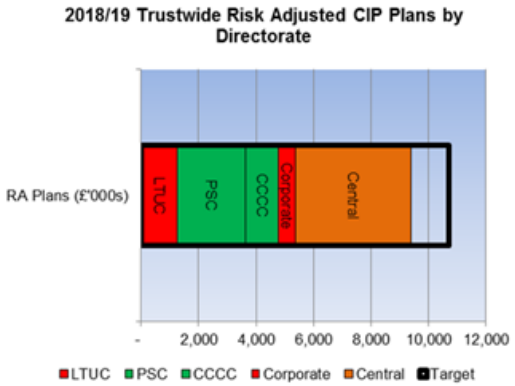
# April 2018 Financial Position

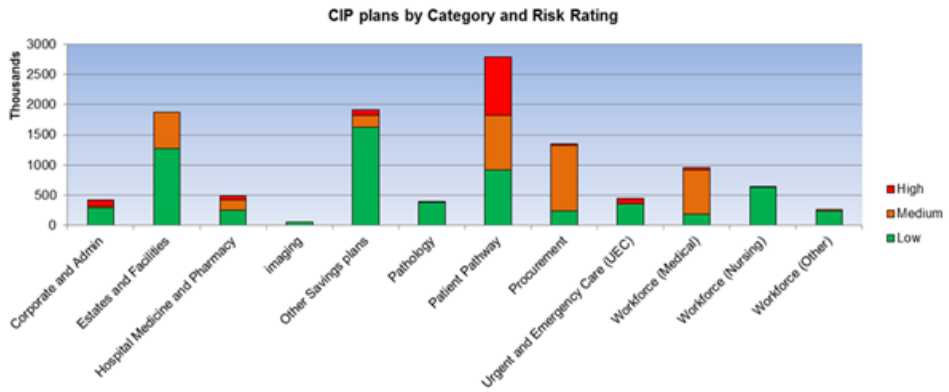
**Cost Improvement Programme**

- The Trustwide CIP programme continues its development and implementation, with 108% of plans in place against the £10.7m target. This reduces to 88% following risk adjustment. Information by directorate is highlighted below.

| | Plans £'000s | RA Plans £'000s |
|---|---|---|
| **Target** | **10,700** | **10,700** |
| LTUC | 1,483 | 1,271 |
| PSC | 3,367 | 2,377 |
| CCCC | 1,251 | 1,124 |
| Corporate | 733 | 599 |
| Central | 4,750 | 4,014 |
| **Total** | **11,584** | **9,385** |
| Variance to target | 884 | - 1,315 |
| % variance | 8% | -12% |




- The are a number of significant and high risk schemes which are being focused on to ensure delivery.

Harrogate and District
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Date of Meeting:** | 30 May 2018 | **Agenda item:** | 8.0 |
| **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<br>Mr Jonathan Green, Information Analyst Specialist | | |
| **Report Purpose:** | **Decision** ✓ **Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓ | | |
| **Executive Summary:** | • Following an inspection for the level 2 – Baby Friendly Initiative North Yorkshire has been successful<br>• Work on the creation of an area to support GP streaming and a dedicated Paediatric Waiting area has now commenced.<br>• HDFT failed to deliver the 62 day and 14 day Breast Symptomatic standard in April. | | |

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

| **Key implications** | |
|---|---|
| **Risk Assessment:** | Risks associated with the content of the report are reflected in the Board Assurance Framework via: BAF 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:**

It is recommended that the Board/Committee:

- *Note items included in the report.*

## 1.0 SERVICE ACTIVITY

The table below summarises the April 2018 position on activity for the main points of delivery, along with the April 2017 position for comparison.

| | Apr-18 | | | Apr-17 | | |
|---|---|---|---|---|---|---|
| **Activity type** | **Actual** | **Plan** | **Variance** | **Actual** | **Plan** | **Variance** |
| **New outpatients** | 7675 | 7748 | -0.9% | 6829 | 7000 | -2.4% |
| **Follow-up outpatients** | 15440 | 15565 | -0.8% | 14019 | 14039 | -0.1% |
| **Elective inpatients** | 297 | 279 | 6.4% | 246 | 273 | -9.9% |
| **Elective day cases** | 2441 | 2618 | -6.8% | 2105 | 2263 | -7.0% |
| **Non-electives** | 1664 | 1809 | -8.0% | 1733 | 1757 | -1.4% |
| **A&E attendances** | 4315 | 4141 | 4.2% | 4207 | 3987 | 5.5% |

Overall outpatient activity was close to plan in April for both new and follow-ups, which is an improvement on recent months.

April remained challenging in regard to bed occupancy. However elective inpatient activity overall was much improved in relation to plan and was significantly improved in comparison to the same month last financial year.

Elective day cases were below plan, largely linked to Endoscopy under delivery, which in part can be attributed to endoscopy washer maintenance which impacts significantly, as well as unexpected leave of one of the Endoscopists. Further work is being done in relation to the phasing of Endoscopy activity and the new unit. Elective inpatient activity was 6.4% over plan for the month, with Orthopaedics being 18.7% over plan. This is linked to work being done to fill as many free lists as possible with the Locum T&O Consultant, fellows undertaking lists, and a high fill rate for weekend work.

Challenges are still present in relation to Ophthalmology staffing, although a number of Health Care Assistants have started which will help with clinic capacity. Theatres have also recruited five nurses (four from the overseas programme due to start in the autumn). It is anticipated that further improvements in productivity will be made as the reliance on agency staff in theatres reduces.

Work on productivity continues across Planned & Surgical Care Directorate and six joint and hip arthroscopy lists have been tested with successful outcome.

The continued rise in A&E attendances requires monitoring, early data analysis suggests this is not from HaRD CCG and it relates mainly to minor presentations.

## 2.0 CHILDREN'S AND COUNTYWIDE COMMUNITY SERVICES

Acute Paediatric Medical staffing continues to be of concern and all efforts are being undertaken to cover clinics and medical rotas for June, to minimise the impact on patient care. Alongside maternity leave and vacancies within paediatrics, Woodlands Ward has higher levels of sick leave (5.4%) of which 3% is long term which means staffing is currently challenging. This has the potential to increase the use of agency staff within the service.

The Community Dental service has reported higher levels of referrals and acuity which they are analysing which is resulting in a slow increase in waiting times. Action has been taken to recruit to an interim dentist (2 days per week) in the Scarborough area who will help reduce the paediatric waiting times and numbers on the east coast area.

Following an inspection for the Level 2 Baby Friendly Initiative, North Yorkshire has been successful delivered through the close partnership working within the Local Authority. The feedback and scoring for the inspection were consistently high which has resulted in North Yorkshire being well placed to move onto level 3 straight away.

## 3.0 CANCER SERVICES

Performance

Performance against the 14 day standard for breast symptomatic patients was below the required 93% standard for the third consecutive month in April with 75.9% of patients seen within 14 days. Work is ongoing to understand the reasons for this decrease in performance, and preliminary investigations indicate that the number of suspected breast cancer referrals received on a Monday has increased in the last 3 months which has had an impact on the number of clinics and slots available before the 14 day target. The delivery of this standard has become challenging across the WYAAT Trusts and therefore the Chief Operating Officers have agreed to collaborate in a review of capacity and demand for these services.

Provisional data indicates that Trust performance for the 62 day standard was below the 85% standard in April with 83.3% of patients treated within 62 days. Those cases where patients waited longer than 62 days will be reviewed by the breach panel on 23rd May.

The new national Cancer Waiting Times (CWT) database is now live and accepts submissions of the latest version of the CWT dataset. This dataset contains new data fields allowing the capture of data relating to the 28 day diagnosis standard and also details of inter-provider transfers (IPT). Performance against the 28 day standard will be reported nationally from April 2019, and from July 2018 the IPT data will be used to calculate 62 day performance based on national re-allocation guidance.

100k Genomes Project

The 100k Genomes Project is a national initiative designed to create a new genomic medicine service for the NHS and thereby transforming the way people are cared for. The project will sequence 100,000 genomes from around 70,000 people - participants are NHS patients with a rare disease, plus their families, and patients with cancer.

NHS England has confirmed that as of 20th April 2018 HDFT meets the requirements to start recruiting to the breast cancer pathway in the first instance and then colorectal.

Inter-Provider Transfer (IPT) performance

As stated above, expected 62-day performance for April with the current allocation rules is at 83.3%. A total of 8 patients were treated at tertiary centres in the month following a 2WW referral to Harrogate. Of these, 5 were transferred by day 38 (62.5%).

Shadow reporting of the 62 day standard shows that when the national re-allocation rules are applied, performance would have been 1.5% lower for April.

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

| ACTUAL performance | Apr-18 | May-18 | Jun-18 | Q1 |
|---|---|---|---|---|
| Total | **45.0** | | | **45.0** |
| Within 62 days | 37.5 | | | **37.5** |
| Outside 62 days | 7.5 | | | **7.5** |
| Performance | 83.3% | | | **83.3%** |

| Re-allocation (NATIONAL) | Apr-18 | May-18 | Jun-18 | Q1 |
|---|---|---|---|---|
| Total | **44.0** | | | **44.0** |
| Within 62 days | 36.0 | | | **36.0** |
| Outside 62 days | 8.0 | | | **8.0** |
| Performance | 81.8% | | | **81.8%** |

| Difference (National/Actual) | Apr-18 | May-18 | Jun-18 | Q1 |
|---|---|---|---|---|
| Total | **-1.0** | | | **-1.0** |
| Within 62 days | -1.5 | | | **-1.5** |
| Outside 62 days | 0.5 | | | **0.5** |
| % difference | -1.5% | | | **-1.5%** |

| IPTs (actual patients) SENT | Apr-18 | May-18 | Jun-18 | Q1 |
|---|---|---|---|---|
| Total | **8** | | | **8** |
| Within 38 days | 5 | | | **5** |
| Outside 38 days | 3 | | | **3** |
| Performance | 62.5% | | | **62.5%** |

## 4.0 ED PERFORMANCE

Work on the creation of an area to support GP streaming and a dedicated Paediatric Waiting area has now commenced.

ED performance in April 2018 was below the 95% target as breaches occurred mainly due to bed pressures. A decrease in bed occupancy has been observed in recent weeks with improved discharge numbers and a reduction in the number of patients with a length of stay of 21 days or over. However, there has been an increase in the volume of patients through ED and some very high activity days have resulted in ED breaches of minor patients which have led to a significant impact on our performance. With the Winter / WYAZ funding which supported additional staff in ED no longer being in place, this has meant the department has been dealing with high volumes of patients as they return to the baseline established staffing resources. The days where there are very high volumes of breaches will be reviewed to see what learning can be gained for future planning.

The next wave of Action on A&E will begin in May where each A&E delivery board will have to pick a topic to focus on during these sections. The Harrogate system has chosen “Discharge – Why not Home, Why not today?”. This was the agreed priority as there are issues around delivering the delayed transfers of care target as well as the high number of “Stranded patients” occupying hospital beds in comparison to other Trusts in the North.

## 5.0 DIAGNOSTIC BREACHES

In April, a significant number of diagnostic 6-week breaches were reported (64 in ultrasound and 24 in cardiology). The majority of these patients were seen in early May and a significantly improved position is anticipated for end May.

**Radiology**

Within the month, demand outstripped capacity. Due to estates work in the department, there has been a reduction in the number of rooms available in the department. This has meant the service has been reliant on evening and weekend sessions to maintain activity. Unfortunately even with these additional sessions, there was not enough capacity to prevent breaches. Extra list have been put in place for May and options are being explored for the longer term to increase room availability by moving the DEXA scanner out of the department.

**Cardio Respiratory**

A shortage of administrative support for the Cardio Respiratory team resulted in a significant back log of bookings. There were also capacity issues in the department with demand for echo tests outstripping the slots available. To overcome this, additional clinic and managerial staff have received the appropriate training to undertake bookings when the administrative support is unavailable. Prior to this, additional sessions are being held to support the capacity gap.

A Business Case to create two substantive Consultant Cardiology posts has recently been approved. In recent years, the department has been reliant on the use of locum appointments and additional sessions from external consultants. These posts will make the medical staffing model in the specialty more sustainable and also support the repatriation of Cardiology work that has been referred to other providers.

## 6.0 CQC INSIGHT FOR ACUTE NHS TRUSTS – MONTHLY UPDATE

CQC published the latest Insight packs for all Trusts on 21 April 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. Only one of the 12 indicators included in the composite score are identified as having a significantly declining performance:

- Staff flu vaccination uptake (based on the change from Sept 2015 – Feb 2016 to Sept 2016 – Feb 2017);

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

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

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

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

- Much worse compared nationally – 0 (0%)

63 indicators have been compared to data from 12 months previous, of which 4 (6%) have shown an improvement and three (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.

## 7.0 GENERAL DATA PROTECTION REGULATION (GDPR)

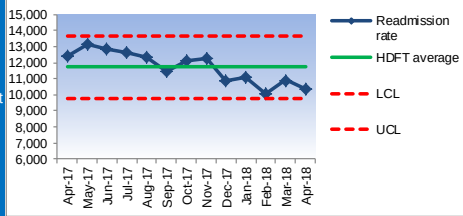
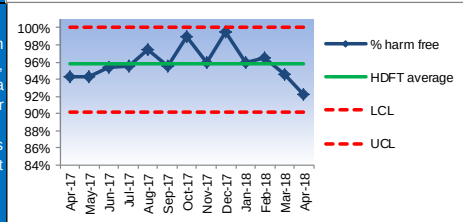
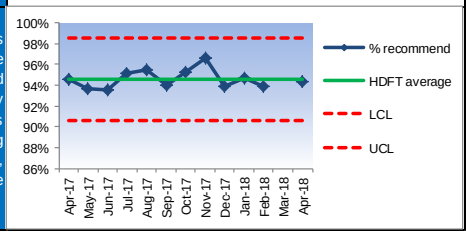
The General Data Protection Regulation (GDPR) comes into force on 25th May 2018 and replaces the UK Data Protection Act 1998. In general the principles of data protection remain similar; however there is greater focus on evidence-based compliance with requirements for transparency, more extensive rights for data subjects and harsher penalties for non-compliance. Many of the main concepts and principles are the same as the current Data Protection Act (DPA) and the Information Commissioner's Office (ICO) has published a checklist and guidance to support organisations in implementing the regulation. The Trust's update against the ICO guidance is shown in Appendix A.

## 8.0 PROPOSED ADDITIONAL METRICS

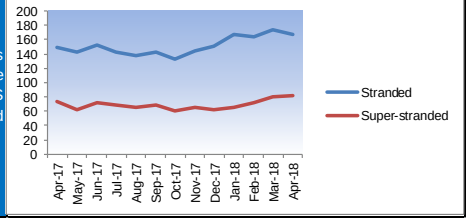
Appendix B shows a mock-up of the proposed additional metrics for the integrated board report focussed on adult community services as discussed at Board previously.

| ICO Guidance | HDFT review update |
|---|---|
| **Awareness**<br>Decision makers and key people in your business are aware that the law is changing to the GDPR and appreciate the impact this is likely to have. Your business has identified areas that could cause compliance problems under the GDPR and has recorded these on the organisation's risk register. Your business is raising awareness, across the organisation of the changes that are coming.<br><br>You should make sure that decision makers and key people in your organisation are aware that the law is changing to the GDPR. They need to appreciate the impact this is likely to have and identify areas that could cause compliance problems under the GDPR. It would be useful to start by looking at your organisation's risk register, if you have one. | ● July 2017 initial report to Board of Directors<br>● Update on Information Governance intranet page<br>● Team brief update in March 2018<br>● Meetings with key services e.g.HR, Company Secretary, Supplies<br>● Communication to be issued to all staff noting contract change and privacy notice<br>● Data Protection Officer and Information Governance Manager completed GDPR Foundation and Practioner certification |
| **Accountability**<br>The new accountability principle in Article 5(2) requires you to demonstrate that you comply with the principles and states explicitly that this is your responsibility. You are expected to put into place comprehensive but proportionate governance measures. Good practice tools that the ICO has championed for a long time such as privacy impact assessments and privacy by design are now legally required in certain circumstances<br><br>It is recommended that you implement appropriate technical and organisational measures that ensure and demonstrate that you comply. This may include internal data protection policies, staff training, internal audits of processing activities and reviews of internal HR policies.<br><br>Ultimately, these measures should minimise the risk of breaches and uphold the protection of personal data. Practically, this is likely to mean more policies and procedures for organisations, although many organisations will already have good governance measures in place. | ● Created Data Protection Impact Assessment template<br>● Reviewed relevant policies<br>● Maintained Data Protection Officer role<br>● Data Security and Protection Regulation (DSPR) completion<br>● Continued cyber security testing and audit<br>● Implemented tighter organisational security and confidentiality measures and controls |
| **Information We Hold**<br>You must maintain internal records of processing activities. You should document what personal data you hold, where it came from and who you share it with. You may need to organise an information audit across the organisation or within particular business areas to identify the data that you process and how it flows into, through and out of the organisation. The GDPR updates rights for a networked world.<br><br>You must maintain additional internal records of your processing activities. There are some similarities with 'registrable particulars' under the DPA which must be notified to the ICO. | ● Data mapping exercise carried out on an annual basis<br>● Data mapping template reviewed to ensure compliance with GDPR, amalgamted with corperate and clinical record inventory<br>● Information Asset register and associated documents completed 2017/18. To be reviewed when rolled out for 2018/19 |
| **Communicating Privacy Information**<br>You should review your current privacy notices and put a plan in place for making any necessary changes in time for GDPR implementation.<br><br>The information you supply about the processing of personal data must be concise, transparent, intelligible and easily accessible; written in clear and plain language, particularly if addressed to a child; and free of charge. | ● Privacy notices for patients, staff and Foundation Trust members ratified by the Data and Information Governance Steering Group (DIGSG) |
| **Individuals' Rights**<br>You should check your procedures to ensure they cover all the rights individuals have, including how you would delete personal data or provide data electronically and in a commonly used format. | ● Relevant policies reviewed |
| **Subject Access Requests**<br>You should update your procedures and plan how you will handle requests within the new timescales and provide any additional information. | ● Application form amended<br>● Relevant services informed of reduced timescales and removal of payment<br>● Relevant policies and procedures amended<br>● Information on Trust web site amended<br>● July 2017 Management Accounts and Finance informed |
| **Lawful Basis for Processing Personal Data**<br>You should look at the various types of data processing you carry out, identify your lawful basis for carrying it out and document it.<br><br>You have to explain your lawful basis for processing personal data in your privacy notice. The lawful bases in the GDPR are broadly the same as those in the DPA so it should be possible to look at the various types of data processing you carry out and to identify your lawful basis for doing so. You should document this in order to help you comply with the GDPR's 'accountability' requirements. | ● Data mapping template includes lawful basis for processing<br>● Sharing agreement and template amended in line with GDPR<br>● NHS Contract clauses have been amended to cover GDPR |
| **Consent**<br>You should review how you seek, record and manage consent and whether you need to make any changes. Refresh existing consents now if they don't meet the GDPR standard. | ● Where consent used the process has been reviewed to ensure explicit consent where appropriate<br>● Services who previously used 'opt out' will now use 'opt in' |
| **Children**<br>You should start thinking now about whether you need to put systems in place to verify individuals' ages and to obtain parental or guardian consent for any data processing activity.<br><br>You must ensure that you write your privacy information (such as your privacy notice) in a clear, plain way that a child will understand. | ● Privacy notices written in plain English |
| **Data Breaches**<br>You should make sure you have the right procedures in place to detect, report and investigate a personal data breach. | ● Risk Management aware of reduced timescales, exploring options for Datix<br>● Review of relevant policies |
| **Data Protection By Design And Data Protection Impact Assessments**<br>As part of a data protection by design approach, the GDPR requires organisations to conduct data protection impact assessments (DPIAs) in specific circumstances. DPIAs are a tool which can help you identify the most effective way to comply with your data protection obligations and meet individuals' expectations of privacy. An effective DPIA will allow you to identify and fix problems at an early stage, reducing the associated costs and damage to reputation which might otherwise occur. | ● DPIA template created and shared with senior IT Team, Head of IMT Projects and Business Development<br>● IG Manager completed PIA training<br>● SIRO and DPO are member of IMT Steering Group and EPR Board |
| **Data Protection Officer**<br>You should designate someone to take responsibility for data protection compliance and assess where this role will sit within your organisation's structure and governance arrangements. You should consider whether you are required to formally designate a Data Protection Officer. | ● Confirmation of no conflict of interrest<br>● DPO role maintained<br>● Relevant training completed |
| **International**<br>If your organisation operates in more than one EU member state (i.e. you carry out cross-border processing), you should determine your lead data protection supervisory authority. Article 29 Working Party guidelines will help you do this. | N/A |

## Proposed Adult Community Services metrics

| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Community Care Teams - patient contacts**  | The chart shows the number of face to face patient contacts for the community care teams. |   | There were 10,400 face to face patient contacts in April. During 2017/18, there were a number of restructures of the teams within these services and a reduction to baseline contracted establishment as the Vanguard work came to an end. This will have impacted upon the activity levels recorded over this period. Therefore caution should be exercised when reviewing the trend over time. |
| **Safety thermometer - harm free care - Community Care Teams**  | 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. A high score is good. Whilst there is no nationally defined target for this measure, a score of 95% or above is considered best practice. |   | The harm free percentage for April was 92.2%, remaining below 95% and a reduction on last month. The majority of harms reported this month were old pressure ulcers. |
| **OPEL level - Community Care Teams**  | The OPEL (Operational Pressures Escalation Level) is a measure of operational pressure being experienced by the community care teams. A value of 1 to 4 is agreed each day, with 1 denoted the lowest level of operational pressure and 4 denoting the highest. The chart shows the average level reported by adult community services during the month. | **to be added** | The Trust has been using the OPEL measure for community services since November 2017. This has been shared within the Trust on operational reports each day. Going forward, the information will be recorded and retained in a database so that we can report on the trend over time. |
| **Friends & Family Test (FFT) - Adult community services**  | 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 adult community services including specilait nurisng teams, community care teams, community podiatry and GP OOH. A high percentage is good. |   | 94.3% of patients surveyed in April would recommend our services. 180 patients from adult community services responded to the survey this month. This is lower than the normal monthly average of around 400 responses due to a problem with the automated phone call surveys which was rectified in mid-April. The data for March 2018 is not included as there were very few responses from community services due to this issue. |

## Proposed additional metrics

| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Stranded patients**  | This indicator shows the average number of patients that were in the hosptital with a length of stay ove ofever 7 days (defined as stranded patients by NHS Improvement) or over 21 days (super-stranded patients).<br>A low number is good. |   | The number of stranded and super-stranded patients at HDFT has reduced in April. However we are still identified as an outlier when compared to other local Trusts. |

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| | | | |
|---|---|---|---|
| **Date of Meeting:** | 30 May 2018 | **Agenda item:** | 9.0 |
| **Report to:** | Board of Directors | | |
| **Title:** | Report by the Director of Workforce and Organisational Development | | |
| **Sponsoring Director:** | Mr Phillip Marshall, Director of Workforce and Organisational Development | | |
| **Author(s):** | Mr Phillip Marshall, Director of Workforce and Organisational Development | | |
| **Report Purpose:** | **Decision** | | **Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓ |
| **Executive Summary:** | • The results of the Q4 Staff Friends and Family Test have been analysed<br>• Local Clinical Excellence Awards have been made to 19 Trust Consultants<br>• An update on progress with the Clinical Workforce Strategy shows considerable progress, with some challenges | | |

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

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

**Action Required by the Board of Directors:**

**The Board of Directors is requested to:**

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

### a) Sickness Absence

The overall sickness absence rate across the Trust for March 2018 was 4.51% which is a decrease from February of 0.17%. The Trust is currently 0.61% above the overall Trust target of 3.9%.

Looking at the overall sickness and the split between short and long-term sickness absence for the last three months, (December, January and February) there had been an increase in short-term sickness and this has continued during March. Short-term sickness absence is 2.38% and long-term sickness absence stands at 2.13%. There has been a decrease in absence rates across three of the four Directorates, including Corporate Service 1.98%, Long Term and Unscheduled Care 4.36% and Planned and Surgical Care 4.84%. Children's and Countywide Community Care showed an increase in March to 4.93%. The main reason for short-term absence within all four Directorates is attributed to cold and flu, and gastro reasons, and the top reasons for long- term sickness absences are anxiety/stress and musculoskeletal problems.

The key focus currently is on short-term sickness; however, long-term sickness absence continues to be managed by consistently working with management across the Trust to help support a reduction in absence rates. This is being done by managing absence in accordance with the Managing and Promoting Health and Wellbeing policy and actively creating action plans to support employees back into work. The HR team is trying to pro-actively support the reduction of short-term absence including the roll-out of an absence crib sheet, regular attendance at management meetings and ongoing research into other effective solutions that could potentially be implemented in the Trust.

### b) Recruitment of Non-Executive Directors

Late last year two Non-Executive Directors indicated that they would be leaving the Board of Directors during 2018. Mr Neil McLean has relocated to the south of England and therefore would not be available to attend the Trust on a regular basis. Mr Ian Ward, the Senior Independent Director, would not renew his membership of the Board at the expiry of his second term of three years, in early autumn.

The appointment of Non-Executive Directors is a responsibility of the Council of Governors and the timetable and details of the process were agreed at a meeting held on 3 January. A wide range of media was used to publicise the vacancies and applications closed on 23 February. Ninety-nine applications were received and a long-listing by the Nominations Committee reduced this to a list of 23, which was considered in-committee on 13 March.

