NHS
Harrogate and District
NHS Foundation Trust

**The meeting of the Board of Directors held in public will take place on**
**Wednesday 27 June 2018**
**Boardroom, Harrogate District Hospital, HG2 7SX**
**Start: 9.00am Finish: 12.30pm**

| AGENDA | | | |
|---|---|---|---|
| **Item No.** | **Item** | **Lead** | **Paper No.** |
| **9.00am – 10.30am** | | | |
| **1.0** | **Welcome and Apologies for Absence**<br>*To receive any apologies for absence:*<br>*Mr Phillip Marshall* | 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 meeting held on 30 May 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** | **Board governance documents for approval:**<br>• **Board of Directors Terms of Reference review**<br>• **Board Code of Conduct review**<br>• **Division of responsibility between the Chairman and the Chief Executive**<br>• **Future Board Dates**<br>*To receive for comment and approval* | Mrs A Schofield, Chairman | 5.0<br>Append A<br><br>Append B<br>Append C<br><br>Append D |
| **6.0** | **Report by the Chief Executive Including the Integrated Board Report**<br>*To receive the report for comment* | Dr R Tolcher, Chief Executive | 6.0 |
| **7.0** | **Report by the Finance Director**<br>*To receive the report for comment* | Mr J Coulter, Deputy Chief Executive/ Finance Director | 7.0 |
| **8.0** | **Report from the Chief Operating Officer**<br>*To receive the report for comment* | Mr R Harrison, Chief Operating Officer | 8.0 |
| **10.30am – 10.40am** | | | |
| **Break** | | | |
| **10.40am – 12.00pm** | | | |

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| **8.1** | **Supported Discharge Service Business Case**<br>*To receive the report for comment and approval* | Mr R Harrison, Chief Operating Officer | 8.1 |
| **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 |
| **10.0** | **Report from the Chief Nurse**<br>*To receive the report for comment* | Mrs J Foster, Chief Nurse | 10.0 |
| **11.0** | **Report from the Medical Director**<br>*To receive the report for comment* | Dr D Scullion, Medical Director | 11.0 |
| **11.1** | **National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Annual Report**<br>*To receive the report for comment* | Mr David Lavalette, Consultant Trauma & Orthopaedic Surgeon | 11.1 |
| **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 6 June 2018.*<br>*13.2 To receive the report from the Finance Committee meeting held 14 June 2018.* | Mrs L Webster, Quality Committee Chair<br>Mrs M Taylor, Finance Committee Chair | 13.1<br>13.2 |
| **14.0** | **Other matters relating to compliance with the Trust's Licence or other exceptional items to report, including issues reported to the Regulators**<br>*To receive an update on any matters of compliance* | Mrs A Schofield, Chairman | - |
| **15.0** | **Any other relevant business**<br>*By permission of the Chairman* | Mrs A Schofield, Chairman | - |
| **12.00pm – 12.30pm** | | | |
| **-** | **Research Update and Patient Story** | 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 June 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 30 May 2018 at 9.00am in the Boardroom at Harrogate General Hospital

**Present:**
Mr Jonathan Coulter, Deputy Chief Executive/Finance Director
Mrs Jill Foster, Chief Nurse
Mr Robert Harrison, Chief Operating Officer
Mr Phillip Marshall, Director of Workforce and Organisational Development
Ms Laura Robson, Non-Executive Director
Mrs Angela Schofield, Chairman
Dr David Scullion, Medical 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 David Earl, Deputy Medical Director
Dr Kat Johnson, Clinical Director, Planned and Surgical Care
Mrs Katherine Roberts, Company Secretary (minutes)

**Patient Story**

Mrs Schofield welcomed Ms Lynne Boyd (Matron, HDFT Community Services) to the meeting.

Ms Boyd shared a story about a patient with an end of life diagnosis who was cared for at home by her daughters with support from the Trust's Community Care Team. Following the patient's death her daughters wrote to the Trust about several concerns they had regarding her care. These concerns included communications between the Community Care Team and the family, the completion of paperwork, availability of equipment and staff use of mobile phones when at the family's home. The family were invited to attend the team's Quality of Care meeting to share their concerns. The meeting was very well attended and staff responded positively and sought to learn from the issues highlighted by the family. A number of actions had been taken as a result, in particular a halt on the use of 'pink sheets' for record keeping.

Mrs Schofield thanked Ms Boyd for sharing the story and being so open about the team's experience. The Board were invited to comment on the story and ask questions.

Following a question from Dr Tolcher, Ms Boyd confirmed the fundamentals of care provided to the patient had not suffered as a result of the issues highlighted.

Mrs Webster noted the importance of sharing learning from the concerns raised by the family. She suggested this should be used as an example of good practice for other quality of care teams.

Mr Harrison commented on the impact the Vanguard programme had on staff. He reflected that the Board had recognised the risks of the programme, but the distraction of seeking to innovate and change at pace should be considered when future programmes were discussed. The Board needed to ensure that change did not impact detrimentally on staff.

Mrs Foster thanked the team for their courage in addressing the concerns raised by the family, and said she felt this was a good way to use patient feedback.

The Board thanked Ms Boyd for attending the meeting and presenting the patient story.

**1.0 Welcome and Apologies for Absence**

1.1 Mrs Schofield noted there was one apology for the meeting from Maureen Taylor.

1.2 It was confirmed a quorum was present at the meeting.

1.3 The Board welcomed Mr Richard Stiff to his first meeting. Mr Stiff provided a brief introduction to his professional background.

1.4 Mrs Schofield welcomed observers to the meeting; Liz Dean (Public Governor), Carolyn Heaney (Public Governor), Mikalie Lord (Staff Governor) and Paul Widdowfield (Communications & Marketing Manager). In addition Mrs Schofield welcomed John Lester and Amrita Sidhu from NHS Improvement.

**2.0 Declarations of Interest and Board Register of Interests**

2.1 No declarations of interest were received. All Directors confirmed that they had no direct or indirect interest in any item on the agenda which they were required to disclose to the meeting.

2.2 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 22 April 2018**

The draft minutes of the meeting held on 25 April 2018 were approved with the following amendments:

- Overview by the Chairman should refer to Mrs, and not Mr Schofield.
- Minute 7.3, should read "*NHS Improvement had awarded an additional £1.1m to the Trust. This income was expected to be received in June 2018, and would assist the Trust's cash position."*
- Minute 8.2, should read *"The letter offered to reduce the 2018/19 control total to £0 (before provider sustainability funding), however if this was achieved…"*

- Minute 10.7 should refer to Ms, and not Mr Robson.
- Minute 16.1, should read *"Mrs Webster reported the Quality Committee had considered and noted the quality priorities for 2018/19."*

**APPROVED:**
**The Board of Directors approved the minutes of the meeting held on 25 April 2018 as an accurate record of proceedings subject to a number of amendments.**

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

4.1 Completed actions were noted. In addition it was confirmed actions 76 and 87 were complete.

4.2 Mr Harrison provided an update on action 81. Further work was required to include quality measures for Children's Services within the Integrated Board Report. It was agreed to extend the deadline for this action to September 2018.

**4.3 ACTION: schedule visit for Board to the new Endoscopy Unit.**

4.4 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 76 and 87.**

**Overview by the Chairman**

Mrs Schofield noted a number of items:

- The Board had held an extraordinary meeting in private on 23 May 2018 to approve the Trust's Annual Report and Accounts 2017/18. She expressed the Board's thanks to everyone involved in preparing the Annual Report and Accounts.
- The Board held a workshop (as the Corporate Trustee of Harrogate Hospital and Community Charity) to consider proposed changes to the governance structure supporting the charity. Final proposals would be presented to a future meeting of the Corporate Trustee of Harrogate Hospital and Community Charity.
- A Council of Governors meeting was held on 1 May 2018.
- A Board strategy / development day would be held on 21 June 2018.
- A 'Board to Board' meeting had been scheduled with Harrogate and Rural District CCG on 26 June 2018.
- A 'Board to Board' meeting with the Council of Governors would be held later in the day.
- It was noted the NHS 70th Birthday would take place on 5 July 2018.

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

**5.0 Arrangements for conducting Board business - discussion paper**

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

5.2 It was proposed the Board reduce from ten to six bi-monthly public meetings per year. In the alternate months the Board would meet and hold an informal development

session / workshop. It was felt this approach would support the Board to be more productive. These arrangements would be reviewed after one year.

5.3 Mrs Schofield confirmed the proposals included within the paper had been discussed on a number of occasions, including with the Council of Governors.

5.4 Mr Stiff commented the proposal was in line with arrangements adopted by a number of other Foundation Trusts.

5.5 Mr Ward said that he supported the proposal and agreed it would enable the Board to be more effective. However he noted that as a Foundation Trust it was critical that the Board was accountable to the public. He suggested that consideration should be given to how members of the public could be encouraged to attend and observe public meetings of the Board.

**5.6 ACTION: further consideration to be given to how members of the public could be encouraged to attend and observe public meetings of the Board.**

5.7 Following a question from Mrs Webster it was confirmed actions arising from the informal development sessions would be tracked via the Board's action log.

5.8 There was a short discussion regarding the potential impact of the proposals on the future programme of Director Inspections and Patient Safety Visits. It was agreed these would continue.

**5.9 ACTION: Mrs Foster to progress a programme of Director Inspections and Patient Safety Visits.**

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

- **considered and approved the proposals contained within the report, to commence in August 2018 when the first informal Board workshop would take place.**
- **agreed to review this arrangement for conducting Board business in May 2019**

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

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

6.2 Dr Tolcher provided an update on two strategic issues which had been announced in recent days. First she noted that West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) had been accepted onto the shadow Integrated Care System programme. This was a very positive step for the WY&H HCP.

6.3 Second she highlighted a series of announcements by NHS England and NHS Improvement which signified a new era of alignment between the two organisations. Seven integrated regional teams would be created with additional powers and responsibilities devolved to them. In addition there was a proposal to form a new NHS assembly, which would act as a forum to co-design a new ten year plan for the NHS. There would be a series of new national appointments, including a single NHS Medical Director and Chief Nurse.

6.4 Mr Thompson queried whether the Trust would be able to gain access to capital via the WY&H HCP. Dr Tolcher explained that bids for capital were likely to be segmented into large and small capital schemes. It would be critical for the Trust to demonstrate how its application for capital funding would fit with the strategic priorities of WY&H. Mr Coulter added that the move to an Integrated Care System would be helpful because the region would have a degree of subsidiarity over capital investment. Mr Harrison noted the importance of capital investment for regular maintenance of the Trust's estate in order to 'keep the lights on'.

**6.5 ACTION: Mrs Roberts to schedule a Board workshop regarding capital funding.**

6.6 Dr Tolcher reported the Trust's performance against the 18 weeks referral to treatment target, and the A&E four hour standards, which had improved in April 2018. The month had also seen lower non elective activity than previous years.

6.7 Delays in the 14 day symptomatic breast pathway were the result of increased patient demand. Dr Tolcher said she felt the delays did not present a clinical risk and was satisfied that the majority of patients were seen by day 15, however work was ongoing to improve the position. Trusts across WY&H were struggling with the 14 day target and were therefore considering joint solutions to resolve the current difficulties. Following a question from Mrs Webster, Mr Harrison explained that there was an issue with radiologist availability, surgical capacity and there had been a change guidance which required consultant surgeons to see patients at their first appointment. He also noted a change in the pattern of referrals; the team were considering how they could alter the timing of clinics to address this.

6.8 Provisional data indicated that the Trust's performance for the 62 day standard was below the 85% standard in April 2018. Dr Tolcher noted these were small numbers and often complex cases and provided reassurance that a robust breach analysis was completed in all cases which had breached 62 days.

6.9 Dr Tolcher reported that the Trust had achieved a deficit position of £2.3m for April 2018. She noted that although this was in line with the plan agreed with NHS Improvement (based on a breakeven control total) it is behind the Trust's internal set stretch target. Factors which had contributed this position included non-elective and day case income had been adverse to plan, an additional £200k had been spent on ward staffing. In addition spending on medical agency staff had been £160k higher than expected. It was also noted that achievement of Cost Improvement Plans (CIP) was £80k below the forecast.

6.10 Dr Tolcher confirmed that in early May 2018 the Executive Team had taken rapid action to address the ward staffing issue. More robust approval processes had been introduced; from this point forward the Trust's Heads of Nurses had been given oversight of any additional staffing requests.

6.11 It was confirmed that there had been changes to the oversight of CIP achievement. A new CIP oversight board chaired by Mr Coulter had been established. In addition there had been a change to leadership of the programme. All directorates had been required to prepare risk adjusted CIP plans by the end of June 2018 which would deliver the full year CIP target.

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

- **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.**

**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 Following on from the headlines reported by Dr Tolcher, Mr Coulter confirmed that the April 2018 position had been caused in part by a decline in non-elective activity but an increase in costs, and in addition the agency ceiling was breached in month.

7.3 Mr Coulter explained wards had significantly overspent during April 2018, with significant agency spend and employment above establishment. He noted that the financial performance triangulated with other information such as safer staffing levels which showed the Trust had staffing above establishment. He confirmed actions had been taken to resolve the issue but these were the start of a process to revert to establishment levels. The Trust would take part in the NHS Improvement Enhanced Care Collaborative in July 2018.

7.4 Mr Coulter reported that the over spend on medical staffing related to a small number of individuals, however some rates were expensive and above cap.

7.5 The CIP programme would be led by Mrs Beth Barron who reported to Mr Harrison. The new approach would bring an increased focus on CIP delivery and reducing reliance on non-recurrent measures.

7.6 Mr Ward expressed concern that some of the issues and actions highlighted had been noted previously, he queried how the Board could be assured these actions would work. In particular he highlighted actions to address overspending on medical locums, and why staffing levels had not reduced to reflect the level of activity in month.

7.7 Mr Coulter explained the Trust had included a reserve of £2m for medical staffing in the 2018/19 plan. There were a number of specialties which would continue to rely on support from locum doctors because longer term staffing solutions had not been identified, for example oncology. Spend on medical locums had been consistent for around 24 months. Dr Scullion noted the critical role of locum doctors in supporting the Trust. Mr Harrison added that locum doctors supported de-minimis staffing levels in departments such as paediatrics, where the establishment could not be varied in response to levels of patient demand.

7.8 Dr Tolcher said she wanted the Board to be clear that some actions and solutions were within the Trust's gift to resolve, and others were not. There were a number of medical staffing issues which it was not realistic would be solved in the short term, however the Trust continued to work on long term solutions. Other issues, such as spending on additional nursing did present an opportunity to bring about immediate change. She acknowledged that the Trust faced a challenge regarding nurse staffing as the Staff Friends and Family survey results made clear that staff had a perception that

staffing levels were not sufficient to deliver the quality of care they aspired to deliver despite evidence from national patient surveys and benchmark data suggesting that patient satisfaction and outcomes were excellent.

7.9 Mrs Foster agreed that activity had reduced in April 2018, but noted that wards were still full. During May, bed occupancy had reduced and this had resulted in a reduction in staffing. She highlighted a number of actions being taken to address the issue of overspending on ward staffing, includomg participation in the NHS Improvement collaborative, work to review enhanced care risk assessments and the introduction of more frequent reviews of patients requiring enhance care. Mrs Foster provided reassurance about the approval process for staffing above establishment and the process by which safe staffing levels were determined.

7.10 Mr Alldred agreed that escalation beds had remained open during April 2018 and bed occupancy had remained high. He acknowledged that his directorate had a key role in ensuring safe levels of staffing while managing the financial pressures and this was a difficult balance.

7.11 Mr Marshall noted gaps in doctors in training staffing; he said it was a sobering thought to consider the workforce gaps which would continue for the medium to long term.

7.12 Mr Ward thanked the executive directors for their helpful comments.

7.13 Mr Coulter noted a number of risks highlighted within the report, including achieving income from other sources to offset the Aligned Incentive Contract with Harrogate and Rural District (HaRD) CCG, reducing demand for outpatient and elective care from patients living within the HaRD CCG area, receiving full funding for the agenda for change pay award, winter funding and achieving CIP delivery.

7.14 Mr Thompson reflected that he felt the Trust tended to be over-optimistic, and as a result CIPs needed to go further and be more ambitious. Mr Coulter said that in was important for the organisation to maintain a balance and would prefer the Trust to be optimistic as this would support staff to be motivated, and attract people to want to work for the organisation. However it was important for the Board to recognise when the organisation was being overly optimistic. He said there remained a need to create momentum in delivery of CIPs, and noted that of the 159 CIP schemes identified, 61 of the schemes had no value attached at this stage.

7.15 Mrs Webster queried whether it would be helpful to reinstate rolling forecast reporting as had been utilised by the Finance Committee during 2017/18.

7.16 In conclusion Mrs Schofield thanked members of the Board for a good discussion. She added that culture was critical to success and she wanted the Trust to be a ‘can do’ organisation.

**APPROVED:**
**The Board of Directors noted the contents of the report and the actions that were being progressed to achieve the financial plan.**

**8.0 Integrated Board Report**

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

8.2 Ms Robson queried why the organisation was required to record pressure ulcers which were pre-existing to the Trust even though the Trust had no input to these patients' care. Mrs Foster explained this was a national requirement. Dr Tolcher added that it was important that the prevalence of pressure ulcers within the wider health and care system was recognised.

8.3 Dr Earl provided an update on roll-out of the new Datix incident reporting system. He explained that external support had been engaged to develop the system to make it easier for staff to report incidents. An exact date for launch of the new system was to be confirmed.

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

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

**9.0 Report from the Chief Operating Officer**

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

9.2 Mr Harrison highlighted activity against plan on outpatient activity, day cases and elective activity. He confirmed non elective activity for May 2018 was on plan. As of that day, the Trust had no escalation beds open and Ripon Hospital was operating at the baseline bed position.

9.3 He drew attention to a notable shift in attendance at the Accident and Emergency Department, with activity 7.4% above plan in April and May 2018, and with a pattern of minor attendances in the late evening period. These changes had affected performance, and the department was considering how they could reshape the model to address this different and unexpected demand.

9.4 Mr Stiff suggested the Trust should have a separate GDPR privacy statement for children and young people.

**9.5 ACTION: Mr Harrison to consider developing a separate GDPR privacy statement for children and young people.**

9.6 Mrs Foster drew attention to achievement of the Baby Friendly Initiative by Children's Services in North Yorkshire.

9.7 The Board welcomed the proposed additional metrics for the Integrated Board Report focussed on Adult Community Services.

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

- **Received and noted the contents of the report.**
- **Agreed inclusion of the proposed additional metrics for the Integrated Board Report.**

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

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

10.2 Mr Marshall highlighted that his report included an update on the clinical workforce strategy, the staff friends and family test results, partnerships with local universities to develop the future NHS workforce and plans for the creation of a new medical bank across WY&H.

10.3 Dr Tolcher noted the staff friends and family test results had shown a small deterioration. She noted the paradox between an apparent perception amongst staff regarding unsafe staffing levels while ward staffing appeared to consistently be above establishment and the Trust provided above average care hours per day per patient.

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

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

**11.0 Report from the Chief Nurse**

11.1 The report had been circulated in advance of the meeting and was taken as read. Mrs Foster highlighted the NHS Improvement review of ward staffing which would take place in July 2018, analysis of care hours per patient, and noted a reduction in pressure ulcers,

11.2 Ms Robson queried the degree of flexibility to move registered nurses between wards in order to address staffing issues as they arose. Mrs Foster said that this did occur, but there was not a separate flexible team of registered nurses available to address gaps.

**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 community and hospital acquired pressure ulcers in month;**
- **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.**

**12.0 Annual Patient Experience and Complaints Report**

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

12.2 Mrs Foster welcomed the ten percent reduction in the number of complaints received by the Trust; this was evidence of the quality of care being provided to patients. Significant progress had been made on improving the timeliness of complaint responses. It was noted that no complaints referred to the ombudsman had been upheld.

12.3 Following a question from Mr Thompson it was confirmed the Quality Committee

had considered how the timeliness of complaint responses could be further improved and determined that the deadline for responding to complaints should not be extended.

**APPROVED:**
**The Board of Directors:**
- **Received and noted the report.**

**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 highlighted a number of national reports received in month and noted an update on the response to the national breast screening incident update. He confirmed that approximately 70 patients are thought to have been affected within the Harrogate region, anyone highlighted would be fast tracked for review.

13.3 Dr Scullion expressed his frustration at slow progress on implementation of the ReSPECT project.

**APPROVED:**
**The Board of Directors:**
- **Received and noted the report.**

**14.0 Guardian of Safe Working Hours Quarterly Report**

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

14.2 Dr Scullion said the Trust's standing was good and confirmed the Guardian of Safe Working Hours had no on-going concerns.

14.3 It was noted that Dr Gray had expressed concerns about the level of junior doctor vacancies and the impact this would have on the supply of future consultants. Mrs Schofield asked whether the Trust had any contingency plans to address this risk. Dr Tolcher said that although the Trust was taking some actions, this was an issue which could only be addressed at regional and national level.

**APPROVED:**
**The Board of Directors:**
- **Received and noted the report.**
- **Considered the points at the end of the report.**

**15.0 Learning from Deaths Report**

15.1 The report had been circulated in advance of the meeting and was taken as read. Dr Scullion confirmed he had nothing further to highlight.

15.2 The Board noted the report.

**APPROVED:**
**The Board of Directors:**
- **Received and noted the report.**

## 16.0 NHS Resolution: Safer Maternity Incentive Scheme

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

16.2 Dr Johnson explained NHS Resolution had asked all Trusts to assess progress against ten standards. The aim was to further improve the safety of maternity care.

16.3 The Trust had assessed performance as green for four areas, amber for five areas and red for one area. The red action related to midwifery workforce planning, specifically to the supernumerary labour ward coordinator. Dr Johnson noted that significant investment or a change to the structure of the establishment would be required to provide this.

16.4 Dr Johnson reflected that the Trust had been very honest in its assessment. An action plan was in place to further improve performance.

16.5 It was noted that the Quality Committee would receive a report in the following week regarding the 'safer births' bundle which aimed to reduce the number of still births. Dr Johnson noted that the biggest challenge related to scanning of all women with high risk pregnancies. This related to the Trust's capacity for scanning.

16.6 The Board delegated authority to the Chief Nurse to approve the final submission to NHS Resolution.

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

- **Received and noted the report.**
- **Endorsed the content and action plan and delegated authority to Mrs Foster to approve the final version of the submission to NHS Resolution.**

## 17.0 Oral Reports from Directorates

### 17.1 Planned and Surgical Care Directorate

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

- The Trust had participated in a three day maternal and neonatal safety collaborative. As a result, projects would be progressed which would focus on smoking cessation, readmissions of babies, jaundice pathways and breast feeding.
- The business case for the FLIP project had been stalled due to the cost attributed. Further work was needed to achieve the desired outcome, namely ring-fenced beds, from within available resources.

### 17.2 Children's and County Wide Community Services Directorate

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

- The Trust would be participating in safeguarding week in June 2018. There would be a focus on identifying bruises in non-mobile babies.
- There had been a recent issue with the Sterile Service Department. Acute services had been prioritised over community services; which had caused an

issue for community dental teams. As a response new contingency arrangements had been put in place.
- Work continued to mobilise the new 0-19 Children's Services contracts. It was noted an unexpected issue regarding paper records had been identified.

**17.3 Long Term and Unscheduled Care Directorate**

17.3.1 Mr Alldred provided a verbal update from the Long Term and Unscheduled Care Directorate:
- The radiology team was under significant pressure and actions were being progressed to address this issue.
- Work had commenced to consider how the Trust could work in partnership with other organisations to further improve the efficiency of the pathology service.

**18.0 Committee Chair Reports**

Mrs Schofield welcomed reports from the Board's committees.

**18.1 Report from the Quality Committee meeting held on 2 May 2018 and the Quality Committee Annual Report 2017/18**

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

18.1.2 Mrs Webster noted the hot spots regarding children's safeguarding issues with GPs and a number of additions to the committee's work plan.

18.1.3 The Board welcomed the Quality Committee Annual Report 2017/18 and agreed the committee had operated within its terms of reference.

**APPROVED:**
**The Board of Directors:**
- **Noted Quality Committee Annual Report 2017/18**

**18.2 Report from the Audit Committee meetings held on 3 May and 17 May 2018 and the Audit Committee's Annual Report 2017/18.**

18.2.1 Mr Thompson presented a report from the Audit Committee meetings held on 3 May 2018 and 17 May 2018. The report had been circulated in advance of the meeting and was taken as read.

18.2.2 The Board welcomed the Audit Committee Annual Report 2017/18 and agreed the committee had operated within its terms of reference.

**APPROVED:**
**The Board of Directors:**
- **Noted the Audit Committee's Annual Report 2017/18**

**18.3 Finance Committee's Annual Report 2017/18.**

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

18.3.2 The Board noted the Finance Committee's Annual Report 2017/18 and agreed the

committee had operated within its terms of reference.

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

- **Noted the Finance Committee's Annual Report 2017/18.**

**19.0 Council of Governors minutes of the meeting held 3 February 2018**

19.1 The Board noted the minutes of the Council of Governors meeting held 3 February 2018.

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

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

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

There were no other items of business.

**22.0 Board Evaluation**

Mr Harrison welcomed the time devoted to considering the Trust's financial position.

**23.0 Confidential Motion**

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

The Board agreed the motion unanimously. The meeting closed at 12.40pm.