Six candidates were short-listed for interviews, which were held on 9 April. Candidates discussed relevant issues with two focus groups, comprised of Governors and staff, and were then interviewed formally by the Nominations Committee. Following this two preferred candidates were selected for the appointments, subject to satisfactory completion of pre-employment checks and approval by the Council of Governors. Mr Richard Stiff's appointment was confirmed by the Council of Governors at their meeting on 2 May. The second preferred candidate is in the process of completing their pre-employment checks and the Council of Governors will consider the approval of this appointment at their next meeting on 1 August.

### c) Staff Friends and Family Test Report: Quarter 4

The Staff Friends and Family Test (SFFT) is a staff engagement activity that offers staff the opportunity to speak up and to provide them with the confidence to do so, to ensure that their views are heard and acted upon.

The HDFT SFFT for Quarter 4 was open from 19 February to 9 March 2018, with 4051 staff being invited to partake in the process and 686 choosing to engage in the process, 17% of those invited. This was a 7% point decrease from Q2, equating to a reduction of 381 respondents. There were some IT infrastructure issues within the Children's Services community teams in particular, which negatively impacted on their ability to access the Staff Friends and Family Test and to therefore contribute to the feedback for Q4. This impacted on the reduction in response rate from Q2.

As is normal, two questions are posed to staff:-

*Would you recommend the Trust as a place to receive care or treatment?*

The results highlight that 83.2% of the staff who responded would be likely to recommend care or treatment at HDFT to their family and friends if they needed care or treatment (this is a 0.5% point decrease from Q2). It is evident from the results that the fundamental reasons for staff recommending HDFT as a place for treatment or care are due to the professional, compassionate staff who are committed to providing high standards of care, the friendliness experienced in locations where the Trust provides services and their personal experience of receiving care at HDFT.

The percentage of staff who responded who are unlikely to recommend HDFT to their friends or family for care or treatment is 5.8% (this is a 0.4% increase from Q2).

The results identify that of those staff who would not recommend treatment or care at HDFT were primarily concerned with perceived unsafe staffing levels that staff believe pose a safety risk; this was followed by respondents not living in the local area and HDFT therefore not being a feasible option for them.

*Would you recommend the Trust as a place to work?*

Of the staff who responded, 65% would recommend HDFT as a place to work (this is a 0.3% point increase from Q2).

The most significant reason for staff recommending HDFT as a place to work was due to the strong sense of teamwork and support within services, some describing HDFT as a friendly and enjoyable place to work where they feel valued and listened to by a supportive management team.

In terms of those who would not recommend HDFT as a place to work, a significant number of respondents were concerned about perceived unsafe staffing levels, their unmanageable workloads, the support available from their line manager and the resultant impact on their stress levels, wellbeing and job satisfaction.

There was a 2.2% point increase since Q2 in the number of staff that would be unlikely to recommend the Trust as a place to work.

There is a continuing theme from the survey results with regards to comments about staffing levels and the resultant impact on safety and staff wellbeing. These comments have been shared at the Senior Management Team meeting.

A Staff Engagement action plan for 2018/19 has been developed to identify the key areas for focus from the National Staff Survey and the key themes from the Staff Friends and Family Test results. It is planned to link this feedback to the Directorates at a local level as well as using other key work streams, such as Health & Wellbeing, to identify actions that would make a difference to staff.

### d) Consultants' Clinical Excellence Awards

The Clinical Excellence Local Awards Committee met on 18 and 23 April 2018 to discuss the submissions in respect of Consultants' Clinical Excellence Awards for 2017.

No applications were received from Associate Specialists for Discretionary Points or from Senior Staff Practitioners for Optional Points**.**

**Clinical Excellence Awards**

Forty-one applications were received and 19 Consultants were granted an award as follows:

| Consultant | Specialty | Now at Level |
|---|---|---|
| Mr M Adelekan | General Surgery | 1 |
| Dr V Barros D'Sa | Palliative Care | 1 |
| Dr R Buccoliero | Neurology | 2 |
| Dr J Child | Respiratory | 2 |
| Dr T Collyer | Anaesthetics | 4 |
| Dr A Culverwell | Radiology | 2 |
| Dr G Davies | Gastroenterology | 8 |
| Dr D Earl | Anaesthetics | 6 |
| Dr D Fascia | Radiology | 1 |
| Dr C Hall | Haematology | 8 |
| Dr S Holbrook | Anaesthetics | 1 |
| Dr C Lawson | Rheumatology | 3 |
| Mrs S Mackenzie | Ophthalmology | 3 |
| Dr H Moss | Radiology | 9 |
| Dr W Peat | Anaesthetics | 3 |
| Mr E Powell-Smith | Trauma and Orthopaedics | 1 |
| Dr K Scott | Microbiology | 2 |
| Dr J Smith | Acute Medicine | 4 |
| Dr G Walters | Ophthalmology | 8 |

The Trust is grateful to the Local Negotiating Committee (LNC) and the medical staff body generally, for their agreement to defer the 2017 award date to 1 October 2017.

This has enabled a non-recurrent saving to be made. Copies of applications from some consultants that received an award have been shared (with their consent) with consultants that did not receive an award in order to assist with improving future applications.

A new system for local CEAs will be introduced for 2018 and future years following national agreement. We will shortly commence engagement with the LNC on how this will operate and more details will be shared with all consultant colleagues in due course.

### e) Job Planning

| APRIL 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 | 100.00% | |
| LT & UC | 55 | 43 | 78.18% | 10 | 18.18% | 2 | 3.63% | 1 | 83.63% | |
| P & SC | 68 | 36 | 52.94% | 30 | 44.12% | 2 | 2.94% | 0 | 71.01% | |
| **Total** | **135** | **91** | **67.41%** | **40** | **18.38%** | **4** | **2.94%** | 0 | **76.68%** | |

| APRIL 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 | 6 | 100.00% | 0 | 0.00% | 0 | 0.00% | 3 | 33% | |
| LT & UC | 10 | 4 | 40.00% | 6 | 60.00% | 0 | 0.00% | 0 | 41.67% | |
| P & SC | 37 | 16 | 43.24% | 6 | 16.22% | 15 | 40.54% | 0 | 38.88% | |
| **Total** | **53** | **26** | **49.06%** | **12** | **22.64%** | **15** | **28.30%** | 0 | **38.89%** | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Excludes locums, maternity leave, bank; new starters u/6 months | **Change from previous month (current JPs)** | **Improved** | | **No change** | | **Worse** | | | | |

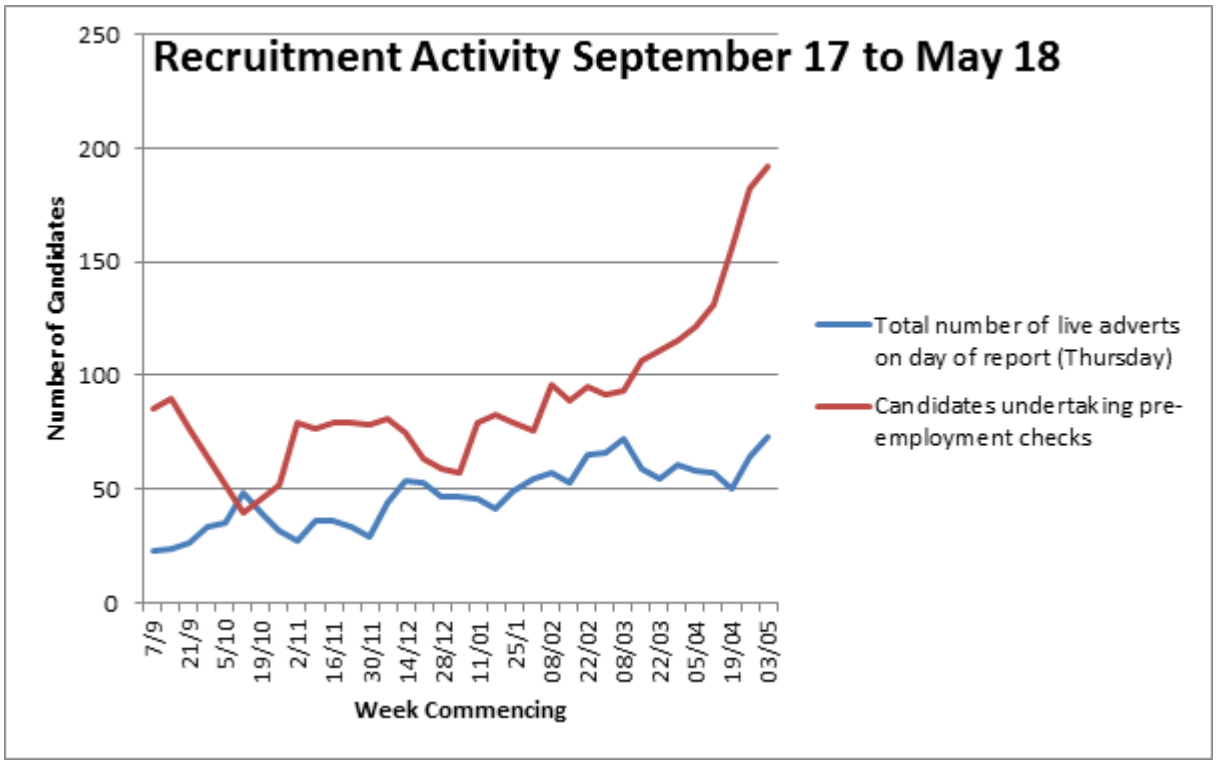
The April job planning figures (shown above) show a concerning reduction in the number of Consultants with current job plans, although some of these are no more than a month out of date. The position for SAS doctors has, however, shown an improvement overall, driven by completion of all SAS doctor job plans in the Children's and County Wide Community Care Directorate and a slight improvement in Planned and Surgical Care (P&SC). The job planning summit with P&SC took place on 19 April. Future arrangements for job planning using the NHS Improvement guidance and a revitalised Job Planning Policy will be discussed with the Local Negotiating Committee in July.

### f) Personal Resilience

As part of a continuing focus on Health and Wellbeing, the Trust launched a Building Personal Resilience training programme for Medical Students and HDFT staff in April 2018. The training demonstrates a range of techniques designed to enhance psychological health, personal resilience, and general life effectiveness and has shown clinically significant improvements in individual's mental health when it was piloted at Northumbria Healthcare NHS Foundation Trust. It has proved very popular with Trust staff with numerous cohorts already fully booked; in the first week alone the e-mail inbox received approximately 60 enquiries. Dates specifically targeted at medical student placements will start from September and information is being circulated via Leeds University Medical School. Forthcoming dates are advertised on the Personal Resilience page on the Trust's Intranet.

### g) Recruitment Update – Factual References

Since the introduction of Trustwide recruitment controls in August 2017 the recruitment team has been monitoring activity on a weekly basis. Recently, this reporting has highlighted unprecedented levels of recruitment activity. The most concerning of these metrics relates to the number of candidates being processed for pre-employment checks, this has traditionally been around 70 candidates but is currently running around 200 candidates. The graph below gives an indication of current level of activity and how these have increased since September 2017.




Timely recruitment is a key factor in ensuring that the Trust has appropriate staffing levels in place to maintain sustainable services. Earlier this year, in order to continuously improve the productivity and efficiency of the recruitment process a new process for internal candidates was introduced. This included a streamlined approach to pre-employment checks, including the use of factual references.

Across the region, and in fact nationally, there is a focus on progressing the streamlining agenda for all elements of workforce information. A number of local Trusts (including Leeds and Barnsley) operate factual references for external candidates as part of the recruitment process. With effect from 7 May the recruitment team has rolled out the use of factual references for all recruitment campaigns, including external candidates. Factual references will include employment dates, sickness information and employee relations information. Managers will still be asked to approve the factual reference and will have the opportunity to seek further information personally should they feel this is necessary.

The monitoring of recruitment activity will continue on a weekly basis; this information will continue to be used to support further improvements in systems and processes within the recruitment team.

**f) Clinical Workforce Strategy Action Plan Update**

*'Excellent care every time, delivered by an excellent workforce where every contact counts'*

In May of last year the Workforce & Organisational Development team launched the five-year Clinical Workforce Strategy with a focus on:

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 and Efficiency – create a sustainable, permanent workforce; improve staff retention and resilience

A year on we are in the process of reviewing 'the story so far!' against these key strategic goals and considering the current risks and challenges as we move into year two of planning and implementation.

Significant work is underway to provide solutions to the workforce challenges being presented at both national and local levels. This includes:

- The approval to recruit our second cohort of four trainee Advanced Clinical Practitioners. They are to be placed in our Clinical Assessment Team and in our Emergency Department, which is the area where we have the highest overspend in Doctor in Training costs to support weekend rotas
- Our first cohort of 12 apprentice Nurse Associates, who are based on our in-patient ward areas. We are proud to report that we were able to recruit nine of these apprentices from our existing Health Care Assistant workforce, providing career development opportunities and support our desire to 'grow' our own workforce
- Additional roles, including Physicians Associates (placements in September supported by Health Education England funding to demonstrate the impact of the role). Apprentice schemes in both Pharmacist and Pharmacy Technician roles are being developed with potential for further ward skill-mix review
- The recruitment of our first cohort of apprentice Health Care Assistants, based on our inpatient wards, providing entry level roles and a career pathway in NHS healthcare
- Work has been undertaken with three of our local Universities to develop a Harrogate Pathway pre-registration nursing degree programme, which will ensure that we have a guaranteed supply of registered nurses upon qualification
- We have reduced the agency/locum spend for specialty doctors and associate specialists (SAS doctors) by 42.2% (equating to £863,000) from 2015/16 spend by successfully recruiting to permanent roles and by the introduction of an innovative rotation and development programme.

Alongside the good news and positives, there have also been some increasing challenges and cost pressures that have arisen during the first year of the deployment of our Clinical Workforce Strategy, including:

- Due to escalating service demands and also reflecting the national challenges of shortages in the supply of Registered Nurses, our temporary spend on agency nurses and health care assistants has increased significantly

The next step for the development of the Clinical Workforce Strategy is to take the key messages from year one to each Clinical Directorate and to review this and to plan for year two (with a line of sight to years three to five) and to consider strategic and operational approaches to meeting both the existing and emergent workforce challenges. Workshops to address these are taking place during May and early June, with an overarching 'summary and review' session being held with the Leadership Forum on 22 June.

A more comprehensive report will therefore be available for the June 2018 Board Report.

**P Marshall**
**Director of Workforce and Organisational Development**
**May 2018**

Harrogate and District
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Date of Meeting:** | 30 May 2018 | **Agenda item:** | 10.1 |
| **Report to:** | Board of Directors | | |
| **Title:** | Annual Patient Experience Report | | |
| **Sponsoring Director:** | Jill Foster, Chief Nurse | | |
| **Author(s):** | Melanie Jackson, Patient Safety Manager<br>Andrea Leng, Head of Risk Management | | |
| **Report Purpose:** | **Decision** | | **Discussion/ Consultation** | | **Assurance** | ✓ | **Information** | ✓ |
| **Executive Summary:** | • Please note the issues highlighted in the executive summary enclosed | | |

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

| **Key implications** | |
|---|---|
| **Risk Assessment:** | None identified. |
| **Legal / regulatory:** | None identified |
| **Resource:** | None identified |
| **Impact Assessment:** | Not applicable |
| **Conflicts of Interest:** | None identified. |
| **Reference documents:** | None |
| **Assurance:** | Report reviewed at LPEG on 16 May 2018 |

**Action Required by the Board of Directors:**

It is recommended that the Board/Committee notes items included within the report

# Patient Experience Report
# Quarter 4
# 2017/2018

## Contents

## 1. Executive Summary

This is the quarter 4 patient experience report and will be presented to the Learning from Patient Experience Steering Group and Quality Committee. We have changed the format since the last report to look at trends of complaints and concerns in a different way. Comments are welcomed regarding content and presentation.

The key points to note are:

- 60 complaints received in Q4 (48 in Q3) and 100% were acknowledged within three working days.
- The response rate in Q4 was the highest it has been all year at 63% against a target of 95%. It is noted that the winter pressures have continued to have an impact on the response rate with staff prioritising clinical work. A programme of training has been undertaken with the Directorates to increase the number of Lead Investigators in each Directorate. A total of 46 staff were trained across the three Clinical Directorates and Corporate.
- The % of complaints upheld in Q4 at the time of the report remains steady at 63%. The themes of those complaints upheld are communication, clinical care / treatment, Trust policies / procedures, medication / pain relief, non-clinical facilities, cancellation of operation and consent issues
- 13% of the complaints in Q4 originated from concerns that the PET handled initially and tried to resolve outside of the complaints process.
- The total number of contacts dealt with informally as PALS contacts by the PET in Q4 is 248.
- One new PHSO request was received in Q4. The PHSO is currently reviewing the complaint file in order to make a decision about whether to investigate. Of all the cases that have been referred to the PHSO since 2016/17 (10 cases) none have been upheld. This is very positive news and indicates that our complaints investigation process is thorough and robust.
- The number of new actions in Q4 delivered to deadline is 54% so far. Year to date we are only averaging 44% of actions delivered to deadline. This is significantly short of our target of 100%. The Directorates have been asked to ensure realistic target dates are identified at the point of setting the action and also to look at processes for reviewing progress against actions. All actions for 2015/16 are now closed and the Directorates are asked to work on making progress against those actions still open from 2016/17.
- Throughout the year there has been some key learning and changes to process as a result of complaints. These include development of policy and processes to ensure we are acting in line with the Gender Recognition Act, review and improvements to the Out of Hours urgent helpline for the district nursing team and the introduction of a weekend advice line for high risk diabetic patients.
- In keeping with previous years the top locations throughout 2017/18 are Outpatients, ED and CATT Ward. The top 10 are the same as last year with the exception of Byland Ward and Orthopaedic Outpatients which do not feature this year. Instead Theatres and Endoscopy Unit now fall into the top 10 for 2017/18. The complaints where the location was theatres do not reflect the care given by theatre staff, they are related to the clinical outcome from surgery. The complaints about Endoscopy reflect the care delivered in the unit.
- The top specialities in 2017/18 are Trauma and Orthopaedics and ED which are the same as last year. However new specialties of Health Visiting, Endoscopy, Ophthalmology feature this year for the first time. No recurring themes have been identified.
- Communication and attitude are amongst the top subjects complained about in 2017/18 again. Discharge arrangements and discharge too early feature in the top 10 sub subjects for the year - they did not feature last year.
- The number of comments received has fallen in Q4 (61 in Q3 to 33 in Q4). The majority of comments are left via the comment form box at the main reception to Harrogate Hospital. We know that feedback is being given through a number of different routes including twitter and direct to Matrons with the introduction of their extended working hours. These are not captured by the Patient Experience Team. The development of a Patient Experience POD in the main entrance of the hospital is expected to be completed later in the summer which will provide a focal point for patients and visitors to the Trust.
- 116 formal compliments were received in Q4 which has doubled from Q3. 46% of the compliments were about communication & attitude, 22% regarding the clinical care received and 22 % related to the efficiency of the service.

## 2. Patient and Public Involvement (Including FFT)

## NATIONAL PATIENT SURVEYS

**Summary of national patient survey results**

The following detail regarding published results for National Surveys has been included in the 2017/18 Quality Account.

**Emergency Department Survey 2016**

Results from the National ED Survey 2016 were published on the CQC website in October 2017. As expected from the initial Picker results, performance for HDFT was excellent and the Trust was identified as performing 'better' than expected compared to other trusts. This was because a higher proportion of patients responded positively about the care they had received. This is a brilliant result for the staff in the department.

**Children & Young People's Inpatient & Day Case Survey 2016**

Results from the National Children & Young People's Survey 2016 were published on the CQC website in November 2017. We performed better than other Trusts on four questions, and worse on three questions.

Questions on which we performed better:

- Did you like the hospital food?
- Did the hospital staff answer your questions?
- Before the operations or procedures, did hospital staff explain to you what would be done?
- Before your child had any operations or procedures did a member of staff explain to you what would be done?

Questions on which we performed worse:

- Did members of staff treating your child communicate with them in a way that your child could understand?
- When you left hospital, did you know what was going to happen next with your care?
- When you left hospital, did you know what was going to happen next with your child's care?

A multidisciplinary workshop was held with staff to review the results and pull together an action plan to address the areas for improvement.

**National Cancer Survey 2016**

The National Cancer Patient Experience Survey 2016 is the sixth iteration of the survey first undertaken in 2010. In all surveys we have been one of the top performing Trusts in the country. The consistency of such attainments provides us with assurance regarding the sustained provision of high quality cancer care.

Asked to rate their care on a scale of zero (very poor) to 10 (very good), respondents gave an average rating of 9.0. The following questions are also included in phase 1 of the Cancer Dashboard developed by Public Health England and NHS England:

- 84% of respondents said that they were definitely involved as much as they wanted to be in decisions about their care and treatment
- 97% of respondents said that they were given the name of a Clinical Nurse Specialist who would support them through their treatment

- 93% of respondents said that it had been ‘quite easy’ or ‘very easy’ to contact their Clinical Nurse Specialist
- 88% of respondents said that, overall, they were always treated with respect and dignity while they were in hospital
- 96% of respondents said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital.
- 64% of respondents said that they thought the GPs and nurses at their general practice definitely did everything they could to support them while they were having cancer treatment.

For some cancer sites the report does not provide any site specific data regarding quality of the service. i.e. sites with less than 20 respondents, or where we only provide diagnostic facilities, or in the case of skin cancer where treatment is provided as an outpatient procedure. We have no reason to believe that these results would not be replicated due to culture and approach to cancer care across the Trust; however we cannot be complacent and local methods of gaining service user views are therefore being implemented for these areas.

**National Maternity Survey 2017**

Results from the National Maternity Survey 2017 were published on the CQC website in January 2018. Our 2017 banding compared to the ‘expected range’ is better for 5 questions and as expected for all others. The questions where we performed better than expected are:

- Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?
- Thinking about your care during labour and birth, were you treated with respect and dignity?
- Did you have confidence and trust in the staff caring for you during your labour and birth?
- Would you have liked to have seen a midwife…
- Did a midwife tell you that you would need to arrange a postnatal check-up of your own health with your GP? (Around 6-8 weeks after the birth)

Our performance has worsened since the 2015 survey on 4 questions:

- Were you offered any of the following choices about where to have your baby?
- During your antenatal check-ups, did the midwives appear to be aware of your medical history?
- Did the midwife or midwives that you saw appear to be aware of the medical history of you and your baby?
- Were you given information or offered advice from a health professional about contraception?

Our performance has improved since the 2015 survey on 2 questions:

- Did you have confidence and trust in the staff caring for you during your labour and birth?
- In the six weeks after the birth of your baby did you receive help and advice from a midwife or health visitor about feeding your baby?

**Current National Surveys**

- National Inpatient Survey 2017 – awaiting CQC publication of results
- National Cancer Survey 2017 – awaiting publication of results by Quality Health
- National Maternity Survey 2018 – sampling

**Upcoming National Surveys this year**

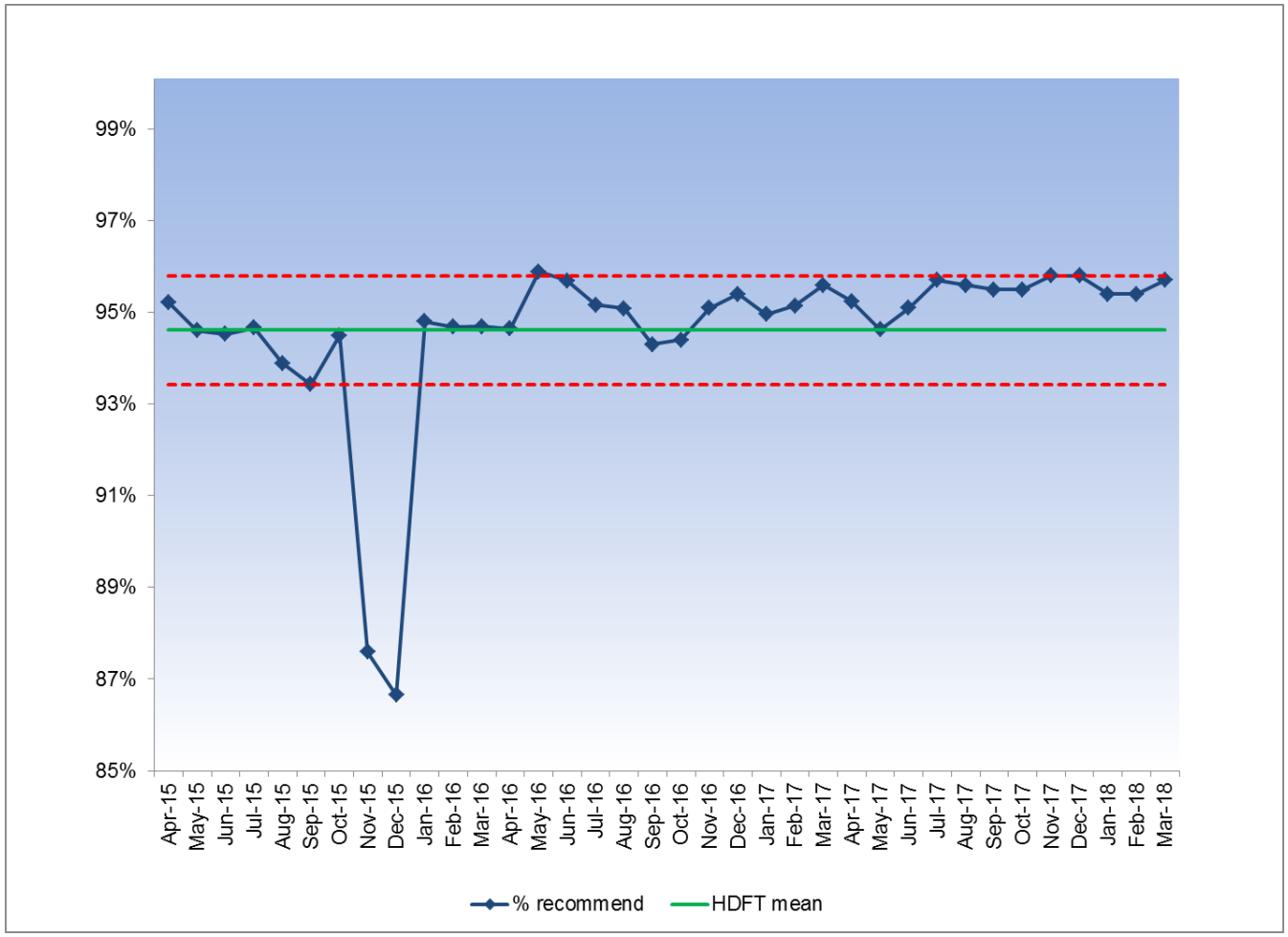
- National Inpatient Survey 2018
- National Cancer Survey 2018
- National Emergency Department Survey 2018

## Friends and Family Test (FFT)

The FFT methodology is in place for inpatients, Emergency Department, Maternity Services, Outpatients, Day Surgery and Community Services. Further work is being undertaken to implement for children's services. The processes for collecting data vary depending on the service but involve paper questionnaires with results entered into a database by volunteers, and an automated process for telephone calls to patients following a contact with some services.

| | | 2017/18 | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Service** | | **Q1** | **Q2** | **Q3** | Jan 2018 | Feb 2018 | Mar 2018 | **Q4** |
| **Inpatients incl. Day Cases** | Recommend % | **96.76 %** | **96.96 %** | **96.82 %** | 95.73 % | 97.76 % | 97.77 % | **97.07 %** |
| | Not recommend % | **0.97 %** | **0.77 %** | **1.04 %** | 1.15 % | 0.48 % | 1.30 % | **0.96 %** |
| | Resp. Rate % | **24.80%** | **24.49%** | **24.26%** | 22.94% | 25.24% | 22.99% | **23.72%** |
| | Inputted Resp. | **1760** | **1680** | **1730** | 609 | 625 | 539 | **1773** |
| **Inpatients** | Recommend % | **97.51 %** | **96.75 %** | **96.85 %** | 95.22 % | 97.74 % | 97.86 % | **97.08 %** |
| | Not recommend % | **0.48 %** | **0.94 %** | **1.16 %** | 0.96 % | 0.75 % | 0.71 % | **0.80 %** |
| | Resp. Rate % | **20.60%** | **19.47%** | **18.21%** | 12.00% | 16.21% | 16.36% | **14.82%** |
| | Inputted Resp. | **1044** | **955** | **952** | 209 | 265 | 280 | **754** |
| **Day Cases** | Recommend % | **95.67 %** | **97.24 %** | **96.79 %** | 96.00 % | 97.78 % | 97.68 % | **97.06 %** |
| | Not recommend % | **1.68 %** | **0.55 %** | **0.90 %** | 1.25 % | 0.28 % | 1.93 % | **1.08 %** |
| | Resp. Rate % | **35.29%** | **37.10%** | **40.86%** | 43.76% | 42.81% | 40.92% | **42.67%** |
| | Inputted Resp. | **716** | **725** | **778** | 400 | 360 | 259 | **1019** |
| **Outpatients/ Ward Attenders** | Recommend % | **94.97 %** | **95.27 %** | **95.65 %** | 95.35 % | 95.48 % | 97.41 % | **95.46 %** |
| | Not recommend % | **1.60 %** | **1.55 %** | **1.68 %** | 1.76 % | 1.48 % | | **1.59 %** |
| | Resp. Rate % | **28.41%** | **29.88%** | **30.02%** | 32.03% | 32.53% | 29.07% | **32.21%** |
| | Inputted Resp. | **8272** | **8075** | **7447** | 3012 | 2967 | 116 | **6095** |
| **Emergency Department incl. MIUs** | Recommend % | **91.00 %** | **92.73 %** | **90.97 %** | 93.81 % | 91.61 % | 89.33 % | **91.80 %** |
| | Not recommend % | **3.60 %** | **2.66 %** | **3.97 %** | 4.42 % | 4.52 % | 5.14 % | **4.66 %** |
| | Resp. Rate % | **6.04%** | **5.53%** | **5.71%** | 10.36% | 10.73% | 7.26% | **9.35%** |
| | Inputted Resp. | **611** | **564** | **554** | 339 | 310 | 253 | **902** |
| **Maternity** | Recommend % | **98.25 %** | **99.25 %** | **97.42 %** | 98.23 % | 95.79 % | 97.42 % | **97.21 %** |
| | Not recommend % | **0.29 %** | | **0.49 %** | 1.33 % | 2.63 % | 1.03 % | **1.64 %** |
| | Resp. Rate % | **30.63%** | **27.82%** | **36.08%** | 31.92% | 29.73% | 27.79% | **29.83%** |
| | Inputted Resp. | **686** | **670** | **815** | 226 | 190 | 194 | **610** |
| **Community** | Recommend % | **93.89 %** | **94.59 %** | **95.12 %** | 94.51 % | 93.81 % | 100.00 % | **94.23 %** |
| | Not recommend % | **1.61 %** | **1.59 %** | **1.78 %** | 2.00 % | 2.17 % | | **2.06 %** |
| | Resp. Rate % | **19.18%** | **24.14%** | **26.19%** | 26.77% | 22.62% | 7.69% | **24.45%** |
| | Inputted Resp. | **1736** | **942** | **901** | 401 | 323 | 4 | **728** |

**Overall**




The chart shows the overall score (% who would recommend the service) for all HDFT services currently participating in the FFT survey.

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%).

There were various technical problems with the automated phone call service between December 2015 and August 2016 which impacted on response rate and results. Issues were resolved in August 2016 and phone calls reinstated to all services that were previously using them. However during March 2018 around 1,100 patients responded to the survey. This is significantly lower than the normal monthly average of around 4,000 responses and is due to another problem with the automated phone call surveys during March. Work is underway with the supplier of this service to understand and resolve these issues.

## Patient Information

There is a process for developing new patient information leaflets that includes clear guidance about content, format and readability and this is evaluated by our volunteer lay reader panels. The lay readers are sent draft patient information leaflets and asked to review these against some specific standards and to return any comments and suggestions for improvement. The author is expected to consider the feedback and use this to develop the final draft. Due to issues with the final approval process, in December, the Senior Nurse/ Matrons team undertook an exercise to catch up with a back log of leaflets awaiting approval resulting in a large number of leaflets being given final approval.

Between 01/01/18 and 31/03/18, 19 leaflets were sent for reader testing however due to continuing issues with the final approval process, no patient information leaflets were given final approval between these dates.

| Patient Information Leaflet | Author | Department | Date to reader panel |
|---|---|---|---|
| Learning disability service leaflet (tri-fold) | Ben Haywood | L&D | 05/01/2018 |
| Learning disability service (A5) | Ben Haywood | L&D | 05/01/2018 |
| How to collect and store a urine sample | Lynn Briggs | NHS Choices website | 05/01/2018 |
| Information Session appointment | Michael Richards | Pharmacy | 05/01/2018 |
| Bowel prep for people with diabetes requiring bowel prep for lower endoscopic investigations - afternoon | Dr Kathryn Johnson | | 17/01/2018 |
| Bowel prep for people with diabetes requiring bowel prep for lower endoscopic investigations - morning | Dr Kathryn Johnson | | 17/01/2018 |
| mastectomy and lymph node biopsy | l Groves & Aniamma Abraham | staff nurse private patients | 23/01/2018 |
| Pilot urolift | l. Groves & Aniamma Abraham | staff nurse private patients | 23/01/2018 |
| Eyelid surgery | Dr Mustafa Yusuf , Sarah Mackenzie2 | Ophthalmology | 26/01/2018 |
| Removal of eyelid lumps | Dr Mustafa Yusuf , Sarah Mackenzie2 | Ophthalmology | 26/01/2018 |
| Ferinject | Emma Harris | Consultant Haematologist | 22/02/2018 |
| Instructions following oral surgery | Emma Bolland | Dental Nurse | 22/02/2018 |
| pain after surgery | heather lain | Acute Pain | 22/02/2018 |
| Chalazion removal | Dr Mustafa Yusuf , Sarah Mackenzie2 | Ophthalmology | 22/02/2018 |

| Patient Information Leaflet | Author | Department | Date to reader panel |
|---|---|---|---|
| Diastasis Rectus Abdominus (DRA) | Jenny Dawson | Physio | 22/02/2018 |
| DLBCL - previously treated large B cell lymphoma | Lesley Wright | Macmillan haem nurse | 22/02/2018 |
| Guide to admin of subcutaneous meds (palliative care) | Kath Lambert | Palliative med | 22/02/2018 |
| Pelvic organ prolapse | Caroline Bilmen | Physio | 22/02/2018 |
| Care of wound drains following breast surgery | Aniamma Abraham | Staff nurse private patients | 22/02/2018 |
| Asthma wheeze | SJ Foxton/ Ros Parkinson | Pead Resp nurse | 15/03/2018 |
| Diabetes having chemo with steroids | Dr Kathryn Johnson | Diabetes nurse | 15/03/2018 |
| Learning disability service leaflet (tri-fold) | Ben Haywood | L&D | 05/01/2018 |

Once approved and uploaded it is the responsibility of the author to review their resource on the intranet to ensure that it is accurate and contains up to date information. On 03/05/18 there were 564 documents uploaded to the Information for Patients section of the intranet. Of the 564 documents, 195 had passed their review date. There are also 87 current documents with a review date longer than 2 years which is the current standard review period, and 20 with a review date longer than 3 years.

Performance around document control over previous quarters is as follows:

- October 2015: 219/610 (35.9%) information leaflets past their review date
- January 2016: 115/595 (19.3%)
- April 2016: 96/586 (16.4%)
- August 2016: 107/593 (18%)
- November 2016: 130/590 (22%)
- January 2017: 148/597 (24.8%)
- May 2017: 161/598 (26.9%)
- July 2017: 160/606 (26.4%)
- October 2017 209/594 (35.2%)
- January 2018 299/581 (51.4%)
- May 2018 195/564 (34.3%)

Whilst the position regarding out of date patient information leaflets has improved since last quarter, there remain a significant number of intranet documents which are past review date. To address this requires individual document owners to review and update each policy and guideline. There may be consultation and approval processes required which all take time to complete and is impacted by staffing pressures. However the following actions are being progressed:

1. Archiving all documents with a review date earlier than 1 January 2016.
2. Development of guidance for document labelling, safe uploading of documents to the intranet, and which document types should / should not be uploaded. This is to be circulated to all staff confirmed to required administrative access by directorates, and the need for training will be assessed.
3. Removal of administrative access to upload documents for all other staff not requiring this.

## 3. NHS Choices & Care Opinion

### NHS Choices

A sample of positive and negative comments left on NHS Choices has been provided.

**Harrogate District Hospital** – Based on 88 ratings

80% of reviews left in Q4 were positive and 20% were negative. This was based on 10 reviews

---

**Ripon & District Community Hospital** –Based on 24 ratings

There were 0 reviews left during Q4.

Thank you so so much to the nursing staff and all other staff for my operation on Tuesday 6th march! They helped me when I was in pain and gave me so much compassion! Was treat with kindness and care:)
Visited in March 2018. Posted on 07 March 2018

Consultant dismissive, uncaring and lacked any reassuring tools.

Didn't introduce herself

Used terminology such as I think, in my opinion, refused to even think of a biopsy

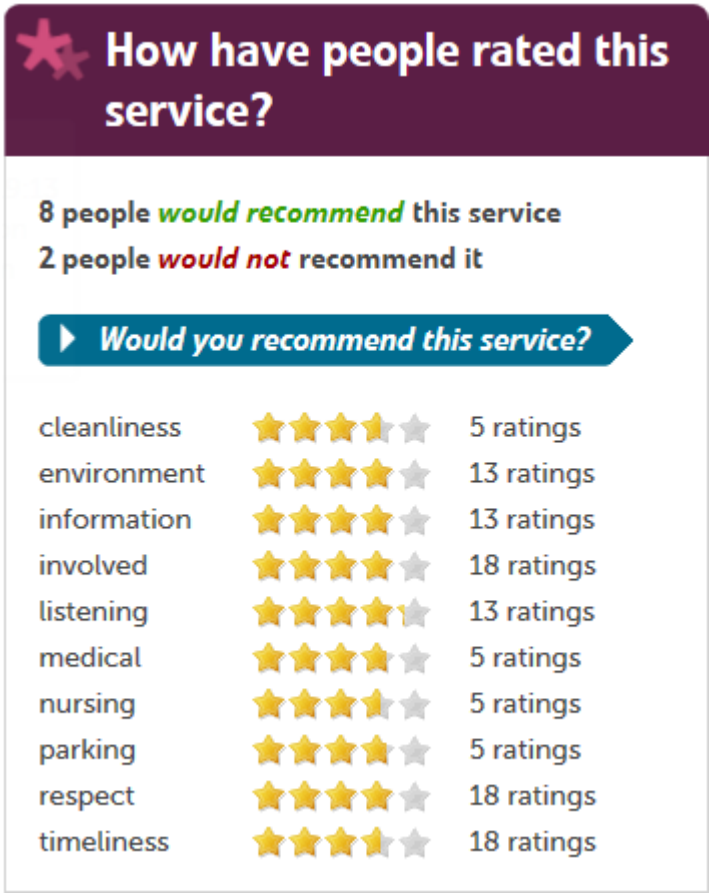
Suggested I go to another hosp[ital]

An apology wouldn't go amiss
Visited in February 2018. Posted on 07 February 2018

Referred by my GP practice and with a letter on Friday January 5 we waited to be seen approximately two hours but on being called the treatment, tests and X-rays were efficient and speedy. A registrar came from theatre to assess me and it was finally decided I should go home and return if I became worse. All the staff who treated me were fantastic and helpful and kept me informed of what was happening. Thank you all very much.
Visited in January 2018. Posted on 11 January 2018

Arrived at Day surgery at 12 and left at 6. From the beginning to the end I was treat with respect and consideration, this did not detract from total professionalism of the staff. Every step of the procedure was explained and invited comments or questions. The staff I encountered are a credit to the hospital. Thank you
Visited in January 2018. Posted on 27 January 2018

## Care Opinion

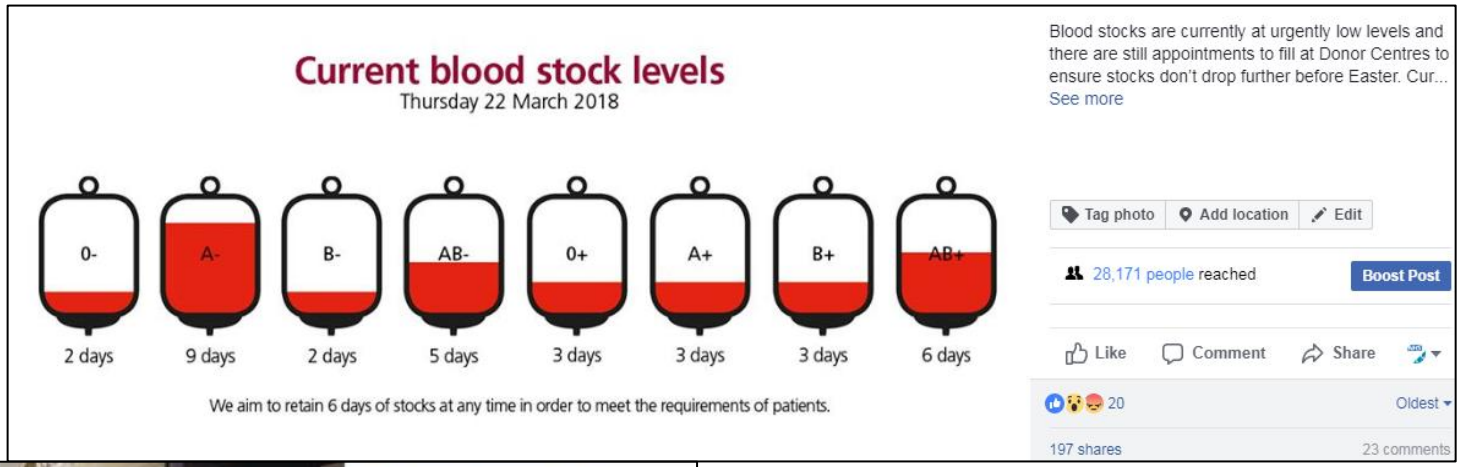




The Communications and Marketing Manager is responsible for responding to feedback left on NHS Choices and Care Opinion. Generally a comment is left to thank the person for leaving feedback. If the comment is positive, it is passed onto relevant staff. If the comment is negative, the person is asked to contact the Patient Experience team.

We have previously reported that due to a reduction in the capacity in the Communications and Marketing Team, there was a back log of posts to respond to. However following the end of the recent vacancy freeze the Communications Assistant post has been recruited to and as the Care Opinion Activity information above describes, 97% of the last 100 stories have now been responded to.

## Q4 Social Media samples (positive & negative)

- **Positive:** Communicating NHS England's call for blood donations over Easter – due to low stocks. Facebook post reached nearly 30k people, being shared 197 times.



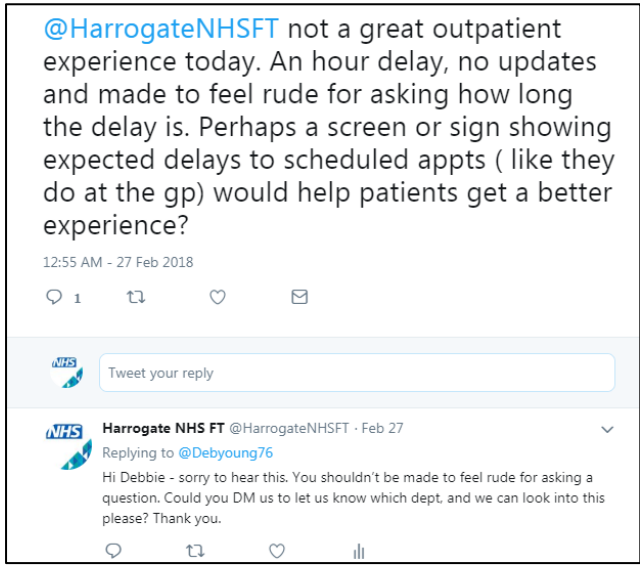


- **Positive:** Example of positive engagement for Making a Difference Award winners post – Lee Davis, Porter. Post reached nearly 3,300 people, with 217 engaging with the post. Examples of positive replies can also be seen below.

- **Positive:** Praise for our services received via Tweet on Twitter.

- **Negative:** Public complaint through Twitter – patient directed to PET for them to assist and resolve situation.


- **Negative > Positive:** Complaint through Twitter resolved via communication with patient, directing them to PET who liaised with relevant service.




- **Positive:** Introduction of public Wi-Fi at Harrogate District Hospital received positively by both staff and patients on Facebook – reaching over 8,000 people.

## 4. Complaints

| Quarter Data | 2015/16 | 2016/17 | 2017/18 | | | |
|---|---|---|---|---|---|---|
| | Total | Total | Q1 | Q2 | Q3 | Q4 |
| Total Number of formal complaints* | **213** | **234** | 52 | 49 | 48 | **60** |
| % responded to by deadline (target 95%**) | **52%** | **38%** | 42% | 61% | 58% | **63%** |
| % upheld | **68%** | **61%** | 62% | 57% | 67% | **72%** |
| Number returned for further local resolution | **31** | **5** | 0 | 0 | 0 | **0** |
| Number of new PHSO requests | **5** | **5** | 2 | 0 | 2 | **1** |
| Total informal requests (PALS contacts)*** | **676** | **936** | 231 | 291 | 286 | **248** |

**Number of complaints compared with average of complaints received in previous year. (Green if below HDFT average for 2016/17, Amber if above HDFT average for 2016/17)*
*** of those deadlines reached at time of report. Target rate set in Jan 2016*
**** Our aim is to increase informal contacts and reduce complaints*

| Year to Date Position | 2015/16 | 2016/17 | 2017/18 | | | |
|---|---|---|---|---|---|---|
| | Total | Total | Q1 | Q2 | Q3 | Q4 |
| Complaints received by PHSO (YTD) | **5** | **5** | 2 | 0 | 2 | **1** |
| Complaints investigated by PHSO as % of received by PHSO | **80% (4 out of 5)** | **4/5 (80%)** | 2 (100%) | n/a | 0% | **0%** |
| Complaints upheld by Ombudsman as % of received (nat av=47% at Q4) | **20%** | **0%** | 0% | n/a | n/a | **n/a** |
| Number of complaint actions developed | **445** | **402** | 105 | 67 | 115 | **43** |
| % of actions completed within deadline (target 100%) | **34%** | **40%** | 33% | 41% | 50% | **54%** |

Out of the 60 complaints received in Q4 100% of cases were acknowledged within 3 working days (where we were the lead organisation in charge of the investigation).

## Complaint numbers by Directorate

**Quarter Data**

| Quarter Data (2017/18 Q4) | LTUC | PSC | CCWCC | Corp |
|---|---|---|---|---|
| Total Number of formal complaints | 23 | 27 | 7 | 3 |
| % responded to by deadline (target 95%*) | 57% | 71% | 60% | 50% |

| Quarter Data (2017/18 Q3) | LTUC | PSC | CCWCC | Corp |
|---|---|---|---|---|
| Total Number of formal complaints | 18 | 23 | 7 | 0 |
| % responded to by deadline (target 95%*) | 44% | 61% | 86% | n/a |

| Quarter Data (2017/18 Q2) | LTUC | PSC | CCWCC | Corp |
|---|---|---|---|---|
| Total Number of formal complaints | 15 | 29 | 5 | 0 |
| % responded to by deadline (target 95%*) | 60% | 59% | 80% | n/a |

| Quarter Data (2017/18 Q1) | LTUC | PSC | CCWCC | Corp |
|---|---|---|---|---|
| Total Number of formal complaints | 24 | 22 | 6 | 0 |
| % responded to by deadline (target 95%*) | 17% | 76% | 33% | n/a |

* of those deadlines reached at time of report. Target rate set in Jan 2016

**Annual Data**

| Annual Data (2017/18) | LTUC | PSC | CCWCC | Corp |
|---|---|---|---|---|
| Total Number of formal complaints | 80 | 101 | 25 | 3 |
| % responded to by deadline (target 95%*) | 41% | 65% | 65% | 50% |

| Annual Data (2016/17) | LTUC | PSC | CCWCC | Corp |
|---|---|---|---|---|
| Total Number of formal complaints | 94 | 113 | 24 | 3 |
| % responded to by deadline (target 95%*) | 44% | 33% | 38% | 33% |

* of those deadlines reached at time of report. Target rate set in Jan 2016

## Top 5 complaint sub-subjects during Q4

| Complaints by Sub-subject (primary) - Top ( 5 ) | |
|---|---|
| **Communication with patient** | 9 |
| **Delay or failure to diagnose (inc missed fracture)** | 8 |
| **Discharge arrangements (inc lack of or poor planning)** | 5 |
| **Prescribing error** | 3 |
| **Care needs not adequately met** | 2 |
| **Totals:** | 27 |

## Breakdown of complaints during 2017/18

| Complaints by Sub-subject - Top ( 10 ) | |
|---|---|
| **Communication with patient** | 41 |
| **Delay or failure to diagnose (inc missed fracture)** | 27 |
| **Communication with relatives / carers** | 27 |
| **Attitude of medical staff** | 23 |
| **Attitude of nursing staff / midwives** | 19 |
| **Failure to follow procedure** | 18 |
| **Discharge arrangements (inc lack of or poor planning)** | 15 |
| **Inadequate pain management** | 13 |
| **Discharged too early** | 12 |
| **Post treatment complications** | 10 |
| **Totals:** | 205 |

Discharge arrangements and discharge too early feature in the top 10 - - they did not feature last year. There has been an initiative on discharge over the past 12 months to improve the number of patients with a discharge date and get patients discharged as soon as it is appropriate to do so. It is possible that the communication surrounding this has not been sufficient to meet / manage the expectations of the patients and their families which is why we are seeing more complaints about the discharge arrangements and timing of discharge.

| Complaints by Location (exact) - Top ( 10 ) | |
|---|---|
| **Outpatients (not orthopaedics)** | 29 |
| **Emergency Department** | 20 |
| **CATT Ward** | 13 |
| **Theatres** | 10 |
| **Wensleydale Ward** | 10 |
| **Endoscopy Unit** | 8 |
| **Central Labour Ward Suite** | 8 |
| **Jervaulx Ward** | 7 |
| **Littondale Ward** | 6 |
| **Nidderdale Ward** | 6 |
| **Totals:** | 117 |

In keeping with previous years the top locations are Outpatients, ED and CATT Ward. The top 10 are the same as last year with the exception of Byland Ward and Orthopaedic Outpatients which do not feature this year. Instead Theatres and Endoscopy Unit now fall into the top 10 for 2017/18.

| Complaints by Specialty (primary) - Top ( 10 ) | |
|---|---|
| **Trauma & Orthopaedics** | 24 |
| **Emergency Department** | 21 |
| **Medicine for the Elderly** | 16 |
| **Maternity Services** | 14 |
| **General Surgery** | 13 |
| **Health Visiting** | 9 |
| **Ophthalmology** | 7 |
| **Endoscopy** | 7 |
| **Urology** | 7 |
| **Gynaecology** | 6 |
| **Totals:** | 124 |

The top specialties in 2017/18 are Trauma and Orthopaedics and ED which are the same as last year. However new specialties of Health Visiting, Endoscopy, Ophthalmology feature this year for the first time.