NHS
Harrogate and District
NHS Foundation Trust

# HDFT Board of Directors Actions Schedule
## Action Log
## June 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 | **Complete** Considered at Board Strategy Day on 21 June 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 | September 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 (see action 97 below) | Proposals will be discussed by the Board on 28 June 2018 and an update provided to the Board in July 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 | **Complete** added to Board work plan |
| 92 | April 2018 (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 | Update at meeting |
| 93 | April 2018 (minute 12.2) | Mrs Foster to add percentage figures to analysis of staffing on adult in-Patient Wards in order to assist the context of the report. | Mrs J Foster, Chief Nurse | June 2018 | Update at meeting |
| 94 | April 2018 (minute 12.3) | Mrs Foster to schedule director inspections for 2018/19 | Mrs J Foster, Chief Nurse | June 2018 (see action 97 below) | Proposals will be discussed by the Board on 28 June 2018 and an update provided to the Board in |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | July 2018 |
| 95 | May 2018 (minute 4.3) | Schedule visit for Board to the new endoscopy unit. | Mr Jonathan Coulter, Deputy Chief Executive / Mrs Roberts, Company Secretary | August 2018 | |
| 96 | May 2018 (minute 5.6) | Further consideration to be given to how members of the public could be encouraged to attend and observe public meetings of the Board. | Mrs Angela Schofield, Chairman | June 2018 | **Complete** Package of actions agreed to increase public awareness of Trust Board meetings. |
| 97 | May 2018 (minute 5.9) | Mrs Foster to progress a programme of Director Inspections and Patient Safety Visits. | Mrs J Foster, Chief Nurse | July 2018 | Proposals will be discussed by the Board on 28 June 2018 and an update provided to the Board in July 2018 |
| 98 | May 2018 (minute 6.5) | Mrs Roberts to schedule a board workshop regarding capital funding | Mrs Katherine Roberts, Company Secretary | July 2018 | |
| 99 | May 2018 (minute 9.5) | Mr Harrison to consider developing a separate GDPR privacy statement for children and young people. | Mr Harrison, Chief Operating Officer | July 2018 | |

Harrogate and District
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|---|---|---|---|
| **Date of Meeting:** | 27 June 2018 | **Agenda item:** | 5.0 |
| **Report to:** | Board of Directors | | |
| **Title:** | Board governance documents for approval | | |
| **Sponsoring Director:** | Mrs Angela Schofield, Chairman<br>Dr Ros Tolcher, Chief Executive | | |
| **Author(s):** | Mrs Katherine Roberts, Company Secretary | | |

**Report Purpose:**

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

**Executive Summary:**

- The Board of Directors has Terms of Reference which require annual review. A number of minor amendments are proposed, which are highlighted for consideration by the Board.
- The Trust is required to 'comply or explain' with the Code of Governance for NHS Foundation Trusts. The Company Secretary prepares an annual assessment against the Code which is reported to the Audit Committee and is summarised in the Trust's Annual Report. During the review in May 2018 two documents were identified as in place, but due for review:
  - Board Code of Conduct
  - Statement of the division of responsibility between the Chairman and the Chief Executive
- Updated versions of these documents are presented for comment and approval by the Board. Both documents are based on best governance practice recommended by NHS Providers.
- In May 2018 the Board agreed to move to a new schedule of dates. Appendix D is a schedule of future Board and Finance Committee dates.

**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:** | The Trust is required to 'comply or explain' with the Code of Governance for NHS Foundation Trusts. The 'Board Code of Conduct' and 'Statement of the division of responsibility between the Chairman and the Chief Executive' are key documents in achieving compliance with the Code. |
| **Resource:** | None identified. |
| **Impact Assessment:** | Not applicable. |
| **Conflicts of** | None identified. |

| | |
|---|---|
| **Interest:** | |
| **Reference documents:** | Appendix A: Board Terms of Reference<br>Appendix B: Code of Conduct<br>Appendix C: Statement of the division of responsibility between the Chairman and the Chief Executive<br>Appendix D: Schedule of future Board and Committee dates<br><br>NHS Foundation Trust Code of Governance:<br>https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/327068/CodeofGovernanceJuly2014.pdf |
| **Assurance:** | Not applicable, this matter is reserved to the Board. |

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

It is recommended that the Board:

- Considers and approves the updated:
  - Terms of Reference,
  - Code of Conduct, and;
  - Statement of the division of responsibility between the Chairman and the Chief Executive

- Approves the schedule of future Board and Finance Committee dates.

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Harrogate and District
NHS Foundation Trust

**Harrogate and District NHS Foundation Trust Board of Directors**

**Terms of Reference**

## 1. Introduction

1.1 Harrogate and District NHS Foundation Trust is led by a unitary Board of Directors which is responsible for exercising all the powers of the Trust on its behalf, however may delegate any of those powers to a committee of the Board (comprised of a group of Board Directors) or to an Executive Director.

1.2 The Board of Directors, in its capacity as Corporate Trustee, takes responsibility for the overall management and governance of charitable funds and related fund-raising activity.

## 2. Membership

2.1 The members of the Board shall comprise of the Chairman of the Trust, Chief Executive Officer, all the Non-Executive Directors and Executive Directors who hold voting rights on the Board.

2.2 In accordance with the Trust's Constitution, the composition of the Board of Directors shall be:

- The Chairman of the Trust;
- A minimum of six Non-Executive Directors (including the Vice-Chairman and the Senior Independent Director);
- The Chief Executive Officer (also the Chief Accountable Officer);
- Executive Directors to include as a minimum:
    - Director of Finance (also the Chief Accounting Officer);
    - Medical Director (who shall be a registered medical or dental practitioner);
    - Chief Nurse (who shall be a registered nurse or midwife);
    - Two other Executive Directors (currently the Chief Operating Officer and Director of Workforce and Organisational Development);

2.3 The Deputy Chief Executive shall be selected from the Executive Director cohort (currently the Director of Finance).

2.4 Only members of the Board shall be entitled to attend meetings.

2.5 Clinical Directors from the three operational directorates, and the Company Secretary, will have a standing invitation to meetings of the Board of Directors, but will not hold voting rights. Other officers of the Trust and other individuals may be invited to attend meetings or part of meetings as required by the Board or as the Chairman sees fit.

2.6 The record of attendance of members will be included in the annual report of the Board.

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## 3.0 Voting

3.1 Members of the Board will each be entitled to cast a single vote on matters before it. In the case of an equality of votes the Chairman of the meeting is to have a casting vote. Provisions to deal with conflicts of interest are provided for in the Trust's Constitution and Standing Orders.

## 4. Quorum

4.1 No business shall be transacted at meetings of the Board unless a minimum of five voting Directors are present including at least two Executive Directors and three Non-Executive Directors. A duly convened meeting of the Board at which a quorum is present shall be competent to exercise all or any of the authorities, powers or discretions vested in or exercisable by the Trust.

4.2 An officer representing an Executive Director at meetings of the Board of Directors may not count towards the quorum, unless formal 'acting up' status has been previously agreed.

## 5. Frequency

5.1 The Board shall meet formally in public on a bi-monthly basis, at a location that it may determine. There will be a minimum of ~~ten~~ six meetings per year. Additional meetings of the Board may be called in accordance with the Trust's Standing Orders.

## 6.0 Notice of Meetings

6.1 Meetings of the Board shall be called by the Company S~~s~~ecretary in accordance with the annual schedule of business or as determined by the Chairman.

6.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Board and any other person required to attend no later than five working days before the date of the meeting. Supporting papers shall be sent to members and other attendees as appropriate at the same time.

6.3 The agenda of the Board of Director meetings held in public shall be forwarded to the Council of Governors prior to the meeting, and ensure that agenda, minutes and supporting papers are available publicly on the Trust's website.

6.4 After each Board meeting held in public, the Board of Directors must make available a copy of the minutes to the Council of Governors.

## 7.0 Meetings Administration

7.1 The Company Secretary shall minute the proceedings and resolutions of all meetings of the Board, including the names of those present and in attendance.

7.2 The Company Secretary shall keep a separate record of all points of action arising from the meetings and all issues carried forward.

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7.3 The Chairman shall ascertain, at the beginning of each meeting, the existence of any conflicts of interest and determine how they should be managed in accordance with the Constitution and Standing Orders. ~~t~~The Company Secretary shall minute the~~m~~ conflicts of interest, and approach chosen to manage them~~accordingly~~.

**8.0 Main Responsibilities**

8.1 The general duty of the Board and of each Director individually, is to promote the success of the organisation so as to maximise the benefits for the members of the organisation as a whole, and for the public.

8.2 As a unitary body, the Board of Directors is responsible for decision making associated with:

8.2.1 The strategic direction of the Trust;

8.2.2 The provision of high quality and safe healthcare services, healthcare delivery, education, training and research;

8.2.3 Overall performance of the Trust in relation to standards set by regulatory bodies.

8.2.4 Ensuring the Trust exercises the its functions effectively, efficiently and economically;

8.2.5 Ensuring effective arrangements are in place for governance and risk management;

8.2.6 Ensuring compliance with the Trust's Provider Licence and associated legislation, regulation and best practice.

**9.0 Duties**

9.1 Leadership and Culture. The Board:

9.1.1 Ensures there is a clear vision for the Trust that people understand and that is being implemented within a framework of prudent and effective controls.

9.1.2 Sets values, ensuring they are widely communicated and that the behaviour of the Board is entirely consistent with those values.

9.1.3 Promotes and patient-centred culture of openness, transparency and candour, has an intolerance of poor standards and fosters a culture which puts patients first.

9.1.4 Ensures the Trust is an excellent employer through the development of a workforce strategy and its appropriate implementation and operation.

9.1.5 Ensures that Directors, Governors, staff and volunteers adhere to any codes of conduct adopted or introduced.

9.1.6 Implements an effective Board and Committee structure and clear lines of accountability and reporting throughout the organisation.

9.1.7 Ensures there are appropriately constituted appointment arrangements for senior appointments such as Executive Directors and consultant medical staff.

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9.2 Strategy. The Board:

9.2.1 Sets and maintains the Trust's strategic vision, aims and objectives ensuring that the necessary financial, physical and human resources are in place for it to meet its objectives.

9.2.2 Develops and maintains an annual business plan, with due regard to the views of the Council of Governors, and ensures its delivery, as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders.

9.2.3 Ensures that national policies and strategies are effectively addressed and implemented within the Trust.

9.3 Quality and Performance. The Board:

9.3.1 Ensures that the Trust's quality of service responsibilities for clinical effectiveness, patient safety and patient experience are achieved.

9.3.2 Monitors and reviews management performance to ensure the Trust's objectives are met and identifies opportunities for improving the delivery of high quality services.

9.3.3 Monitors feedback relating to the experiences of people who use the services and the processes for proactive engagement.

9.3.4 Ensures it engages with all stakeholders, including patients and staff on quality issues and that issues are escalated appropriately and dealt with when required.

9.3.5 Ensures the proper management of resources and that responsibility for financial and quality of service are achieved.

9.3.6 Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required.

9.3.7 Ensures that there are sound processes and mechanisms in place to ensure effective patient and carer involvement with regard to development of care plans, the review of quality of services provided and the development of new services.

9.1.8 Ensures that there are sound processes in place to ensure compliance with, and awareness of equality and diversity standards.

9.1.9 Ensures that the organisation promotes clinical research.

9.4 Finance. The Board:

9.4.1 Ensures the Trust operates effectively, efficiently and economically to ensure the continuing financial viability of the organisation.

9.4.2 Ensures the proper management of resources and that financial and quality of service responsibilities are fulfilled, and ensures the achievement of targets and requirements of stakeholders within available resources.

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9.4.3 Ensure effective financial stewardship through effective value for money, financial control and financial planning and strategy.

9.4.4 Acts as Corporate Trustee for the Trust's fundraising charity, charity number 1050008 (*registered as the Harrogate and District NHS Foundation Trust Charitable Fund*) and in respect of all existing charitable funds.

9.4.5 Oversee the effective management of the Harrogate Hospital & Community Charity and ensure good governance and legal compliance in the areas of public fund-raising and donor data protection.

9.5 Governance. The Board:

9.5.1 Ensures compliance with relevant principles, systems and standards of good corporate governance and has regard to contemporary guidance, and appropriate codes of conduct, accountability, openness and transparency.

9.5.2 Ensures that the Trust complies with the requirements of its Licence, governance and assurance obligations in the delivery of safe clinically effective services.

9.5.3 Ensures that the Trust has comprehensive governance arrangements in place guarantee the resources vested in the Trust are appropriately managed and deployed.

9.5.4 Ensures that all required returns and disclosures are made to the Regulators.

9.5.5 Formulates, implements and reviews Standing Orders and Standing Financial Instructions as a means of regulating the conduct and transactions of the Trust's business.

9.5.6 Agrees the schedules of matters reserved for decision by the Board of Directors.

9.5.7 Ensures proper management of, and compliance, with, statutory requirements of the Trust and, ensures the statutory duties of the Trust are effectively discharged.

9.5.8 Establishes appeals panels as required by employment policies particularly to address appeals against dismissal and final stage grievance hearings.

9.6 Risk Management and Internal Control. The Board:

9.6.1 Determines the nature and extent of the risk it is willing to take in achieving its strategic objectives.

9.6.2 Ensures that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements in line with the requirements of the Provider Licence.

9.6.3 Ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities.

9.7 Communication and Engagement. The Board:

9.7.1 Ensures relationships are maintained with the Trust's stakeholders, regulators, public, governors, staff and patients, such that the Trust can discharge its wider duties.

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9.7.2 Meets its engagement obligations in respect of the Council of Governors and members and ensures that the Governors are equipped with the skills and knowledge they require to undertake their role.

9.7.3 Works in partnership with service users, carers, local health organisations, local government authorities and others to provide safe, effective, accessible and well governed services.

9.7.4 Ensures the effective dissemination of information on organisational strategies and plans, providing a mechanism for feedback.

9.7.5 Holds an annual meeting of its members which is open to the public.

9.7.6 Approves and publishes the Trust's Annual Report and Accounts, Quality Accounts and other statutory submissions.

## 10.0 Committees

10.1 The Board is responsible for establishing and maintaining committees with delegated responsibilities and powers as prescribed by the Trust's Standing Orders and/or by the Board of Directors.

## 11. Review and revision

11.1 These Terms of Reference will be reviewed annually and the Board will conduct an annual review of its effectiveness and shall act on its findings.

~~Approved~~ DRAFT June 2018~~May 2017~~

Harrogate and District
NHS Foundation Trust

# Code of Conduct for the Board of Directors

## 1. Introduction

High standards of corporate and personal conduct are an essential component of public life. The purpose of this code is to provide clear guidance on the standards of conduct and behaviour expected of all Directors.

As an NHS Foundation Trust, Harrogate and District NHS Foundation Trust (HDFT) complies with the principles of best practice applicable to corporate governance in the NHS/health sector and with any relevant code of practice. The HDFT Board of Directors is a unitary Board, meaning that Directors have equal and shared accountability. This code also applies to non voting and Clinical Directors who attend Board of Director meetings.

This code, with the Code of Conduct for Governors and the NHS Constitution, forms part of the framework designed to promote the highest possible standards of conduct and behaviour within the Foundation Trust. The code is intended to operate in conjunction with the NHS Foundation Trust Code of Governance, the Trust's Constitution, the Trust's Conflicts of Interest Policy and with the Trust's Standing Orders.

The code applies at all times when Directors and are carrying out the business of the Foundation Trust or representing the Foundation Trust.

## 2. Principles of public life

All Directors and are expected to abide by the Nolan principles of: selflessness, integrity, objectivity, accountability, honesty, transparency and leadership:

**Selflessness**
Holders of public office should act solely in terms of the public interest: they should not do so in order to gain financial or other benefits for themselves, their family or their friends.

**Integrity**
Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

**Objectivity**
In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit alone.

**Accountability**
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

**Openness**
Holders of public office should be as open as possible about all the decisions and actions they take: they should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

**Honesty**
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

**Leadership**
Holders of public office should promote and support these principles by leadership and example**.**

**3. General principles**

Foundation Trust Boards of Directors have a duty to conduct business with probity, to respond to staff, patients and suppliers impartially, to achieve value for money from the public funds with which they are entrusted and to demonstrate high ethical standards of personal conduct. The general duty of the Board and of each Director individually, is to:

- Promote the success of the organisation so as to maximise the benefits for the members of the organisation as a whole and for the public.
- Work with the Trust's Council of Governors in an open and transparent way and observe and embed of a duty of candour throughout the organisation.
- Set an example in the conduct of its business and to promote the highest corporate standards of conduct.
- Ensure that the provisions of the Constitution, the Standing Orders, Standing Financial Instructions and accompanying scheme of delegation conform to best practice and serve to enhance standards of conduct. The Board of Directors expects that this code will inform and govern the decisions and conduct of all Directors.

**4. Confidentiality & access to information**

Directors must comply with the Trust's confidentiality policies and procedures. Directors must not disclose any confidential information, except in specified lawful circumstances and advisably, only in consultation with the Company Secretary..

Information on decisions made by the Board of Directors and information supporting those decisions should be made easily available in a way that is understandable. Positive responses should be given to reasonable requests for information and in accordance with the Freedom of Information Act 2000 and other applicable legislation and Directors must not seek to prevent a person from gaining access to information to which they are legally entitled.

The Board of Directors has adopted policies and procedures to protect confidentiality of personal information and to ensure compliance with the Data Protection Act, the Freedom of Information Act and other relevant legislation which will be followed at all times by Board of Directors.

Nothing said in this code precludes Directors from making a protected disclosure within the meaning of the Public Disclosure Act 1998.

**5. Fit and proper person**

It is a legal and regulatory requirement that a Director serving on the Board of Directors is a 'fit and proper person'. Directors must certify on appointment, and each year, that they are/remain a fit and proper person. If circumstances change so that a Director can no longer be regarded as a fit and proper person or if it comes to light that a Director is not a fit and proper person they are suspended from being a Director with immediate effect pending confirmation and any appeal. Where it is confirmed that a Director is no longer a fit and proper person their membership of the Board would be terminated.

**6. Register of interests**

Directors are required to register all relevant interests on the Trust's register of interests in accordance with the provisions of the Constitution, the Trust's Standing Orders and Conflicts of Interest Policy. It is the responsibility of each Director to update their register entry if their interests change. A pro forma is available from the Company Secretary. Failure to register a relevant interest in a timely manner may constitute a breach of this code.

## 7. Conflicts of interest

Directors have a statutory duty to avoid a situation in which they have (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Foundation Trust. Directors have a further statutory duty not to accept a benefit from a third party by reason of being a Director or for doing (or not doing) anything in that capacity.

If a Director has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to the other Directors. If such a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. Any such declaration must be made at the earliest opportunity and before the Trust enters into the transaction or arrangement.

The Chair will advise Directors in respect of any conflicts of interest that arise during Board of Directors meetings, including whether the interest is such that the Director should withdraw from the meeting for the period of the discussion. In the event of disagreement it is for the Board of Directors to decide whether a Director must withdraw from the meeting. The Company Secretary will provide advice on any conflicts that arise between meetings.

## 8. Gifts & hospitality

The Board of Directors will set an example in the use of public funds and the need for good value in incurring public expenditure. The use of the Foundation Trust budget for hospitality and entertainment, including hospitality at conferences or seminars, will be carefully considered. All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector. The Board of Directors is conscious of the fact that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage the reputation of the Foundation Trust in the eyes of the community.

The Board of Directors has adopted a policy on gifts and hospitality (The Conflicts of Interst Policy) which will be followed at all times by Directors. Directors must not accept gifts or hospitality other than in compliance with this policy.

## 9. Whistle-blowing / Speaking Up

The Board of Directors acknowledges that staff must have a proper and widely publicised procedure for voicing complaints or concerns about maladministration, malpractice, breaches of this code and other concerns of an ethical nature and positively establishes a culture for sharing concerns. The Board of Directors has adopted a Speaking Up (whistle-blowing) policy on raising matters of concern which will be followed at all times by Directors and all staff.

## 10. The Bribery Act 2010

The Board of Directors will ensure that it acts at all times in compliance with the Bribery Act 2010, acknowledging that it is a criminal offence to give, promise, or offer a bribe and to request, agree or receive a bribe.

## 11. Personal conduct

Directors are expected to conduct themselves in a manner that reflects positively on the Foundation Trust and not to conduct themselves in a manner that could reasonably be regarded as bringing their office or the Foundation Trust into disrepute.

Specifically Directors must:

- Act in the best interests of the Foundation Trust and adhere to its values and this code of conduct.
- Respect others and treat them with dignity and fairness.

- Seek to ensure that no one is unlawfully discriminated against and promote equal opportunities and social inclusion.
- Be honest and act with integrity and probity.
- Contribute to the workings of the Board of Directors in order for it to fulfil its role and functions.
- Recognise that the Board of Directors is collectively responsible for the exercise of its powers and the performance of the Foundation Trust
- Raise concerns and provide appropriate challenge regarding the running of the Trust or a proposed action where appropriate.
- Recognise the differing roles of the Chair, Senior Independent Director, Chief Executive, Vice Chair, Executive Directors and Non-Executive Directors.
- Make every effort to attend Board of Director meetings, sub committee meetings and others (including Council of Governor meetings and the Annual Members meeting) as required.
- Adhere to good practice in respect of the conduct of meetings and respect the views of others.
- Take and consider advice on issues where appropriate.
- Recognise and fully support the Council of Governors to represent the interests of the Foundation Trust's Members and partner organisations in the governance and performance of the Foundation Trust, and to have regard to the views of the Council of Governors.
- Not use their position for personal advantage or seek to gain preferential treatment; nor seek improperly to confer an advantage or disadvantage on any other person.
- Accept responsibility for their performance, learning and development.
- Complete appraisal and mandatory training and other training as requested.

Appropriate conduct extends to outside of the workplace and the use of social media.

**12. Compliance**

The members of the Board of Directors will satisfy themselves that the actions of the Board of Directors and Directors in conducting business fully reflect the values, general principles and provisions in this code and, as far as is reasonably practicable, that concerns expressed by staff or others are fully investigated and acted upon. All Directors, on appointment, will be required to give an undertaking to abide by the provisions of this code of conduct.

I hereby agree to the code of conduct for the Board of Directors of Harrogate and District NHS Foundation Trust.

Signed:

Name:

Position:

Date:

Harrogate and District
NHS Foundation Trust

**Statement of the division of responsibility between the Chairman and the Chief Executive**

| **Chairman** | **Chief Executive (Chief Executive)** |
|---|---|
| Reports to the Board of Directors and Council of Governors. | Reports to the Chairman and to the Board of Directors and is the Accountable Officer for the Trust. |
| Other than the Chief Executive, no executive reports to the Chairman. | All members of the management structure report either directly or indirectly, to the Chief Executive. |
| Ensures effective operation of the Board of Directors and Council of Governors. | Runs the trust's operation and day to day business. |
| Ensures that the Board of Directors as a whole play a full part in the development and determination of the Trust's strategy and overall objectives. | Responsible for proposing and developing the foundation trust's strategy and overall objectives |
| The guardian of the Board of Directors' decision-making processes. | Implements the decisions of the Board of Directors and its committees. |
| Leads the Board of Directors and the Council of Governors. | Ensures the provision of information and support to the Board of Directors and Council of Governors. |
| Ensures the Board of Directors and Council of Governors work together effectively. | Facilitates and supports effective joint working between the Board of Directors and Council of Governors. |
| Oversees the operation of the Board of Directors and sets its agenda. | Provides input to the board of director's agenda on behalf of the executive team. |
| Ensures the board of director's and council of governor's agendas take full account of the important issues facing the trust | Ensures the Chairman is aware of the important issues facing the trust and proposes agenda items accordingly. |
| Ensures the Board of Directors and Council of Governors receive accurate, timely and clear information. | Ensures the provision of reports to the Board of Directors which contain accurate, timely and clear information. |
| Ensures compliance with the board of director's approved procedures, including the Board Code of Conduct, Standing Orders, and Standing Financial Instructions. | Ensures the compliance of the executive team with the board of director's approved procedures, including the Board Code of Conduct, Standing Orders, and Standing Financial Instructions. |
| Arranges informal meetings of the directors to ensure that sufficient time and consideration is given to complex, contentious or sensitive issues. | Ensures that the Chairman is alerted to forthcoming complex, contentious or sensitive issues affecting the foundation trust |

| | |
|---|---|
| Proposes a schedule of matters reserved to the Board of Directors; proposes terms of reference for each Board of Directors committee and proposes other board policies and procedures. | Provides input as appropriate on changes to the schedule of matters reserved to the Board of Directors and committee terms of reference. |
| Facilitates the effective contribution and the provisions of effective challenge by all members of the Board of Directors. | Supports the Chairman in facilitating effective contributions by executive directors including effective challenge. |
| Facilitates constructive relationships between executive and non-executive members of the Board of Directors. | Supports the Chairman in sustaining constructive relations between executive and non-executive members of the board. |
| Ensures that constructive relations exist between elected and appointed members of the Council of Governors. | Supports the Chairman in ensuring constructive relations between elected and appointed members of the Council of Governors. |
| Ensures constructive and productive relations between the Board of Directors and the Council of Governors. | Supports the Chairman in ensuring constructive relations between the Board of Directors and the Council of Governors. |
| Ensures that the non-executive directors are able to lead in being accountable to the Council of Governors for the Board of Directors. | Ensures the presence and support of executives to the non-executive directors in order to facilitate the accountability relationship. |
| Leads the Council of Governors in holding the non-executive directors to account, ensuring the accountability process works effectively. | Supports the Chairman in delivering an effective accountability process. |
| Chairs the remuneration committee and initiates change succession planning measures at board level to ensure appropriate change. Ensures the appointment of effective and suitable members and chairs for Board of Directors committees. | Provides information and advice on succession planning to the Chairman, the remuneration committee and to other members of the Board of Directors, particularly in respect of executive directors. |
| Proposes the membership and the chairs of Board of Directors committees. | If so appointed by the Board of Directors, serve on any committee. |
| Ensure effective communication on the part of the trust with patients, members, clients, staff and other stakeholders. | Lead the communication programme with members and stakeholders. |
| Lead the provision of a properly constructed induction programme for new non-executive directors. | Contribute to induction programmes for new non-executive directors and ensure that appropriate management time is made available for the process. |
| Lead in updating the skills and knowledge and in meeting the development needs of individual non-executive directors and of the Board of Directors as a whole. | Ensure that the development needs of the executive directors and other senior management staff are identified and met. |

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|---|---|
| Ensure that members of the Council of Governors have the skills, knowledge and familiarity with the foundation trust to fulfil their role. | Ensure the provision of appropriate development, training and information for the Council of Governors. |
| Ensure that the performance of the Board of Directors and Council of Governors as a whole, their committees, and individual members of both are periodically assessed. This will normally include an externally led assessment at least once in every three years. | Ensure that performance reviews are carried out at least once a year for each of the executive directors. Provide input to the wider board of director's and council of governor's evaluation process. |
| Promote the highest standards of integrity, probity and corporate governance throughout the organisation and particularly at board of director level. | Conduct the affairs of the foundation trust in compliance with the highest standards of integrity, probity and corporate governance. Promote continuing compliance across the organisation. |
| Ensure a good flow of information each way between the Board of Directors, board committees, the Council of Governors, senior management and non-executive directors. | Provide effective information and communication systems. |

*Approved: DRAFT June 2018*
*Due for review: Two years from approval*

Appendix D

Harrogate and District NHS Foundation Trust

**BOARD OF DIRECTORS AND FINANCE COMMITTEE**

**REVISED MEETING DATES FOR 2018**

| Meeting | Date | Time | Location |
|---|---|---|---|
| Board Workshop | 29/08/2018 | To be confirmed | To be confirmed |
| Finance Committee | 03/09/2018 | 12.30pm – 2.30pm | Board Room |
| Board Meeting | 26/09/2018 | 9.00am – 3.00pm | Board Room |
| Finance Committee | 29/10/2018 | 1.00pm – 3.30pm | Board Room |
| Board Workshop | 31/10/2018 | To be confirmed | To be confirmed |
| Board Meeting | 28/11/2018 | 9.00am – 3.00pm | Board Room |
| Board Workshop | 19/12/2018 | To be confirmed | To be confirmed |
| Finance Committee | 07/01/2019 | 1.00pm – 3.30pm | Board Room |

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| | | | |
|---|---|---|---|
| **Date of Meeting:** | 27 June 2018 | **Agenda item:** | 6.0 |
| **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:** | • West Yorkshire and Harrogate HCP has been confirmed as a wave 2 shadow ICS (Integrated Care System).<br>• Operational and financial performance improved in Month 2. The Trust met the A&E 4 hour standard and all cancer pathway standards with the exception of the 14 day symptomatic breast patients. RTT continues to improve but remains below the 92% standard. | | |

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

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

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

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

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

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

Operational and financial performance improved in Month 2. The Trust met the A&E 4 hour standard and all cancer pathway standards with the exception of the 14 day maximum wait for symptomatic breast patient's which although better than in month 1 remains below the 93% standard. RTT also continues to improve but remains below the 92% standard.

### 1.2 HDFT Annual Quality Conference

The Trust hosted another highly successful Quality Conference on 13th June. This annual event forms a pillar of our Quality Charter and was attended by more than 120 colleagues in Harrogate and some 25 individuals at the satellite site in Darlington to which all keynote sessions were transmitted live. Sessions included the importance of human factors in patient safety; the use of quality improvement methodology; learning from the financial services industry and creating a social movement to drive improvements in care. I would like to record my thanks to the many Trust colleagues who contributed as speakers and break-out session leaders, as well as those who participated with such enthusiasm on the day.

## 2.0 FINANCIAL POSITION

### 2.1 Financial performance

The Trust reported a deficit for the month of May of £59k which represents an in month adverse variance of £468k against the Trust's internal plan. The year to date position is therefore an adverse variance to the internal plan of £1.3m.

The Trust continues to show a positive variance of £527k against the NHSI submitted plan.

As in previous months, the main drivers of the overspending are the additional costs of bank, agency and locum staffing, and some shortfall in CIP attainment. Strengthened controls in respect of above establishment pay costs are now in place and we anticipate a significant reduction in expenditure on additional support workers in the June position.

The Trust reported a rating of 3 in May in line with the annual plan submitted to NHS Improvement.

Further details are contained in the Finance Director's report.

### 2.2 NHSI Diagnostic

Verbal feedback following a series of visits and desktop review has been provided. An update will be provided at the meeting.

### 2.3 2018/19 Operating Plan and priorities

The Trust has received feedback from NHSI on the 2018/19 operating plan. There are a small number of matters for further consideration, including activity profiling and the extent to

which bed capacity will flex in the winter months. Trusts are also asked to clarify workforce numbers and planned expenditure on bank and agency.

There will be a renewed national focus on reducing the number of people whose length of stay (LOS) exceeds 21 days which helpfully aligns to our internal priorities. See further details at item 6.4 below.

## 3.0 STRATEGIC UPDATE

### 3.1 NHS National Funding

The government has announced a £20bn long-term funding plan for the NHS, representing an average annual rise of 3.4% above inflation through to 2023, aligned to the development of a 10 year NHS Strategy. The NHS has been tasked with producing this strategy to improve performance, specifically on cancer and mental health care, and unpick barriers to progress. It should be noted that the funding is for the NHS England (NHSE) commissioning budget only. This means it does not include capital funding, public health, health education, or social care.

It was also announced that a further £1.25bn has been found to deal with an increase in pensions costs associated with the new Agenda for Change pay deal.

Details are yet to emerge however this is a very welcome announcement and offers some hope for future years of planning. It should be noted that national workforce supply gaps remain a significant challenges and all possible efforts to secure the right workforce for the foreseeable needs of the service must be pursued.

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

#### Accountable Care System

West Yorkshire and Harrogate Health and Care Partnership has been named as one of four areas joining the new Integrated Care System programme, putting the area at the forefront of nationwide action to provide better co-ordinated and more joined up care for 2.6 million people.

The draft Memorandum of Understanding (MoU) for the partnership has now been discussed by organisational boards and place based Health and Wellbeing Boards. Very positive progress has been made and final sign off by the Board will be sought in September. Work continues to agree the local deal in respect of the anticipated long term plan for the NHS and funding settlement referred to above.

#### WY&H Stroke Services

Work continues within the West Yorkshire and Harrogate HCP to determine the optimum model for delivery of stroke services, including hyper-acute care. Prior engagement and diagnostic work has shown that the needs of local people will be best met through the provision of four hyper-acute services for West Yorkshire and Harrogate. This would enable improved performance on the national stroke standards and preserve acute stroke care at Harrogate with hyper-acute patients being treated in the first instance in neighbouring hyper-acute units.

## 4.0 WORKING IN PARTNERSHIP

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

There has been no meeting of the HSLG since the last report to the Board of Directors. Positive progress continues in the HSLG subgroups.

## 5.0 SENIOR MANAGEMENT TEAM (SMT) MEETING

The SMT met on 20th June 2018. The following key areas are for noting:

- The Director of Infection Prevention and control noted the potential emergence of a super-resistant bacterium. Further information is being sought from Public Health England.
    - Financial performance and drivers of adverse variance were discussed. Support worker numbers are at establishment but expenditure is 24% above budget due to continued use of additional staff to support enhanced care.
- Expenditure in respect of Harrogate CCG activity is above plan. Work is underway to agree actions which manage this position and allows for the foreseeable cost of winter pressures.
- Doctors and nurses have been removed from the Tier 2 visa cap which will help with overseas recruitment.

## 6.0 COMMUNICATIONS RECEIVED AND ACTED UPON OR TO NOTE

### 6.1 Letter from NHS Improvement regarding Patient Safety Alerts and Never Events

NHS Improvement has written to the Trust regarding identified concerns about governance processes within the NHS to address Patient Safety Alerts. They cited two recent Patient Safety Alerts, related to air flowmeters and nasogastric tube safety, and expressed their concern that the continued occurrence of relevant Never Events within the NHS (not within HDFT) indicates that actions that would have prevented the Never Events have not been completed. The Trust has been asked to review processes for compliance with Patient Safety Alerts and where necessary correct the relevant alert status declared to NHS Improvement via the Central Alerting System.

### 6.2 Next Steps on Aligning the Work of NHS England and NHS Improvement

As I reported verbally to the Board in May 2018, NHS England and NHS Improvement have announced plans to work more closely together. This will include the creation of seven integrated regional teams, each led by a Regional Director, who will have much wider responsibilities and greater power compared to the current structure. The proposals also include changes to a number of national roles, with the function of the national level arms-length bodies changing to being one of supporting the Regional Directors and working with them to create the national level strategic framework.

### 6.3 Health and Social Care Select Committee report into integrated ways of planning and delivering health care

The Health and Social Care Select Committee has published a report of its inquiry into the development of new integrated ways of planning and delivering local health and care services. In addition NHSE and NHSI published their written submissions which summarise the shift in national policy focus from competition to collaboration.

The key recommendations of the report were:

- Integrated care will improve patient experience, particularly for those with long-term conditions. However while it may reduce demand on hospital services, the Committee concluded there is a lack of evidence that integration, at least in the short term, saves money.
- The Government and the NHS must improve how they communicate NHS reforms to the public, making the case for change in the health service, clearly and persuasively.
- The Department of Health and Social Care (DHSC) and national bodies should adopt an evolutionary, transparent and consultative approach to determining the future shape of health and care. The law would need to change to enable the structural integration of health and care.
- The national bodies should clearly define the outcomes they are seeking to achieve for patients by promoting more integrated care, and the criteria they will use to measure this.
- STPs should be encouraged to adopt the principle of subsidiarity so that decisions are made at the most appropriate local level
- ACOs should be introduced in primary legislation as NHS bodies. The national bodies must take proactive steps to dispel misleading assertions about the privatisation and Americanisation of the NHS including the publication of an annual assessment of private sector involvement in NHS care.

### 6.4 Letter from NHS Improvement regarding reducing Long Stays in Hospital

Pauline Philip (national director of urgent and emergency care) wrote to the Trust on 13 June announcing a new national ambition to lower bed occupancy by reducing the number of long stay patients (and long stay bed days) in acute hospitals by a minimum of 25%, freeing up at least 4,000 beds compared to 2017/18.

The Trust has been asked to work with our system partners to deliver on this ambition. The level of improvement expected from each system is based on the proportion of beds occupied by long stay patients, with the most challenged systems expected to make the greatest levels of improvement. During 2017/18 (the baseline year) 27.7% of people admitted to the Trust experienced a LOS of greater than 21 days. Our target is to reduce this by 27% which represents a reduction of 20 beds. This capacity is required by December 2018.

## 7.0 BOARD ASSURANCE AND CORPORATE RISK

### 7.1 Board Assurance Framework (BAF)

The BAF was reviewed by the Director Team, Company Secretary and the Deputy Director of Governance on 14 June 2018.

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* | |
| **BAF 2** | Risk of a high level of frailty in the local population | *Amber 8 ↔* | *Unchanged at* | ✓ |
| **BAF 3** | Risk of a failure to learn from feedback and Incidents | *Amber 9 ↔* | *Unchanged at* | |
| **BAF 5** | Risk of maintaining service sustainability | *Amber 9 ↔* | *Unchanged at* | |
| **BAF 9** | Risk of a failure to deliver the Operational Plan | *Red 12 ↔* | *Unchanged at* | |
| **BAF 10** | Risk of breaching the terms of the Trust's Licence to operate | *Yellow 5 ↔* | *Unchanged at* | ✓ |
| **BAF 12** | Risk of external funding constraints | *Red 12 ↔* | *Unchanged a 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* | ✓ |
| **BAF 14** | Risk of delivery of integrated models of care | *Red 12 ↔* | *Unchanged at* | |
| **BAF 15** | Risk of misalignment of strategic plans | *Amber 8 ↔* | *Unchanged at* | ✓ |
| **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* | |

## 7.2 Corporate Risk Register (CRR)

The CRR was reviewed at the monthly meeting of the Corporate Risk Review Group on 8 June 2018. The Corporate Risk Register contains 10 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. | 12 | ↓ | *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* | |
| 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). | 12 | ↓ | *3* | *Mar-19* | |
| 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* | *Aug-18* | |
| 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* | |

*Progress key*

*1 = fully on plan across all actions*

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

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

*4 = actions defined but largely behind plan*

*5 = actions not yet fully defined*

**Risks added to the corporate risk register**

None

**Risks removed from corporate risk register**

None

**Risks with amended target dates or target scores**

See summary

## 8.0 DOCUMENTS SIGNED AND SEALED

The following documents have been sealed during the month:

- Contract with William Birch and Sons Limited for alteration works to the nuclear medicines department (installation of Gamma Camera).
- Deed of Novation transferring contract with Serviceline from the Trust to Harrogate Healthcare Facilities Management (HHFM).

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|---|---|---|---|
| **Date of Meeting:** | 27 June 2018 | **Agenda item:** | 6.0 |
| **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 position of £59k. This equates to an in month adverse variance of £468k against the Trust's internal plan and a year to date deficit of £2.4m, significantly behind the year to date internal plan of a £1.1m deficit.
- At 4.1% of the pay bill, agency expenditure in May remains high, breaching the agency ceiling for the second consecutive month.
- HDFT's performance against A&E 4-hour standard was above 95% in May despite an increase in A&E attendances.
- The Trust reported 18 weeks performance of 91.1% in May - an improvement on recent months but remaining below the 92% standard.
- The 2 week wait cancer waiting times standard for breast symptomatic patients was not achieved for the fourth consecutive month.
- Delayed transfers of care reduced to 2.5% in May, an improvement on recent months and below the local standard of 3.5%.

**Related Trust Objectives**

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

**Key implications**

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

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

The Board of Directors are asked to receive and note the content of the report.

# Integrated board report - May 2018

## Key points this month

1. The Trust reported a deficit position of £59k. This equates to an in month adverse variance of £468k against the Trust's internal plan and a year to date deficit of £2.4m, significantly behind the year to date internal plan of a £1.1m deficit.

2. At 4.1% of the pay bill, agency expenditure in May remains high, breaching the agency ceiling for the second consecutive month.

3. Staff sickness absence has reduced for the third successive month to 4.2%, but remains above the local threshold of 3.9%.

4. HDFT's performance against A&E 4-hour standard was above 95% in May despite an increase in A&E attendances.

5. The Trust reported 18 weeks performance of 91.1% in May - an improvement on recent months but remaining below the 92% standard.

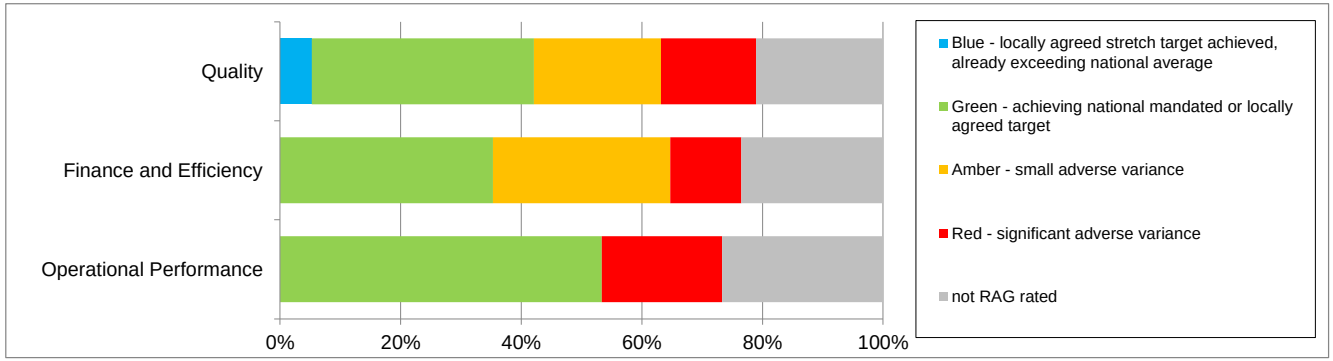
6. The 2 week wait cancer waiting times standard for breast symptomatic patients was not achieved for the fourth consecutive month.

7. Elective length of stay reduced in May and the Trust is now in the top 25% of Trusts nationally.

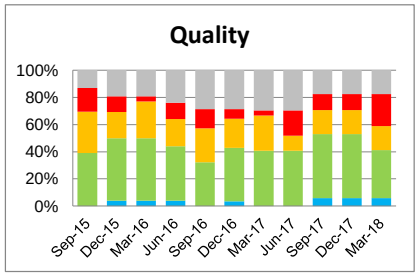
8. Delayed transfers of care reduced to 2.5% in May, an improvement on recent months and below the local standard of 3.5%.

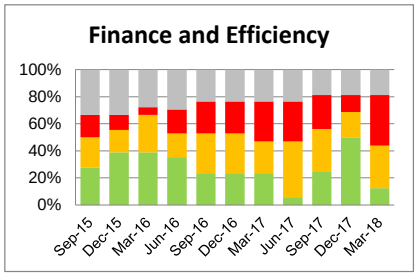
9. Following discussion in last month's board meeting, five new metrics have been added to the report this month focussing on adult community services.

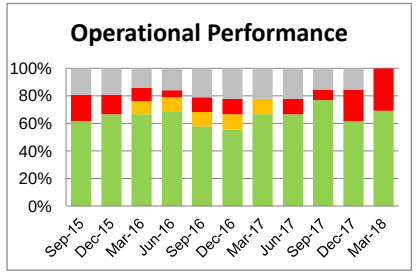
## Summary of indicators - current month



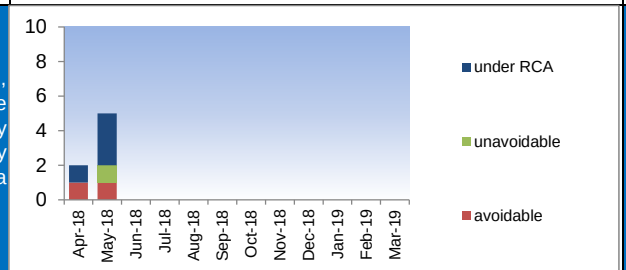
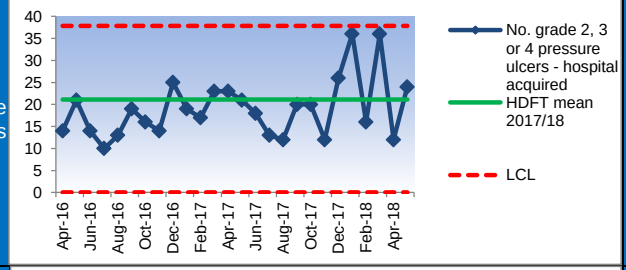
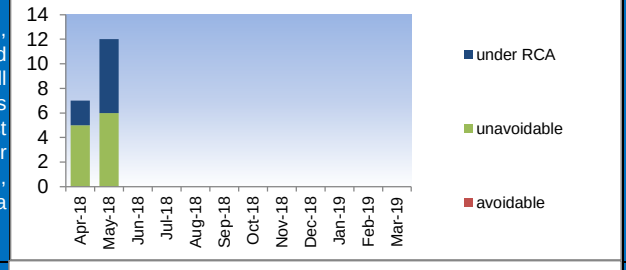
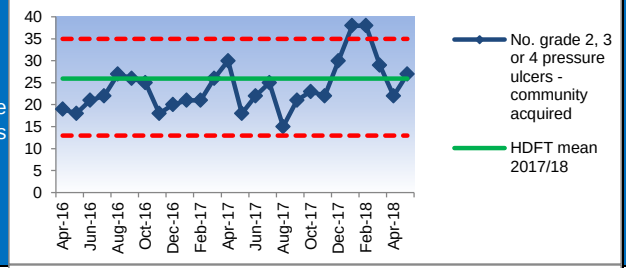

## Summary of indicators - recent trends



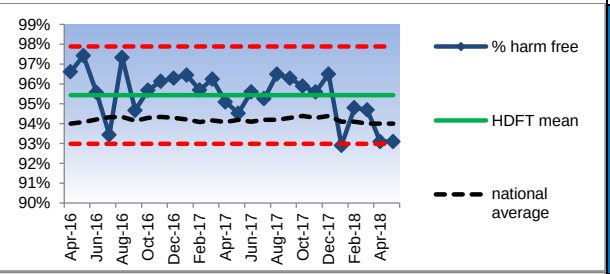
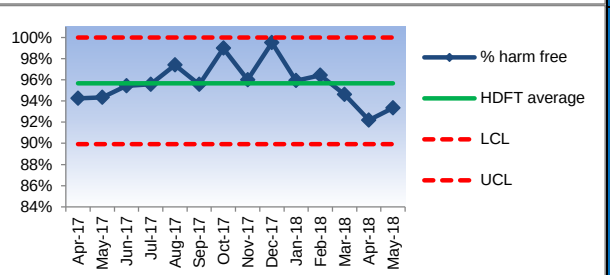
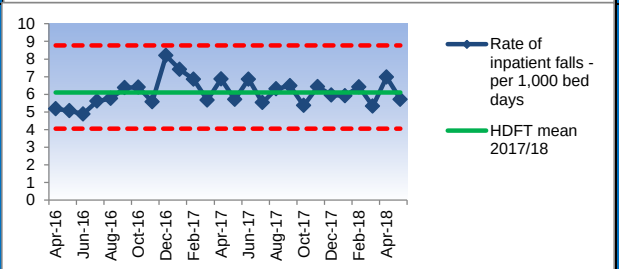
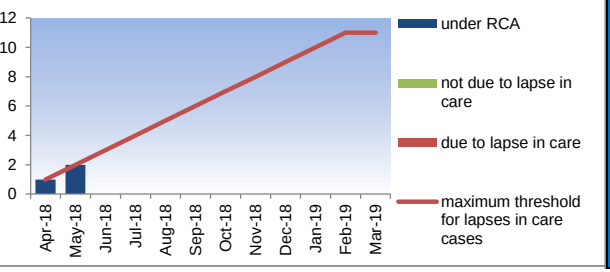



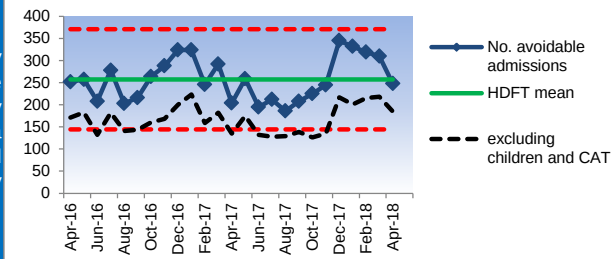
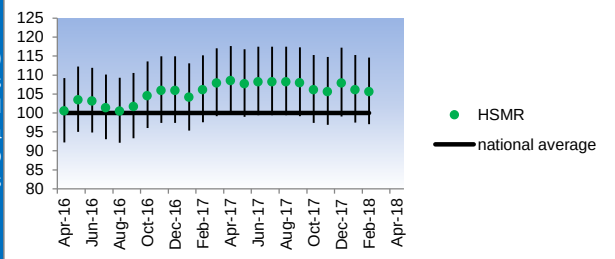
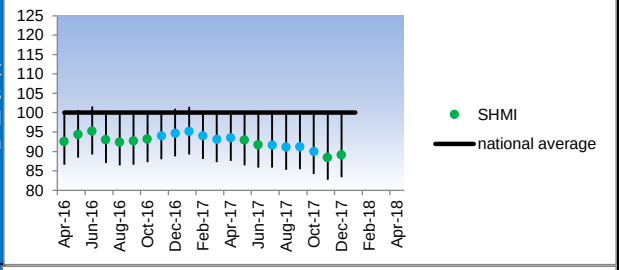
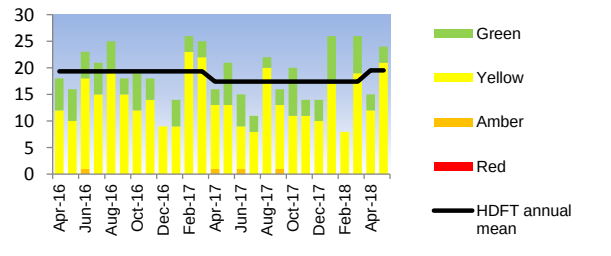
## Quality - May 2018

| 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 3 hospital acquired unstageable or category 3 pressure ulcers reported in May, bringing the year to date total to 5. This compares to an average of 5 per month reported in 2017/18.<br><br>For the 5 cases reported in 2018/19 to date, 1 has been assessed as avoidable, 1 as unavoidable and 3 are still under root cause analysis (RCA). No category 4 hospital acquired pressure ulcers have been reported in 2018/19 to date. |
| | The chart includes category 2, 3 and 4 and unstageable hospital acquired pressure ulcers. The data includes hospital teams only. |  | The number of hospital acquired category 2-4 (or unstageable) pressure ulcers reported in May was 24, an increase on last month and above 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 5 community acquired unstageable or category 3 pressure ulcers reported in May, compared to 7 last month. The average per month reported in 2017/18 was 12.<br><br>For the 12 cases reported in 2018/19 to date, 0 have been assessed as avoidable, 6 as unavoidable and 6 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 May was 27 cases, an increase on last month and just above the average per month reported in 2017/18. |