## Update on actions developed in light of complaints

**Annual data**

| Actions 2016/17 | |
|---|---|
| Number of actions developed | 402 |
| % completed within deadline | 40% |
| % still open (of total)and past due date | 15% |

| Actions 2017/18 | |
|---|---|
| Number of actions developed | 330 |
| % completed within deadline | 44% |
| % still open (of total)and past due date | 33% |

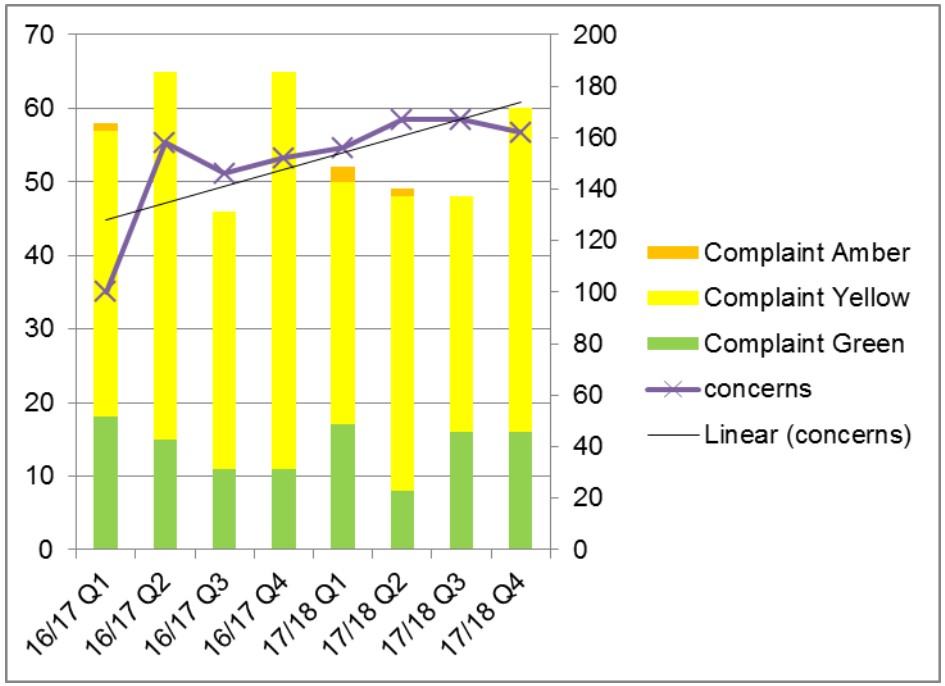
**Quarterly data**

| Actions Q1 17/18 | |
|---|---|
| Number of actions developed | 105 |
| % completed within deadline | 33% |
| % still open (of total) and past due date | 40% |

| Actions Q2 17/18 | |
|---|---|
| Number of actions developed | 64 |
| % completed within deadline | 37% |
| % still open (of total) and past due date | 41% |

| Actions Q3 17/18 | |
|---|---|
| Number of actions developed | 88 |
| % completed within deadline | 70% |
| % still open (of total) and past due date | 22% |

| Actions Q4 17/18 | |
|---|---|
| Number of actions developed | 43 |
| % completed within deadline | 54% |
| % still open (of total) and past due date | 31% |




The above graph demonstrates the number of concerns in relation to the number of complaints. This is showing an upward trend in the number of concerns.

**Themes from complaints about communication and attitude 17/18**

121 complaints included communication or attitude in 2017/18.

Further review of these complaints has been undertaken to see if any common themes can be identified. Only those aspects which were upheld were included in this review.

| Theme | % |
|---|---|
| **Lack of communication to patient or family** | 36 |
| **Rude / dismissive / abrupt / aggressive / judgemental language or behaviours used** | 19 |
| **Inappropriate comments made by staff** | 13 |
| **Other (e.g inaccurate / lack of documentation; no compassion, defensive)** | 12 |
| **Patient / family not listened to** | 8 |
| **Incorrect / conflicting information provided** | 6 |
| **Breakdown in communication between teams / organisations** | 6 |

As can be seen from the data above the most common complaint is lack of communication / information to the patient and their family. It is recommended that the Directorates focus their attention this forthcoming year on improving this aspect of communication. Further focussed work on identifying the reasons behind this failure to communicate (or perceived failure) would be useful.

Communication is a common theme amongst all complaints. The above graph demonstrates the number of complaints which feature communication or attitude since 2015/16. There has been no demonstrable improvement in this area despite the various initiatives over the years

## Parliamentary Health Service Ombudsman (PHSO)

### PHSO Cases Q1 2017/18

| Issue | Incident Date | Area | Synopsis | Status |
|---|---|---|---|---|
| Complainant suffered problems with loss of sensation in arm following operation on knee | 12/06/2015 | General Surgery | Complainant believes we did not consider MRI findings before commencing with anaesthetic and operation. Quality of life has been affected and patient wants financial compensation | Closed - PHSO has investigated and not upheld the complaint |
| Delay in diagnosis of fracture | 07/09/2016 | Orthopaedic Outpatients | Complainant raises concerns about the care provided by the fracture clinic on two occasions in September 2016. Believes a fracture was missed and would like reimbursing for the cost of the private x-ray she obtained herself | Closed - PHSO has investigated and not upheld the complaint |

### PHSO Cases Q2 2017/18

No cases have been referred to the PHSO in Q2

### PHSO Cases Q3 2017/18

| Issue | Incident Date | Area | Synopsis | Status |
|---|---|---|---|---|
| Concerns about overall care received - medical & nursing care and communication with patient and family | 07/11/2014 | Elderly Medicine | 12 page letter received from wife with 30 issues for addressing - Very unhappy with care & communication provided to late husband | Closed - PHSO have reviewed complaint file and decided not to investigate |
| Unhappy that catheter removal appointment was not before his holiday to USA | 22/04/2017 | Urology | Patient presented to Emergency Department in urinary retention. Catheter inserted and appointment made with Urology Consultant to review removal at a later date. Patient paid to have this removed privately as did not want a catheter in situ on his holiday abroad as we had no clinic slots to accommodate bringing his appointment forward. | Closed - PHSO decided not to investigate but asked the Trust to write an apology to patient for misleading them that alternative treatment option may have been available. |

### PHSO Cases Q4 2017/18

| Issue | Incident Date | Area | Synopsis | Status |
|---|---|---|---|---|
| Unhappy with support provided following birth by Health Visitor | 18/08/2015 | Health Visiting | Complainant believes health visitor not act upon concerns after birth regarding constipation, and didn't take appropriate action when baby dropped centile in weight. No follow up was provided following discharge to monitor weight. | PHSO currently undertaking preliminary review to make a decision whether to investigate or not |

## 5. Concerns and Comments (positive suggestions for improvement)

| | Total 16/17 | 17/18 Q1 | 17/18 Q2 | 17/18 Q3 | 17/18 Q4 | Total 17/18 |
|---|---|---|---|---|---|---|
| **Number of Concerns** | **555** | 156 | 167 | 167 | **163** | **653** |
| **Number of Comments** | **182** | 33 | 52 | 62 | **33** | **180** |
| **Number of Information Requests** | **198** | 42 | 72 | 57 | **52** | **223** |
| **Total Informal requests** | **936** | 231 | 291 | 286 | **248** | **1056** |

LPEG members have expressed an interest in finding out how many complaints start out as concerns.

Out of the 60 complaints logged in Q4, 8 (13%) of these were originally handled and logged as concerns. We do not have any data on how many cases may have been handled informally by front line staff before reaching the PET.

| Concerns by Sub-subject - Top ( 10 ) | |
|---|---|
| **Communication with patient** | 84 |
| **Attitude of medical staff** | 34 |
| **Wait for operation / procedure** | 31 |
| **Appointment Cancellations** | 20 |
| **Attitude of nursing staff / midwives** | 20 |
| **Appointment error** | 20 |
| **Communication with relatives / carers** | 20 |
| **Delay in giving information / results** | 20 |
| **Attitude of Admin and Clerical staff** | 20 |
| **Attitude of other staff** | 19 |
| **Totals:** | 288 |

There have been a number of concerns this year about the length of the waiting list, mainly in Orthopaedic Surgery. Particularly in terms of the disparity between the information regarding waiting times given in clinic by the medical staff and the information provided by the secretarial / admin staff when chasing for information on a date for surgery.

## 6. Compliments Received by Chief Executive / Chairman

| | Total 16/17 | 17/18 Q1 | 17/18 Q2 | 17/18 Q3 | 17/18 Q4 | Total 17/18 |
|---|---|---|---|---|---|---|
| **Total Number of Compliments** | **325** | 78 | 69 | 53 | **116** | **316** |

The compliments received by the PET in Q4 17/18 were grouped into themes.

| Theme | % |
|---|---|
| **Communication** | 14% |
| **Attitude** | 32% |
| **Clinical Care / overall experience** | 32% |
| **Efficiency of service** | 22% |

## 7. Appendix 3- Grading of Concerns and Complaints

| Rating | Type | Description | Level of investigation | Internal Reporting | External Reporting | Response* |
|---|---|---|---|---|---|---|
| **1 White** | **Concern** | Unsatisfactory service or issue easily resolved with simple action | **Line manager Matron** | LPEG | | Within 2 days |
| **2 Green** *Low* | **Complaint** (*resolution plan agreed by Lead Investigator with complainant; final response sign off by CE*) | Unsatisfactory service user experience related to care clinical or non-clinical, minimal impact. No risk of litigation. | **Directorate** | LPEG & Q of C Teams<br><br>Dashboard | Annual Korner return (Health and Social Care Information Centre (HSCIC)) | Within 25 working days |
| **3 Yellow** *Moderate* | | Unsatisfactory service user experience in several areas but not causing lasting problems. Some potential for litigation (if so refer to CORM). | **Directorate** | LPEG & Q of C Teams<br><br>CORM<br><br>Dashboard | Annual Korner return (HSCIC) | Up to 25 working days |
| **4 Amber** *High* | **Complaint** (*resolution plan / terms of reference sent to complainant to agree & final response sign off by CE*) | Significant issues of standards, quality of care, safeguarding, with quality assurance or serious risk management issues that may cause lasting problems or death. Possibility of litigation and adverse local publicity (refer to CORM) | **Consider outwith Directorate involved** *(if SI concise or comprehensive RCA with external input)* | LPEG<br>CORM<br><br>Dashboard<br><br>If SI= Board | Annual Korner return (HSCIC)<br><br>Consider SI & CCG | Up to 60 working days |
| **5 Red** *Extreme* | | Serious adverse incidents also raised as a complaint causing long-term damage or death such as criminal offence, gross substandard care or gross professional misconduct, multiple allegations of neglect resulting in serious harm or death. | **Outwith Directorate** Comprehensive RCA | LPEG<br>CORM<br><br>Dashboard<br><br>**<u>Board</u>** | Annual Korner return (HSCIC)<br><br>**<u>SI & CCG</u>**<br><br>**<u>Monitor</u>** | Within 90 working days |

***NB If a complaint is multi-agency or if the staff involved are absent the timescale may be negotiated with PET and the complainant. This should be agreed within 7 working days of the complaint**

Harrogate and District
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Date of Meeting:** | 30 May 2018 | **Agenda item:** | 11.1 |
| **Report to:** | Board of Directors | | |
| **Title:** | Guardian of Safe Working Hours Quarterly Report | | |
| **Sponsoring Director:** | Dr D Scullion, Medical Director | | |
| **Author(s):** | Dr C Gray, Guardian of Safe Working Hours | | |
| **Report Purpose:** | **Decision** | | **Discussion/ Consultation** | | **Assurance** | ✓ | **Information** | |
| **Executive Summary:** | The Board of Directors is asked to note:<br>• The Guardian has no on-going concerns;<br>• The number of Exception Reports is below the national average; and<br>• There is a continuing national recruitment crisis in trainee doctors but vacancies in this Trust are at 9.1% which is comparatively low. | | |
| **Related Trust Objectives** | | | |
| **To deliver high quality care** | ✓ | **To work with partners to deliver integrated care:** | | **To ensure clinical and financial sustainability:** | |
| **Key implications** | | | |
| **Risk Assessment:** | Risks associated with the content of the report are reflected in the Board Assurance Framework | | |
| **Legal / regulatory:** | None identified. | | |
| **Resource:** | None identified. | | |
| **Impact Assessment:** | Not applicable. | | |
| **Conflicts of Interest:** | None identified. | | |
| **Reference documents:** | None. | | |
| **Assurance:** | | | |
| **Action Required by the Board of Directors:** | | | |
| The Board of Directors is asked to **receive and note** the content of the report.<br>The Board of Directors is requested to **consider the points** at the end of the report. | | | |

This is the fifth quarterly report of the Guardian of Safe Working Hours for Doctors and Dentists in training. Its purpose is to report to the Board of Directors the state of safe working of doctors in training ('junior doctors') in relation to their working hours, gaps in rotas and their educational experience. This report covers the period 1 January to 31 March 2018.

The report provides the Board with up-dated quarterly evidence to support its assurance that the issues of safety within the Guardian's remit are in a satisfactory state.

The Trust now has all trainee doctors employed on the 2016 Terms and Conditions of Service (TCS) contract.

Thirty-five exception reports have been received from trainees and dealt with (Q3 2017/18: 25). These have mainly concerned over-runs of working hours ('hours and rest') owing to the busy state of the wards and to individual patient matters. Exception reporting is low in this Trust and in decline regionally overall although highly variable.

There having been no breach of the European Working Time Directive, no fine has yet been levied. National trends in medical post-graduate training continue to be adverse.

There has been one regional meeting for guardians this quarter. There has been no national meeting this year and none is planned. One trainee doctors' forum has been held jointly with the Deputy Director of Medical Education. These will continue bi-monthly.

The CQC have announced that they will henceforward in inspections interview Guardians of Safe Working and representative trainee doctors concerning exception reports.

One directorate has had a spell of increased exception reporting owing to rota gaps and colleagues off sick.

This is the key quality assurance statement for the Board:

'The Board is advised that overall working hours across the organisation are satisfactory and that there are presently no unaddressed specific concerns in departments or directorates.'

## 1 Introduction

This is the fifth quarterly report of the Guardian of Safe Working Hours which presents the Trust's statistics in brief form: more detailed data are held in the DRS computer system and are available on request.

Its purpose is to report to the Board of Directors the state of safe working of doctors in training ('junior doctors') in relation to their working hours, gaps in rotas and their educational experience. The quarterly report is a contractual duty upon the employer under the 2016 TCS.

The report provides the Board with up-dated quarterly evidence to support its assurance that the issues of safety within the Guardian's remit are in a satisfactory state.

The Trust now has all its trainee doctors employed on the new 2016 TCS which started in December 2016.

Owing to the Trust taking on the lead employer role for the GP training scheme, the Guardian has been requested to take on the guardian role for ~30 GP specialty trainees on placement with GP surgeries in the Harrogate District. This should not be onerous as these trainees work nine to five and are 'low maintenance.'

## 2 High level data

**In May 2018:**

| | |
|---|---|
| Number of doctors / dentists in training (total established Deanery posts) | 121 [last quarter: 121] |
| Number of doctors / dentists posts on 2016 TCS (total) | 121 [last quarter: 121] |
| Number of doctors / dentists in training actually in post | 110 [last quarter: 109] |
| Number of doctors/dentists in Trust posts (additional to Deanery posts) | 14 [last quarter: 14] |
| Number of doctors/dentists in Trust posts actually in post | 13 [last quarter 13] |
| 'Gaps' in deanery posts | 9.1% |
| 'Gaps' in deanery and Trust posts combined | 8.9% |
| Amount of time available in job plan for Guardian to do the role | 1.5 PAs per week |
| Admin support provided to the Guardian (if any) | none [assistance from HR Department] |
| Amount of job-planned time for educational supervisors | 0.5 PAs per trainee |

## 3 Exception reports

Exception reports are individual notifications by trainee doctors who have had a problem occasion causing them to vary their working hours from the contracted rota by more than ½ hour. Exception reports have a time-limited process for response by the Trust. At any one time there will usually be reports awaiting attention by individual clinical supervisors.

This is a full quarter covering the period 1 January - 31 March 2018.

| Exception reports by department: hours/rest | | | | |
|---|---|---|---|---|
| Specialty | No. exceptions carried over from last report | No. exceptions raised | No. exceptions closed | No. exceptions outstanding |
| General Surgery | 0 | 16 | 16 | 0 |
| Ophthalmology | 0 | 7 | 7 | 0 |
| General Medicine | 0 | 5 | 5 | 0 |
| Paediatrics | 0 | 2 | 2 | 0 |
| Total | 0 | 30 | 30 | 0 |

The exception reports were from 5 FY1 doctors and the rest from specialist registrar grades. The majority of exceptions reported concern overtime working ['hours and rest']. There have been five exception reports in the reporting quarter mentioning defective educational experience, usually missed opportunities to attend clinic or theatre sessions.

Exception reporting has a potential procedural barrier. Doctors new to the Trust must activate their password on the DRS system within seven days. If they do not do so they are locked out and must get a new password. This may account for some delay in reporting exceptions; some doctors tend to batch them.

If a doctor has overworked their contracted hours on an occasion, then they are entitled under the TCS to over-time pay or time off in lieu. If the over-work is caused by rota gaps, then time off is not appropriate if it will compound the shortage situation. The doctor is entitled to overtime pay even if their overtime commitment followed from their own inefficiency or misjudgment. Clinical supervisors are expected to guide their trainees in efficient working, prioritizing clinical activities and making timely hand-overs to over-night teams. The Trust will incur a small cost each month in some hours' over-time pay; but this is offset by vacant posts owing to rota gaps. Overall, the Trust is heavily over-spent on medical locum costs.

The job of filling posts, balancing rotas and workloads properly belongs to clinical directorates with professional support from the HR function. Individual trainees' employment experiences are managed by their individual clinical supervisor - a clinical consultant usually in the same or a related specialty. The Guardian has no actual managerial power over individuals in directorates.

Of course, ideal conditions of employment for trainee doctors are one obligation amongst many in the Trust, particularly in periods of winter pressures.

## 4 Work schedule reviews and interventions

### 4a Work schedule review

A work schedule review would be undertaken to investigate any case of systematic or repeated over-working of contracted hours where the planned schedule itself is questioned. No work schedule review has been necessary to date.

### 4b Interventions

***Specialty U***

In this specialty, one trainee put in several exception reports, each relating to overworking owing to a gap in the rota. The trainee then went off sick over a bank holiday weekend. This was a directorate with an action plan to prevent these difficulties. The Guardian had several tense e-mail and spoken exchanges with directorate management.

But I am satisfied that the directorate places high value on its doctors in training and makes strenuous managerial efforts to provide a safe working environment. It is impossible for managers to cover sudden unexpected vacancies, particularly over bank holiday weekends. The directorate had encountered some 'gaming' strategies from trainees demanding premium pay to do extra duty. This case has been suitably managed by the clinical supervisor who made changes in the activities of middle grade doctors to relieve the burden on the junior doctors when there is a gap. Directorates should avoid e-mail messaging with contents unsympathetic to the trainees.

With about 9% gaps in rotas usually prevalent in the Trust, from time to time this must impact on individual trainees, particularly out-of-hours and at weekends. Sudden absences by colleagues on a rota are particularly challenging. Directorate managers must take reasonable steps to reduce the stress on trainees affected by rota gaps.

Directorate managers at all levels have stated that all grades of staff in all professions are working very hard owing to clinical pressures, which is of course true. Their underlying question

is: ‘So why do trainee doctors get special attention.’ The answer is that only trainee doctors have a contract which provides exception reporting and a guardian role.

The exception reporting system makes an accountable record of trainees ‘complaints’ and the actions taken by the Trust. If a trainee should suffer harm from workplace stress, then this would be very difficult for the Trust to defend.

Trainee doctors may be perceived to have a possibly unfair advantage under their contract of employment compared to other caring professions such as nursing.

Inevitably, workforce pressures are increasing throughout the NHS.

## 5 Vacancies

There were 11 [Q3: 12] vacancies in May 2018 [9.1% of 121 deanery established posts overall].

In February and August each year there are planned cohort changes; at other times of year there are always a few doctors coming and going for personal reasons. At any one time, there are gaps owing to failure of recruitment and vacant posts are at different stages of re-advertisement and recruitment. One current gap is a doctor on maternity leave.

Of course, rota gaps add to the strain on the trainees in post and add to the Trust’s workforce costs by necessitating locum and other temporary employees.

The percentage of vacancies is far worse in other Trusts: we are doing relatively well.

The Guardian has access to the HR database of trainee doctors which is up-dated monthly.

## 6 Fines

The Guardian has the contractual power to penalize departments/directorates for failure to ensure safe working hours and particularly repeated breaches of the Working Time Directive. This section should list all fines levied during the previous quarter, and the departments against which they have been levied. Additionally, the report should indicate the total amount of money levied in fines to date, the total amount disbursed and the balance in the Guardian of Safe Working Hours’ account. A list of items against which the fines have been disbursed should be attached as an appendix.

No fine has been necessary to date. There have been no identified breaches of the Working Time Directive. Fines have been levied in other trusts in the thousands of pounds.

Working time rules may of course change after BREXIT.

| Fines (cumulative) | | | |
|---|---|---|---|
| Balance at end of last quarter | Fines this quarter | Disbursements this quarter | Balance at end of this quarter |
| £0 | £0 | £0 | £0 |

## 7 Regional Meeting

There has been one regional meeting for Guardians this quarter on 20th March 2018 at York.

This was more of the same. There is no new development in this field. The deputy deans have a siege mentality owing to their intractable problems in attracting sufficient trainees to the region. The meeting tends to spend its time on finely detailed contractual issues and dissecting tiny points about rules on the head of a pin.

There appears to be a worsening trend in trainees avoiding deanery training programmes. Only about 50 per cent of trainees proceed directly from FY School to higher training in Primary Care or hospital specialties. The remainder go abroad, leave medicine or seek non-training posts. Of course, doctors have always been going abroad and have usually returned; have been out of medicine between jobs owing to spousal relocation and so on; and others have had a period undecided on what specialty to choose for training. But this seems to be an adverse trend. Anecdotally, good trainees are choosing the non-deanery route. The former 'Lost Tribes of SHOs' which were so frowned upon a decade ago are now re-appearing in new guise as short-term trust posts variously termed 'FY3' and 'Trust Doctor'. [These doctors are of course very helpful in plugging gaps' in rotas; but their absence from training posts creates the gaps in the first place.] These doctors may eventually reach the specialist register by the CESAR route and not by formal specialist training with a CCT.

Post-graduate deans can say what they like but trainees are voting with their feet. If half the trainees delay or avoid entering specialist training, then training schemes will empty by half and half as many trainees will qualify for consultant and GP principal posts in five years' time. But this is not even across the country with a gradient from the south-east where posts generally fill to the north-west where posts generally do not fill. Further, immigration is tightly controlled. Although the population is living longer, senior doctors have no intention in working longer. There have been disincentives in tax and pension policy which perversely have stimulated a wave of early retirement and retire-and-return schemes. Overall, the medical workforce is a catastrophe in evolution. The NHS workforce strategy is not addressing this in any way. HEE seem paralysed by anxiety, ignoring large elephants in every room.

## 8 Disclosure

These quarterly Guardian reports are submitted to Health Education England at their request and by standing consent of the Trust Board of Directors. A regional summary is assembled and discussed at the regional meeting each time. Guardians assume that their quarterly reports to their boards of directors are open to the public domain.

CQC will henceforward request submission of quarterly reports for inspections.

Health Education England has requested periodical download of the entire database of exception reports for the purpose of research by the mining of big data. The Board has agreed to this. HEE has not yet accessed any data although they have been invited.

The Trust had a Freedom of Information request in April 2018. This was from the BMA. The question was asked of all NHS trusts of how many exception reports resulted from rota gaps. Precise data was not available on the exact question put. It is obvious that some exception reports come from rota gaps. It is well known that all trusts have vacancies for doctors in training. It follows that these gaps will have adverse effects sometimes.

## 9 Confidentiality

Given that Guardians' reports may be in the public domain, the identities of specialties, doctors and supervisors are concealed in the Guardian's quarterly report. Full data are available to the Board of Directors in private session on request.

## 10 CQC

There has been no enquiry from CQC to date.

Future CQC inspections will include inspectors in addition to usual practice interviewing the Guardian of Safe Working Hours and representative trainee doctors about exception reports. Quarterly reports [such as this document] will be submitted for inspection.

## 11 Issues arising

a. The Trust continues in comparatively good standing. We have had a below-average rate of exception reporting.
b. There is an on-going problem of sporadic over-work and reduced educational opportunity for trainee doctors owing to colleagues off sick and rota gaps. Current instances are under management within the directorate concerned.
c. Reluctance in trainees to report exceptions exists regionally and nationally.
d. Exception reports are being received and processed.
e. There are gaps in rotas owing to failed recruitment. This a worsening issue throughout medical specialties especially in the North of England, but this Trust is doing relatively well.
f. The Guardian is expecting to meet CQC inspectors in due course.
g. The Guardian has agreed to take under the guardian role the ~30 GP specialty trainees on practice placements in the Harrogate District.