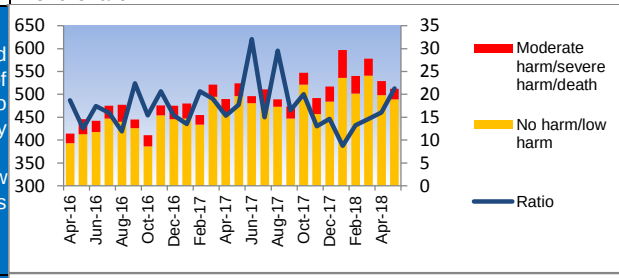
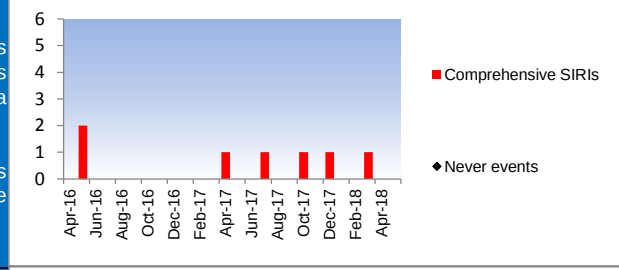
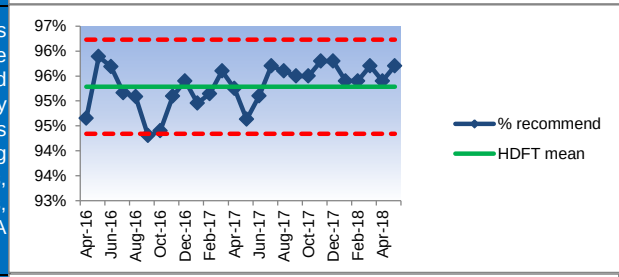
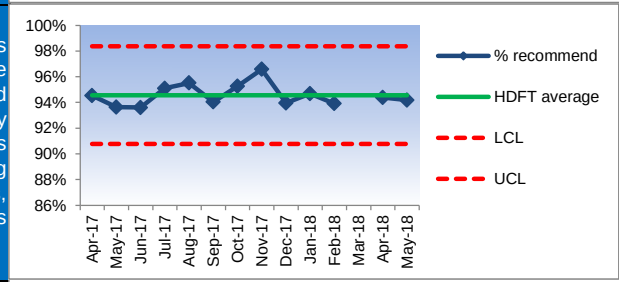
# Quality - May 2018

| 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 May was 93.1%, no change on last month and remaining below 95%. The majority of harms reported this month were pressure ulcers reported by both the hospital and the community teams. |
| **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 May was 93.3%, an improvement on last month but remaining below 95%. |
| **Falls** ✓ | The number of inpatient falls expressed as a rate per 1,000 bed days. The data includes falls causing harm and those not causing harm. A low rate is good. |  | The rate of inpatient falls was 5.71 per 1,000 bed days in May, a decrease on last month and below the average HDFT rate for 2017/18. There were 3 falls resulting in a fracture in May (3 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.<br>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 May, bringing the year to date total to 2. Root cause analysis (RCA) is in progress for both cases.<br><br>No hospital apportioned MRSA cases have been reported in 2018/19 to date. |

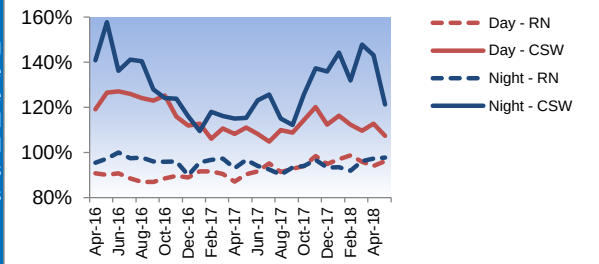
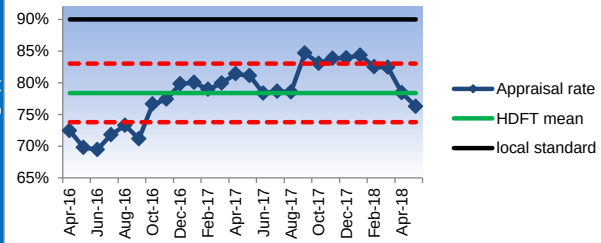
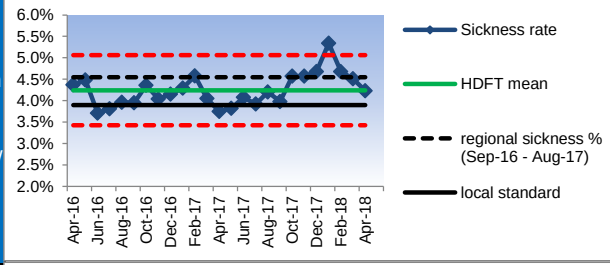
# Quality - May 2018

| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Avoidable admissions** ✓ | The chart shows the number of avoidable emergency admissions to HDFT as per the national definition. The admissions included are those where the primary diagnosis of the patient does not normally require a hospital admission. Conditions include pneumonia and urinary tract infections in adults and respiratory conditions in children. |  | Provisional data indicates that there were 248 avoidable admissions in April, a decrease on recent months and in line with the usual seasonal trend. However this month's figure is above the level reported in April last year (204).<br><br>Adult admissions (excluding CAT attendances) also decreased this month to 185, compared to 218 last month. |
| **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 February 2018 was 105.5, a decrease on last month and remaining within expected levels. At specialty level, 3 specialties have a higher than expected standardised mortality rate (Geriatric Medicine, Respiratory Medicine and Trauma & Orthopaedics).<br><br>As detailed in last month's report, we are currently reporting 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. |  | 24 complaints were received in May which is above the average for 2017/18. However, no complaints were classified as amber or red this month. The complaints received this month are in relation to a number of different HDFT services. However there were a number of complaints about discharge arrangements this month. |

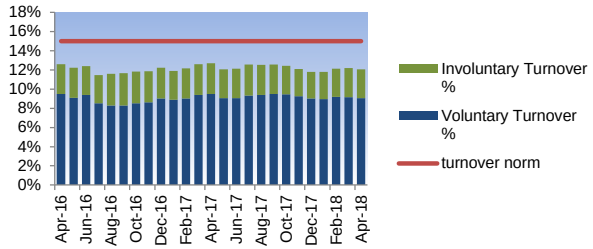
# Quality - May 2018

| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **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 18, 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. |
| **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 May. 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. |  | 95.7% of patients surveyed in May would recommend our services, in line with recent months and remaining above the latest published national average (93%).<br><br>Around 5,100 patients responded to the survey this month. The issue with the automated phone call surveys has now been resolved and the number of responses are now in line with historical averages. |
| **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 specialist nursing teams, community care teams, community podiatry and GP OOH. A high percentage is good. |  | 94.2% of patients surveyed in May would recommend our services. 460 patients from adult community services responded to the survey this month. The data for March 2018 is not included as there were very few responses from community services due to an issue with the automated phone call surveys which was rectified in mid-April. |

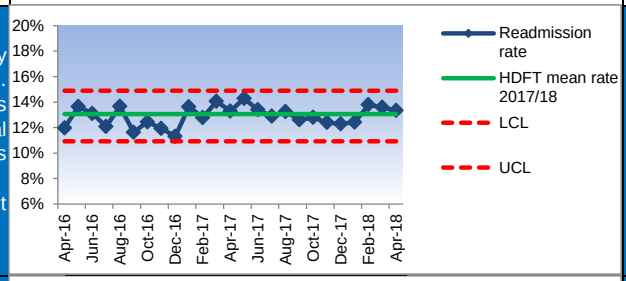
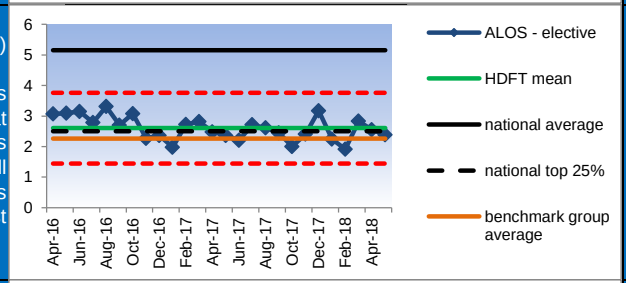
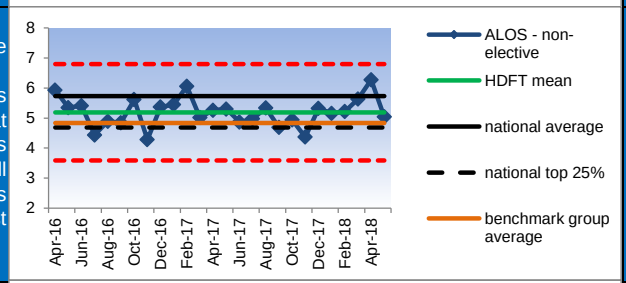
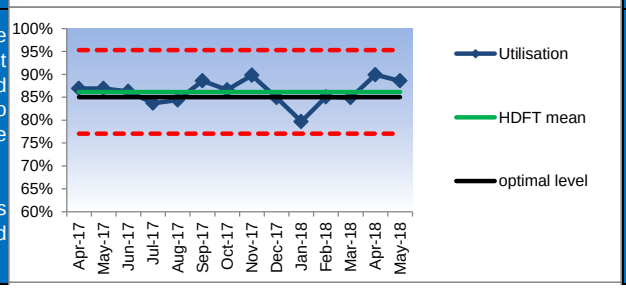
# Quality - May 2018

| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **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 102% in May, a reduction on last month but remaining above 100%. Care Support Worker staffing remains high compared to plan - this is reflective of the increased need for 1-1 care. Whilst safer staffing levels for registered nurses remains below 100%, the staffing level achieved still enables the delivery of safe care. Achieving safe staffing levels remains challenging and requires the increasing use of temporary staff through the nurse bank and agencies. |
| **Staff appraisal rates** ✓ | The chart shows the staff appraisal rate over the most recent rolling 12 months. The Trusts aims to have 90% of staff appraised. A high percentage is good. |  | The appraisal rate in May was 76.3%. 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. |
| **Mandatory training rates** ✓ | The table shows the most recent training rates for all mandatory elements for substantive staff. | | The data shown is for the end of May and excludes the Harrogate Healthcare Facilities Management (HHFM) staff who transferred into the new organisation on the 1st March 2018 and excludes Stockton who Tupe transferred in to the Trust on 1st April 2018. The overall training rate for mandatory elements for substantive staff is 91% and has increased 2% since the last reporting cycle. |
| **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 has reduced for the third successive month to 4.23%, from 4.51% last month. Short term absences have reduced in month, however return to work completion remains low across all directorates. The attendance management lead will focus back on long term absence and the development of plans to support individuals to return to work where possible. |

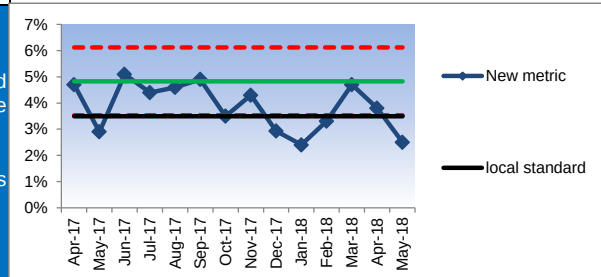
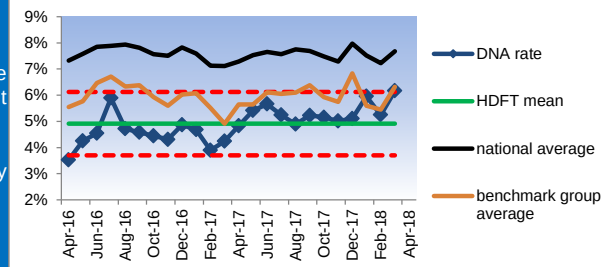
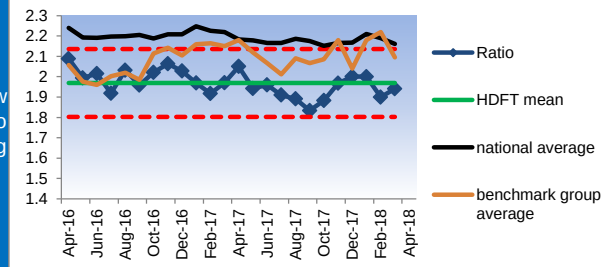
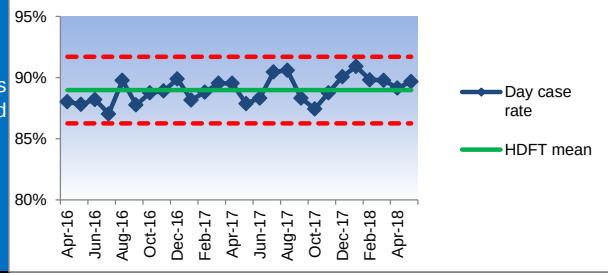
| Competence Name | % completed |
|---|---|
| Equality, Diversity and Human Rights - Level 1 | 90 |
| Fire Safety Awareness | 76 |
| Infection Control - No Renewal\| | 99 |
| Infection Prevention & Control (Including Hand Hygiene) 2 | 81 |
| Data Security Awareness | 93 |
| Preventing Radicalisation - Level 1 and 2 (December 2015) | 97 |
| Safeguarding Adults Awareness Elearning (Dec 2015) | 97 |
| Safeguarding Children & Young People Level 1 - Introduction eLearning | 94 |
| Risk Awareness (Replaced Basic Risk Management May 2018) | 97 |

| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **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. |

# Finance and Efficiency - May 2018

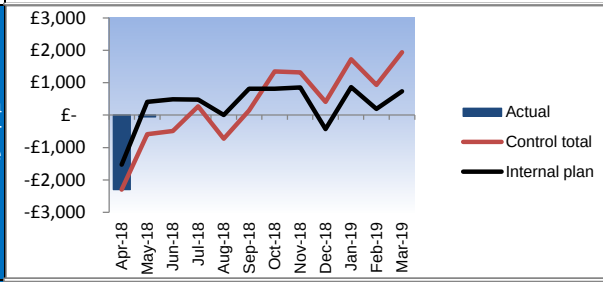
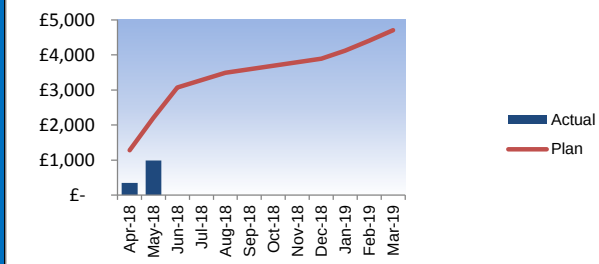
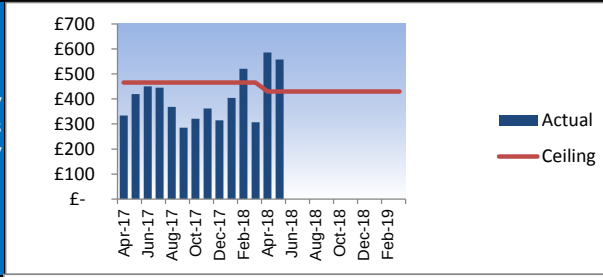
| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Readmissions**  | % of patients readmitted to hospital as an emergency within 30 days of discharge (PbR exclusions applied). To ensure that we are not discharging patients inappropriately early 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 April was 222. This equates to 13.3% 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 May was 2.4 days. This is a decrease on last month and places HDFT in the top 25% of Trusts nationally in the most recently available benchmarking data. |
| **Length of stay - non-elective**  | Average length of stay in days for non-elective (emergency) patients.<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 May was 5.0 days, a significant decrease on last month and below the average for HDFT. 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 88.6% in May, remaining 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 - May 2018

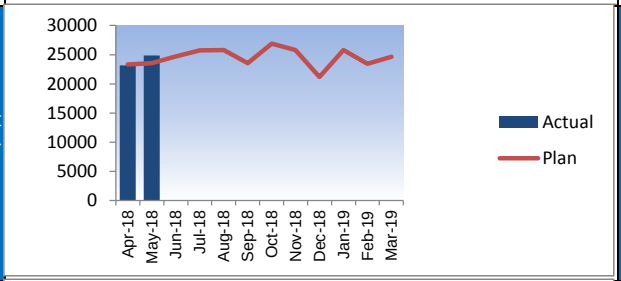
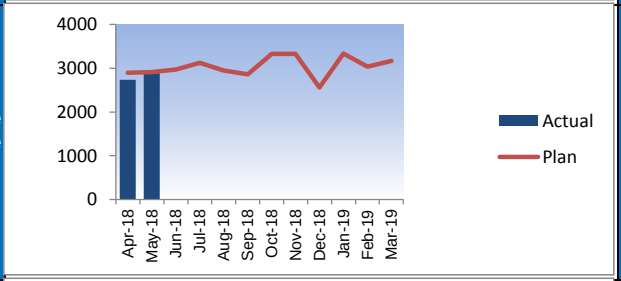
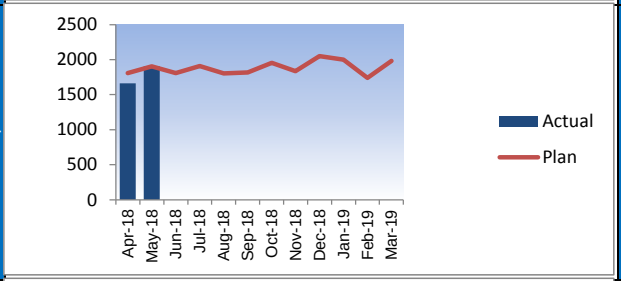
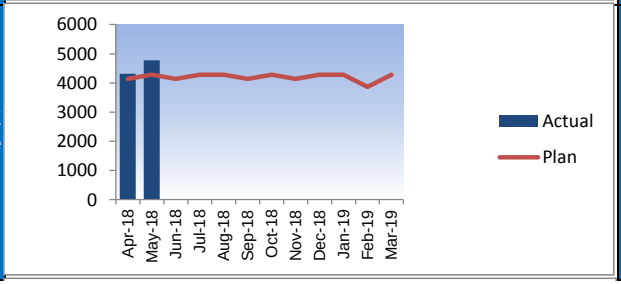
| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Delayed transfers of care** ✓ | The proportion of bed days lost due to being occupied by patients who are medically fit for discharge but are still in hospital. A low rate is preferable.<br><br>The maximum threshold shown on the chart (3.5%) has been agreed with HARD CCG. |  | In May, 2.5% of bed days were lost due to delayed transfers of care, an improvement on recent months and below the local standard of 3.5%.<br><br>From last month, this metric calcluates 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. |
| **Outpatient DNA rate** ✓ | Percentage of new outpatient attendances where the patient does not attend their appointment, without notifying the trust in advance.<br><br>A low percentage is good. Patient DNAs will usually result in an unused clinic slot. |  | HDFT's DNA rate increased to 6.2% in March. This is in line with the benchmarked group of trusts and below 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 1.94 in March, an increase on last month but 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 89.7% in May, an increase on last month above the average day case rate for 2017/18 (89.3%). |

# Finance and Efficiency - May 2018

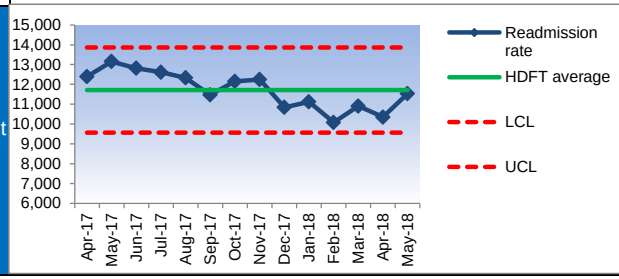
Harrogate and District NHS Foundation Trust

| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Surplus / deficit and variance to plan** | Monthly Surplus/Deficit (£'000s). In some months, a deficit is planned for. This indicator reports positive or adverse variance against the planned position for the month. |  | The Trust reported a deficit position of £59k. This equates to an in month adverse variance of £468k against the Trust's internal plan. This results in a year to date deficit of £2.4m, significantly behind the year to date internal plan of a £1.1m deficit. |
| **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 / 3<br>**Financial Sustainability Risk Rating: 3 / 3** | The Trust reported a 3 in May, in line with the planned risk rating. The current rate of agency spend is adding further risk here. |
| **Capital spend** | Cumulative Capital Expenditure by month (£'000s) |  | Capital expenditure continues to be behind plan, however, this is the result of phasing of larger schemes which are anticipated to be finalised soon. |
| **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 4.1% of the pay bill, actual agency expenditure in May remains high, breaching the agency ceiling for the second consecutive month. This is discussed in more detail in other board reports. |

# Finance and Efficiency - May 2018

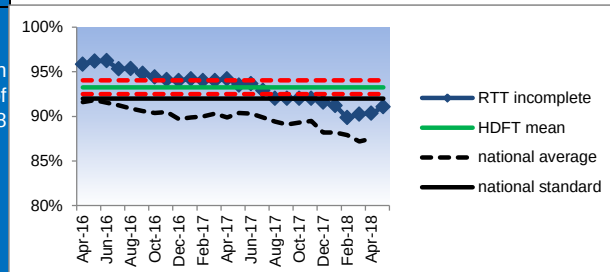
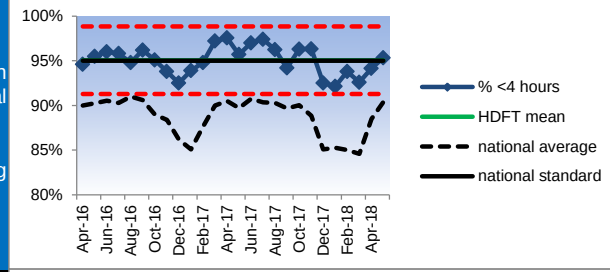
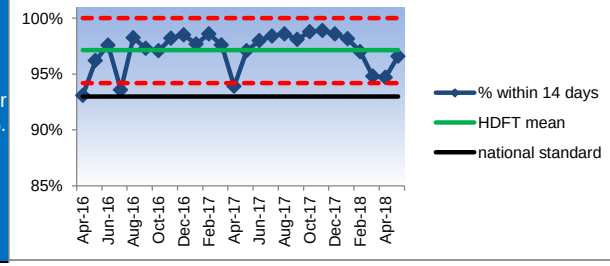
| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Outpatient activity against plan** ✓ | The chart shows the position against plan for outpatient activity. The data includes all outpatient attendances - new and follow-up, consultant and non-consultant led. |  | Outpatient activity was 5.7% above plan in May. 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 0.4% below plan in May, an improvement on last month's position. 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 0.1% below plan in May. 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 significantly above plan in May (11.5%). The main increase seen has been in minor attendances predominantly in the early evenings. Explanations for this increase are being looked into, in discussion with HARD CCG. |

## Finance and Efficiency - May 2018

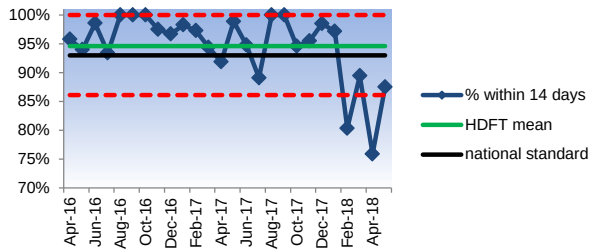
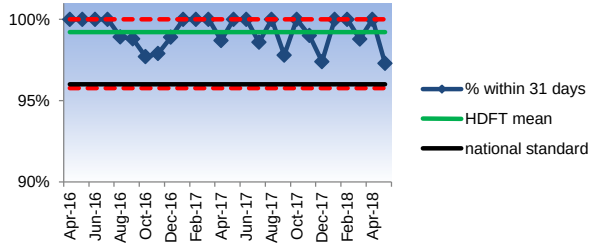
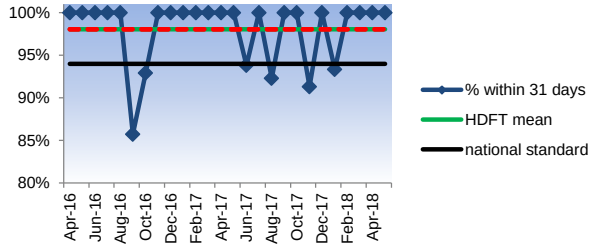
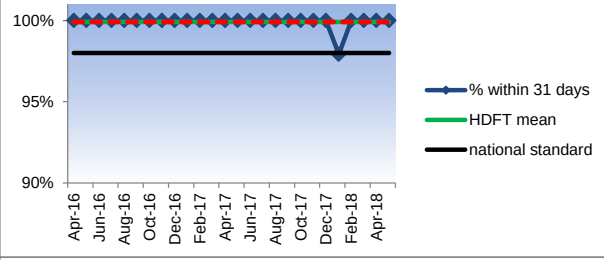
| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **Community Care Teams - patient contacts**  | The chart shows the number of face to face patient contacts for the community care teams. |   | There were 11,500 face to face patient contacts in May, an increase on last month. 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. |

# Operational Performance - May 2018

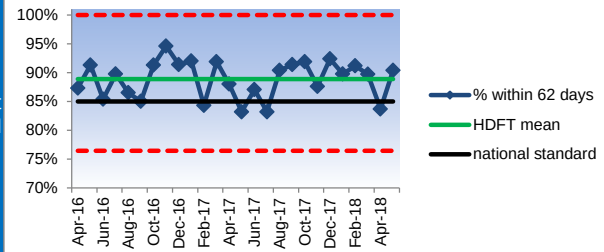
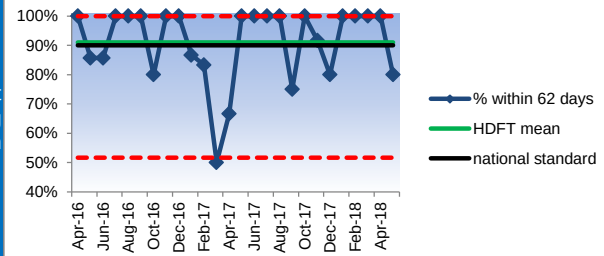
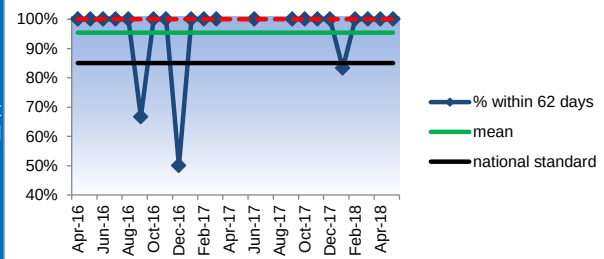
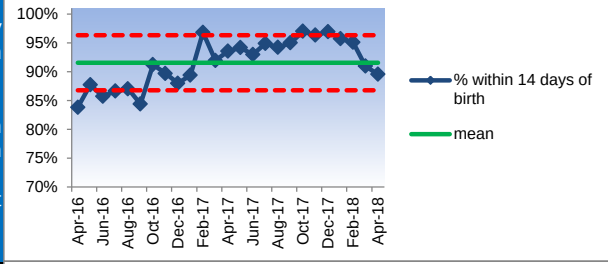
Harrogate and District NHS Foundation Trust

| Indicator name / data quality assessment | Description | Trend chart | Interpretation |
|---|---|---|---|
| **NHS Improvement Single Oversight Framework** ✓ | NHS Improvement use a variety of information to assess a Trust's governance risk rating, including CQC information, access and outcomes metrics, third party reports and quality governance metrics. 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. | **Standard** / **Q1 to date** / **Q2** / **Q3** / **Q4** / **YTD**<br>RTT incomplete pathways: 90.7% / 90.7%<br>A&E 4-hour standard: 94.8% / 94.8%<br>Cancer - 62 days: 87.2% / 87.2%<br>Diagnostic waits: 98.4% / 98.4%<br>Dementia screening - Step 1: 95.9% / 95.9%<br>Dementia screening - Step 2: 93.1% / 93.1%<br>Dementia screening - Step 3: 96.2% / 96.2% | In Quarter 1 to date, HDFT's performance is below the required level for 3 of the operational performance metrics, as detailed below and in this month's Chief Operating Officer's report.<br><br>Performance against the diagnostic waiting times standard improved in May and it is expected that the required 99% will be achieved for the full Quarter 1 overall. |
| **RTT Incomplete pathways performance** ✓ | Percentage of incomplete pathways waiting less than 18 weeks. The national standard is that 92% of incomplete pathways should be waiting less than 18 weeks.<br><br>A high percentage is good. |  | Performance was at 91.1% in May, a continuing improvement on recent months but remaining below the minimum standard of 92%. Two specialties (Trauma & Orthopaedics and Ophthalmology) were below the 92% standard in May, compared to 3 last month. |
| **A&E 4 hour standard** ✓ | Percentage of patients spending less than 4 hours in Accident & Emergency (A&E). The operational standard is 95%.<br><br>The data includes all A&E Departments, including Minor Injury Units (MIUs). A high percentage is good. |  | HDFT's Trust level performance for May was 95.3%, an improvement on last month and above the required 95% standard. This includes data for the Emergency Department at Harrogate and Ripon MIU. Performance for Harrogate ED was at 94.4%. |
| **Cancer - 14 days maximum wait from urgent GP referral for suspected cancer referrals** ✓ | Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%. A high percentage is good. |  | Provisional performance for May was at 96.6%. This is above the 93% standard and an improvement on recent months. |

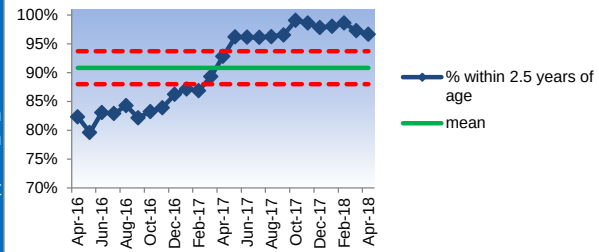
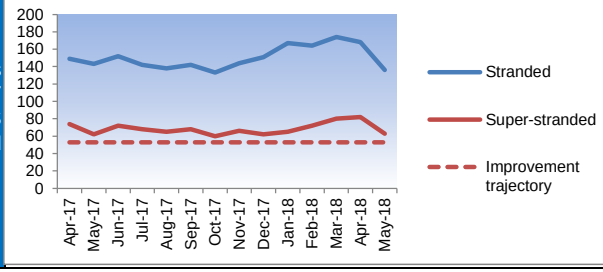
# Operational Performance - May 2018

| 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 May was at 87.5%, an improvement on last month but 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. |  | Performance was at 97.3% in May, remaining above the 96% standard. |
| **Cancer - 31 day wait for second or subsequent treatment: Surgery** ✓ | Percentage of cancer patients starting subsequent surgical treatment within 31 days. The operational standard is 94%. A high percentage is good. |  | Delivery at expected levels. |
| **Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug** ✓ | Percentage of cancer patients starting subsequent drug treatment within 31 days. The operational standard is 98%. A high percentage is good. |  | Delivery at expected levels. |

# Operational Performance - May 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 May was above the required 85% standard at 90.4% with 5 accountable breaches. Of the 11 tumour sites, 3 had performance below 85% in May - breast (1 breach), haematological (1) and lower gastrointestinal (1). 1 patient waited over 104 days in May. The main reason for the delay was 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. |  | Performance was at 80% in May with 1 breach of over 104 days. The main reason for the breach delay was patient choice. However within only 5 eligible pathways, this is below the de mininis level for reporting performance. Performance for Quarter 1 to date is above the required 90% standard. |
| **Cancer - 62 day wait for first treatment from consultant upgrade** ✓ | Percentage of cancer patients starting first treatment within 62 days of consultant upgrade. The operational standard is 85%. A high percentage is good. |  | Delivery at expected levels. With less than 5 eligible pathways in Quarter 1 to date, this is below the de mininis level for reporting performance. |
| **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, Middlesbrough and Stockton. A high percentage is good. The contract does not specify a required level. |  | In April, the validated performance position is that 90% 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. The chart presents a combined performance position for all Children's Services contracts and includes data for Stockton from April 2018 onwards. |

# Operational Performance - May 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, Middlesbrough and Stockton. A high percentage is good. The contract does not specify a required level. |  | In April, 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. The chart presents a combined performance position for all Children's Services contracts and includes data for Stockton from April 2018 onwards. |
| **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. |
| **Stranded patients** ✓ | This indicator shows the average number of patients that were in the hosptital with a length of stay of over 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 May. However we are still identified as an outlier when compared to other local Trusts.<br><br>NHS Improvement has set improvement trajectories for Trusts to reduce the number of super-stranded patients by around 25% by December 2018. HDFT's trajectory has been set at 53, which equates to a 27% improvement on the 2017/18 baseline position. |

# 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. |
| Quality | Friends & Family Test (FFT) - Adult Community Services | **Amber**  | The number of patients surveyed represents a small proportion of the community based contacts that we deliver in a year. |
| 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. |
| Operational Performance | Community Care Teams - patient contacts | **Amber**  | 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. |
| Operational Performance | OPEL level - Community Care Teams | **Amber**  | This indicator is in development. |

NHS
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** | **Safety thermometer - harm free care - community care teams** | % harm free | | |
| **Quality** | **Falls** | IP falls per 1,000 bed days | Blue if YTD position is a reduction of >=50% of HDFT average for 2017/18, Green if YTD position is a reduction of between 20% and 50% of HDFT average for 2017/18, Amber if YTD position is a reduction of up to 20% of HDFT average for 2017/18, Red if YTD position is on or above HDFT average for 2017/18. | 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** | **Friends & Family Test (FFT) - Adult Community Services** | % recommend, % not recommend - combined score for all services currently doing patient FFT | | |
| **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 2017/18, Amber if latest month rate > HDFT average for 2017/18 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. |
| **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 |

| Section | Indicator | Further detail | Traffic light criteria | Rationale/source of traffic light criteria |
|---|---|---|---|---|
| **Finance and efficiency** | **Outpatient DNA rate** | % first OP appointments DNA'd | | |
| **Finance and efficiency** | **Outpatient new to follow up ratio** | No. follow up appointments per new appointment. | Blue if latest month score places HDFT in the top 10% of acute trusts nationally, Green if in top 25%, Amber if within the middle 50%, Red if in bottom 25%. | |
| **Finance and efficiency** | **Day case rate** | % elective admissions that are day case | | Comparison with performance of other acute trusts. |
| **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. | | Locally agreed targets. |
| **Finance and efficiency** | **Elective activity against plan** | Includes inpatient and day case activity | | Locally agreed targets. |
| **Finance and efficiency** | **Non-elective activity against plan** | | | Locally agreed targets. |
| **Finance and efficiency** | **Emergency Department attendances against plan** | Excludes planned followup attendances. | Green if on or above plan in month, amber if below plan by < 3%, red if below plan by > 3%. | Locally agreed targets. |
| **Finance and efficiency** | **Community Care Teams - patient contacts** | Face to face patient contacts | tbc | Locally agreed metric |
| **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%, amber if >= 90% but <95%, red if <90%. | 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 |
| **Operational Performance** | **OPEL level - Community Care Teams** | OPEL (Operational Pressures Escalation Level) experienced by the community care teams | tbc | Locally agreed metric |
| **Operational Performance** | **Stranded patients** | Average number of stranded patients (LOS >7 days) and super-stranded patients (LOS >21 days). | tbc | as defined by NHS Improvement |

**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:** | 27 June 2018 | **Agenda item:** | 7.0 |
| **Report to:** | Board of Directors | | |
| **Title:** | Finance Report | | |
| **Sponsoring Director:** | Jonathan Coulter, Deputy Chief Executive / Finance Director | | |
| **Author(s):** | Finance Department | | |

**Report Purpose:**

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

**Executive Summary:**

- The Trust reported a deficit position of £59k in May. This equates to an in-month adverse variance of £468k against the Trust's internal plan.
- This results in a year to date deficit of £2.4m, behind the year to date internal plan of a £1.1m deficit. It is, however, ahead of the control total plan of a £2.9m deficit meaning the Trust is reporting achievement of Provider Sustainability Funding.
- Key drivers for this variance relate to ward pay expenditure, theatres pay expenditure and CIP achievement.

**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:**

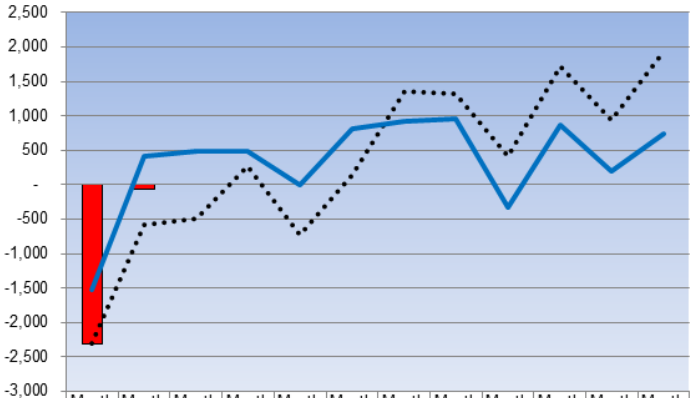
The Board of Directors is asked to note the contents of this report and the actions that are being progressed to achieve the financial plan.

# May 2018 Financial Position

**Financial Performance**

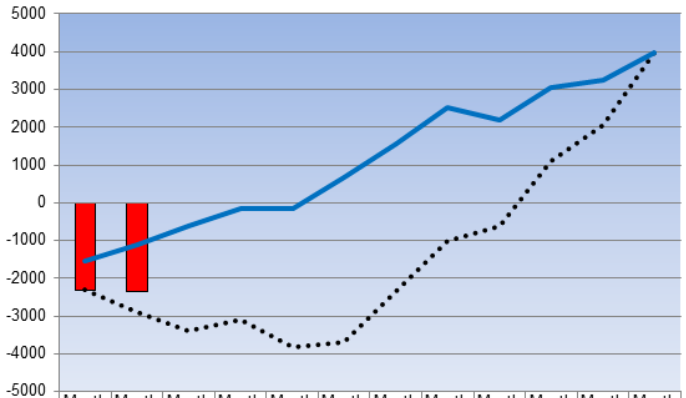
- As highlighted below, the Trust reported a deficit position of £59k in May. This equates to an in month adverse variance of £468k against the Trusts internal plan. This results in a year to date deficit of £2.4m, behind the year to date internal plan of a £1.1m deficit.

**HDFT Monthly Financial Performance (£'000s)**




| | 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 | -59 | | | | | | | | | | |
| 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 | 917 | 950 | -330 | 860 | 192 | 734 |

**HDFT Cumulative Financial Performance (£'000s)**

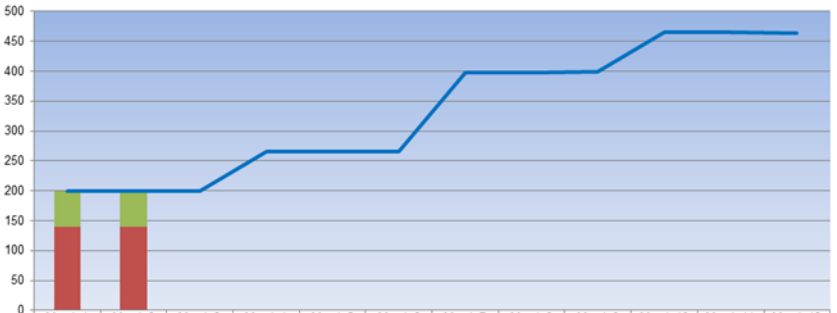



| | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Month 7 | Month 8 | Month 9 | Month 10 | Month 11 | Month 12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Actual | -2303 | -2,362 | | | | | | | | | | |
| External Plan | -2303 | -2,889 | -3,378 | -3,107 | -3,836 | -3,692 | -2,341 | -1,026 | -620 | 1,107 | 2,042 | 3,983 |
| Internal Plan | -1526 | -1,117 | -631 | -152 | -152 | 660 | 1,577 | 2,527 | 2,197 | 3,057 | 3,249 | 3,983 |

- However, as a result of being ahead of the external plan set with NHS Improvement, the Trust is currently reporting full achievement of the Provider Sustainability Funding (PSF, formally Sustainability and Transformation Funding). Both criteria are therefore assumed as Achieved, however, there is an element of risk in relation to A&E performance.

- If the Trust continues to achieve the external plan in June then the control total for the quarter will be achieved and PSF cash will follow. It should be noted that Trust has yet to receive the final allocation of 2017/18 Sustainability and Transformation Funding.

**HDFT Monthly Provider Sustainability Funding (£'000s)**



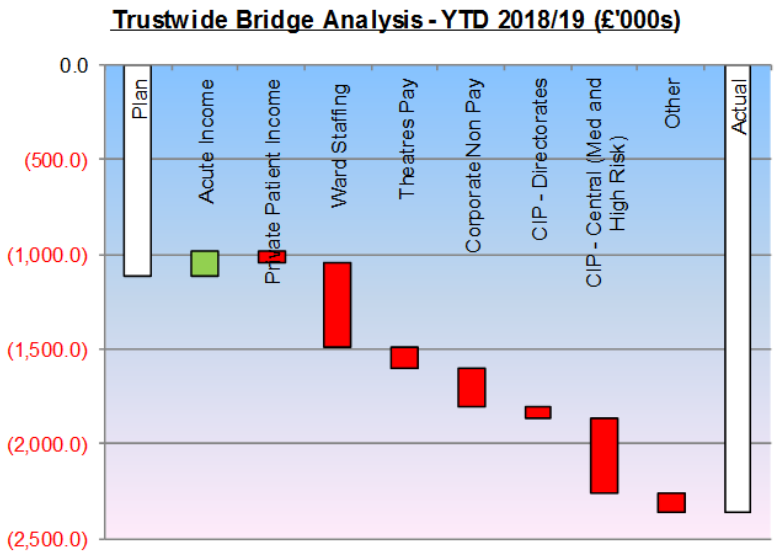

| | Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | Month 7 | Month 8 | Month 9 | Month 10 | Month 11 | Month 12 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PSF A&E | 60 | 60 | | | | | | | | | | |
| PSF Financial | 139 | 139 | | | | | | | | | | |
| PSF Plan | 199 | 199 | 199 | 266 | 266 | 265 | 398 | 398 | 399 | 465 | 465 | 464 |

# May 2018 Financial Position

**Financial Performance Cont.**

• The drivers for this position are highlighted in the following information -

| Variance to Budget | £'000s |
|---|---|
| **Plan** | **(1,117)** |
| Acute Income | 130 |
| Private Patient Income | (61) |
| Ward Staffing | (441) |
| Theatres Pay | (109) |
| Corporate Non Pay | (203) |
| CIP - Directorates | (66) |
| CIP - Central (Med and High Risk) | (392) |
| Other | (103) |
| **Actual** | **(2,362)** |




• The headline messages for Trustwide financial performance are therefore –

– ***Although specific areas of capacity remain challenged, clinical income is generally at planned levels.***

– ***Ward staffing continues to be a significant area of overspend, with underlying expenditure needing to be addressed.***

– ***Theatres and Corporate Non Pay are also significant pressures with various actions underway or needing to be addressed.***

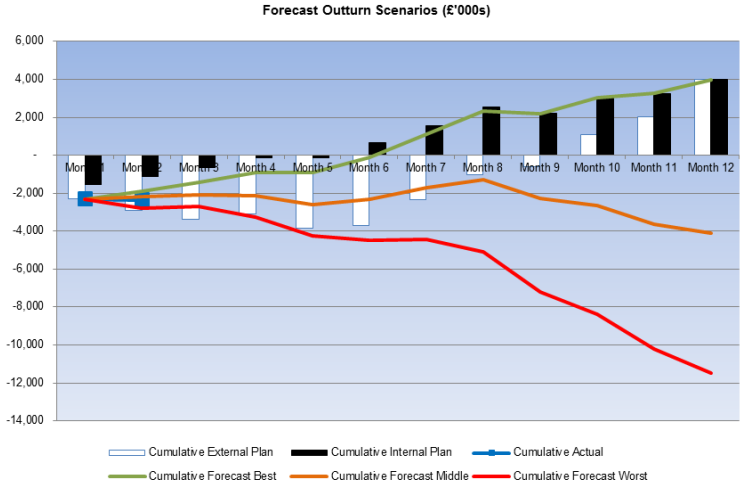
– ***CIP delivery is not at 100% as at the end of May, however, a number of plans need to be actioned before June month end to give a better reflection of risk in this area.***

• The report contains further details in relation to these issues.

# May 2018 Financial Position

**Financial Performance Cont.**

- 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.

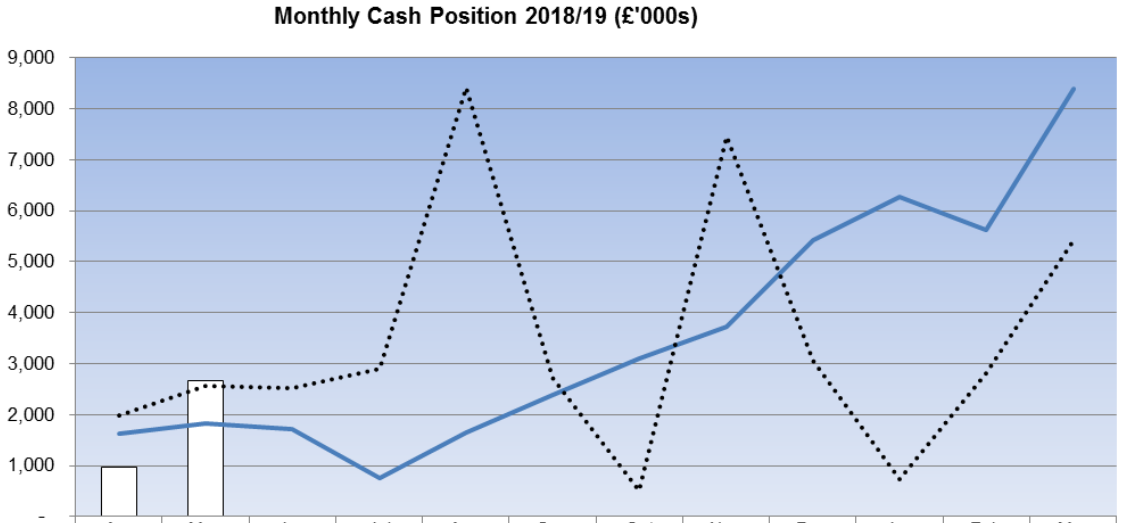



| | Best Case £m | Medium Case £m | Worse case £m | comment |
|---|---|---|---|---|
| Plan | 4.0 | 4.0 | 4.0 | |
| Ward staffing pressures | | -1.0 | -1.5 | current cost pressure |
| CIP delivery | | -0.9 | -3.2 | medium - risk adj, worse - national expectation |
| Income risk | | -1.0 | -2.0 | substitution 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 | |

# May 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 May was £2,674k. Although this is ahead of plan, any favourable variance needs to be seen in the context of the overall improvement required during 2018/19. The position therefore remains significantly pressured.




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2018/19 actual | 976 | 2,674 | | | | | | | | | | |
| 2018/19 plan | 1,627 | 1,837 | 1,719 | 750 | 1,660 | 2,389 | 3,108 | 3,735 | 5,424 | 6,270 | 5,617 | 8,398 |
| 2017/18 actual | 1,989 | 2,563 | 2,523 | 2,891 | 8,404 | 2,715 | 516 | 7,451 | 3,066 | 728 | 2,815 | 5,411 |

- It should be noted this position includes the cash position of HHFM. HHFM had a cash balance of £1.4m at the end of May but was due to make some material payments in June which would reduce this significantly.

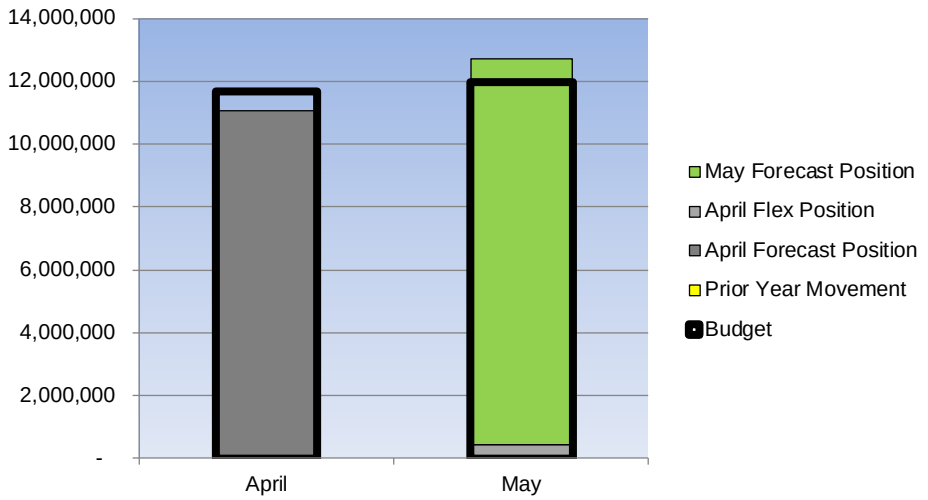
- It is currently taking the Trust over 60 days to pay 95% of invoices (no. and value). Work is ongoing to address this, however, levels of cash mean this remains challenging.