## 12 Actions taken to resolve issues

a. No fine has been necessary this quarter.
b. The Guardian has challenged management in one directorate about overworking of trainee doctors. He has consulted with the Director of Medical Education and directorate managers. The Directorate concerned has responded very vigorously.
c. Probably the majority of trainees work overtime occasionally but none too dangerous degree. Exception reports are widely viewed as an under-estimate of actual overtime working owing to reluctance of some trainees to make exception reports.
d. At the date of reporting, the Board of Directors is assured from the evidence available that:
    i. The exception reporting system is operational for all trainees; they are now all on the 2016 TCS.
    ii. A new GMC trainees' survey has just closed; its results will be available later in the year.
    iii. No systematic problem of unsafe working hours is known to exist currently. Instances of overworking and rota gaps are under investigation and management in one directorate.
    iv. The Guardian can only intervene on notified problems.

## 13 Questions for consideration by the Board of Directors

a. The Board is asked to receive the quarterly report and to consider the assurances provided by the Guardian.
b. There are presently no issues outlined in the report which are not being (or cannot be) tackled.
c. The Guardian makes no request for escalation, internally, externally or both, which might be recommended in order to ensure that safe working hours would not be compromised in the future.
d. Issues of medical [and indeed all healthcare professional] workforce planning are an urgent strategic challenge to the Trust and to the entire NHS. The Trust always has vacancies gaps in trainee doctor posts; these currently run at 9.1 per cent.
e. Safe working hours, trainees' exception reports and rota gaps now are added to the regular data requests by CQC in their inspection process.
f. HEE has access to our exception reporting data.
g. A freedom of information request on exception reports and rota gaps was answered.

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| | | | |
|---|---|---|---|
| **Date of Meeting:** | 30 May 2018 | **Agenda item:** | 11.2 |
| **Report to:** | Board of Directors | | |
| **Title:** | Learning from Deaths report Q4 2017/18 | | |
| **Sponsoring Director:** | Dr David Scullion, Medical Director | | |
| **Author(s):** | Dr Sylvia Wood, Deputy Director of Governance | | |
| **Report Purpose:** | **Decision** | | **Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓ |
| **Executive Summary:** | Board to note quarterly report of learning from deaths process. Findings from ongoing review of deaths following cardiac arrest are also included. | | |

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

| **Key implications** | |
|---|---|
| **Risk Assessment:** | The learning from deaths process aims to identify areas where improvements can be made to patient care which will reduce clinical risk. |
| **Legal / regulatory:** | There is a requirement to collect and publish specified information on deaths including learning points every quarter with a paper and agenda item to public Board meetings from Q3 2017/18 onwards. |
| **Resource:** | There is a time resource required to undertake the case note reviews, data collection and analysis. |
| **Impact Assessment:** | Not applicable. |
| **Conflicts of Interest:** | None identified. |
| **Reference documents:** | HDFT Learning from Deaths Policy |
| **Assurance:** | Learning from quarterly reports are reviewed at the Improving Patient Safety Steering Group. |

**Action Required by the Board of Directors:**

It is recommended that the Board

- Notes items included within the report;

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

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

During Q4 the Trust has started using the RCP National Mortality Review Tool which is hosted on Datix. A number of key staff had training in the form of an online WebEx session. The data for this report and ongoing quarterly reports will be extracted from the Datix mortality review dashboard.

During 2017/18 some specific focused reviews have been undertaken:

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

## Results

The date of death (or admission if the date of death is not recorded on the SJR) is the date that has been used for the data analysis rather than the date that the SJR was undertaken. Some of the SJRs undertaken during Q4 relate to deaths that occurred earlier in 2017/18 for various reasons. All case note reviews undertaken during Q4 have been included in this report.

Numbers of case note reviews and deaths

| SJRs undertaken | 2014/15 | 2015/16 | 2016/17 | 2017/18 | | | | Total |
|---|---|---|---|---|---|---|---|---|
| | | | | Q1 2017/18 | Q2 2017/18 | Q3 2017/18 | Q4 2017/18 | |
| Previously reported | 4 | 27 | 40 | 2 | 8 | 13 | N/a | 94 |
| Undertaken during Q4 | 0 | 0 | 0 | 1 | 0 | 1 | 6 | 8 |
| Total | 4 | 27 | 40 | 3 | 8 | 14 | 6 | 102 |

Numbers of inpatient deaths and case note reviews during 2017/18

| | 2017/18 | | | | Total |
|---|---|---|---|---|---|
| | Q1 2017/18 | Q2 2017/18 | Q3 2017/18 | Q4 2017/18 | |
| No of inpatient deaths | 145 | 140 | 167 | 205 | 657 |
| No of SJRs | 3 | 8 | 14 | 6 | 31 |

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

Assessment of care – case note reviews undertaken in Q4 2017/18

| | Good or excellent care (score 4-5) | Average care (score 3) | Poor care (score 1-2) | N/A | Total |
|---|---|---|---|---|---|
| Admission and initial management | 7 | 1 | 0 | 0 | 8 |
| On-going care | 4 | 1 | 0 | 3 | 8 |
| Care during procedure | 0 | 0 | 0 | 8 | 8 |
| Peri-operative care | 0 | 0 | 0 | 8 | 6 |
| End of life care | 8 | 0 | 0 | 0 | 8 |
| Overall assessment of care received | 7 | 1 | 0 | 0 | 8 |
| Overall assessment of patient record | 8 | 0 | 0 | 0 | 8 |

Problems with care – case note reviews undertaken in Q4 2017/18

The SJR proforma has a section that enables the identification of problems in care by various categories described in the table below. Of the 8 case note reviews undertaken in Q4 2017/18:

- Three cases with no problems in care
- Five cases with a total of seven problems in care documented in various categories.

Of these:

- Six were deemed to have resulted in no harm
- One was deemed to result in uncertain harm

| Problem related to: | Total number of cases with a problem with care identified | Number of problems with no harm | Number of cases with a problem in care resulting in harm |
|---|---|---|---|
| Assessment, investigation or diagnosis | 3 | 2 - Ongoing care<br>2 - Admission and initial assessment<br>1 - End of life care | 1 - Admission and initial assessment (uncertain harm) |
| Medication, IV fluids, Electrolytes, oxygen | 1 | | 0 |
| Treatment and management plan | | | |

| | | | |
|---|---|---|---|
| Any other type not fitting the categories above | 1 | 1 - Ongoing care | |
| Operation / invasive procedure | | | |
| Infection management | | | |
| Clinical monitoring | | | |
| **Total** | **5** | **6** | **1** |

Avoidability scores

Avoidability score is not included in the RCP National Mortality Review Tool and therefore will not be included in future reports.

Specific learning points identified from cases with identified problems in care

1. Delay in obtaining result of CT scan from Medica. This has been extensively investigated by direct contact with the outsourcing company and feedback given to the parents of the deceased.
2. Concern related to the death certification process in a patient whose death was unexpected and the exact cause was not established. A post mortem should have been performed.
3. Patient should not have received aspirin as high risk of bleeding.
4. Incorrect falls risk assigned.
5. Patient did not need MRI brain scan.
6. Patient was given oral medication prior to formal swallow assessment.
7. No CXR on admission (but no indication beyond delirium).
8. CXR performed on a Friday afternoon and not reviewed by requesting team or planned weekend review. CXR revealed air under the diaphragm which was not a clinical suspicion.

## Reflection

In general the reviews were of good quality with numerous detailed descriptions of good practice. In a smaller proportion of cases, examples of where practice could be improved were documented. There was only one case where a problem in care was associated with uncertain harm; in all other cases, problems identified were not associated with any harm.

## Learning

1. Local dissemination is through feedback to teams and across the organisation where appropriate. This will be led through the Improving Patient Safety Steering Group (IPSSG).
2. At national level the new web based methodology for documentation of SJR using Datix, will enable identification of themes and wider learning.

## Cardiac arrests

All hospital cardiac arrests are reported to the National Cardiac Arrest Audit (NCAA) to monitor and report on the incidence of, and outcome from, in-hospital cardiac arrest in order

to foster improvements in the prevention, care delivery and outcomes from cardiac arrest. It is a joint initiative between the Resuscitation Council (UK) and ICNARC (Intensive Care National Audit & Research Centre) and is included in the Department of Health Quality Accounts.

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

**Numbers of cardiac arrests and case note reviews**

| | 2017/18 | | | | |
|---|---|---|---|---|---|
| | Q1 2017/18 | Q2 2017/18 | Q3 2017/18 | Q4 2017/18 | Total |
| No of inpatient cardiac arrests | 8 | 11 | 16 | 9 | 44 |
| No of case note reviews | 8 | 11 | 16 | 9 | 44 |
| No of appropriate cardiac arrests | 4 | 3 | 13 | 4 | 24 |
| No of inappropriate cardiac arrests | 4 | 8 | 3 | 5 | 20 |

**Reflection**

The cardiac arrest case note reviews show that the care provided prior to and during resuscitation calls is of a high standard, following national guidelines and hospital policy with no omissions in care. However there are significant numbers (45%) of cardiac arrests that have been deemed inappropriate by the Resuscitation Committee. It is important to appreciate that these decisions are made by the Resuscitation Committee with the benefit of hindsight so are likely to be easier decisions to determine without clinical and time pressures and the need for difficult discussions with patients and their relevant others as DNACPR decision making is a complex and sensitive topic.

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

| Patient had a DNACPR decision in place but not known of or not found | Resuscitation stopped quickly due to futility therefore DNACPR should have been considered pre arrest | Patient had life limiting illness so a DNACPR should have been considered | DNACPR put in place post arrest therefore should have been considered prior to arrest |
|---|---|---|---|
| 4 | 5 | 8 | 6 |

**Learning**

The SJRs and case note reviews of cardiac arrest patients both emphasise the increasing frailty and complexity of patients, some of whose death in hospital is expected. It is therefore important that discussions and realistic treatment plans are in place for these patients including whether cardio pulmonary resuscitation would be clinically appropriate. It is

recommended that these patients should have had discussions about resuscitation or their future care discussed as part of advanced care planning either prior to or on admission to hospital. Annual DNACPR audit identifies that this occurs for many patients but should happen in more situations to ensure that patients receive appropriate and realistic treatment and that this is communicated with them.

Actions include:

1. Local dissemination of findings through feedback to clinicians and teams and across the organisation where appropriate. This will be led through the Resuscitation Committee and escalated to the Improving Patient Safety Steering Group (IPSSG) where appropriate.
2. Inclusion of findings from case note reviews in resuscitation training and DNACPR decision making training materials.
3. Implementation of the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) process in the trust and ideally in partnership with GPs to improve advanced care planning and discussion of resuscitation for patients and relevant others across all care areas.

**Summary**

This is an evolving process. The mortality review process is reproducible and is providing a rich seam of learning which, albeit not necessarily affecting outcomes, will allow us to improve end of life care in many patients.

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

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| | | | |
|---|---|---|---|
| **Date of Meeting:** | 30 May 2018 | **Agenda item:** | 11.3 |
| **Report to:** | Board of Directors | | |
| **Title:** | NHS Resolution: Safer Maternity Incentive Scheme | | |
| **Sponsoring Director:** | Jill Foster, Chief Nurse | | |
| **Author(s):** | Dr Kat Johnson, Clinical Director Planned and Surgical Care<br>Alison Pedlingham, Head of Midwifery | | |
| **Report Purpose:** | **Decision** ✓ **Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓ | | |
| **Executive Summary:** | • This benchmarking template details the Trust's position against the 10 maternity actions necessary for a 10% rebate in maternity NHSLA premium.<br>• The Trust is green for four actions in the action plan, amber for five and red for one action.<br>• The red action relates to midwifery workforce planning, specifically to the supernumerary labour ward coordinator – significant investment or a change to the structure of the establishment would be required to provide this.<br>• The amber actions have clear action plans but significant investment is required for full implementation of the Saving Babies Lives Care Bundle, specifically the scanning of high risk pregnancies element.<br>• Reducing stillbirths is a quality priority for 2018/19 and a benchmark report will be brought to the June Quality Committee. | | |

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

| **Key implications** | |
|---|---|
| **Risk Assessment:** | There is a risk of significant investment being required to fully meet all 10 actions and to recover the full 10% discount. Meeting all 10 actions would reduce the risk of safety incidents within maternity. |
| **Legal / regulatory:** | Non identified |
| **Resource:** | Detail any resource or finance implications. Or insert 'none identified'. |
| **Impact Assessment:** | Not applicable |
| **Conflicts of Interest:** | None identified. |
| **Reference documents:** | None |
| **Assurance:** | Reviewed at SMT April 2018 |

**Action Required by the Board of Directors:**

That the Board:

- *Notes items included within the report;.*
- *Subject to comments received from the Board, endorses the content and action plan*

## NHS Resolution CNST Incentive Scheme – Benchmarking April 2018

| NHS Resolution CNST Incentive Scheme – Criteria One | | RED | AMBER | GREEN | Validation Process |
|---|---|---|---|---|---|
| **Q1** | **Are you using the National Perinatal Mortality Review Tool to review perinatal deaths?** | | | ✓ | Self-certification report to Board using template report.<br><br>Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) data will be used to cross-reference against Trust self-certification. |
| Q1a | Are you able to demonstrate use of the NPMRT to review perinatal deaths January 2018 – April 2018? | | | ✓ | |
| Q1b | Are you using the NPMRT to review perinatal deaths that pre-date the NPMRT's launch? | | | ✓ | |

**Comments:**
**Action:**

1. Standard Operating Procedure to be written about process for review of case, including timeframe, and involvement of patient, including patient information sheet and contact details. Early conversation to be held with patient to notify of process – to include as part of SOP.

2. To review all cases from January 2018 to April 2018 using the tool through a multi-disciplinary forum as above.

3. Use the tool to retrospectively review all cases from April 2017 – January 2018.

**Evidence submitted:**
Patient information leaflet NPMR tool

## NHS Resolution CNST Incentive Scheme – Benchmarking April 2018

| NHS Resolution CNST Incentive Scheme – Criteria Two | | RED | AMBER | GREEN | Validation Process |
|---|---|---|---|---|---|
| **Q2** | **Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?** | | | ✓ | Self-certification report to Board using template report.<br><br>NHS Digital data will be used to cross-reference against Trust self-certification.<br><br>Trusts assessed against the required standard for March 2018 submitted by the end of May 2018 - (this will be at provider level data rather than site level data).<br><br>*** valid excludes not known and missing**<br><br>**Where the criteria assesses the quality of booking, delivery or births data and no data of that type are submitted, the criteria is not met.** |
| Q2a | Are you able to demonstrate progress on at least 8 out of the following 10 criteria: | | | ✓ | |
| Q2b | Have you submitted MSDS in all of the last three months (i.e. data relating to January - March 2018)? | | | ✓ | |
| Q2c | Did your latest submission contain booking appointments in the month? | | | ✓ | |
| Q2d | Did your latest submission contain method of delivery for at least 80% of births? | | | ✓ | |
| Q2e | Did your latest submission contain at least 80% of HES births expectation (unless reason understood)? | | | ✓ | |
| Q2f | Did your latest submission contain all of the tables 501, 502, 404, 409? | | | ✓ | |
| Q2g | Did your latest submission contain all the tables 401,406,408,508,602 (unless justifiably blank)? | | | ✓ | |
| Q2h | Did your latest submission contain valid* smoking at booking for at least 80% of bookings? | | | ✓ | |
| Q2i | Did your latest submission contain valid baby's first feed for at least 80% of births? | | | ✓ | |
| Q2j | Did your latest submission contain valid in days gestational age for at least 80% of births? | | | ✓ | |
| Q2k | Did your latest submission contain valid* presentation at onset for at least 80% of deliveries where onset of labour recorded? | | | ✓ | |

**Comments:**
**Evidence submitted:**
Copy of CNST data submitted Q3 (Oct-Dec 2017)

## NHS Resolution CNST Incentive Scheme – Benchmarking April 2018

| NHS Resolution CNST Incentive Scheme – Criteria Three | | RED | AMBER | GREEN | Validation Process |
|---|---|---|---|---|---|
| **Q3** | **Can you demonstrate that you have transitional care facilities in place and operational to support the implementation of the ATAIN Programme?** | | ✓ | | Self-certification report to Board using template report.<br><br>NHS Resolution will cross-check trusts' self-reporting with Neonatal Operational Delivery Networks to verify the Trust's progress against this action.<br><br>**Trusts should be assessing their transitional care provision as at end April 2018.** |
| Q3a | Do you provide a service delivery model where care, additional to normal infant care, is provided in a postnatal clinical setting or in a bespoke transitional care unit with the mother as primary care giver, supported by appropriately trained healthcare professionals?<br><br>Additional care requirements may include: care for late preterm infants, provision of intravenous antibiotics, provision of complementary nasogastric tube feed. | | ✓ | ✓ | |

**Comments:**

Intravenous antibiotics are routinely given on the postnatal ward.
Babies are admitted to the postnatal ward from 36 weeks gestation
Hypoglycaemia policy in place.
Jaundice policy in place
ATAIN data 2017/18 showed 3% of term babies were admitted to SCBU (well below national ATAIN aim of <6% opf term babies admitted to SCBU)

Gaps:
1.No current transitional care arrangements for babies <36 weeks
2. No current transitional care arrangements for complementary NG tube feeding

**Action:**

1. Development of transitional care arrangements for babies less than 36 weeks.
2. Development of transitional care arrangements for complementary nasogastric feeding.

**Evidence submitted:**
ATAIN data

## NHS Resolution CNST Incentive Scheme – Benchmarking April 2018

| NHS Resolution CNST Incentive Scheme – Criteria Four | | RED | AMBER | GREEN | Validation Process |
|---|---|---|---|---|---|
| **Q4** | **Can you demonstrate an effective system of medical workforce planning?** | | | ✓ | Self-certification report to Board using report template and completed RCOG Workforce monitoring tool. |
| Q4a | There should be no more than 20% of middle grade sessions on labour ward filled by consultants acting down from other sessions. | | | ✓ | |
| Q4b | Can you conduct a self-assessment against any consecutive 4 week period in March or April using the Royal College of Obstetricians and Gynaecologists (RCOG) workforce monitoring tool (to follow in late January/early February) | | | ✓ | |

**Evidence submitted:**
Medical staffing guideline (updated May 2017)
RCOG workforce monitoring data showing 0% of middle grade sessions on labour ward filled by consultants acting down from other sessions.

## NHS Resolution CNST Incentive Scheme – Benchmarking April 2018

| NHS Resolution CNST Incentive Scheme – Criteria Five | | RED | AMBER | GREEN | Validation Process |
|---|---|---|---|---|---|
| **Q5** | **Can you demonstrate an effective system of midwifery workforce planning?** | | ✓ | | Self-certification report to Board using template report.<br><br>**Trusts should be evidencing the position as at end April 2018. Evidence for item 1 could include Board minutes or evidence of a full audit or table-top exercise using a tool such as Birthrate+** |
| Q5a | Can you provide evidence of a systematic, evidence-based process to calculate midwifery staffing establishment? | ✓ | | | |
| Q5b | Does your trust policy demonstrate that, as standard, midwifery labour ward shifts are rostered in a way that allows the labour ward coordinator to have supernumerary status (defined as having no case load of their own during that shift)? | ✓ | | | |
| Q5c | Do you include the neonatal workforce within work force plans? | ✓ | | | |

**Action:**
Purchase of the BirthRate Plus Acuity tool agreed by Planned and Surgical Care Directorate (awaiting confirmation from the company on the introduction of an app) = £4200 (in year 1)

Completion of a workforce development plan to ensure DS coordinator is supernumerary (defined as having no case load of their own during the shift)

Work the paediatric department to include the neonatal workforce within workforce plans for maternity.

**Evidence submitted:**
Minimum staffing guideline (updated December 2017)
Maternity staffing report 2017 (updated March 2018)
HDFT acuity quotation from Birthrate Plus - 2018

## NHS Resolution CNST Incentive Scheme – Benchmarking April 2018

| NHS Resolution CNST Incentive Scheme – Criteria Six | | RED | AMBER | GREEN | Validation Process |
|---|---|---|---|---|---|
| **Q6** | **Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives care bundle?** | | ✓ | | Self-certification report to Board using template report.<br><br>NHS Resolution to cross-check Trusts' self-reporting with NHS England.<br><br>**Trusts should be evidencing the position as at end April 2018.** |
| Q6a | Can you demonstrate Board level consideration of the SBL care bundle in a way that supports the delivery of safer maternity services? | | ✓ | | |
| Q6b | Can you provide Board minutes demonstrating that each element of the SBL care bundle has been implemented or that an alternative intervention put in place to deliver against element(s)? | | ✓ | | |

**Comments:**

**See Survey 9 submission data**

**Note rated as green for 'Screening and monitoring all pregnancies based on the assessment of risk for FGR' – current scanning resource does not allow full compliance with the Care Bundle recommendations.**

**Reducing Stillbirth is a trust quality priority for 2017/18 and will be monitored through the Quality Committee (board subgroup)**

**Action:**

1. Review and completion of a Business case to support scanning in line with saving babies Lives.
2. Provide Quality Committee with a gap analysis and action plan for SBL Care Bundle June 2018.

## NHS Resolution CNST Incentive Scheme – Benchmarking April 2018

| NHS Resolution CNST Incentive Scheme – Criteria Seven | | RED | AMBER | GREEN | Validation Process |
|---|---|---|---|---|---|
| **Q7** | **Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?** | | ✓ | | This action is self-explanatory.<br><br>Evidence would include minutes of regular MVP meetings demonstrating their business.<br><br>Trusts should be evidencing the position as at end April 2018.<br><br>Self-certification report to Board using template report. |

**Action:**
To continue work started to fully implement a Maternity Voices Partnership Forum.

**Evidence submitted:**

You Said We Did (Q3 and Q4) 2017/18
Completed Picker action Plan 2015
Picker/CQC results (powerpoint presentation) 2017
Action Plan for Picker/CQC 2017
Patient Voice Group report to maternity (December 2017)

## NHS Resolution CNST Incentive Scheme – Benchmarking April 2018

| NHS Resolution CNST Incentive Scheme – Criteria Eight | | RED | AMBER | GREEN | Validation Process |
|---|---|---|---|---|---|
| **Q8** | **Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?** | | ✓ | | **MINIMUM EVIDENCE**: Completion of the 'CNST local training record' form following each training day, including details of the programme used as well as entering all attendees on their local training database to ensure they can demonstrate the percentage attendance for each staff group.<br><br>Self-certification report to Board using template report. |
| Q8a | Does training should include fetal monitoring in labour and integrated team-working with relevant simulated emergencies and/or hands on workshops? | | | ✓ | |
| Q8b | Is the training syllabus based on current evidence, national guidelines/recommendations, any relevant local audit findings, risk issues and case review feedback, and include the use of local charts, emergency boxes, algorithms and pro-formas. There should also be feedback on local maternal and neonatal outcomes? | | | ✓ | |
| Q8c | Do the Maternity staff attendees include: obstetricians (including Consultants, staff grades and trainees); obstetric anaesthetic staff (Consultants and relevant trainees); midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and stand alone birth centres) and bank midwives); maternity theatre and critical care staff; health care assistants (to be included in the maternity skill drills as a minimum) and other relevant clinical members of the maternity team? | | ✓ | | |

**Action:**

- To raise the profile of the importance of an annual face to face update in fetal monitoring and evidence of competency with staff and line managers, mandatory for midwives and Obstetricians.
- To encourage medical staff to book on training.
- Compliance with this training will be monitored through Maternity Risk Management Group and Departmental Obstetric/midwifery meetings.