# May 2018 Financial Position

**Income and Activity**

- Overall, the Trust reported a year to date favourable variance of £114k for NHS clinical income. This is a positive reflection on the planning which was undertaken for 2018/19. There are some challenges in this position which are being addressed at directorate level.

| Income Reporting (£'s) | April | May | YTD |
|---|---|---|---|
| **Budget** | **11,652,913** | **11,973,467** | **23,626,380** |
| Prior Year Movement | 78,799 | - 18,267 | 60,532 |
| April Forecast Position | 10,979,910 | | 10,979,910 |
| April Flex Position | | 443,440 | 443,440 |
| May Forecast Position | | 12,268,017 | 12,268,017 |
| **Total Actual** | **11,058,709** | **12,693,190** | **23,751,899** |
| **Variance** | **- 594,204** | **719,723** | **125,519** |
| | | | |
| Percentage Variance | -5.10% | 6.01% | 0.53% |




- The current income position for the top 5 commissioners based on annual contract values is highlighted in the table below. This equates to 86% of the Trust's planned income.

| Commissioner | YTD Plan | YTD Actual | Variance | % Variance |
|---|---|---|---|---|
| HaRD CCG | 17,212,166 | 17,460,949 | 248,783 | 1% |
| Leeds CCGs | 4,398,800 | 4,423,885 | 25,085 | 1% |
| NHS England | 2,935,674 | 3,287,996 | 352,322 | 12% |
| Durham Council | 1,916,981 | 1,921,919 | 4,938 | 0% |
| North Yorkshire County Council | 1,319,266 | 1,295,945 | - 23,321 | -2% |

# May 2018 Financial Position

**Workforce**

- The Trust continued to report an adverse pay variance in May, taking the year to date balance to £216k overspent, including costs related to HHFM. This is summarised in the tables below.

| £'s | CHILDRENS AND COUNTY WIDE | | | CORPORATE SERVICES | | | LONG TERM AND UNSCHEDULED | | | PLANNED AND SURGICAL CARE | | | Trustwide | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | YTD budget | YTD Actual | YTD Variance | YTD budget | YTD Actual | YTD Variance | YTD budget | YTD Actual | YTD Variance | YTD budget | YTD Actual | YTD Variance | YTD budget | YTD Actual | YTD Variance |
| PERMANENT | 6,661,470 | 6,234,255 | 427,215 | 2,109,360 | 2,011,772 | 97,588 | 8,762,298 | 8,201,020 | 561,278 | 7,764,554 | 7,269,261 | 495,293 | 26,642,977 | 24,926,862 | 1,716,115 |
| BANK | 9,882 | 36,124 | -26,242 | 300 | 7,647 | -7,347 | 42,366 | 207,731 | -165,365 | 22,966 | 95,767 | -72,801 | 76,030 | 378,659 | -302,629 |
| LOCUM | 0 | 39,126 | -39,126 | | | | 85,100 | 519,412 | -434,312 | 24,682 | 268,091 | -243,409 | 109,782 | 830,293 | -720,511 |
| AGENCY | 6,000 | 58,028 | -52,028 | 2,632 | 35,052 | -32,420 | 77,830 | 341,229 | -263,399 | 64,632 | 501,464 | -436,832 | 233,792 | 1,142,827 | -909,035 |
| **Grand Total** | **6,677,352** | **6,367,533** | **309,819** | **2,112,292** | **2,054,472** | **57,820** | **8,967,594** | **9,269,392** | **-301,798** | **7,876,834** | **8,134,583** | **-257,749** | **27,062,581** | **27,278,641** | **-216,060** |

| | May Budget WTE | May Contracted WTE | May Variance WTE | May Variance % |
|---|---|---|---|---|
| Adult Community Services | 124.78 | 126.19 | 1.41 | 1% |
| Children's Services | 619.82 | 587.96 | -31.86 | -5% |
| Medical Staffing | 332.68 | 315.50 | -17.18 | -5% |
| Theatres and Day Surgery | 133.41 | 106.36 | -27.05 | -20% |
| RN - Wards | 385.50 | 356.63 | -28.87 | -7% |
| HCA - Wards | 219.45 | 218.44 | -1.01 | 0% |
| Other | 1,885.76 | 1,770.80 | -114.96 | -6% |
| **Total** | **3,701.40** | **3,481.88** | **-219.52** | **-6%** |

| | May Budget £'s | May Actual £'s | May Variance £'s | May Variance % | YTD Budget £'s | YTD Actual £'s | YTD Variance £'s | YTD Variance % |
|---|---|---|---|---|---|---|---|---|
| Adult Community Services | 353,303 | 375,753 | 22,450 | 6% | 706,806 | 766,808 | 60,002 | 8% |
| Children's Services | 2,071,384 | 1,922,561 | -148,823 | -7% | 4,098,319 | 3,853,859 | -244,460 | -6% |
| Medical Staffing | 3,194,032 | 3,203,809 | 9,777 | 0% | 6,316,744 | 6,288,772 | -27,972 | 0% |
| Theatres and Day Surgery | 387,288 | 440,618 | 53,330 | 14% | 771,560 | 897,857 | 126,297 | 16% |
| RN - Wards | 1,347,392 | 1,440,770 | 93,378 | 7% | 2,724,084 | 2,880,118 | 156,034 | 6% |
| HCA - Wards | 461,379 | 572,236 | 110,857 | 24% | 978,058 | 1,234,791 | 256,733 | 26% |
| Other | 5,768,047 | 5,717,493 | -50,554 | -1% | 11,467,010 | 11,356,436 | -110,574 | -1% |
| **Total** | **13,582,825** | **13,673,239** | **90,414** | **1%** | **27,062,581** | **27,278,641** | **216,060** | **1%** |

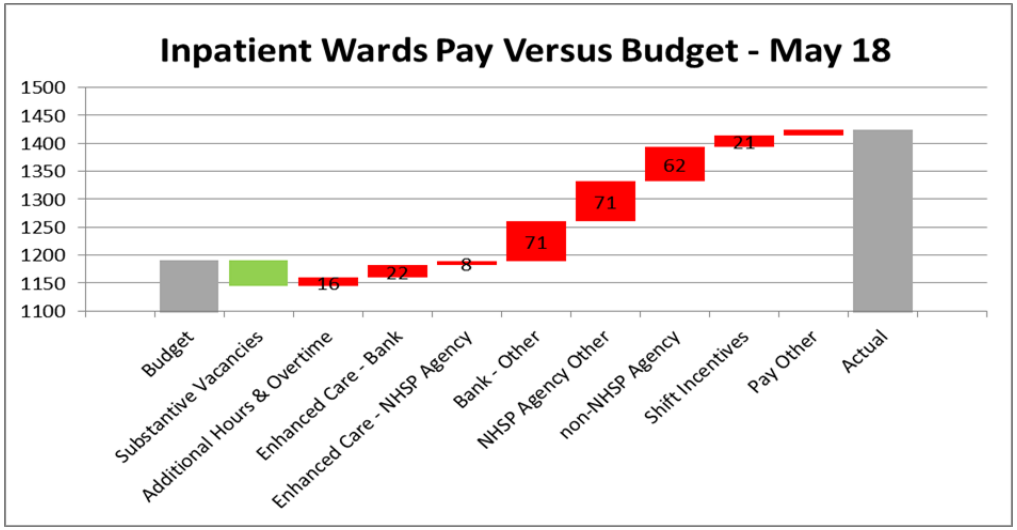
- As reported in the IBR, May agency expenditure remains high, breaching the agency ceiling for the second consecutive month.

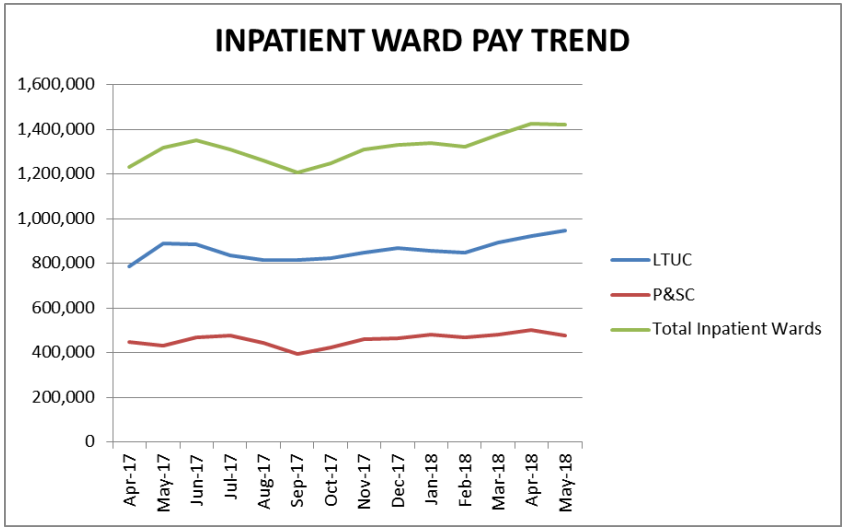
- Workforce Efficiency Group has continued the work in relation to implementing actions to address the risk areas above. Ward Nursing (RN and HCA) and Theatres and Day Surgery Staffing remain significant overspends, with Medical Staffing also a high risk. These are discussed in more detail on the following pages.

# May 2018 Financial Position

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

- As outlined in the summary information on the previous page, and in last months report, expenditure in relation to ward areas continues to be significantly above plan. The drivers for this and overall trend are outlined in the following graphs -




- The inpatient ward spend in May 2018 at £1.422m was roughly in line with April's spend.

- Pay shows an overspend of £225k versus budget with a cumulative overspend of £430k now year-to-date.

- The year-to-date overspend is equivalent to 63 WTE B5 nurses.

- Other bank and agency costs add up to £204k, including £62k on non-NHSP (above cap) agencies which are roughly double the cost of substantive staff.

- Shift incentives are £21k (£20k last month). This is the payment on top of the additional hours payment they receive for working the shifts and works out to 15.65 WTE in month . We are currently reviewing the need for shift incentives as they are c. 25-30% more expensive than bank and below-cap agency charges (over 50% more expensive than standard substantive rates).

# May 2018 Financial Position

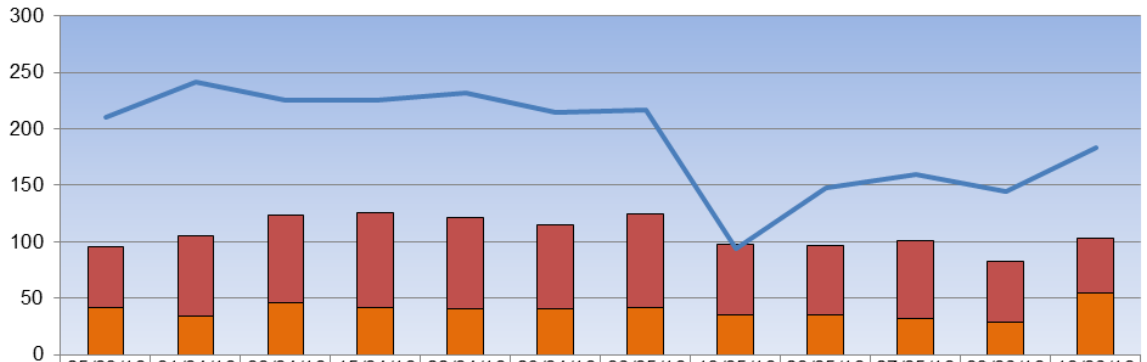
**Workforce continued – Ward Nursing**

• A number of actions have been put in place and will continue to be monitored through the Workforce Efficiency Group.

• As reported last month, there was an initial impact on the requests and fill of shifts, however, this did not have a material impact on the financial position. As well as this, there has been a small rise in recent weeks.

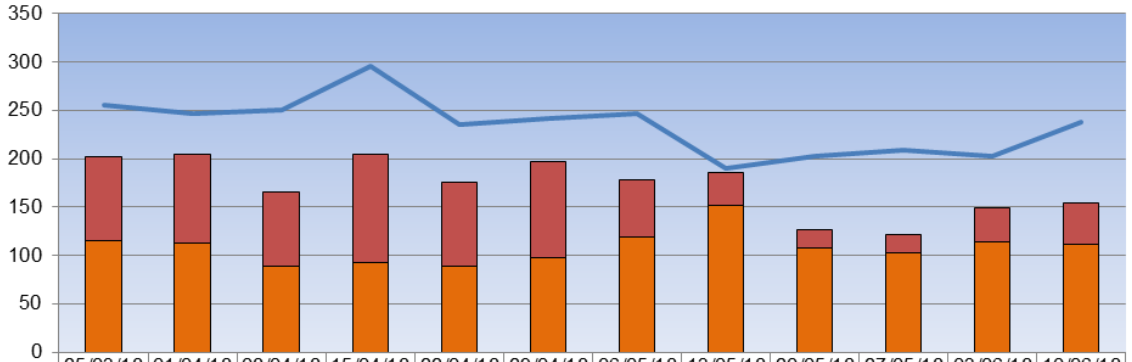
• Further focus has been placed on this in recent weeks and the impact will continue to be closely monitored.

**Registered Nursing Bank requests, Bank and Agency Fill (Shifts)**




| | 25/03/18 | 01/04/18 | 08/04/18 | 15/04/18 | 22/04/18 | 29/04/18 | 06/05/18 | 13/05/18 | 20/05/18 | 27/05/18 | 03/06/18 | 10/06/18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RN Agency Fill | 54 | 71 | 78 | 85 | 81 | 75 | 84 | 63 | 62 | 69 | 53 | 48 |
| RN Bank Fill | 41 | 34 | 46 | 41 | 40 | 40 | 41 | 35 | 35 | 32 | 29 | 55 |
| RN Requests | 210 | 242 | 225 | 225 | 232 | 215 | 217 | 94 | 148 | 160 | 144 | 183 |

**HCA Bank requests, Bank and Agency Fill (Shifts)**



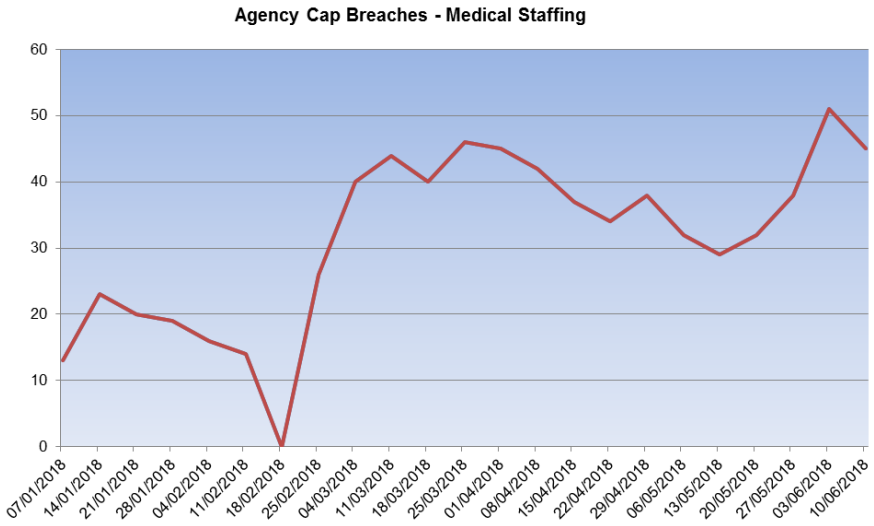

| | 25/03/18 | 01/04/18 | 08/04/18 | 15/04/18 | 22/04/18 | 29/04/18 | 06/05/18 | 13/05/18 | 20/05/18 | 27/05/18 | 03/06/18 | 10/06/18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HCA Agency Fill | 87 | 92 | 76 | 112 | 87 | 100 | 59 | 34 | 19 | 19 | 35 | 43 |
| HCA Bank Fill | 115 | 113 | 89 | 92 | 89 | 97 | 119 | 151 | 108 | 103 | 114 | 111 |
| HCA Requests | 256 | 247 | 250 | 296 | 235 | 241 | 247 | 190 | 203 | 209 | 202 | 238 |

# May 2018 Financial Position

**Workforce Continued – Medical Staffing**

• The Workforce Efficiency Group also discussed the expenditure in relation to medical staffing. The spend is currently in line with the contingency in place at the start of the year, however, the level of expenditure means this continues to be a risk.

• Agency cap breaches are outlined in the graph on the right. All agency shifts continue to be cap breaches.




| | 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 | 20/05/2018 | 27/05/2018 | 03/06/2018 | 10/06/2018 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Shifts | 13 | 23 | 20 | 19 | 16 | 14 | 0 | 26 | 40 | 44 | 40 | 46 | 45 | 42 | 37 | 34 | 38 | 32 | 29 | 32 | 38 | 51 | 45 |
| Breaches | 13 | 23 | 20 | 19 | 16 | 14 | 0 | 26 | 40 | 44 | 40 | 46 | 45 | 42 | 37 | 34 | 38 | 32 | 29 | 32 | 38 | 51 | 45 |

**Corporate – Non Pay**

• As outlined on page 2, there is a significant adverse variance for Corporate Non Pay at present. This relates to –

– Costs in relation to IT contracts

–Costs in relation to property charge

• Both these areas require further investigation, with any actions taken forward through the Corporate Board Meeting.

# May 2018 Financial Position

**Cost Improvement Programme**

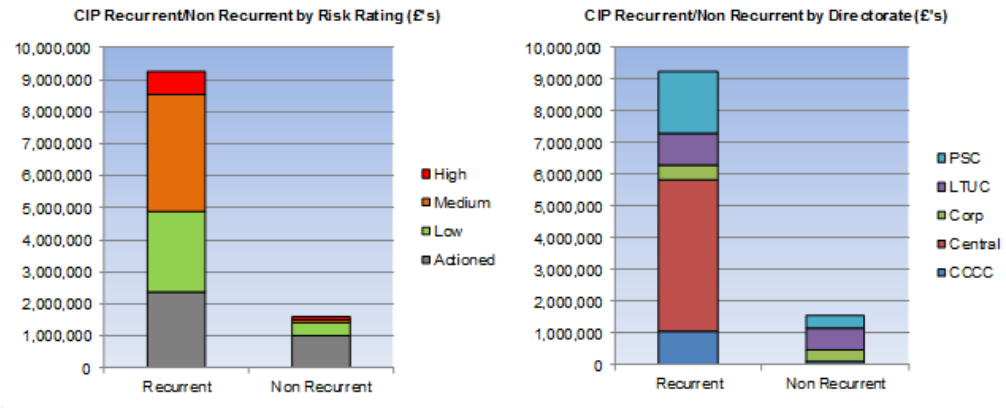
- The Trustwide CIP programme continues its development and implementation, with 101% of plans in place against the £10.7m target. This reduces to 87% following risk adjustment. Information by directorate is highlighted below, as well as progress against key schemes and areas with a high risk to delivery.

**Overall Trust and Directorate Position**

| Summary | Target | Actioned | Low | Medium | High | Total | Total %age | Risk Adjust | Risk Adj %age |
|---|---|---|---|---|---|---|---|---|---|
| Trustwide Summary | 10,700 | 3,376 | 2,894 | 3,774 | 771 | 10,815 | 101% | 9,299 | 87% |
| | | % age of target | 27% | 35% | 7% | | | | |

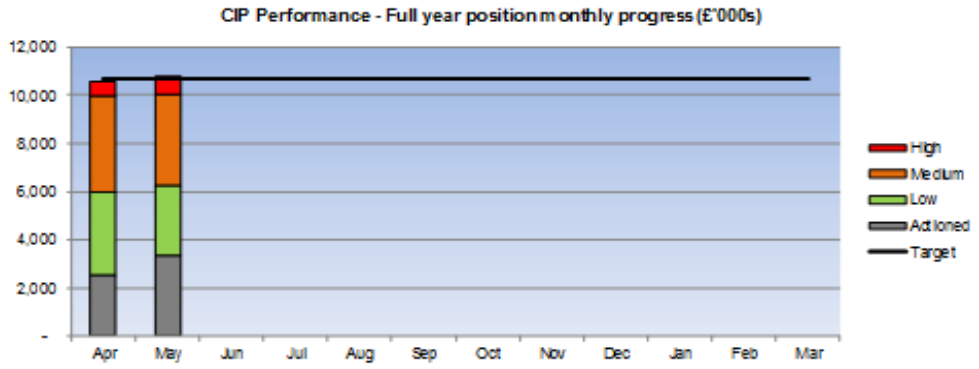
| Summary | Target | Actioned | Low | Medium | High | Total | Total %age | Risk Adjust | Risk Adj %age |
|---|---|---|---|---|---|---|---|---|---|
| Children's and Countywide | 1,133 | 463 | 670 | 64 | 0 | 1,196 | 106% | 1,150 | 102% |
| Corporate | 1,150 | 340 | 174 | 150 | 190 | 854 | 74% | 663 | 58% |
| Other and/or Central Sche | 5,067 | 300 | 1,500 | 2,856 | 96 | 4,752 | 94% | 4,029 | 80% |
| Long Term and Unschedu | 1,645 | 1,169 | 188 | 245 | 55 | 1,656 | 101% | 1,554 | 94% |
| Planned and Surgical Care | 1,705 | 1,105 | 362 | 459 | 430 | 2,357 | 138% | 1,903 | 112% |

**Recurrent/Non Recurrent Position**

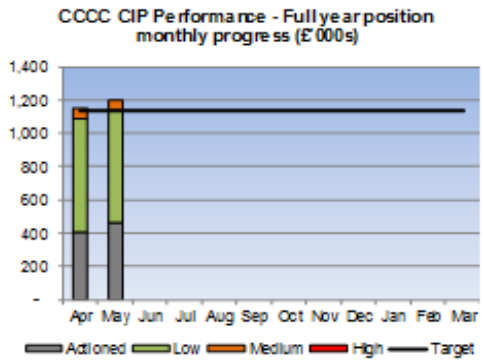


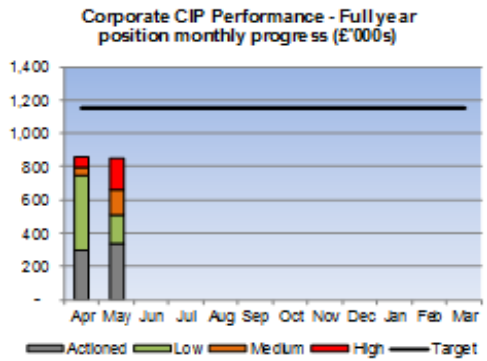
# May 2018 Financial Position

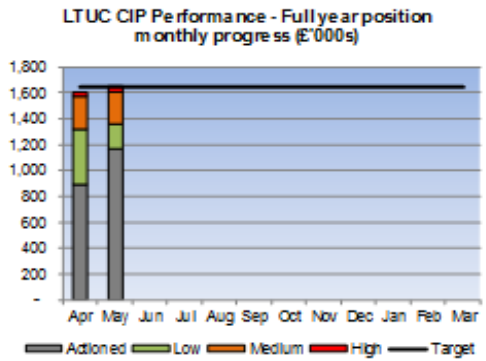
**Cost Improvement Programme Cont.**

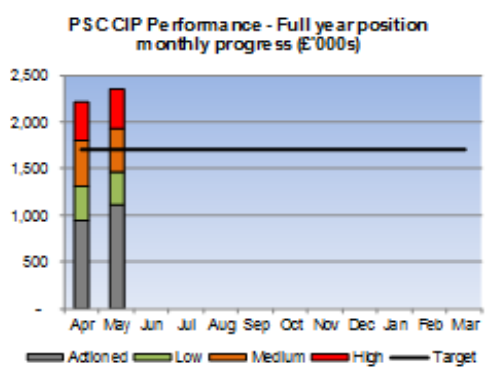


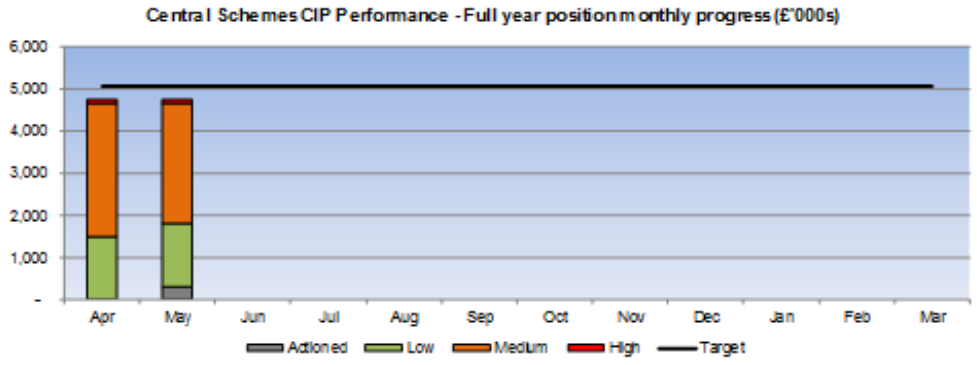

- The Savings Delivery and Oversight Group had its first meeting this month. The groups purpose is to provide oversight to CIP delivery, bringing a greater focus to delivering schemes and addressing concerns or difficulties.
- This group will report progress to SMT each month, supported by the information provided here.



Harrogate and District
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Date of Meeting:** | 27 June 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:** | • HDFT failed to deliver the 14 day Breast Symptomatic standard in May for the fourth consecutive month. However the Trust did achieve >95% for the 4 hour A&E standard.<br>• The results of the 2017 National Inpatient Survey were published in June, and HDFT was ranked 48th out of 147 participating Trusts.<br>• The latest SSNAP (Sentinel Stroke National Audit Programme) results show that HDFT has been rated D overall again but with an improved overall score of 58, compared to 49 in the previous publication. | | |

| **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 May 2018 position on activity for the main points of delivery, along with the May 2017 year-to-date position for comparison.

| | May-17 YTD | | | Apr-18 | | | May-18 | | | May-18 YTD | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Activity type** | **Actual** | **Plan** | **Variance** | **Actual** | **Plan** | **Variance** | **Actual** | **Plan** | **Variance** | **Actual** | **Plan** | **Variance** |
| **New outpatients** | 15333 | 15167 | 1.1% | 7671 | 7748 | -1.0% | 8612 | 7914 | 8.8% | 16283 | 15661 | 4.0% |
| **Follow-up outpatients** | 30570 | 30418 | 0.5% | 15444 | 15565 | -0.8% | 16222 | 15631 | 3.8% | 31666 | 31196 | 1.5% |
| **Elective inpatients** | 574 | 617 | -7.0% | 297 | 279 | 6.4% | 302 | 302 | 0.1% | 599 | 581 | 3.1% |
| **Elective day cases** | 4483 | 4872 | -8.0% | 2440 | 2618 | -6.8% | 2624 | 2611 | 0.5% | 5064 | 5229 | -3.2% |
| **Non-electives** | 3693 | 3579 | 3.2% | 1664 | 1809 | -8.0% | 1903 | 1905 | -0.1% | 3567 | 3713 | -3.9% |
| **A&E attendances** | 8797 | 8107 | 8.5% | 4314 | 4141 | 4.2% | 4771 | 4279 | 11.5% | 9085 | 8419 | 7.9% |

Overall outpatient activity was over plan in May for both new patients and follow-up patients, which is extremely positive given last year's position. Elective day cases remain below plan year to date, which is linked to endoscopy activity under delivery. Work is ongoing to more accurately phase the endoscopy activity for 2018/19 in line with the opening of the new unit and the addition of staff to support this, with increased activity from September onwards. Elective inpatient activity was on plan for May, with orthopaedics being 6.4% over plan. The number of trauma cases was higher than expected in May, which led to some challenges in allocating theatre time to acute and trauma cases and meant that there was at times significant pressure on the surgical wards.

Ophthalmology lists using topical anaesthetic drops have commenced on weekdays and the aim is to also roll this out to weekend lists, which will improve the cataract waiting list position.

## 2.0 PAEDIATRIC MEDICAL STAFFING

Paediatric medical staffing remains a considerable concern with a further loss of two middle grades who left unexpectedly. This is obviously a concern in terms of impact on staff and finances, and while safe care is being maintained, there is a small impact on waiting times for specialist clinics and the timeliness of initial health needs assessments. It is also interesting to note that acute inpatient activity is down but this mirrors the trajectory from previous years. Interviews will take place in June for the CESR posts.

## 3.0 STOCKTON HEALTHY CHILD SERVICES

The implementation of the Stockton Healthy Child Services continues to go extremely well, with positive feedback from staff, commissioners and service users. Performance against a number of the key contractual performance indicators are already showing considerable progress and the service are focusing on performance to demonstrate outcomes and quality. The teams are in a considerable change management process but are already leading the way regarding innovations in the use of social media.

## 4.0 EMERGENCY DEPARTMENT PERFORMANCE

The Trust has now received clarification from NHS Improvement in relation to the 4-hour A&E performance trajectory requirement for the Performance Sustainability Fund (PSF) in 2018/19. This is to maintain or improve our 2017/18 performance position reported in the first three quarters of the year. For Quarter 4, the Trust will receive payment if performance of 95% or above is achieved for the month of March 2019. This means that HDFT need to deliver the following:

Q1 2018/19 – 96.7%
Q2 2018/19 – 96.0%
Q3 2018/19 – 94.9%
Q4 2018/19 – 95% (in March)

Given performance in Quarter 1 to date, it is not possible to deliver the required 96.7% for the quarter overall. In the first half of last year we had additional resource within the Trust associated with WYAAZ funding that stopped in March 2018. In addition, ED attendances are significantly above plan. The Trust can still deliver 95% for Quarter 1 but this will be challenging.

I have challenged the position NHSI has taken in relation to exceeding 95% to achieve the performance payment and have had preliminary feedback from NHSI that achieving 95% may be an acceptable baseline. This will be picked up in the Quarterly Review Meeting with NHSI on 22 June 2018.

## 5.0 CANCER SERVICES

Performance

Performance against the 14 day standard for breast symptomatic patients was below the required 93% standard for the fourth consecutive month in May with 87.5% of patients seen within 14 days. Provisional forecast data for June indicates that this standard will be achieved for the month, but it is not expected that the standard will be delivered for the quarter overall. A review of capacity and demand for these services is ongoing across the WYAAT Trusts.

Provisional data indicates that Trust performance for the 62 day standard was above the 85% standard in May with 90.4% of patients treated within 62 days.

100k Genomes Project

This project aims to create a new genomic medicine service for the NHS, 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.

The figures for overall recruitment to the 100k Genomes project are shown below.

**Cancer**
National figures – 19,061 cancer samples
HDFT has recruited 650 patients and have collected samples from 409 against a cumulative target of 616. This equates to 65%, and our final target is 799.

**Rare Diseases**
National figures – 55,310 rare disease samples
HDFT has recruited 3,492 participants against a target of cumulative 3,316, which equates to 105%. Our final target is 3,977.

Nationally 66,443 genomes have been sequenced and this is a cumulative figure of the pilot work and the main programme.

Inter-Provider Transfer (IPT) performance

As stated above, expected 62-day performance for May with the current allocation rules is at 90.4%. A total of 10 patients were treated at tertiary centres in the month following a 2WW referral to Harrogate. Of these, 8 were transferred by day 38 (80.0%).

Shadow reporting of the 62 day standard shows that when the national re-allocation rules are applied, performance would have been 1% higher for May.

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 | **46.0** | **52.0** | | **98.0** |
| Within 62 days | 38.5 | 47.0 | | **85.5** |
| Outside 62 days | 7.5 | 5.0 | | **12.5** |
| Performance | 83.7% | 90.4% | | **87.2%** |

| Re-allocation (NATIONAL) | Apr-18 | May-18 | Jun-18 | Q1 |
|---|---|---|---|---|
| Total | **45.0** | **52.0** | | **97.0** |
| Within 62 days | 37.0 | 47.5 | | **84.5** |
| Outside 62 days | 8.0 | 4.5 | | **12.5** |
| Performance | 82.2% | 91.3% | | **87.1%** |

| Difference (National/Actual) | Apr-18 | May-18 | Jun-18 | Q1 |
|---|---|---|---|---|
| Total | **-1.0** | **0.0** | | **-1.0** |
| Within 62 days | -1.5 | 0.5 | | **-1.0** |
| Outside 62 days | 0.5 | -0.5 | | **0.0** |
| % difference | -1.5% | 1.0% | | **-0.1%** |

| IPTs (actual patients) SENT | Apr-18 | May-18 | Jun-18 | Q1 |
|---|---|---|---|---|
| Total | **8** | **10** | | **18** |
| Within 38 days | 5 | 8 | | **13** |
| Outside 38 days | 3 | 2 | | **5** |
| Performance | 62.5% | 80.0% | | **72.2%** |

## 6.0 INPATIENT SURVEY 2017

The 2017 inpatient survey was published in June. 570 HDFT inpatients discharged in July 2017 participated in the survey which equates to a response rate of 47% (higher than the national response rate of 41%).

Overall HDFT was ranked 48th out of the 147 participating trusts with an overall score of 7.9, whilst the best performing Trust had an overall score of 8.7. This compares to HDFTs score of 8.0 in the 2016 survey.

HDFT performed better than average on three questions:

- Was your admission date changed by the hospital?
- How would you rate the hospital food?
- Did doctors talk in front of you as if you weren't there?

The Trust did not perform worse than average in any areas.

Our performance has improved since the 2016 survey on the question "During your hospital stay, were you ever asked to give your views on the quality of your care?" and this is no longer showing as worse than average.

Our performance worsened since the 2016 survey on nine questions:

- In your opinion, were there enough nurses on duty to care for you in hospital?
- Did you feel you were involved in decisions about your discharge from hospital?

- After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?
- When you left hospital, did you know what would happen next with your care?
- Did a member of staff tell you about medication side effects to watch for when you went home?
- Were you given clear written or printed information about your medicines?
- Did hospital staff take your family or home situation into account when planning your discharge?
- Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptations made to your home, after leaving hospital?
- Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital? (e.g. services from a GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)

The results will be fully reviewed and any actions will be pulled together by the relevant groups and taken forward at Directorate level.

## 7.0 SENTINEL STROKE NATIONAL AUDIT PROGRAMME (SSNAP)

SSNAP have published the latest results set for the period December 2017 to March 2018.

HDFT has been rated D overall again but with an improved overall score of 58, compared to 49 last time. For this publication period, we have scored A (best) for both data quality indicators meaning that our overall score is not impacted by the data quality adjustment.

Of the 10 domains in the SSNAP data set, 8 have remained at the same score. One domain has seen an improvement since the last report (Occupational therapy) and one domain has seen a deterioration (Discharge processes), however this deterioration may be due to data completeness as some of the metrics we have previously consistently scored 100% on ("joint health and social care plan by discharge", "if in atrial fibrillation discharged on anticoagulants"), we are reporting much lower scores in the last few months (60% or lower).

A number of individual metrics showed some deterioration in this publication but this is likely to be due to operational winter pressures over the period covered by the latest publication, for example the proportion of patients who were admitted to the stroke unit within 4 hours of arrival.

75% of eligible patients were thrombolysed in the latest data set (100% in the last publication), 17% within 1 hour (a slight improvement on 14% in the last publication).

## 8.0 WYAAT STROKE PROJECT

Work is ongoing to develop the options to support the care of Hyper acute strokes for the population of Harrogate. It is clear that the unit in Harrogate will not reach the de minimis number of cases per year to maintain skills to provide that level of care and as such WYAAT are supporting the modelling of options for how that care could be provided going forwards. These options will then be reviewed by clinicians, operational managers from the trusts involved, along with the Yorkshire Ambulance Service at a meeting scheduled for the last week in June. Based on a small selection of chosen scenarios the trusts, plus YAS, will then assess the operational, estates, workforce and financial implications. This more detailed modelling will then be reviewed in early July in order to agree the best option which can then be fed into the West Yorkshire and Harrogate ICS commissioner's business case and support any consultation requirements, and then a full implementation plan can be developed.

Harrogate and District
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Date of Meeting:** | 27 June 2018 | **Agenda item:** | 8.1 |
| **Report to:** | Board of Directors | | |
| **Title:** | Supportive Discharge Service Business Case | | |
| **Sponsoring Director:** | Robert Harrison, Chief Operating Officer | | |
| **Author(s):** | Nikki George-Powell, Occupational Therapist and Lead for SDS<br>Mike Forster, Operational Director, LTUC | | |
| **Report Purpose:** | **Decision** ✓ **Discussion/ Consultation** **Assurance** **Information** | | |
| **Executive Summary:** | The Board of Directors is asked to approve funding to make permanent the Supported Discharge Service pilot and expand its current remit and capacity. This expanded service would allow the equivalent of 15 beds of capacity to transfer from the acute hospital setting into people's homes.<br><br>This business case is part of the Winter Plan and Discharge Strategy aimed at reducing reliance on hospital inpatient beds and the associated workforce and affordability challenge. This strategy involves identifying and building intermediate / discharge facilities to assess capacity across three pathways:<br><br>**Pathway 1:** Assist patients to return to their own home with additional short-term support<br><br>**Pathway 2:** Transfer patients to interim residential rehabilitation or reablement, with the aim to discharge the patient to their own home or usual place of residence<br><br>**Pathway 3:** Transfer patient's to an interim placement for assessment of long-term health and / or social care needs<br><br>This business case will build capacity primarily in **Pathway 1**<br><br>As part of the planning round for 2018/19 the Trust has modelled the inpatient bed capacity required to manage non-elective and elective demand. It is entirely foreseeable that without an alternative strategy there will be periods in Wwinter 2018/19 where, even with all available escalation beds open, there will not be enough capacity to meet demand.<br><br>The cost of delivering the escalation bed requirements are estimated to be **£1,287,300** | | |

| | |
|---|---|
| | This would mean patients being managed in a sub-optimal clinical environment by agency nursing staff for a large proportion of the year.<br><br>The recommended model will seek to mitigate a proportion of these costs and will support patients being managed more appropriately at home and reduce the need for escalation beds. Further plans will be developed to seek to mitigate the residual escalation beds.<br><br>It is entirely foreseeable that Winter will have an impact financially and therefore it is clear that the Trust needs to plan for Winter and ensure it is appropriately resourced. Utilising the principle of the new Aligned Incentive Contract, either the commissioner or provider funds this additionality or we stop doing something else. Iin the absence of external winter funding, resources will need to be moved from the elective part of the HaRD contract and activity reduced accordingly. This will then provide capacity for the Trust to increase elective activity from other CCGs and bed day savings will support maintaining elective activity during Winter. |

**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 case will support the corporate risks associated with ward staffing by reducing reliance on inpatients beds. The case will also support the risk associated delivery of the A&E Target and patient flow by building capacity to support patients being managed in their own home rather than a hospital bed. |
| **Legal / regulatory:** | The case will support the delivery of the 4 hour standard, the 3.5% DTOC standard and reductions in Stranded patients. |
| **Resource:** | These are detailed in the case. |
| **Impact Assessment:** | The case will improve the quality of care we give our patients by supporting early discharge from hospital and reducing occupied bed days. |
| **Conflicts of Interest:** | None identified |
| **Reference documents:** | Full Business Case attached |
| **Assurance:** | Discharge Steering Group. HARD A&E Delivery Board. Directors Meeting. |

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

Approve the Supported Discharge Service Business Case and associated costs.

Harrogate and District
NHS Foundation Trust

# Long Term Unscheduled Care

# Supported Discharge Service

# June 2018

You matter most

## 1 Executive summary

The primary aim of this business case is to outline the benefits of the Trust adopting the proposed model, which is to convert the pilot Supported Discharge Service (SDS) into a permanent team and to expand the cohort of patients to support those who are 'community ready' but require additional short-term support in their home environment.

The key benefits are:

a. To enable a plan to support the foreseeable demand for beds, particularly in the winter, when actually bed capacity is likely to be exceeded.

b. The cumulative throughput of the service would deliver a saving of 15 acute hospital beds.

c. Improved patient flow by increasing capacity in Pathway 1 of the discharge to assess pathways. Early supported discharge would be most beneficial to elderly patients currently admitted to CATT and AMU or to orthopaedic patients in planned care, particularly for patients admitted as an emergency for fractured neck of femur. This is in line with both internal audit and evidence gathered as part of the review from Healthcare at Home. National evidence has demonstrated that early discharge form hospital for these patients' results in lower ongoing need for care and better outcomes.

d. Reduction in the need for escalation beds and for the majority of the year, supporting the directorates to operate within the funded acute bed base. The service has the potential to avoid the need for capital investment in new inpatient wards and associated workforce costs.

e. SDS to work as a funded partner service, operating to clear KPIs and being held to account for delivery of the stated bed savings.

f. Cost effective model for managing the foreseeable non-elective demand.

It is envisaged the SDS can contribute and support the longer term plans and future developments of Therapy services and future integration with partner organisations in the Harrogate Alliance.

## 2 Background information

It is well documented that delayed discharge and long length of stay can have adverse effects upon patients. The Kings Fund 2010 report people long lengths of stay in hospital increase the risk of infection, depression, loss of independence as well as NHS resources being used inappropriately (Department of Health 2010). In other words, older people do not perform well; lose abilities and confidence in hospital environments. Patients who remain in hospital for periods of more than 24-48 hours experience physical de-conditioning and deterioration in function which lead to poorer outcomes. ***This is especially relevant to frail elderly people and often creates a further health and social need.***

The National Audit Office (NAO) found that delayed discharges from hospital has increased 31% in the last 2 years and that 1.15 million bed days in 2015 were occupied by patients that were medically fit to go home. Local evidence shows that Harrogate is an outlier in terms of "Stranded Patients" and also fails to achieve the national 3.5% DTOC standard.

Due to changes in the community contract there is an over establishment within community services which provided the trust with an opportunity to test a different model to support discharge. Research highlights that AHPs are demonstrating that they can 'pull people back home' with timely

assessment of their abilities and quick seamless access to community services. Functional assessments are more accurate especially for patients with cognitive problems, when carried out in the patients own home rather than the hospital environment. Decisions around future care, ability to function in a patient's own environment and wider holistic evaluation of the individuals circumstances are best made following these assessments. A more detailed analysis of available guidance and research is available in Appendix 1.

In March 2017 HDFT trust held an "Every Hour Matters" week which provided community staff with an opportunity to trial whether in-reaching into the trusts acute hospital wards could improve; patient rehabilitation pathways, develop opportunities for patients to receive rehab in a more timely way and support earlier discharge into the community.

A further weekend trial was conducted shortly after this and both trials collected data including patient experience. Discussions concluded that a more lengthy robust trial was needed to further test this approach and the present Pilot SDS was formed.

Despite some initial difficulties with the staffing model the 90 day report in October 2017 demonstrated that the initial metrics and key performance indicators were being met and SDS performance was improving patient flow and patient outcomes. The SDS trial was then permitted to extend operation until the end of March and was staffed using additional community staff from the community over establishment plus 0.6 WTE Band 6 Occupational Therapist secondment from the Frailty inpatient therapy team.

Throughout the pilot, SDS has looked to improve efficiency, use resources effectively and improve patient care, using the principles of the growing body of evidence/research and government initiatives. A representation of available guidance is as follows:

- **Five Year Forward View 2014**
- **Next Steps on the NHS 5 Year Forward 2017 –**
- **AHP into Action Executive summary 2016/17 – 2020/21**
- **Improving Lives, Saving Money Occupational Therapy Campaign 2016 – ongoing** :
- **Quick Guide: Discharge to Assess Transforming Urgent and Emergency Care Services in England.**

## 2.1 Current Position

Within the trust a Discharge Steering Group has been meeting to take forward a program of work to improve discharge from hospital. The trust has worked with partners from NYCC and HaRD CCG to develop a vision of how the Harrogate system can support patients' home via three pathways:

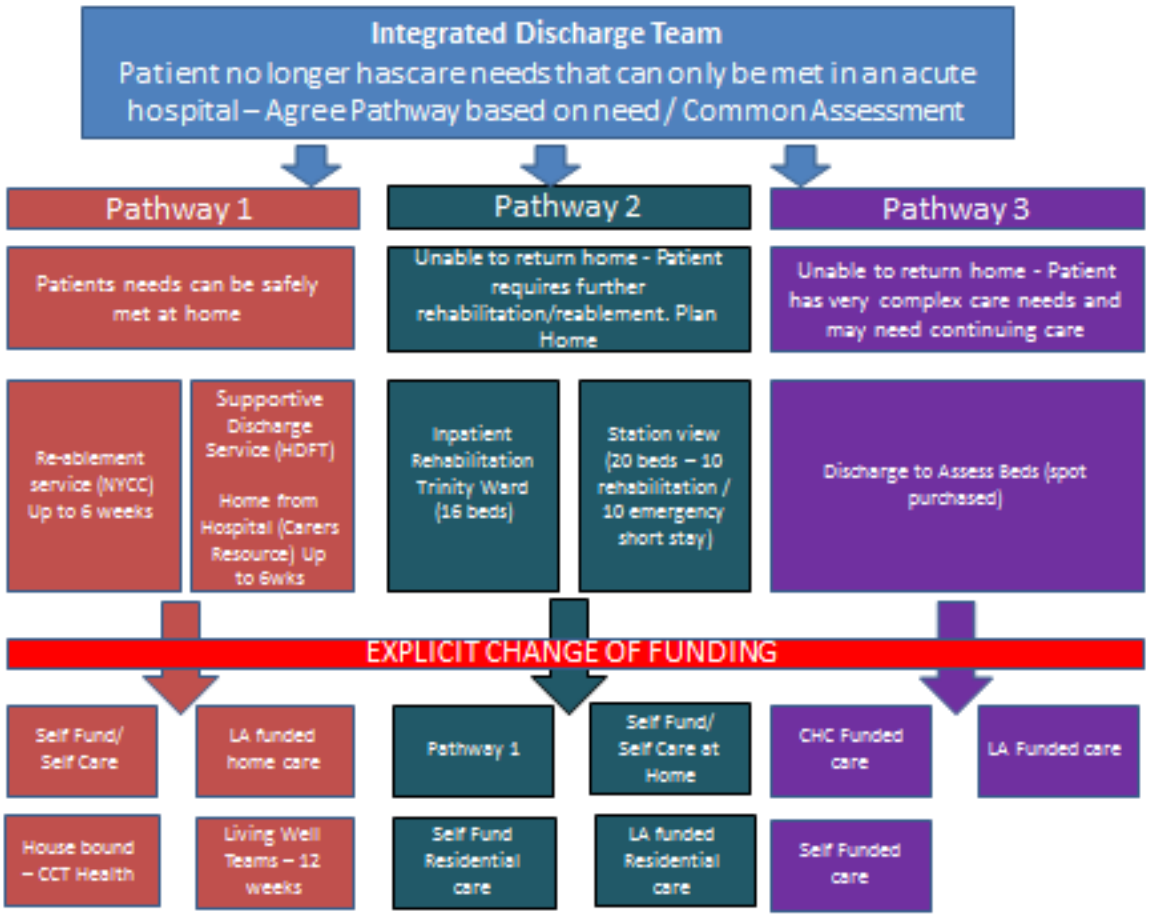
**Pathway 1:** Assist patients to return to their own home with additional short-term support

**Pathway 2:** Transfer patients to interim residential rehabilitation or reablement, with the aim to discharge the patient to their own home or usual place of residence

**Pathway 3:** Transfer patient's to an interim placement for assessment of long-term health and / or social care needs

This vision for discharge pathways is illustrated in Figure 1. The SDS pilot has worked within pathway one, supporting patients back to their own home for assessment and intensive therapy for up to 72 hours post transfer from hospital.

**Figure 1: Discharge Pathways from Acute Hospital Care**




The SDS team went live in July 2017 and have been in operation for 32 weeks. The current SDS model uses a 'pull' approach with the team actively finding suitable cases from the inpatient wards.

The main criteria for the service is that patients are community fit for discharge but require ongoing therapy assessment and intervention in the community. The team have also provided support to bridge delays in packages of care in order to enable timely discharge from an acute hospital bed.

Further information and analysis of the current SDS pilot service can be found in:

**Appendix 1:** SWOT Analysis of Pilot SDS
**Appendix 2**: Data analysis of referrals rates and other service metrics

## 2.2 Aligned Incentive Contract and Winter Planning

With the move to an Aligned Incentive Contract for HaRD CCG it supports the approach to spend the non-elective resources in the most cost effective and patient centred way.

It is entirely foreseeable that winter will have an impact financially and therefore it is clear that the Trust needs to plan for winter and ensure it is appropriately resourced. Utilising the principle of the new Aligned Incentive contract, either the commissioner or provider funds this additionality or we stop doing something else, in the absence of external winter funding, resources will need to be

moved from the elective part of the HaRD contract and activity reduced accordingly. This will then provide capacity for the Trust to increase elective activity from other CCGs and bed day savings will support maintaining elective activity during Winter.

This and the wider winter planning work will also provide assurance to the Board and NHSI that there is a credible and costed winter plan in place to deal with the foreseeable demand and the impact that it can have on Quality, Performance and Finance.

## 2.3 Capacity and Demand Assessment

The financial challenges faced by the NHS are well documented and HDFT is not exempt from these pressures. The need to reduce costs for the whole system is more imperative than ever but this must be achieved without impacting on patient care.

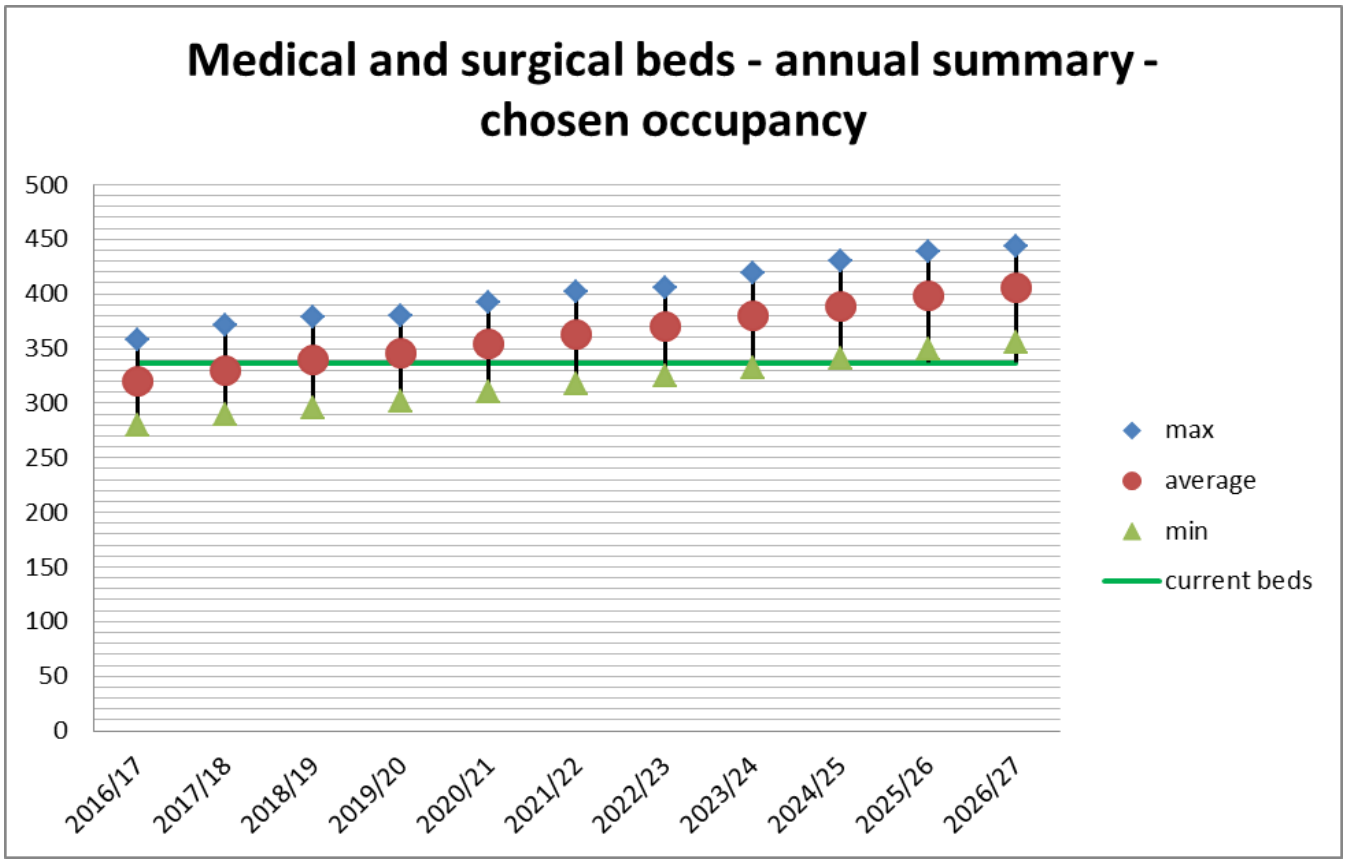
The Trust has drawn up models to look at the bed requirements over the next five years based upon anticipated changes in demand. These clearly indicate that year on year, it will become increasingly difficult to close beds or keep occupancy from exceeding 90% (national guidance would suggest 85% is required to avoid cancelled operations and to support achievement of the ED standard) and over the longer term additional inpatient wards will need to be build and staffed based on current activity projections.