**Evidence submitted:**
Training reports for 2017 and 2018
Training figures for 2017 and 2018
Prompt timetable
Maternity safety CNST local training record attendance sheets for January, February and March 2018
CTG training plan

## NHS Resolution CNST Incentive Scheme – Benchmarking April 2018

| NHS Resolution CNST Incentive Scheme – Criteria Nine | | RED | AMBER | GREEN | Validation Process |
|---|---|---|---|---|---|
| **Q9** | **Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?** | | ✓ | | Trusts should be evidencing the position as at end April 2018.<br><br>Self-certification report to Board using template report. |
| Q9a | Can you evidence of bi-monthly meetings through meeting agendas, minutes etc. demonstrating reviews of published national reports (such as Each Baby Counts and MBRRACE-UK), reviews of locally collected clinical measures, inspection reports and feedback from women and families? | | ✓ | | |
| **Action:**<br>To arrange for named consultant safety champion and the Chief Operating Officer to attend meetings with HOM and Chief Nurse on alternate months, set agenda and TOR to be agreed.<br>**Evidence submitted:**<br>TOR and agenda for Maternity Safety Champions meeting – 1st meeting planned for June 4th 2018. | | | | | |

## NHS Resolution CNST Incentive Scheme – Benchmarking April 2018

| NHS Resolution CNST Incentive Scheme – Criteria | | RED | AMBER | GREEN | Validation Process |
|---|---|---|---|---|---|
| **Q10** | **Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme** | | | ✓ | Trusts should be evidencing the position as at end March 2018.<br><br>Self-certification report to Board using template report with Commissioner sign-off.<br><br>NHS Resolution to cross reference Trust report against the National Neonatal Research Database (NRRD) data. |
| Q10a | Are you reporting all qualifying incidents that occurred in the 2017/18 financial year to NHS Resolution under the Early Notification scheme reporting criteria? | | | ✓ | |

**Action plan: NHS Resolution - 10 maternity safety actions**
**Date: 20th April 2018**
**Action plan owner: A.Pedlingham, K. Johnson**
**Monitoring group / committee: MRMG**

**Action plan progress**

| ID no. | Issue / Audit Finding / Theme | Initial risk (H/M/L) | Action/s | Operational Lead | Responsible Lead | COST | Target Date | Risk at review (H/M/L or complete) | Progress made | Further action/s to ensure completion | Operational Lead (if changed) | Responsible Lead (if changed) | New target date if original passed |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Demonstration of use of the NPMRT to review perinatal deaths January - April 2018 | | Action:<br><br>1. Standard Operating Procedure to be written about process for review of case, including timeframe, and involvement of patient, including patient information sheet and contact details. Early conversation to be held with patient to notify of process – to include as part of SOP.<br><br>2. To review all cases from January 2018 to April 2018 using the tool through a multi-disciplinary forum as above.<br><br>3. Use the tool to retrospectively review all cases from April 2017 – January 2018.<br>. | Sue Oxendale, Bereavement midwife | Debi Gibson, (Matron maternity) | | 31/05/2018 | | Patient information leaflet completed. | | | | |
| 3 | Demonstration transitional care facilities are in place and operational to support the implementation of the ATAIN programme | | 1. Development of transitional care arrangements for babies less than 36 weeks.<br>2. Development of transitional care arrangements for complementary nasogastric feeding. | Charlie Kent (Pannal ward Manager), H. Stuart (Manager SCBU) | Debi Gibson, (Matron maternity), J. Walker (Matron, paediatrics) | | | | | | | | |
| 5 | Demonstration of an effective system of midwifery workforce planning | | Purchase of the BirthRate Plus Acuity tool agreed by Planned and Surgical Care Directorate (awaiting confirmation from the company on the introduction of an app) = £4200 (in year 1)<br><br>Completion of a workforce development plan to ensure DS coordinator is supernumerary (defined as having no case load of their own during the shift)<br><br>Work the paediatric department to include the neonatal workforce within workforce plans for maternity. | Alison Pedlingham (HOM), J.Walker (Matron paediatrics) D. Gibson (Matron maternity) | J. Hammond (Directorate OD), R. Chillery (Directorate OD | £4,200 | 31/05/2018 | | | | | | |
| 6 | Demonstration of compliance with all 4 elements of the 'Saving babies Lives' Care Bundle | | 1. Review and completion of a Business case to support scanning in line with saving babies Lives.<br>2. Provide Quality Committee with a gap analysis and action plan for SBL Care Bundle June 2018. | K. Johnson (Consultant Obstetrician), J. Hammond (Directorate OD) | | **TBC - business case under review** | 30/06/2108 | | | | | | |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 7 | Demonstration of a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum and that you regularly act on feedback. | | To continue work started to fully implement a Maternity Voices Partnership Forum. | D.Gibson (Matron maternity), E.Field (Parent education midwife) | A.Pedlingham (HOM) | | 30/06/2018 | | | | | | |
| 8 | Evidence that 90% of each maternity staff group have attended in-house multi-professional maternity emergency training session within last training year | | • To raise the profile of the importance of an annual face to face update in fetal monitoring and evidence of competency with staff and line managers, mandatory for midwives and Obstetricians.<br>• To encourage medical staff to book on training.<br>• Compliance with this training will be monitored through Maternity Risk Management Group and Departmental Obstetric/midwifery meetings. | K McClune (Professional Development midwife), K. Johnson (Consultant Obstetrician), J. Charlton (Consultant Anaesthetist) | A.Pedlingham (HOM), | | Sep-18 | | | | | | |
| 9 | Demonstration that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to discuss locally identified issues | | Arrange diarised bi-monthly meetings for Chief Nurse, HOM, Consultant Obstetrician and Chief Operating Officer. TOR and provisional agenda completed - need to be agreed at 1st meeting | A.Pedlingham (HOM), K. Johnson (Consultant Obstetrician), Rob Harrison (COO) | Jill Foster (Chief Nurse | | 30/06/2018 | | 1st meeting arranged 4th June 2018. TOR and agenda sent prior to meeting. | | | | |
| | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |

Harrogate and District NHS Foundation Trust

# Board Committee report to the Board of Directors

| | |
|---|---|
| **Committee Name:** | Quality Committee (QC) |
| **Committee Chair:** | LA Webster |
| **Date of last meeting:** | Wednesday 2nd May 2018 |
| **Date of Board meeting for which this report is prepared** | 30 May 2018 |

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

**Hot Spots**
**Falls –** further to a debate at QC Fractures to the Neck of Femur are now categorised as severe harm. It was reported that in the previous three weeks there had been 3 such incidents, each in different locations and all had investigations underway. QC agreed this was an appropriate change to this type of incident.
**0-19 Services –** Challenges are being experienced in some regions where GP's are refusing to share patient information with the Childrens Safeguarding team. The local CCGs are being informed where appropriate.

**Board Request for QC to seek assurance:** No new items this month.

**Reports Received:**

- Safeguarding Children – Annual Report (draft). This was an excellent report from Lorraine Fox, Head of Safeguarding Children, highlighting the significant amount of work and complexity required to deliver high quality care for children requiring this specialist area of care. It was noted that 'Safeguarding' week would be taking place throughout week commencing 25 June and this would be used as an opportunity to launch a number of training initiatives and highlight policies in place.
- Quality Account – final draft reviewed and endorsed by QC
- Childrens and County Wide Community Care Directorate Governance Groups annual report received
- Health & Safety Annual Report – heard about issues re attendance at meetings and as a result the Terms of Reference for this group needs to be revised, however overall results from audits is good.
- Friends & Family Test Annual Report – this report created much debate and it is clear there is much more that could be done to enhance the results. It is anticipated that the ward FFT response rate would be helped by having this information included in the new quality dashboard and promoting use of results by ward managers.

- External Reports –
    - Update on COPD reports and action plans
    - HDGH Critical Care Peer Review Report
    - National Diabetes Audit 2016-17 report
    - National Diabetes Footcare Audit

**Other Items**

- QC annual report approved
- New Look Quality Dashboard – Positive feedback from ward managers view of first draft
- Complaints – Further to discussions at QC seeking further assurance about handling complaints a proposal to conduct a satisfaction survey has been agreed and will be managed via Learning from Patients Group.
- Allergy Bands – Discussions to gain assurance on use of allergy bands continued. A focus on maintaining compliance to be undertaken.
- QC Work Plan Additions
    - Tees, Esk and Wear Valley NHS Trust provides the Trust with an administrative service, training and advice. An annual report containing the detail of work provided will be received by Quality Committee on behalf of the Board.
    - Quality Impact Assessments – a process for oversight of CIP schemes, their cumulative and or longer term impact on quality of services is to be developed and QC will review in September if there is a role for this committee in this process.

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

None

**Matters for decision**

None

**Action Required by Board of Directors:**

Note:

1. Quality Committee Annual Report approved and submitted to Audit Committee
2. Hot spot re Childrens safeguarding issues with GPs
3. Work Plan Additions

# Annual Report of the Quality Committee 2017/18
# Prepared for the Audit Committee April 2018

The purpose of this annual report is to provide assurance that the Quality Committee is working effectively within its terms of reference (ToR) and achieving the required outcomes/impact.

## Purpose of the Committee

The Quality Committee (QC) is an accountable Committee to the Board of Directors. The purpose of which is to oversee arrangements for quality governance and seek assurances on the delivery of high quality care and regulatory compliance.

## Background

The QC has been in existence since July 2015.
The work of this committee continues to evolve as priorities and new areas for focus present during the year, however a standardised base work-plan to deliver the ToR remains in place.

## Membership and attendance

Attendance at meetings has been very good. (Quorate being six core members). (*The Chair is very grateful to members who arrange for a team member to attend on the few occasions where they have been unable to attend.*)
Sue Proctor's departure left a NED gap which was kindly filled on interim by Maureen Taylor, who attended from May until October when we welcomed Laura Robson who joined as a permanent member.
Neil McLean's departure has now created a gap which is being covered until a replacement is made by Angela Schofield.
In November the membership was reviewed and it was agreed that David Plews would replace Phillip Marshall - ToR were amended.

| Member (by title or group representing as per ToR) / Date of Meeting | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Total Attended | No of Meetings per Year | Percentage |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Non-Executive Director (Chair) | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 11 | 12 | 92% |
| Non-Executive Director (N McLean) | 1 | 1 | 1 | 1 | 0 | 0 | 1 | 1 | 1 | 1 | 0 | 1 | 9 | 12 | 75% |
| Non-Executive Director (M Taylor/L Robson) | 0 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 10 | 12 | 83% |
| Chief Nurse | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 12 | 12 | 100% |
| Deputy Medical Director/Medical Director | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 0 | 1 | 1 | 1 | 10 | 12 | 83% |
| Chief Operating Officer | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 1 | 5 | 12 | 42% |
| Director of Workforce and OD | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 11 | 12 | 92% |
| Deputy Director of Governance | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 10 | 12 | 83% |
| Head of Risk Management | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 11 | 12 | 92% |
| Clinical Director - LTUC | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 12 | 12 | 100% |
| Clinical Director - P&SC | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 12 | 12 | 100% |
| Clinical Director - C&CWCC | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 12 | 12 | 100% |
| **Total of members per meeting** | **10** | **12** | **11** | **10** | **10** | **9** | **10** | **10** | **10** | **10** | **11** | **12** | | | |
| *Ad hoc attendance may be by invitation of the Chair. The representative of the subgroups may also be a directorate representative. | | | Maureen Taylor attended on Interim term | | | | Laura Robson new NED | | David Plews replaced Phillip Marshall | | | Angela Schofield rep Neil McLean | | | |
| Head of Nursing, LTUC (& PSC wef Jan 18) | 1 | 0 | 1 | 0 | 0 | 1 | 1 | 1 | 1 | 1 | 2 | 2 | | | |
| Jane Hedley (Public Governor) (observing) | 1 | | | | | | | | | | | | | | |
| Sarah Crawshaw (Governor) (apologies) | | 0 | | | | | | | | | | | | | |
| Rachel Lee, Tissue Viability Nurse Spec. | | 1 | | | | | | | | | | | | | |
| Katherine Roberts (observing) | | | 1 | | 1 | 0 | 1 | 1 | 0 | 1 | 0 | 1 | | | |
| Carmel Lister (Annual Falls Report) | | | 1 | | | | | | | | | | | | |
| Dr M Shepherd (QP Sepsis) (CEM Audits) | | | 1 | | 1 | | | | | | | | | | |
| Ms R Wixey (NICE Compliance Report) | | | 1 | 1 | | | | | | | | | | | |
| Mrs J Farnhill (Adult Safeguarding Report) | | | 1 | | | | | | | | | | | | |
| Mrs S Eddleston (Governor) (observing) | | | | 1 | | | | | | | 1 | | | | |
| Dr J Child (IP&C Annual Report) | | | | 1 | | | | | | | | | | | |
| Mrs L Fox (Safeguarding Children Ann Rep) | | | | 1 | | | | | | | | | | | |
| Pat Jones (Governor) (apologies) | | | | | 0 | | | | | | | | | | |
| Steven Treece (Governor) | | | | | | 1 | | | | | | | | | |
| Laura Robson (NED) (observing) | | | | | | 1 | | | | | | | | | |
| Dr D Earl (QP Sepsis) | | | | | | 1 | | | | | | | | | |
| Ruth Irving (observing) | | | | | | | 1 | | 1 | | | | | | |
| Ann Hill (Governor) | | | | | | | 1 | | | | | | | | |
| Daniel Scott (Staff Governor) | | | | | | | | 1 | | | | | | | |
| Dr J Paisley (Nat Audit of Dementia paper) | | | | | | | | 1 | | | | | | | |
| Angela Schofield (observing) | | | | | | | | | 1 | | | | | | |
| Pamela Allen (Governor) (observing) | | | | | | | | | 1 | | | | | | |
| Clare Cressey (Staff Governor) (observing) | | | | | | | | | | 1 | | | | | |
| Dr S Rahman (Diabetes item) | | | | | | | | | | | 1 | | | | |
| Mrs R Marsh (Governor) (observing) | | | | | | | | | | | | 1 | | | |

NB: The Heads of Nursing from LTUC & PSC attend most meetings and their input is greatly valued.
*In addition to the regular membership we have been pleased to welcome a number of Governors and other observers throughout the year.*

## Date on which ToR were confirmed and any changes to ToR in year

ToR were reviewed in June as part of the annual review.
Last reviewed and approved membership change in November 2017.

| Progress on stated committee objectives or key areas of responsibility |
| --- |
| The Committee has continued its work to gain assurance in relation to the four domains defined in Monitor's 'Well-led framework for governance reviews' guidance for NHS foundation trusts:<br>• Strategy and planning;<br>• Capability and culture;<br>• Process and structures;<br>• Measurement.<br><br>The work-plan remains focussed on the following six key headings:<br>1. To identify current concerns<br>2. Quality Reports<br>3. Patient Safety<br>4. Effective Care and Outcomes<br>5. Patient Experience<br>6. Regulatory and Compliance<br><br>**Identify Current Concerns** – There are three areas considered under this section<br>1. 'Hot Spots' The QC can hear from members about current issues that are impacting upon the ability of the Trust to deliver quality care and to gain assurances that suitable actions / activity is underway to address these. Examples of this are:<br>a) Impact on quality care as a result of the Financial Recovery plan, added as a standing item under this section during the year;<br>b) CPE case and how this was handled;<br>c) Nutrition concerns for a vulnerable patient and learning from this.<br>2. To enable more in depth scrutiny of specific areas of care at the request of the Board. Examples are:<br>a) Specific reports and updates received in relation to the methods put in place to improve the quality of end of life care in the community;<br>b) Assurance gained in respect of quality of care related to avoidable falls and pressure sores.<br><br>3. The QC reviews the Quality Dashboard and Integrated Board Reports (quality section) in depth each month and pursues areas of concern and seeks further assurance where necessary.<br><br>**Quality Dashboard** – QC initiated a review of this report, the data it contains, who uses the data and how this could be improved to add value at Ward and Directorate level. As a result of this a new Dashboard will be introduced during Quarter One of FY18/19. The Committee considers this new version will provide opportunities to identify areas for quality improvement and learning.<br><br>**Quality Reports** – Throughout the year the Committee has heard regular updates from the lead Directorate on their progress to deliver the Trusts 2017/18 quality priorities which were:<br>a) Reduce morbidity and mortality related to sepsis<br>b) Provide high quality stroke care<br>c) Improve learning from incidents, complaints and good practice<br>d) Improve the patient experience of discharge processes<br>e) Strengthen the voice of children, young people and families by seeking patient reported experience and using this in the development of a number of services.<br><br>**Annual Quality Account Report** – The QC retains oversight of this annual account.<br><br>**Patient Safety** – The Patient Safety Report received quarterly – this comprehensive report provides details of a wide range of areas relating to patient safety for example incident |

reporting, safety alerts and document control which is an area for continued focus for QC.

**Effective Care and Outcomes** – Quarterly reports received on the Clinical Effectiveness Audit programme and receives and approves the annual audit plan for the FY.

**External Reports Received** – The system for recording receipt of external reports and a log for the lead individual responsible to action these remains robust and has been enhanced in the year by a RAG rating overview to highlight where action plans are falling behind. Where we consider that a plan requires support or focus we invite the lead to provide an update on progress of action plans to provide the level of assurance required.

**Patient Experience** – Patient Experience Report – this quarterly report is now well embedded and continues to provide assurance on this element of quality. An area the committee has retained focus upon throughout the year is dealing with complaints, specifically closing actions within deadline.

**Quality Charter** – The Annual Report received by the Committee demonstrated significant traction and successes with this initiative and members of the Committee are planning to become Bronze Level Quality of Care Champions.

**Regulatory and Compliance** - a list of reports received is below.

| Summary of Reports received by the Committee |
| --- |
| |

| Reports Received 2017/18 | Month Received |
|---|---|
| **Quality Account** | |
| Timetable for quality account preparation | December |
| Draft report | April |
| Final report | May |
| | |
| **Quality priority updates** | |
| | Baseline, Q2, Q3 |
| | Baseline, Q2, Q3 |
| | Baseline, Q2, Q3 |
| | Baseline, Q2, Q3 |
| | |
| **Annual reports and reviews** | |
| Infection Prevention and Control | December |
| Local Supervising Authority audit report / action plan | October |
| Annual Maternity screening report | December |
| Health and safety annual report | April |
| Annual report - Staff FFT and staff survey re quality of care | April |
| Clinical Effectiveness and Audit annual report | June |
| Annual report from directorate governance groups | May |
| Annual report Quality Committee | May |
| Annual review Quality Committee TOR | June |
| Safeguarding children annual report | July |
| Adult safeguarding annual report | June |
| Nursing and midwifery annual report | June |
| Annual report on pressure ulcers | April |
| Annual report on the management of Controlled Drugs | January |
| Patient FFT | May |
| | |
| **Quarterly reports** | |
| Patient experience report - quarterly | Sept (Q1), Dec (Q2), March (Q3), June (Q4) |
| Clinical audit plan / report - quarterly | Sept (Q1), Dec (Q2), March (Q3), June (Q4) |
| NICE compliance report | Sept (Q1), Dec (Q2), March (Q3), June (Q4) |
| Patient safety quarterly report | Sept (Q1), Dec (Q2), March (Q3), June (Q4) |
| | |
| **Assurance statement and reports** | |
| Quality Charter Update | July, Dec |
| Maternity assurance statement | December, June |
| Report on progress with action plans relating to external reports | February and July |

## Quality Committee Effectiveness Survey

It is recommended corporate governance best practice for committees of the board of directors to undertake annual self-assessment of effectiveness.

A survey of committee members was undertaken in August/September 2017. In addition directors who do not sit on the committee were invited to provide feedback about the Quality Committee.
Twelve people responded to the survey; eight members and four deputies. They answered 25 questions which covered committee focus, committee team working, committee effectiveness, committee engagement and committee leadership.
In addition four directors who do not sit on the committee responded to a shortened version

| |
|---|
| of the survey.<br>c<br>Many areas of governance best practice were confirmed. A small number of areas were highlighted for members of the committee to discuss to further improve the effectiveness of the Committee. |
| Proposed objectives for 2018/19 |
| The Committee will continue to gain assurance under the six headings listed above.<br>The Committee will hear updates from the Directorates on progress to deliver the Quality Priorities for the year, most of which are being carried forward into the new year, with just one new priority being introduced.<br><br>The forward plan for reports to be received during 2018/19 remains unchanged with one exception which is to remove the Staff Friends and Family Test and Staff Survey annual report which is received at a number of other Committees. |
| Conclusion |
| The Quality Committee considers it has delivered to the Terms of Reference as requested by the Board and has comprehensive minutes and actions log on file to further demonstrate this.<br>The Committee has retained a clear forward plan of activity to continue this work throughout 2018/19. |
| Author |
| *Lesley A Webster, Non-Executive Director, Chair Quality Committee.*<br>*Date: 18/04/2018* |

Harrogate and District
NHS Foundation Trust

# Board Committee report to the Board of Directors

| | |
|---|---|
| **Committee Name:** | Audit Committee |
| **Committee Chair:** | Chris Thompson |
| **Date of last meetings:** | 3 and 17 May 2018 |
| **Date of Board meeting for which this report is prepared** | 30 May 2018 |

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

1. At its meeting on 3 May, the Committee considered, and where appropriate approved, a number of documents that had been prepared in connection with the end of year process. These included the following:
   a. Draft Audit Committee Annual Report
   b. Quality Committee Annual Report
   c. Post Project Evaluation ("PPE") Group Annual Report
   d. Corporate Risk Review Group Annual Report
   e. Code of Governance Self Assessment
   f. Local security management Specialist Report
   g. Counter-Fraud Annual Report
   h. Accounts Briefing paper
   i. Draft Financial Statements for the Trust
   j. Draft Financial Statements for the Trust Charitable Fund
   In particular the Committee considered a number of changes that had been made to the draft financial statements following the Accounts Review Meeting on 23rd April.

2. At the meeting on 17 May, the following documents were considered:

   a. Draft Quality Account 2017/18
   b. Audit Committee Annual Report 2017/18
   c. Annual Corporate Governance Statement presented by the Chief Executive
   d. Draft Annual Report 2017/8
   e. Updated Draft Financial Statements for the Trust
   f. Updated Draft Financial Statements for the Trust Charitable Fund
   g. Review of Losses and Special Payments
   h. External Audit ISA 260 Audit Highlights Memoranda and draft letters of representation
   i. Confirmation of External Audit independence

3. The Audit Committee has also undertaken its "normal" programme of work and review during the course of the meetings. This has included reviews of the minutes of Corporate Risk Review Group and the Quality Committee.

4. The most recent version of the Corporate Risk Register was reviewed, with the Committee noting the most recent set of changes that had been made to the Register and confirming that the detailed analysis was consistent with the information most recently provided to the Trust Board of Directors.

5. The Periodic Internal Audit Report considered on 3 May contained details of 16 audits that had been finalised during the period under review. Of these audits, a total of 9 were

follow-up audits following past Limited Assurance findings. It was disappointing to note that four of these follow up audits resulted in Limited Assurance outcomes. However, the Committee did note that in the case of each of these audits, there had been progress on implementing the recommendations of the previous audit, although the improvements were not sufficient to warrant a "significant assurance" outcome.

6. The Committee has been pleased to note that in all instances of Limited Assurance outcomes, the issues raised are now being considered and addressed by the Senior Management Team.

7. The Committee noted a report from the PPE Group for the first time, but was very disappointed to note that of the 22 PPE's considered by the Group over the last 12 months, only two had been received without the need for "chasing" by members of the Group and / or the SMT. We would hope to see some improvement in this situation over the next 12 months.

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

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

## Matters for decision

- The Committee has carefully considered a range of documents relating to the financial year-end that are coming to the Board for consideration and approval. These include:

  - Accounts Briefing paper
  - Draft financial statements for the Trust and for the Charitable Fund
  - Draft representation letters for the Trust and for the Charitable Fund
  - ISA 260 Audit Highlights Memoranda

- The Committee considered at length the treatment that had been adopted in the draft financial statements for the Trust in respect of two particular issues:
  - The Trust is a member of a Group Action with a number of other NHS organisations relating to the rateable value of the properties utilised for the provision of healthcare. The action applies retrospectively and therefore the anticipated benefit of £1,897k has been recorded as negative expenditure within the 2017/18 financial statements on the basis that the Executive consider that the outcome of the Group Action will ultimately benefit the Trust to the full extent anticipated. The external auditors, KPMG do not consider it appropriate to recognise this transaction in the year as the outcome is not "virtually certain", as is prescribed by International Accounting Standard number 37 (IAS37).
  - The Trust incorporated HHFM on 6 November 2017. As a result of this, the Trust carried out a revaluation of its estate as at 1 April 2017 net of VAT. KPMG agree with the principle of the revaluation net of VAT, but considers that the revaluation should have taken place when the company was incorporated in November 2017. Therefore the impact on the financial statements is that the Trust has reduced its in year charge for depreciation between April and November 2017. The benefit from this treatment in the financial statements is estimated at between £240k and £355k

Whilst fully understanding the views of KPMG on these two issues, the Committee were in agreement with the treatment that had been adopted for both of these issues in drafting the financial statements and recommends that the Board of Directors do approve the signing of the 2017/18 financial statements for the Trust and for the Charity. The Committee also recommends the signing of the letters of representation for the Trust and the Charity for submission to the external auditors.

- The Committee also submits its Annual Report for consideration by the Board

## Action Required by Board of Directors:

The Board is asked to note the considerations that took place at the two meetings of the Audit Committee on 3 and 17 May, and also the recommendations made by the Committee.

# ANNUAL REPORT OF THE HDFT AUDIT COMMITTEE 2017/18

## 1. Introduction

In accordance with best practice and the NHS Audit Committee Handbook, this report has been prepared to provide the Board of Directors with a summary of the work of the Audit Committee during the period April 2017 – March 2018, and in particular how it has discharged its responsibilities as set out in its Terms of Reference.

## 2. Meetings & Attendance

The Audit Committee met formally on six occasions during 2017/18. Audit Committee members attendance is set out in the table below. In addition, all Audit Committee members attended an informal meeting in late April 2017 to undertake a detailed review of the draft accounts (relating to the 2016/17 financial year). Members of the Committee also attended relevant Audit Committee training events during the course of the year.

Audit Committee Members' Attendance

| | 4 May | 18 May | 7 Sept | 7 Dec | 6 Feb | 8 Mar |
|---|---|---|---|---|---|---|
| Mr Chris Thompson | Y | Y | Y | Y | Y | Y |
| Ms Laura Robson | | | Y | Y | Y | N |
| Mr Ian Ward | N | Y | Y | N | Y | N |
| Mrs Maureen Taylor | Y | Y | Y | Y | Y | Y |

The Audit Committee had a membership of four Non-Executive Directors and during the 2017/18 financial year this comprised of:

- Mr Chris Thompson (Chairman)
- Mr Ian Ward
- Ms Laura Robson
- Mrs Maureen Taylor

The Committee is supported, at all of its meetings by:

- The Deputy Chief Executive / Finance Director
- The Deputy Director of Finance
- The Head of Financial Accounts
- Deputy Director of Governance
- Company Secretary
- Internal Audit (Head of Internal Audit and Internal Audit Manager)
- External Audit (Director and Senior Manager)

Other representatives (e.g. Chief Nurse, Local Counter Fraud Specialist and Local Security Management Specialist) attend the Audit Committee as and when required.

The attendance details of all attendees at Audit Committee Meetings during 2017/18 are set out in the attached appendix.

The Committee received secretarial and administrative support from Miss Kirstie Anderson who is employed by the Trust's internal audit providers but has no managerial responsibility for the HDFT Internal Audit Plan.

Audit Committee members meet in private prior to the start of each Committee meeting. Separate, private sessions are held with Internal Audit and External Audit prior to Audit Committee meetings as required, and no less than once a year.

There is a documented Audit Committee timetable which schedules the key tasks to be undertaken by the Committee over the course of a year and which is reviewed at each meeting.

Detailed minutes are taken of all Audit Committee meetings and are reported to the Board of Directors.

Action lists are prepared after each meeting and details of cleared actions and those carried forward are presented at the following meeting.

## 3. Duties of the Audit Committee

Following a review of the Audit Committee's terms of reference in January 2018, the key duties of the Audit Committee could be categorised as follows:

| | |
|---|---|
| • Governance, Risk Management & Internal Control | Review of the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives, primarily through the assurances provided by internal and external audit and other assurance functions. |
| • Financial Management & Reporting | Review of the Foundation Trust's Financial Statements and Annual Report, including the Annual Governance Statement, before submission to the Board of Directors.<br><br>Review of the Charitable Trust's Financial Statements and Annual Report before submission to the Board of Directors acting in its role as Corporate Trustee.<br><br>Ensuring that systems for financial reporting are subject to review to ensure completeness and accuracy of information and compliance with relevant legislation and requirements.<br><br>Review of the Trust's Treasury Management Policy, Standing Financial Instructions and systems in place to ensure robust financial management. |
| • Internal Audit & Counter-Fraud Service | Ensuring an effective internal audit and counter-fraud service that meets mandatory standards and provides appropriate, independent assurance to management and the Audit Committee.<br><br>Review of the conclusion and key findings and recommendations from all Internal Audit reports and review of regular reports from the Local Counter Fraud Specialist. |

| | |
|---|---|
| | Monitoring of the implementation of Internal Audit and Counter Fraud recommendations. |
| • Local Security Management Services (LSMS) | Ensuring an effective LSMS service that meets mandatory standards and provides appropriate assurance to management and the Audit Committee.<br><br>Review the annual report and plan for the following year. |
| • External Audit | Ensuring that the organisation benefits from an effective external audit service.<br><br>Review of the work and findings of external audit and monitoring the implementation of any action plans arising. |
| • Clinical & Other Assurance Functions | Review of the work of the Quality committee within the organisation, whose work provides relevant assurance over clinical practice and processes.<br><br>Review of the findings of other significant assurance functions, both internal and external to the organisation, and consideration of the implications for the governance of the organisation. |

**4. <u>Work Performed</u>**

The Committee has organised its work under five headings "Financial Management", "Governance", "Clinical Assurance", "Internal Audit and Counter Fraud" and "External Audit".

***4.1 <u>Financial Management</u>***

The Committee regularly receives updates and reports from the Finance Director on the Trust's financial position and any issues arising. Items discussed in particular during 2017/18 were the establishment of a wholly owed subsidiary company Harrogate Healthcare Facilities Management (HHFM) to manage Estates and Facilities services.

The Committee oversees and monitors the production of the Trust's financial statements. During the 2017/18 financial year, this included:

- an informal but detailed review of the draft accounts prior to submission to Monitor and External Audit on 25 April 2017,
- a formal Committee meeting to discuss the draft accounts and External Audit's findings on 4 May 2017,
- a formal Committee meeting on 18 May 2017 to review the final accounts and Annual Report for 2016/17 (including the Quality Account) prior to submission to the Board of Directors and Monitor.

*[Note: similar meetings have occurred during April and May 2018 relating to the 2017/18 financial statements, Annual Report and Quality Account].*

In January 2018 the Committee formally reviewed and approved the Trust's accounting policies (to be used in relation to the 2017/18 financial statements), considering consistency over time and compliance with the Foundation Trust Financial Reporting Manual. At the same meeting, the Audit Committee also considered the plan and timetable for the production of the Trust's 2017/18 financial statements and annual report.

The Committee also oversees and monitors the production of the Charitable Trust's financial statements. The final Charitable Funds accounts and Annual Report for 2016/17 were reviewed by the Committee on 18 May 2017 prior to submission to the Corporate Trustee.

The Audit Committee also reviewed and approved:

- Single Tender Actions,
- the Trust's Losses & Special Payments register in May 2017,
- the Annual Procurement Savings Report in September 2017,
- revisions to the Trust's Treasury Management Policy in September 2017, and
- the recommendation to the Trust Board of the use of the going concern principle as the basis for the preparation of the 2016/17 accounts in May 2017.

The review of Post Project Evaluations (arising from capital schemes) is a standing item on the Audit Committee's agenda during the year.

### *4.2 Governance, Risk Management & Internal Control*

The Audit Committee receives the minutes of the Corporate Risk Review Group. These minutes provide detail of the changes to the Corporate Risk Register and new risks considered. In addition the Audit Committee receives the minutes of the Quality Committee, which is a formal sub-committee of the Board of Directors.

The Board Assurance Framework, Corporate Risk Register and mechanisms for reporting strategic risks to the Board are reviewed on a periodic basis alongside the review of the Corporate Risk Review Group minutes.

Additionally the Staff Registers of Interests and Gifts and Hospitality were reported to the Audit Committee in 18 May 2017.

The Annual Governance Statement and the Head of Internal Audit Opinion were reviewed by the Audit Committee prior to submission to the Board. The Chief Executive (or another designated Executive Director) attends the Audit Committee annually in May to discuss assurance around the Annual Governance Statement.

In relation to the governance of the Audit Committee itself, the Committee undertook the following tasks during 2017/18:

- Assessment of Audit Committee Effectiveness in January 2018, the findings of which were presented to the Board of Directors.
- Review and approval of Audit Committee Terms of Reference in December 2017 which were presented to the Board of Directors for approval in January 2018.
- Ongoing review and revision of the Audit Committee's timetable.

### *4.3 Clinical Assurance*

The revised Quality and Governance structure means that the Audit Committee receives assurance on the effectiveness of clinical processes through the meeting minutes and Annual Report of the Quality Committee.

### *4.4 Internal Audit & Counter Fraud Service*

Internal Audit and Counter Fraud Services are provided by Audit Yorkshire. The Chair of the Audit Committee sits on the Audit Yorkshire Board which oversees Audit Yorkshire at a strategic level. The Board met on four occasions during 2017/18.

An Internal Audit Charter formally defines the purpose, authority and responsibility of internal audit activity. This document was updated, reviewed and approved by the Audit Committee in September 2017.

The Audit Committee approved the planning methodology to be used by Internal Audit to create the Internal Audit Plan for 2017/18, and gave formal approval of the Internal Audit Operational Plan in March 2017.

The conclusions (including the assurance level and the corporate importance and corporate risk ratings) as well as all findings and recommendations of finalised Internal Audit reports are shared with the Audit Committee. The Committee can, and does, challenge Internal Audit on assurances provided, and requests additional information, clarification or follow-up work if considered necessary. All Internal Audit reports are discussed individually with the Audit Committee.

A system whereby all internal audit recommendations are followed-up on a quarterly basis is in place. Progress towards the implementation of agreed recommendations is reported (including full details of all outstanding recommendations) to the Director Team and the Audit Committee on a quarterly basis. This has been an area of focus by the Committee during the year and Trust management have worked hard to ensure that the process for responding to internal audit recommendations has been improved.

The Counter Fraud Plan was reviewed and approved by the Audit Committee and the Local Counter-Fraud Specialist (LCFS) presented bi-annual reports detailing progress towards achievement of the plan, as well as summaries of investigations undertaken.

The effectiveness of Internal Audit was reviewed by HDFT staff and the Audit Committee in February 2018, resulting in a satisfactory evaluation. The action plan arising from the review is monitored via the Internal Audit Periodic Report to the Audit Committee.

### *4.5 External Audit*

External Audit services are provided by KPMG.

During the 2017/18 financial year the Audit Committee reviewed External Audit's Annual Governance Report and Management Letter in relation to the 2016/17 financial statements. Work was undertaken during 2017/18 to provide guidance on the accounting treatment to be adopted in respect of certain financial arrangements in place at the 31 March 2018.

External Audit regularly updates the Committee on progress against their agreed plan, on any issues arising from their work and on any issues or publications of general interest to Audit Committee members.

The Audit Committee reviewed and approved the External Audit Plan in relation to the 2017/18 financial statements and the related audit fee in February 2018.

The effectiveness of External Audit was reviewed by HDFT staff and the Audit Committee in 4 May 2017, resulting in a satisfactory evaluation which was reported to the Council Governors.

## 5. Specific Significant Issues discussed by the Audit Committee during 2017/18

The following additional significant issues have been discussed by the Audit Committee during 2017/18:

- Ongoing compliance issues with IV Cannula Care and nurse staff rostering
- The Falls Management follow up audit and consideration at the Quality Committee

- The launch of HHFM and impact on governance arrangements
- The timeliness of Post Project Evaluations (PPE's)
- The timeliness of response by management to internal audit draft reports and the implementation of outstanding internal audit recommendations

## 6. Audit Committee Effectiveness Survey

It is recommended corporate governance best practice for committees of the board of directors to undertake annual self-assessment of effectiveness. A survey of committee members and regular attendees at the committee meetings was undertaken in December 2017. Survey results have confirmed the following areas of strength:

- Committee members contribute regularly across the range of topics.
- With regards to mitigating the key risks to the Trust, the Committee is fully aware of key sources of assurance.
- The committee has the right balance of experience, knowledge and skills.
- The Committee is briefed, via the assurance framework, about key risks and assurances received and any gaps in control/assurance in a timely fashion.
- Members feel sufficiently comfortable within the committee environment to be able to express their views, doubts and opinions.
- The Committee understands the messages being given by the Trust's assurance advisors.
- Members provide real and genuine challenge - they do not just seek clarification and/or reassurance.

## 7. Conclusion

The Audit Committee considers that it has conducted itself in accordance with its Terms of Reference and work plan during 2017/18.

The Audit Committee considers that this annual report is consistent with the draft Annual Governance Statement and the Head of Internal Audit Opinion.

***This Audit Committee Annual Report was approved at 3 May 2018 Audit Committee.***

**Appendix – Attendance Details of Attendees at the Audit Committee**

| | 4 May | 18 May | 7 Sept | 7 Dec | 6 Feb | 8 Mar |
|---|---|---|---|---|---|---|
| **HDFT** | | | | | | |
| Mr Jonathan Coulter | Y | Y | Y | Y | Y | Y |
| Mr Thomas Morrison | N | Y | Y | Y | N | N |
| Mr Jordan McKie | Y | Y | Y | Y | N | N |
| Dr Sylvia Wood | N | Y | Y | N | Y | N |
| Mrs K Roberts | | | N | N | Y | N |
| Mr Stuart Kelly | Y | | | | | |
| **Internal Audit & Counter Fraud** | | | | | | |
| Ms Helen Kemp-Taylor | N | Y | Y | N | Y | Y |
| Mr Tom Watson | Y | Y | Y | Y | Y | Y |
| Mr Steve Moss | Y | | N | Y | Y | Y |
| **External Audit** | | | | | | |
| Mr Rashpal Khangura | N | Y | N | Y | Y | N |
| Mr James Boyle | N | N | N | N | N | Y |
| Mr Thilina De Zoysa | N | N | Y | N | N | N |

**Report title:** Annual Report of the Finance Committee 2017/18

**Report to:** Board of Directors

**Report author:** Mrs M Taylor, Non Executive Director

**Date:** 30 May 2018

## 1. Introduction

1.1 This report has been prepared to provide the Board of Directors with a summary of the work of the Finance Committee during the period April 2017 – March 2018, and in particular how it has discharged its responsibilities as set out in its Terms of Reference.

## 2. Meetings & Attendance

2.1 The Finance Committee met formally on six occasions during 2017/18. Finance Committee members attendance is set out in the table below.

| Membership as defined by Terms of Reference | April 2017 | June 2017 | Sept 2017 | Octr 2017 | Dec 2017 | Feb 2018 | Total 6 | % |
|---|---|---|---|---|---|---|---|---|
| Mrs M Taylor, Chairman | Y | Y | Y | Y | Y | Y | **6** | **100** |
| Mr I Ward | Y | Y | Y | N | Y | Y | **5** | **83** |
| Mrs L Webster | Y | Y | Y | Y | N | Y | **5** | **83** |
| Deputy Chief Executive and Director of Finance | Y | Y | Y | Y | Y | Y | **6** | **100** |
| Chief Operating Officer | Y | Y | Y | Y | Y | Y | **6** | **100** |
| Deputy Director of Finance | Y | Y | Y | Y | Y | N | **5** | **83** |
| Deputy Director of Performance and Informatics | Y | Y | Y | Y | Y | Y | **6** | **100** |

2.2 The Finance Committee has a membership of three Non-Executive Directors and during 2017/18 these were:

- Mrs Maureen Taylor (Chairman)
- Mr Ian Ward
- Mrs Lesley Webster

In addition Mr Chris Thompson, Chair of the Audit Committee, attends the Committee as an observer.

2.3 During the year other people have attended the Committee as observers including Angela Schofield/ Sandra Dodson, Chair of the Trust, The Trust Company Secretary, observing Governors, Insight trainees and other staff attending as part of their development. The Committee received secretarial support from Mrs Catherine Gibson up to the September 2017 meeting after which Mrs Gibson left the Trust. From the October 2017 meeting, Mrs Angie Colvin provided secretarial support. Details of all attendees during 2017/18 are attached at Appendix 1.

2.4 The Committee has a documented timetable and work-plan which schedules the key tasks and reports to be considered over the course of the year. This schedule is reviewed at each meeting and additional items are added as required; these are largely one-off project related reports.

2.5 Detailed minutes are taken of all Finance Committee meetings and are reported to the Board of Directors. In addition, the Committee Chair prepares a summary report highlighting significant issues discussed, for consideration at the Board of Directors meeting, in advance of the minutes being agreed.

2.6 An action log is prepared after each meeting and details of cleared actions and those carried forward are presented at the following meeting.

**3. Duties of the Finance Committee**

3.1 Following a review of the Finance Committee's terms of reference in January 2017, the key responsibilities of the Finance Committee can be categorised as follows:

| | |
|---|---|
| **Financial Strategy** | To scrutinise the development of the Trust's financial and commercial strategy, both revenue and capital. This incorporates scrutiny of the assumptions and methodology used in developing the financial strategy, including activity modelling and efficiency assumptions.<br><br>To ensure that annual financial plan is consistent with financial strategy and to review the capital programme in line with the financial plan.<br><br>To recommend to the Board the financial plan for submission to Monitor/NHS Improvement. |
| **Scrutiny & Efficiency** | To scrutinise and ensure appropriate due diligence is undertaken in relation to any significant transactions as defined by Monitor / NHS Improvement.<br><br>Scrutiny of the annual Cost improvement Programme and review the impact on the Trust and to scrutinise the Trust budget prior to approval by the Board. |
| **Financial Performance** | To review the activity plans in line with the financial planning assumptions, including reviewing the financial performance before submission to Monitor / NHS Improvement and assessing the impact of financial performance on the Financial Services Risk Rating<br><br>Overseeing the implementation of service line reporting, review of service line information, profitability of service lines and the impact of activity delivery on financial performance.<br><br>To undertake any relevant matter as requested by the Board of Directors |

## 4. Work Performed

4.1 The Committee has organised its work under six main headings:

- Budget Strategy;
- Performance Against Current Annual Financial Plan;
- Benchmarking Initiatives (bringing together Service Line Reporting and Carter Review);
- Board Assurance Framework;
- Business Development; and
- Significant Projects.

In addition the Committee considers any other financial issues as referred by the Board of Directors.

### 4.2 Budget Strategy

4.2.1 In December 2017 and February 2018, the Committee received reports from the Director of Finance and the Chief Operating Officer on the proposed operational plan for the 2018/19 financial year and the activity assumptions contained within the plan. The Committee scrutinised the processes from which capacity plans and income levels are derived as well as the cost information and sought assurance as to the robustness of the proposed budget. The information provided included presentations prepared by Directorates showing their detailed plans.

4.2.2 At the October meeting the Committee received an update on the findings from the Harrogate Place report in relation to the Harrogate Health system and implications for the Trust.

4.2.3 At the February meeting the Committee received an update on the position of our local commissioner and the implications for the Trust's planning for the coming year.

### 4.3 Performance Against Current Annual Financial Plan

4.3.1 At every meeting the Committee has looked at the latest financial position of the Trust against the financial plan so that this can give the context to forward looking role of the Committee. From September, this has been in the form of the monthly letter to NHS Improvement which includes both income and expenditure variations. Also included is an update on the Trust's cash position, collection of sums due to the Trust and progress towards achieving the Cost Improvement Programme. A capital programme update is received three times each year.

4.3.2 Where timing of meeting dates allows, the Committee receives details of the Use of Resources metric element of the Single Oversight Framework which is declared to NHS Improvement each quarter.

4.3.3 In 2016/17 the Trust did not meet its financial plan. In April 2017, at the request of the Trust Board, the Committee received a detailed analysis of variances in income and expenditure for 2016/17 with a view to understanding the implications for the Trust in 2017/18.

### 4.4 Benchmarking Initiatives

4.4.1 The Committee oversees the implementation within the Trust of a number of initiatives aimed at improving financial performance and efficiency. Service Line Reporting (SLR) has been developed by NHS Improvement to help trusts develop a better understanding of the operational and financial performance of their various services and hence improve their strategic and clinical decision-making.

4.4.2 In addition, the Committee oversees the progress of recommendations arising from the Carter Review. The Model Hospital is one initiative developed to meet these recommendations and it provides a new digital information service from which NHS trusts are able to explore their comparative productivity, quality and responsiveness and hence provide a clearer view of improvement opportunities.

4.4.3 During the year the Committee has received updates on both SLR and the Model Hospital including presentations of the Model Hospital dashboard showing the information available and highlighting the top priority areas for the Trust. An update was also received on Corporate Services benchmarking.

### 4.5 Board Assurance Framework

4.5.1 In June and December 2017, the Committee received reports on BAF 15 on the Board Assurance Framework – Misalignment of Commissioner/partner strategic plans. The risks were reviewed with a view to ensuring that there were no other actions that could be taken to mitigate risk.

### 4.6 Business Development and Projects

4.6.1 At every meeting the Committee received a report from the Director of Finance on business development opportunities within the Trust. This includes bidding to retain existing contracts as well as opportunities to bid for new contracts.

4.6.2 In October 2017, the Committee received a number of updates on the progress with implementing projects:

- Actual compared to planned activity was considered in relation to the introduction of outreach outpatient services to the local population in the new Alwoodley Medical Practice in Leeds;
- Progress in developing the Private Patient Strategy;
- Progress in implementing the various modules of the Web-V project; and
- An update on the Carbon Energy Fund project .

4.6.3 In February 2018, the Committee considered a financial issue relating to the Trust's subsidiary company (Harrogate Healthcare Facilities Management) in advance of consideration by the Trust Board of Directors.

## 5. Finance Committee Self Assessment

5.1 It is recommended corporate governance best practice for committees of the Board of Directors to undertake annual self-assessment of effectiveness. A survey of committee members was undertaken in March / April 2018. In addition Directors who do not sit on the Committee were invited to provide feedback about the Finance Committee.

5.2 Eleven people responded to the survey; five members of the committee plus one regular attendee. They answered 25 questions which covered committee focus, committee team working, committee effectiveness, committee engagement and committee leadership.

5.3 In addition five directors who do not sit on the committee responded to a shortened version of the survey.

5.4 Many areas of governance best practice were confirmed. A small number of areas were highlighted for members of the committee to discuss to further improve the effectiveness of the Committee.

## 6. Conclusion

6.1 The Finance Committee can demonstrate that it has conducted itself in accordance with its Terms of Reference and work plan during 2017/18 and has considered items specifically at the request of the Trust Board.

## Appendix 1: Attendance monitoring

| | April 2017 | June 2017 | Sept 2017 | October 2017 | December 2017 | February 2018 |
|---|---|---|---|---|---|---|
| **Finance Committee Members** | | | | | | |
| Mrs M Taylor, Non-Executive Director and Chair | Y | Y | Y | Y | Y | Y |
| Mr I Ward, Non-Executive Director | Y | Y | Y | N | Y | Y |
| Mrs L Webster, Non-Executive Director | Y | Y | Y | Y | N | Y |
| Mr J Coulter, Deputy Chief Executive and Director of Finance | Y | Y | Y | Y | Y | Y |
| Mr R Harrison, Chief Operating Officer | Y | Y | Y | Y | Y | Y |
| Mr J McKie, Deputy Director of Finance | Y | Y | Y | Y | Y | N |
| Mr P Nicholas, Deputy Director of Performance and Informatics | Y | Y | Y | Y | Y | Y |
| **Observers** | | | | | | |
| Mr C Thompson, Non-Executive Director | Y | Y | Y | N | Y | Y |
| Mrs K Roberts, Company Secretary | | Y | | Y | | |
| Mrs S Dodson, Trust Chairman | Y | | | | | |
| Mrs A Schofield, Trust Chairman | | | | | Y | |
| Ms R Irving, Insight Programme | | | | Y | | Y |
| Mr D Griffin, Insight Programme | Y | | | | | |
| Mr T Morrison, Finance Officer | | | | | | Y |
| **Observing Governors** | | | | | | |
| Mr T Doveston, Public Governor | | Y | | | | |
| Ms S Eddleston, Public Governor | | | Y | | | |
| Ms C Cressey, Staff Governor | | | | Y | | |
| Ms P Allen, Public Governor | | | | | Y | Y |
| | | | | | | |
| **Quorum:** 2 Non-Executive Directors and 1 Executive Director | Yes | Yes | Yes | Yes | Yes | Yes |

Harrogate and District NHS Foundation Trust

# Council of Governors' Meeting

Minutes of the public Council of Governors' meeting held on 3 February 2018 at 10:45 hrs at St. Aidan's Church of England High School, Oatlands Drive, Harrogate, HG2 8JR



**Present:**

Mrs Angela Schofield, Chairman
Ms Pamela Allen, Public Governor/Deputy Chair of Council of Governors
Mrs Cath Clelland, Public Governor
Mrs Angie Colvin, Corporate Affairs and Membership Manager
Ms Clare Cressey, Staff Governor
Miss Sue Eddleston, Public Governor
Mrs Emma Edgar, Staff Governor
Dr Sheila Fisher, Public Governor
Mrs Jill Foster, Chief Nurse (for item 6.5)
Mr Rob Harrison, Chief Operating Officer
Ms Carolyn Heaney, Stakeholder Governor
Cllr. Phil Ireland, Stakeholder Governor
Mrs Mikalie Lord, Staff Governor
Mrs Rosemary Marsh, Public Governor
Mr Phillip Marshall, Director of Workforce and Organisational Development
Mr Andy Masters, Staff Governor
Mrs Zoe Metcalfe, Public Governor
Mrs Katherine Roberts, Company Secretary
Mrs Laura Robson, Non-Executive Director
Dr Daniel Scott, Staff Governor
Dr David Scullion, Medical Director
Mrs Maureen Taylor, Non-Executive Director
Mr Chris Thompson, Non-Executive Director
Dr Ros Tolcher, Chief Executive
Mr Steve Treece, Public Governor
Mrs Lesley Webster, Non-Executive Director

**In attendance:** 3 members of the public

## 1. Welcome and apologies for absence

Mrs Schofield was delighted to see members of the public at the meeting and offered them a warm welcome. She hoped they would find the meeting interesting and informative and welcomed questions for Governors or any member of the Board in attendance. She asked that any questions for item 11.0 on the agenda to be submitted during the break.

Mrs Schofield introduced newly elected Governors: Dr Sheila Fisher, Public Governor for Wetherby and Harewood including Otley and Yeadon, Adel and Wharfedale and Alwoodley wards, Mrs Rosemary Marsh, Public Governor for Harrogate and surrounding villages, Mrs Mikalie Lord, Staff Governor – Non-Clinical and, Mr Andy Masters, Staff Governor – Nursing and Midwifery.

Apologies were received from Dr Pam Bagley, Stakeholder Governor, Mr Jonathan Coulter, Finance Director/Deputy Chief Executive, Mrs Liz Dean, Public Governor, Mr Tony Doveston, Public Governor, Mrs Beth Finch, Stakeholder Governor, Mrs Pat Jones, Public Governor, County Councillor John Mann, Stakeholder Governor, Mr Neil McLean, Non-Executive Director, Mr Ian Ward, Non-Executive Director and, Dr Jim Woods, Stakeholder Governor.

Mrs Schofield confirmed that Mrs Foster would be joining the meeting for item 6.5 on the agenda as she had an existing commitment at a Trust nurse recruitment event that day. Mr Marshall would also be leaving the meeting slightly early due to a pre-existing commitment.

Before moving on, Mrs Schofield wished to thank Ms Cressey on behalf of the Council of Governors and the Board of Directors as this would be her last meeting in her role as Staff Governor representing the interests of staff in the Other-Clinical staff class. Ms Cressey would be transferring to the new company, Harrogate Healthcare Facilities Management Ltd (HHFM) on 1 March. Mrs Schofield wished her all the best for the future.

## 2. Minutes of the last meeting, 1 November 2017

The minutes of the last meeting on 1 November were agreed as a true and accurate record.

## 3. Matters arising and review of action log

Item 1 – Mr Marshall provided a further update on the Global Health Exchange Programme.

Since October 2017, the Trust had welcomed five Global Learners as part of the Global Health Exchange programme; a three year programme, supported by Health Education England (HEE), to enable international nurses to work in the UK on the 'Earn, Learn and Return programme'.

The Trust was pleased to announce that one of the nurses had successfully passed their final objective structured clinical examination (OSCE) and had started a Band 5 position on Byland Ward. Three further nurses who very narrowly missed out on passing their OSCE test at their first attempt had since been successful and were now eligible for Nursing and Midwifery Council (NMC) registration to take on their registered nurse roles with the Trust.

A fifth nurse joined the Trust on 10 January and was undertaking an intensive training course led by the Global Learners Practice Educator. Mr Marshall gave

credit to the Educator for her support and guidance and read out a quote from one of the nurses who had appreciated the support they had received to date.

The Global Learners Working Group had met with other trusts interested in the programme and recently presented at a launch event in Leeds to promote the Trust's experience so far as the first pilot site in the UK.

Mr Marshall was also delighted to inform Governors that the Trust would be participating in two promotional videos later this month and would be hosting a visit by Professor Ian Cumming, Chief Executive of HEE, to meet our Global Learners and senior managers involved in the programme.

Finally, Mr Marshall confirmed that a further 23 international nurses would join the Trust under the same scheme during the next 12 to 18 months and highlighted that the Trust would be working with HEE to explore opportunities to support wider staffing groups with their recruitment strategies.

Mrs Edgar commented that the OSCE was a difficult examination and she recognised that this was a great achievement for everyone involved.

Mrs Schofield took a question from Mr Treece at this stage in the meeting:

**What is the current position regarding the Trust's recruitment activity; in respect of overseas recruitment is the Trust encountering any particular obstacles? In the latter respect I am thinking about media stories about difficulties in getting the necessary paperwork to recruit doctors from outside of the EU."**

Mr Marshall confirmed that since December 2017 two applications for sponsorship had been rejected and this was a disappointing outcome. Both applications had satisfied the Resident Labour Market Test; a test to determine the fact that the Trust had tried without success to recruit from the UK in the first instance.

The Trust had resubmitted one application and the outcome of this was awaited. The second application was not re-submitted as the doctor concerned had found alternative employment. This matter was being escalated to HEE, NHS Providers and NHS Employers due to the potential impact on the Global Health Exchange Programme and future recruitment.

Item 2 - Mrs Colvin confirmed that the process to assign Governors to Quality of Care Teams was progressing well. A further seven Governors would hopefully be joining Quality of Care Teams across the Trust in the near future taking the total number of Governors involved to ten.

Item 3 – Mr Harrison clarified an amendment to what was reported at the last meeting; the Trust had taken up an offer from NHS Digital rather than internal audit to provide a comprehensive review of the Trust's position to cyber security. The overall outcome of the review was very good confirming no security network breaches and the team was working on an action plan to follow-up some minor issues.

There were no other matters arising.

**ACTION:**

- ***Mr Marshall would continue to provide further updates on the Global Health Exchange Programme at future meetings as appropriate.***

## 4. Declaration of interests

There were no additional declarations of interests received from Governors than those listed on Paper 4.0.

Mr Thompson declared an interest in item 7.1 on the agenda and would leave the room at that stage.

Mrs Schofield highlighted Ms Cressey's potential transfer to the new company HHFM however, this did not preclude her from the meeting, it was just a note of interest.

## 5. Chairman's verbal update

Mrs Schofield stated that it was good to welcome new Governors to the Council. Vacancies however remained for Public Governors for The Rest of England, Ripon and West District and, Knaresborough and East District. Due to Ms Cressey's potential transfer to HHFM, there would also be a vacancy for a Staff Governor for the Other-Clinical staff class. Mrs Colvin confirmed the timetable for the By-Election was still being finalised.

The advert for two Non-Executive Directors closed on 23 February and interviews would take place on 9 April.

Mrs Schofield confirmed Dr Tolcher would include an update on winter pressures in her presentation at item 10 on the agenda and she thanked staff across the Trust who continued to provide safe, high quality care throughout the challenging winter period. She also thanked the senior management team for their leadership and ongoing support.

Mrs Schofield was delighted to highlight further expansion of the Trust's Children's 0-19 services in Stockton-On-Tees and Gateshead and a new contract in Sunderland would commence on 1 July. The Trust was the UK's largest provider of Children's services with contracts in place across North Yorkshire, Middlesbrough, County Durham and Darlington.

Mrs Schofield reiterated the need to focus on financial efficiency and the involvement of Governors in the annual planning cycle.

Mrs Schofield referred to the Board's approval in November 2017 to establish the wholly owned subsidiary company, HHFM, to provide estates and facilities services to the Trust. Mr Harrison and Mr Thompson would provide further details in their presentation at item 8 on the agenda.

Mrs Schofield was also delighted to comment on the launch of a new campaign by The Harrogate Advertiser to publicly recognise the valuable work of the Trust's

dedicated NHS staff[1]. The first of the new 'Health Heroes' articles featured the Child Development Centre team. Mrs Schofield thanked The Advertiser and Mr Widdowfield, the Trust's Communications and Marketing Manager, for this project and looked forward to seeing more.

Finally, Mrs Schofield confirmed there had been lots of questions submitted for item 11 on the agenda however, she would try to bring in questions where they were relevant on the agenda.

There were no questions for Mrs Schofield.

## 6. Governor Sub-Committee Reports

Mrs Schofield moved on to clarify the role of the two formal sub committees and the Patient and Public Involvement, Learning from Patient Experience Group. She said how important it was for the general public to hear about the work of these sub-committees and thanked Governors for their commitment and involvement.

### 6.1 Volunteering and Education

The report from the Volunteering and Education Governor Working Group, chaired by Mrs Jones, had been circulated prior to the meeting and was taken as read.

There were no questions in relation to the paper to pass to Mrs Jones who was unable to attend the meeting.

### 6.2 Membership Development and Communications

The report from the Membership Development and Communications Governor Working Group, chaired by Ms Allen, had been circulated prior to the meeting and was taken as read.

Mrs Allen confirmed that the next membership communication would be the last to be sent out by post and all future communications would continue to be sent out electronically with a link to further details on the website. She explained that sending out postal communications was very expensive and, in line with other Trusts, the priority was to fund patient care over postal communications.

There were no questions for Ms Allen.

### 6.3 Patient and Public Involvement – Learning from Patient Experience

The report from Miss Eddleston, on the last meeting of the Learning from Patient Experience Group, had been circulated prior to the meeting and was taken as read.

Miss Eddleston highlighted the Trust's Equality Delivery System (EDS2) Stakeholder event which took place on 15 January. She commented on the assurance that she had gained from the Trust's self-evaluation scoring and

the evidence of continued improvement from the presentations including, the Gypsy, Roma and Traveller community, the Trust's Youth Forum and, achieving better health outcomes for patients with learning difficulties. These presentations provided a snapshot of the Trust's achievements described in the EDS2 document and Miss Eddleston encouraged people to look at full report which would be published on the Trust's website.

There were no questions for Miss Eddleston.

**6.4 Annual Plan update from Governors**

Ms Allen summarised how Governors had been involved in the annual planning cycle to date. Two meetings had taken place in October and December 2017 and the next meeting was scheduled for 19 February; all Governors were encouraged to attend. The Trust had met with NHS Improvement (NHSI) to consider and identify any areas of learning from 2017/18 which could be adopted for 2018/19 planning. Key process headlines included:

- Directorates were developing activity and capacity plans by specialty.
- The Annual Plan would be risk assessed.
- There was an important focus on workforce pressures which would impact on activity.
- Early in 2018 capital and service development priorities for 2018/19 would be agreed.
- The Cost Improvement Programme (CIP) for 2018/19 had been set at £10.2M; 4.75% of the Trusts budget.

**6.5 Update on Quality Account Process**

Mrs Foster arrived at this stage in the meeting and was pleased to report that the nurse recruitment event taking place at the Trust that day was going extremely well. She was delighted that the event had received media interest with BBC One's Look North filming on site and she had been interviewed by Radio York.

The event featured information stalls on the broad-range of care delivered by the Trust, tours of the hospital, the opportunity to meet specialist nurses and the senior nursing team, as well as a chance to hear about the Trust's new two-year preceptorship course. Interviews were also taking place for prospective nurses offering them the chance to walk away with a conditional offer of employment.

Moving on to the update on the Quality Account process, Mrs Foster outlined the purpose of the Quality Account, an integral part of the Annual Report and Account, which reflected on the highest priorities of the Trust for the forthcoming year and reported on progress made in the past year.

Mrs Foster highlighted the importance of stakeholder engagement in producing the Quality Account and to determine the quality priorities for the coming year. This would involve engaging with a variety of stakeholders,

including Clinical Commissioning Groups (CCGs), Healthwatch and Governors, to ensure local community representation.

Mrs Foster summarised the quality priorities for 2017/18 and asked Governors to think about areas to focus on in 2018/19. The stakeholder meeting would be held in March and the final report would be submitted for publication at the end of May.

There were no questions for Mrs Foster.

## 7. Report from the Nominations Committee

The Nominations Committee had met on 3 January to discuss the process to appoint two new Non-Executive Directors. Mr McLean, having moved to the South of England would be stepping down from the Board of Directors at the end of March and Mr Ward would not be seeking extension to his second term of office at the end of September. Mrs Schofield added that Mr Ward was flexible and would be willing to leave earlier if the preferred candidate wished to commence in post earlier than 1 October. The Nominations Committee also identified the panel who would be shortlisting and interviewing candidates and Mrs Schofield expressed her gratitude to those involved in such a time consuming process. Governors who were not on the shortlisting and interview panel would have the opportunity to meet the candidates by taking part in the focus groups which formed part of the recruitment process.

Mrs Schofield referred to the minutes of the meeting held on 3 January and these were approved.

There were no questions for the Nominations Committee and the Council of Governors was in unanimous agreement to proceed with the recruitment process as recommended.

### 7.1 Report from the Remuneration Committee

Mr Thompson had declared an interest in this item on the agenda and left the room at this stage in the meeting.

Mrs Schofield summarised Paper 7.1 which had been circulated prior to the meeting and taken as read. In addition, Mrs Schofield also confirmed that the recruitment process for a Chairman of HHFM was underway and, when recruited, the recruitment process for two further Non-Executive Directors would commence.

Mrs Schofield highlighted the debate held by the Remuneration Committee on 3 January as to whether the issue of remuneration for Mr Thompson was a matter for Governors. This was confirmed as Mr Thompson was a Non-Executive Director of the Trust's Board and all decisions regarding remuneration of Trust Non-Executive Directors were the responsibility of the Council of Governors. The Committee held a robust discussion regarding the additional responsibility allowance in recognition of the additional time commitment and the increased responsibilities.

Mrs Schofield opened up the floor for questions.

Mrs Clelland expressed concerns regarding the timing of this matter; dealing with a pay increment for Mr Thompson before the new company had been set up and could demonstrate its benefits.

In response, Dr Tolcher acknowledged Mrs Clelland's sensitivity to the workforce involved however, she explained the need to establish the business and set the remuneration of the board members to be able to go out to market to attract the right candidates for the Chairman and external Non-Executive Directors.

Mrs Schofield reiterated that the new company now existed and staff would be transferring on 1 March. Mr Thompson was already taking on additional responsibilities and his role on the HHFM Board would be the only post subject to Governor consideration.

Mrs Clelland asked if the remuneration for the Chairman and additional Non-Executive Directors had been established.

Based on benchmarking information and time commitment, Mr Marshall confirmed that remuneration for HHFM's Chairman would be around £7k and Non-Executive Directors around £4k. He confirmed it would be the responsibility of the Board Remuneration Committee to approve the final remuneration for these posts.

In response to Dr Scott's request for clarification on the role of the Council of Governors, Mr Harrison explained that both Mr Coulter and Mr Thompson would serve on HHFM Board due to their role on the Trust Board and both of these HHFM roles would be paid by the Trust. Other members of the HHFM Board would be paid by HHFM and therefore subject to consideration by the Trust Board as HHFM was a subsidiary company of the Trust.

There were no further questions and the Council of Governors approved the recommendation by the Remuneration Committee that an additional responsibility allowance of £4k per annum should be paid to Mr Thompson in addition to his current agreed level of remuneration. The minutes of the Remuneration Committee held on 3 January were also approved.

Mr Thompson returned to the room at this stage in the meeting.

**8. Presentation – Update on the establishment of the Trust's wholly-owned subsidiary company to deliver Estates and Facilities services**

The report at Paper 8 had been circulated prior to the meeting to support the presentation where both Mr Harrison and Mr Thompson highlighted key stages from the establishment of the new wholly owned subsidiary company HHFM. This included the background and business case, the benefits and future opportunities, impact on staff, governance arrangements, reserved powers and progress.

Mrs Schofield opened up the floor for questions.

Mrs Marsh asked if any other trusts had set up similar subsidiary companies.

Mr Harrison confirmed a number of trusts had in fact already set up subsidiary companies and many others were now exploring this opportunity. The Trust had undertaken dialogue with a number of trusts in the North East and North West and visited Blackpool Teaching Hospitals NHS Foundation Trust and Barnsley Hospital NHS Foundation Trust. Mr Harrison added that, whilst this appeared quite new in the NHS, the education sector had progressed subsidiary companies for many years.

Miss Eddleston referred to the 350 Trust staff affected as stated in the presentation and asked if this was the total number of staff.

Mr Harrison confirmed that 350 staff would be transferred to the new company from the Trust however, as the company developed and planned additional work, they would have their own strategy to recruit new staff as required.

On behalf of Staff Governors, Mrs Edgar asked if any disadvantages were foreseen.

Mr Thompson reassured Governors that Non-Executive Directors had been very close to each stage in establishing HHFM and was assured that the Trust and HHFM had carefully considered the impact upon staff. He acknowledged that this would bring uncertainty but hoped that Governors would be encouraged from the degree of ongoing communications and engagement events with staff. He emphasised that HHFM was part of the Trust and the values that defined the Trust's culture would remain in place with HHFM. He also explained how this could open doors for new opportunities such as taking on additional work, subject to approval.

Ms Cressey commented that staff working together on the Trust site would probably not know who works for the Trust and who works for HHFM.

Mr Harrison explained that staff on different terms and conditions existed already in the Trust. The majority of work undertaken by HHFM would be for the Trust and the work base for the majority of staff would remain the same.

Mrs Clelland made further comments regarding representation from a Trust Governor on the HHFM Board, workforce terms and conditions, and tax benefits.

It was noted that the creation of HHFM, and the transfer of assets and staff to the new company, would not be a significant or material transaction and did not therefore require approval by the Council of Governors. This had been confirmed following consideration of the Trust's Constitution, the Trust's legal advisers, and also by NHS Improvement.

Mrs Schofield referred to Paper 9 on the agenda which proposed amendments to the Trust's Constitution to include a Stakeholder Governor from HHFM. The Joint Negotiating Consultative Committee would be meeting the following week regarding further details on pensions and remuneration packages and therefore additional information to what was provided in the presentation was not available at this stage. The financial benefits identified to the Trust would be £3.1m in 207/18 and £1.2m recurrent in future years; further details were commercial in confidence.

Mrs Schofield thanked Mr Harrison and Mr Thompson for their informative presentation and hoped that Governors would be assured from the level of detail provided in the presentation.

**9. HDFT Constitution**

Mrs Schofield referred to Paper 9 which had been circulated prior to the meeting and taken as read. The Council of Governors approved the proposed amendments to the Trust's Constitution and the process to select a Stakeholder Governor by the HHFM Board. It was noted that a further process would be undertaken to review the Constitution in early 2018 and the terms of reference for the Constitution Review Working Group were agreed.

**10. Chief Executive's Strategic and Operational Update, including Integrated Board Report (IBR)**

Dr Tolcher presented the following headlines:

- **Operational Performance**
- **Strategic Developments**
- **Planning for 2018/19**

Operational Performance

Taking a snapshot from the December 2017 IBR, Dr Tolcher confirmed that the financial position was on plan at the end of Quarter 3 however some areas of operational performance had dipped and the Trust had experienced significant winter pressures in December.

Two of the key areas where the Trust was below the required national target level were the 4 hour A&E standard and the 18 week referral to treatment pathway. An explanation for this related to the predictable pressures at this time of year with high numbers of people arriving in the Emergency Department and the impact on the ability to undertake planned work. Dr Tolcher referred to the diagram in her presentation which demonstrated that the whole country was struggling to meet the 18 week target and the Trust had marginally missed this with a performance of 91.6% against the 92% standard. The Trust was focussed on looking at measures to improve on performance.

Dr Tolcher confirmed that attendances to A&E were up by 6% in the last quarter which equated to approximately 300 additional emergency admissions. She was pleased to report that winter funding had been awarded and the patient safety thermometer offered assurance that the Trust was sustaining safe care. Dr Tolcher reiterated Mrs Schofield's earlier comment that this was a credit to all staff and thanked everyone for their continued hard work.

Dr Tolcher summarised the financial position confirming that the Trust had secured Sustainability and Transformation funding of £2.45m however the underlying position remained challenging.

Strategic Developments

Dr Tolcher explained the newly named Integrated Care Systems and described how the West Yorkshire and Harrogate Integrated Care System would be focussing on integration of mental health, physical health and care services within a fixed financial envelope.

Planning for 2018/19

Dr Tolcher summarised key planning highlights for 2018/19 including: activity modelling based on historical trends, population growth and changes to commissioning; £10.2m savings plan; transition for adult community services in Harrogate and, the mobilisation of additional Children's Community Services in Gateshead and Stockton.

Mrs Schofield thanked Dr Tolcher for her update and opened up questions from the floor.

Mr Treece echoed the comments that staff had worked hard. He asked how long the Trust expected actions to be in place to deal with winter pressures. Dr Tolcher commented that it was becoming normal for ongoing pressures, similar to those during the winter, to continue almost all year round. She explained that the Trust had received additional winter funding and had provided support to the wider population area which would continue until the end of March.

Dr Fisher asked if there had been any training implications for staff due to the additional winter pressures. Dr Tolcher confirmed there had been no impact on training and added that the Trust had cancelled approximately 30 elective procedures however day cases continued.

Ms Cressey referred to the presentation from Mr Forster and Dr Shepherd on Winter Planning and the Emergency Care Winter Challenge at the last Council of Governors' meeting in November 2017 and asked if this had gone to plan. Dr Tolcher confirmed plans had gone as well as the Trust could have hoped for and gave credit to Dr Shepherd and the staff in the Emergency Department for their continued hard work and positive team approach.

There were no further questions for Dr Tolcher.

**11. Question and Answer session for members of the public and Governors**

Mrs Schofield moved to the tabled questions submitted prior to the meeting and during the break.

**Mr Matt Walker, Parliamentary Spokesperson, Harrogate and Knaresborough Liberal Democrats had submitted the following questions. Mr Walker could not attend the meeting so Mrs Schofield read it out on his behalf.**

**"Will HDFTs carparks be managed by Harrogate Healthcare Facilities Management Limited when it is established?**

**If this is the case what guidelines will HDFT put in place to ensure parking charge reviews are set fairly for patients and staff parking at the hospital?"**

Mr Harrison confirmed that the carparks would be managed by HHFM however the Trust would remain responsible for car park charges.

**Mrs Lord, Staff Governor, had submitted the following questions:**

"**What assurances can NEDs give that the Trusts controls on recruitment are generating the expected financial savings?"**

Mrs Webster informed the Council that the Trust's controls on recruitment were being reviewed through the Quality Committee in addition to any implications that the recruitment freeze may have on quality and staff wellbeing.

**"What assurances can the NEDs give that there is parity in the controls enforced for both clinical and non-clinical staff vacancies?"**

Mrs Webster confirmed it was regrettable that vacancies in some non-clinical posts were being held and she understood that Dr Tolcher would be reviewing this approach further following a recent meeting with Staff Governors.

**Mrs Fiona Wilson, member of staff had submitted the following questions.**

**"The Trust currently pays at least the living wage to all its employees. Is this principle going to be maintained by the HHFM Board?"**

Mr Harrison confirmed a letter had gone from the HHFM Board to staff to confirm that the company would mirror the Trust's position to pay the living wage the following year. This would be reviewed annually by the HHFM Board.

**"Will the financial accounts of HHFM be declared in the Trust's Annual Report and declared and discussed at the Trust's Annual Members' Meeting?"**

Mr Thompson confirmed the financial accounts would be consolidated into the Trust's Annual Report and provided at the Trust's Annual Members' Meeting in 2019.

Mrs Schofield thanked everyone for their questions.

## 12. Non-Executive Directors' Feedback

There was no other feedback received in addition to that discussed throughout the meeting.

## 13. Any other relevant business not included on the agenda

There were no further items of business.

## 14. Member Evaluation

Mrs Schofield sought views about the meeting.

Mrs Edgar commented that it was a good approach to schedule submitted questions throughout the meeting.

Mrs Clelland commented that the establishment of HHFM was a significant change for the Trust; she referred to the Council of Governors' role to hold Non-Executive Directors to account, to be able to exercise challenge and receive assurance. Mrs Edgar commented that she had heard staff talk positively about the presentations they had received and Mrs Clelland was pleased to hear this. Mrs Schofield was pleased for the Board to continue to provide updates and give the Council the opportunity to ask questions, but clarified that HHFM was not a matter for Governors to approve.

Ms Cressey was pleased to comment that she felt assured, in particular, as member of staff affected, as a line manager and currently a Staff Governor.

Dr Fisher added a note of reassurance from Mr Harrison's presentation that the NHS was following a familiar model used in the educations sector. She had seen it working well and felt that a Stakeholder Governor from HHFM on the Council would be beneficial.

Ms Allen commented that the Trust had kept Governors informed and felt reassured with the process.

## 15. Close of meeting

Mrs Schofield closed the meeting. She thanked everyone for attending and confirmed the next meeting would take place on Wednesday, 2 May at 5.45 – 8.00pm



[1] https://www.harrogateadvertiser.co.uk/news/health/harrogate-s-health-heroes-meet-the-child-therapists-who-change-lives-1-8965684

Harrogate and District
NHS Foundation Trust

**HARROGATE AND DISTRICT NHS FOUNDATION TRUST**
**GLOSSARY OF ABBREVIATIONS**

# A

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

# B

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

# C

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

# D

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|---|---|
| **Datix** | *National Software Programme for Risk Management* |
| **DBS** | *Disclosure and Barring Service* |

| | |
|---|---|
| **DNA** | *Did not attend* |
| **DoH** | *Department of Health* |
| **DoLS** | *Deprivation of Liberty Safeguards* |
| **Dr Foster** | *Provides health information and NHS performance data to the public* |
| **DSU** | *Day Surgery Unit* |
| **DToC** | *Delayed Transfer of Care* |

# E

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|---|---|
| **E&D** | *Equality and Diversity* |
| **eNEWS** | *National Early Warning Score* |
| **ENT** | *Ear, Nose and Throat* |
| **EoLC** | *End of Life Care* |
| **ERCP** | *Endoscopic Retrograde Cholangiopancreatography* |
| **ESR** | *Electronic Staff Record* |
| **EU** | *European Union* |
| **EWTD** | *European Working Time Directive* |

# F

| | |
|---|---|
| **FAQ** | *Frequently Asked Questions* |
| **FFT** | *Friends and Family Test* |
| **FC** | *Finance Committee* |
| **FNP** | *Family Nurse Partnership* |
| **FOI** | *Freedom of Information* |
| **FT** | *NHS Foundation Trusts* |
| **FTSU** | *Freedom to Speak Up* |
| **FY DR** | *Foundation Year doctor* |

# G

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|---|---|
| **GIRFT** | Get it Right First Time |
| **GPOOH** | GP Out of Hours |
| **GWG MD&C** | Governor Working Group – Membership Development and Communications |
| **GWG V&E** | Governor Working Group – Volunteering and Education |

# H

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

| | |
|---|---|
| **HSMR** | *Hospital Standardised Mortality Ratios* |

# I

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

# K

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

# L

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

# M

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

# N

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

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| **NYCC** | *North Yorkshire County Council* |

# O

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|---|---|
| **OD** | *Organisational Development* |
| **ODG** | *Operational Delivery Group* |
| **ODP** | *Operating Department Practitioner* |
| **OPEL** | *Operational Pressures Escalation Levels* |
| **OSCE** | *The Objective Structured Clinical Examination* |

# P

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

# Q

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

# R

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|---|---|
| **RCA** | *Route Cause Analysis* |
| **RN** | *Registered Nurse* |
| **RTT** | *Referral to Treatment. The current RTT Target is 18 weeks.* |

# S

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|---|---|
| **SALT** | *Speech and Language Therapy* |
| **SAS DR** | *Speciality and Associate specialist doctors* |
| **SCBU** | *Special Care Baby Unit* |
| **SHMI** | *Summary Hospital Mortality Indicator* |
| **SHU** | *Sheffield Hallum University* |
| **SI** | *Serious Incident* |
| **SID** | *Senior Independent Director* |
| **SIRI** | *Serious Incidents Requiring Investigation* |
| **SLA** | *Service Level Agreement* |
| **SMR** | *Standardised Mortality rate – see Mortality Rate* |
| **SMT** | *Senior Management Team* |

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| **SPF** | *Social Partnership Forum* |
| **SpR** | *Specialist Registrar – medical staff grade below consultant* |
| **ST DR** | *Specialist trainee doctors* |
| **STEIS** | *Strategic Executive Information System* |
| **STP** | *Sustainability and Transformation Plan/Partnerships* |

# T

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|---|---|
| **TARN** | *Trauma Audit Research Network* |
| **TOR** | *Terms of Reference* |
| **TU** | *Trade Union* |
| **TUPE** | *Transfer of Undertakings (Protection of Employment) Regulations 2006* |

# V

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

# W

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

# Y

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|---|---|
| **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***