Bed modelling for LTUC as outlined in Figure 2 demonstrates that bed occupancy will be above 100% for the majority of the year while Figure 3 shows the modelling done by the Trust on the need for beds over a longer period.

Figure 2: 2018-19 Bed Modelling for LTUC

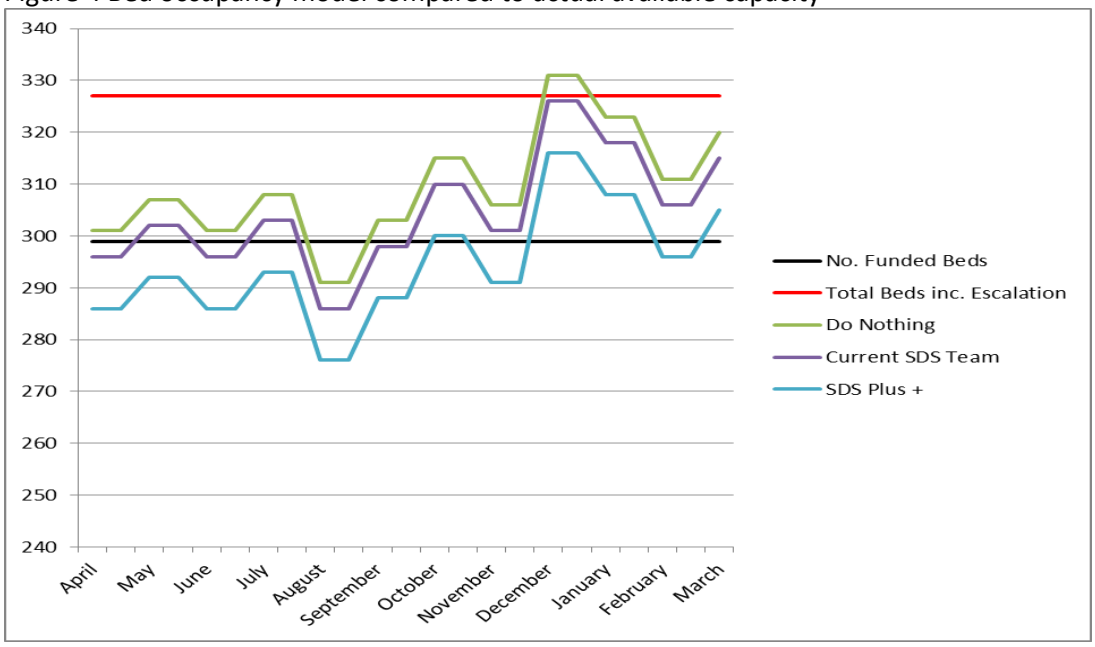
| **Bed Reduction Plan 2018/19 - Long Term and Unscheduled Care** | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Projection based on projected activity and LOS** | | | | | | | | | | | | | |
| | | Projected Bed Numbers | | | | | | | | | | | |
| Ward | Funded bed numbers | **April** | **May** | **June** | **July** | **August** | **Sept** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **March** |
| CATT | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 |
| AMU | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 | 28 |
| Byland | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 |
| Jerv | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 | 30 |
| Oakdale | 26 | 26 | 26 | 26 | 26 | 26 | 26 | 26 | 26 | 26 | 26 | 26 | 26 |
| Granby | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 |
| Trinity | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 | 16 |
| Total 100% Occ | 176 | 176 | 176 | 176 | 176 | 176 | 176 | 176 | 176 | 176 | 176 | 176 | 176 |
| Modeling Bed Requirment | | **181** | **176** | **166** | **177** | **173** | **166** | **177** | **197** | **191** | **191** | **185** | **186** |
| Variance - Based on 100% Occupancy* | | -5 | 0 | 10 | -1 | 3 | 10 | -1 | -21 | -15 | -15 | -9 | -10 |
| Variance - Based on achieving 90% Occupancy** | | -23 | -18 | -8 | -19 | -15 | -8 | -19 | -39 | -33 | -33 | -27 | -28 |

Figure 3: Trust Bed Modelling 2016 to 2016 (modelling based on 90%).




Therefore, developing safe means of reducing admissions and lengths of stay must underpin Trust strategy for the forthcoming years. The Supported Discharge Service is one of a number of strategies aimed at improving flow and capacity across the acute bed base, primarily through reducing length of stay effective use of beds, and improved discharge planning by providing rehabilitation in the appropriate place. The impact of SDS can be seen in the figure below:

Figure 4 Bed occupancy model compared to actual available capacity

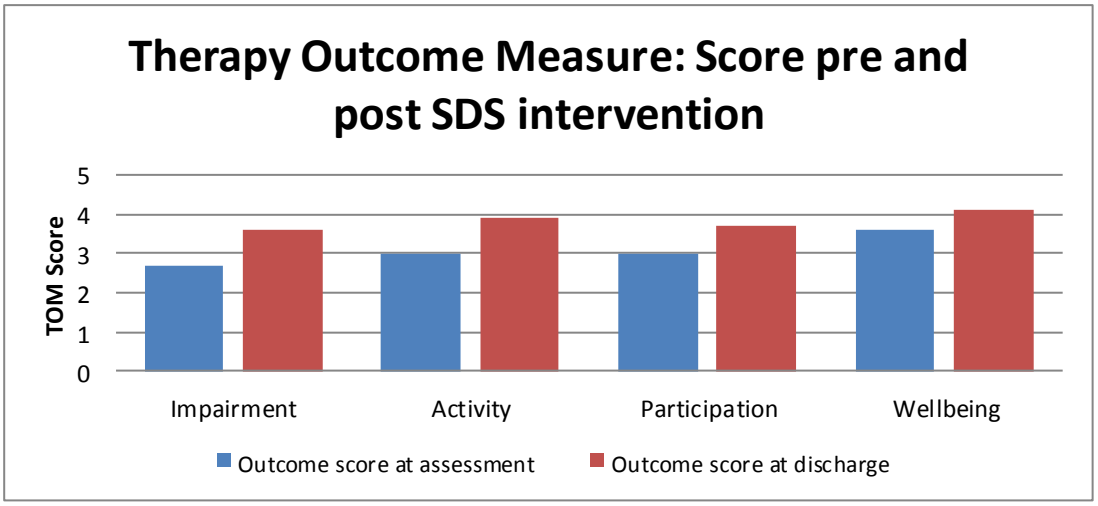


## 2.4 Performance & Activity

To date the team have supported 394 discharges home, just under two per day. The team estimate that they have saved a total of 975 acute hospital bed days, equating to 4.4 acute beds.

The team have used the Therapy Outcome Measure (TOM; Enderby and John 2015) to monitor patient's abilities and problems in the four domains of Impairment, Activity, Participation and Wellbeing. Figure 5 outlines the outcomes achieved across the cohort of patients discharged via the service.

**Figure 5: TOM Score pre & post SDS intervention**




Issues with current model:

1. The service has not been able to achieve a fully established team in terms of skill mix and banding. Staffing structure has been variable due to issues around staff sickness, maternity leave and CCT staff uptake on moving from substantive posts to work within a pilot team.

2. Whilst the team have proactively in reached to the wards to find suitable cases for the service, there has been an unreliable and variable referral pathway to the service from the wards. Should the team become substantive, further work would need to be undertaken with the wards to sure-up pathways to the service and challenge risk-averse practice amongst peers which can delay discharge to the community. This will be addressed through the LTUC Unscheduled Care Program and the work streams relating to Tomorrow's Ward and Discharge. The intention is identify patients who may require support on discharge earlier in the pathway and manage these through the Integrated Discharge Team. The Consultant in Elderly Care associated with Option 4 (SDS ++) will also be tasked with championing out of hospital pathways with the ward based staff.

## 2.5 Options Identification

Options available to the organisation are as follows:

1. Do nothing

2. To make the current SDS service and staffing substantive

3. To enhance the SDS service for more complex rehabilitation up to 7 days with nursing input and extended hours of operation

4. To enhance the SDS service to support a virtual ward with additional nursing, therapy and MDA staff alongside 0.5 Geriatrician

## 2.6 Options Appraisal

Option 1: Do Nothing

The current SDS trial would conclude and staff presently working within the service would return to community services. Community services hold a 7.46 wte therapy over establishment presenting a cost pressure on the community. SDS service would not exist and Acute and community services would need to revert back to previous ways of working. This would most definitely affect patient flow, lose beds saved (4.4 beds per day), reduced patient outcomes and satisfaction and create pressure and confusion for in patient staff.

Option 2. To make the current SDS service and staffing substantive (SDS)

Recruit to current SDS establishment with amended skill mix where all benefits of the team detailed previously would continue. It would be expected that the service would become sustainable, confidence and use of the team amongst HDFT staff and partner organisations would develop and grow. Opportunities detailed in the SWOT analysis would be explored as a priority and by implementing the opportunities it would be expected that team would continue to provide sufficient discharges from the acute bed base to save the equivalent 5 of beds.

Option 3. To enhance the SDS service for more complex rehabilitation up to 7 days with nursing input and extended hours of operation (SDS +)

The expanded team and criteria would deliver sufficient discharges from the acute bed base to save the equivalent of 10 beds.

Option 4. To enhance the SDS service to support a virtual ward with additional nursing, therapy and MDA staff alongside 0.5 Geriatrician (SDS ++)

The team has demonstrated that it is ideally placed to trial new ways of working, stretch boundaries and has provided learning which can be transferred and inform future developments of SDS and other services.

It is strongly believed that the team could deliver more if further resources were made available. The Trust recently commissioned an independent company “Hospital at Home” to undertake a point prevalence in the Trust and they have identified opportunities to manage at least 16 beds worth of activity outside the Trust. Half of the activity is medical and half surgical (predominantly Orthopaedics which is likely to be therapy led). The elderly care team also acknowledge that there are a number of patients who are currently admitted for 20+ days who could be supported more effectively in the community if robust therapy, nursing and geriatrician provision was available.

The current over establishment within Elderly Care Consultants (linked to previous agreements around maternity cover) provide a unique opportunity to test this model without committing

additional expenditure on medical staff. The additional group of patients managed within this cohort has the potential to expand above the current 5 beds but we need to test this model to identify the full opportunity.

## 2.7 Preferred Option

Option 4 is the preferred option as it offers the greatest bed saving. Some costs are already committed in 2018/19 (such as the baseline SDS staffing and Elderly Care Consultant) which provides a unique opportunity to trial this model and the impact on beds.

Ward staffing is a key driver of HDFT cost and this option provides a cheaper alternative to manage 15 beds of capacity than an inpatient ward. It would also allow us to test the virtual ward model which has the potential to be expanded to release further bed savings in the future.

The approach will also deliver wider system savings as national evidence has shown that getting patients home earlier in their patient journey results in; more accurate assessments of ongoing care, lower levels of decompensation associated with extended lengths of stay resulting in lower continuing health and social care costs. It is proposed that current costs across the system should be captured and discussed as part of the Provider Collaborative. There could then be the opportunity to support joint expansion of this approach if it was shown it helped reduce costs in continuing health or social care. This will be taken forward through the Provider Joint Management Team Meeting.

### 2.7.1 Financial Analysis

**Costs associated with the three options**

| | | 17-18 Pay Scale | | | 18-19 Proposed Pay Scale | | | To be funded |
|---|---|---|---|---|---|---|---|---|
| | | Mid Point | WTE | Cost | Mid Point | WTE | Cost | Cost |
| **Option 2 - Supported Discharge Service (SDS)** | B7 Occupational Therapist | | 0.56 | 30,300 | | 0.56 | 31,300 | 1,000 |
| | B6 Therapist | | 4.60 | 184,200 | | 4.60 | 192,500 | 8,300 |
| | B5 Occ Therapy | | 0.60 | 17,000 | | 0.60 | 18,000 | 1,000 |
| | B3 Multi-Disaplinary Assistant | | 4.80 | 129,800 | | 4.80 | 132,800 | 3,000 |
| | Non Pay | | | 24,500 | | | 24,500 | |
| | | | **10.56** | **385,800** | | **10.56** | **399,100** | **13,300** |
| **Option 3 - SDS plus** | B7 Occupational Therapist | 52,410 | 0.80 | 41,900 | 54,016 | 0.80 | 43,200 | 1,300 |
| | B6 Therapist/Nursing | 43,431 | 5.50 | 238,900 | 45,582 | 5.50 | 250,700 | 11,800 |
| | B3 Multi-Disaplinary Assistant | 26,742 | 5.80 | 155,100 | 27,581 | 5.80 | 160,000 | 4,900 |
| | Non Pay | | | 28,000 | | | 28,000 | |
| | | | **12.10** | **463,900** | | **12.10** | **481,900** | **18,000** |
| **Option 4 - Virtual Ward & SDS +Plus** | Conusltant Geriatrician | 116,832 | 0.50 | 58,400 | 116,832 | 0.50 | 58,400 | 0 |
| | B7 Occupational Therapist | 52,410 | 0.80 | 41,900 | 54,016 | 0.80 | 43,200 | 1,300 |
| | B6 Therapist/Nursing | 43,431 | 7.60 | 330,100 | 45,582 | 7.60 | 346,400 | 16,300 |
| | B3 Multi-Disaplinary Assistant | 26,742 | 8.00 | 213,900 | 27,581 | 8.00 | 220,700 | 6,800 |
| | Non Pay | | | 39,100 | | | 39,100 | |
| | | | **16.90** | **683,400** | | **16.90** | **707,800** | **24,400** |

Some costs within the above are already a pressure within the community budget (and elderly care) with no income to cover the costs. This is due to over recruitment associated with the Vanguard which was not funded on a recurrent basis and left the Trust with a cost pressure.

The costs associate with option 4 is £707,800. The additional potential cost pressure (on top of the current risk) would be **£332,067** for addition 10.6 beds of impact (4.4 bed impact in current position).

The analysis shown in Figure 3 enables the actual costs of staffing the escalation capacity required to meet the bed demand. Without this case there will be period in December and January where, even with all escalation open, there would not be enough bed capacity to meet demand. This is likely to be a more common occurrence based on the bed modelling data presented earlier in the case. While option 3 appears to be the most cost effective it will result in more escalation areas being open for a greater period along with the associated risk to patient safety, experience and nurse agency staffing usage. This is also more likely to result in elective cancellations and potential impact on A&E and resulting in loss of income and access to the performance element of the provider sustainability fund (£1.2m per year). Therefore Option 4 becomes the more cost effective model.

| | Total Cost – escalation and SDS model (£) | Variance from do nothing option |
|---|---|---|
| Option 1 - Do nothing | £1,287,300 | |
| Option 2 – SDS | £1,365,500 | +£78,200 |
| Option 3 – SDS + | £1,169,900 | -£117,400 |
| Option 4 – SDS ++ | £1,184,700 | -£102,600 |

### 2.7.2 Quality Analysis

Based on the data collected from the SDS pilot, there have been a number of successes as outlined in achievements above. However, it is understood that there is great potential to support more patients at home. The national data provided from NHS England looking at the number of patients in hospital for 7 days or longer (ie stranded patients) shows that approximately 60% of inpatients at HDFT have a LOS greater than 7 days. This places HDFT at the top for stranded patients in the North.

It is therefore proposed that option 4 would provide:

1. Greater mix of skills within the team. A recent review of the activity by HRG would suggest that a large proportion of admissions are related to respiratory or cardiac problems and falls. This would in turn suggest that in order to facilitate earlier discharge, patients may have ongoing medical needs that could be supported by experienced nursing staff in the community for a short period of time as part of their rehabilitation. Equally, Geriatrician review at point of discharge and / or in the community may facilitate earlier discharge in the patient's pathway and an overall reduction in length of stay. If SDS have experienced nurses working alongside the therapy support in the community it would provide a more robust and flexible set of skills as part of a broader MDT to support this rapid review and discharge model.

2. Increased capacity. With an increase in the capacity of SDS the team would be able to offer extended support to a small cohort of patients as and when required. This flexibility would enable to the team to support patient on the boundary of discharge pathway 1 and 2.

It is envisaged that the service would proactive manage and pull patients through their service in order to maintain the bed savings stated. The activity and savings are demonstrated across three levels of the service illustrate in Figure 3.

In summary:

Level Green: These cohorts of patients are those SDS have supported in the pilot. It is envisaged that in option 4 the team would support approximately 12 patient's home via this level of the service per week saving the equivalent of 5 beds.

Level Yellow: This is a new cohort of patients who, through audit and professional option, SDS have identified could be supported home. This group of patients may have more complex needs that can be best met by a mix of therapy and nursing input across 7 days. These patients may also require support in to the evening. It is envisaged that in option 4 the team would support approximately 5 patients home via this level of the service per week in order to save the equivalent of 5 acute hospital beds

Level Red: This is a new cohort of patients who, through audit and professional opinion, SDS and the elderly the care team have identified could be supported home. This group of patients may have more complex needs that can be best met by a mix of therapy, nursing and geriatrician input across 7 days. These patients may also require support in to the evening. It is envisaged that in option 4 the team would support approximately two patient's home via this level of the service per week in order to save the equivalent of 5 acute hospital beds. This cohort has the possibility to deliver more bed savings once the service is commissioned and additional opportunities can be identified. This would be equivalent to a 5-10% reduction in "Super stranded patients" with the Trust being given the ambition to reduce this cohort of patients occupying hospital beds by 27%.

Together the three service levels will save the equivalent of 15 acute hospital beds.

### 2.7.3 Workforce

The workforce required for the preferred option (4) is:

8 WTE MDA
7.6 WTE Band 6
0.8 Band 7
TOTAL 16.4 wte

### 2.7.4 Staff Consultations/Engagement Plan

Staff movement within therapy services and elsewhere in the organisation means recruitment will be possible and will resolve the issue of overstaffing in the community contract. Initial recruitment could be restricted to staff within community services and then opened up to external advert. We anticipate that we will be able to reduce the over establishment of physiotherapists with the recruitment to SDS but may not be able to reduce the Occupational therapy over establishment. Development of rotational posts, secondments etc could be used to cover some of the occupational therapy vacancies within the hospital.

As part of an agreement around Maternity cover we have additional consultant resource within Elderly Care in 2018/19 and the PA's associated with Option 4 could be provided from this resource.

### 2.7.5 Accommodation & Equipment Requirements

Consideration must be given to providing the team with a suitable workspace. To date, they have shared the therapy office, but this is simply not large enough or sustainable in the long term. It is possible, therefore, that there may be some cost implications if additional furniture storage and IT resources are required. We estimate 3 / 4 desks, chairs and lap tops would be required plus a filing cabinet for patient notes and staff files.

Ideally the accommodation would be within an Integrated / Collocated Discharge Team. This is part of the vision for Discharge at Harrogate Hospital and involved colocation of the complex discharge team (HDFT) SDS (HDFT), Social Care (NYCC/Leeds) and Hospital at Home (Carers Resource).

### 2.8 Risk Analysis of Preferred Option

| Risk / Issue | Description | Original consequence | Original likelihood | Original risk | Actions:<br>Either what will be done to realise a benefit OR<br>What will be done to mitigate an ISSUE or RISK |
|---|---|---|---|---|---|
| 1. | A risk of the resistance to the change in culture required to identify patients suitable for the service and 'release' to the community. | 3 | 4 | 12 | • Staff training and promotion of the service when<br>• Develop screening process<br>• Support and develop Integrated Discharge Hub and implementation of the discharge pathways. |
| 2. | A risk that partner agencies do not take over care in a timely manner constraining the capacity of SDS | 3 | 4 | 12 | • Agreement is required between HDFT and partner agencies that patients supported by SDS are able to access social care services such as reablement under the same terms as inpatients |
| 3. | A risk that the service cannot recruit into the different professional roles required with the level of experience and skill required. | 3 | 3 | 9 | • The service will attempt to recruit internally from over established areas, however, there may be a gap in the level of experience and skill required. If that was the case, the team would need support from the organisation to recruit externally. |

### 2.10 Implementation of Preferred Option

Given that the preferred option is to expand the team and recruit to new roles, consideration should be made around the time frame of staff recruitment and the fact that the SDS pilot was intended to only operate until the end of March 2018. Without an agreement that SDS could continue operating in its current form until staff are recruited, a gap in service provision should be anticipated.

Long-term the trust may explore a model of therapy which in reaches in to the acute services but is predominately based in the community. As there may be gaps across the trust for therapy posts there may be opportunity to recruit to shared roles across acute and community services or with partner organisations.

If the situation arises that SDS will temporarily cease to operate, then existing SDS staff would need consultation of some form around their redeployment. Other effected staff within the organisation would need communication around the gap in SDS operation and alternative processes implemented until the substantive team is up and running.

## 2.11 Impact on other services

Consideration should be given as to whether other services will be affected by this implication, together with an analysis of what this impact will be and to what levels. This section will then need to demonstrate that the other departments have been fully engaged and have both the capacity and funding to facilitate this development.

| SERVICE | LEVEL OF IMPACT |
|---|---|
| **Radiology** | None anticipated. |
| **Theatres** | None anticipated. |
| **Medical secretarial** | None anticipated. |
| **Community services** | This could increase demand on community services, but conversations have already been underway for some months and there is a strong appetite to work collaborative between services.<br><br>There is the possibility that this reduces the workload of CCT's (associated with discharge) and also had the potential to reduce POC required and better take up of reablement. |
| **Pathology** | None anticipated. |
| **Therapy services** | Efforts must be made to ensure that SDS complement current therapy provision, rather than detracting from it or undermining it. |
| **Reception support** | None anticipated. |
| **Other hospitals etc.** | None anticipated. |
| **Estates** | If a suitable space can be found for the team to locate to, there may be an element of work required to manage this process. |
| **Land and property** | None anticipated. |
| **Marketing and communications** | We have an exisiting comms strategy for the project and this would be maintained, with assistance from the Improvement & Transformation department as well as Trust Comms. |
| **IT hardware and software/licences** | Lap tops to support mobile working |
| **Medical records** | None anticipated. |
| **Domestics** | None anticipated. |
| **Hotel services including portering, catering, Royal Mail postal costs, couriers / van drivers / transport / taxis, laundry and linen etc.** | May see a marginal increase in activity if throughput on the wards is increased as a result of improved flow. |
| **Clinical coding** | None anticipated. |
| **Information services** | If the service becomes substantive, we may request that current data collection systems are improved upon e.g. amalgamated into existing systems |
| **Finance Department / Commissioner negotiations etc** | None anticipated. |

## 2.12 Post project evaluation

Post Project Evaluation (PPE) is a mandatory part of the business process and has to be undertaken in accordance with the Trust's Capital Investment Manual and the Standing Financial Instructions.

PPEs of service developments/business cases are undertaken via the Trust's "PPE Non Capital Form", an example of which can be found on the Trust's intranet site at http://nww.hdft.nhs.uk/corporate/planning-department/post-project-evaluations/.

This service development/business case will be assessed against the objectives set out within it, as well as ascertaining the strengths or weaknesses of the development, it will provide the opportunity to learn lessons for future developments, share best practices or rectify situations where appropriate.

The PPE will be requested 12 months after approval date and will be issued to the business case author for completion and return to the Planning Department, who will forward the evaluation to the PPE Group and Audit Committee for assurance.

## 3 Recommendation

The Board is recommended to approve option 4 to implement SDS Plus +

# Appendices

## Appendix 1

SWOT Analysis of the pilot Supported Discharge Service

| Strengths | Weaknesses |
|---|---|
| Fully operational and ready to operate beyond March 2018.<br><br>Supporting discharges from all wards including Trinity Ward (RCH) as capacity allows<br><br>Delivers responsive assessment function in the patients usual place of residence – provides rehab in timely manner and reduces need for longer term POC<br><br>Increases patient flow/eases capacity pressures/generates additional income through greater utilisation of beds.<br><br>Reduces length of stay, improves patient outcomes, satisfaction and reduces de-conditioning , promotes quicker recovery (Appendix 6)<br><br>Skilled collective AHP workforce.<br><br>'can do' service.<br><br>Puts patient and family at the forefront of decisions and empowers<br><br>Positive In patient staff feedback<br><br>Able to maintain SDS 24-72 hour input – seamless transfer to other services.<br><br>Supported development of Integrated Discharge Hub and the development Discharge pathways.<br><br>Developing links with community services/NYCC when joint assessing patients.<br><br>Developing joined up working with charitable organisations and out of area services - Neighbourhood team, Red Cross, Age UK | Not Substantive<br><br>Inconsistency of referrals – not offered to all suitable patients -decisions around referrals are dependent upon staff on wards – understanding of service reluctance to refer?<br><br>Possible bridging need for 7 day CATT/AMU OT service.<br><br>Late in the day discharges from Wards.<br><br>NYCC process following NOA/NOD prior to discharge.<br><br>Office Space<br><br>Reduced capacity when working out of area and with unfamiliar teams See Appendix 13 for information regarding numbers of out of area patients<br><br>Referrals assessed not suitable for SDS |

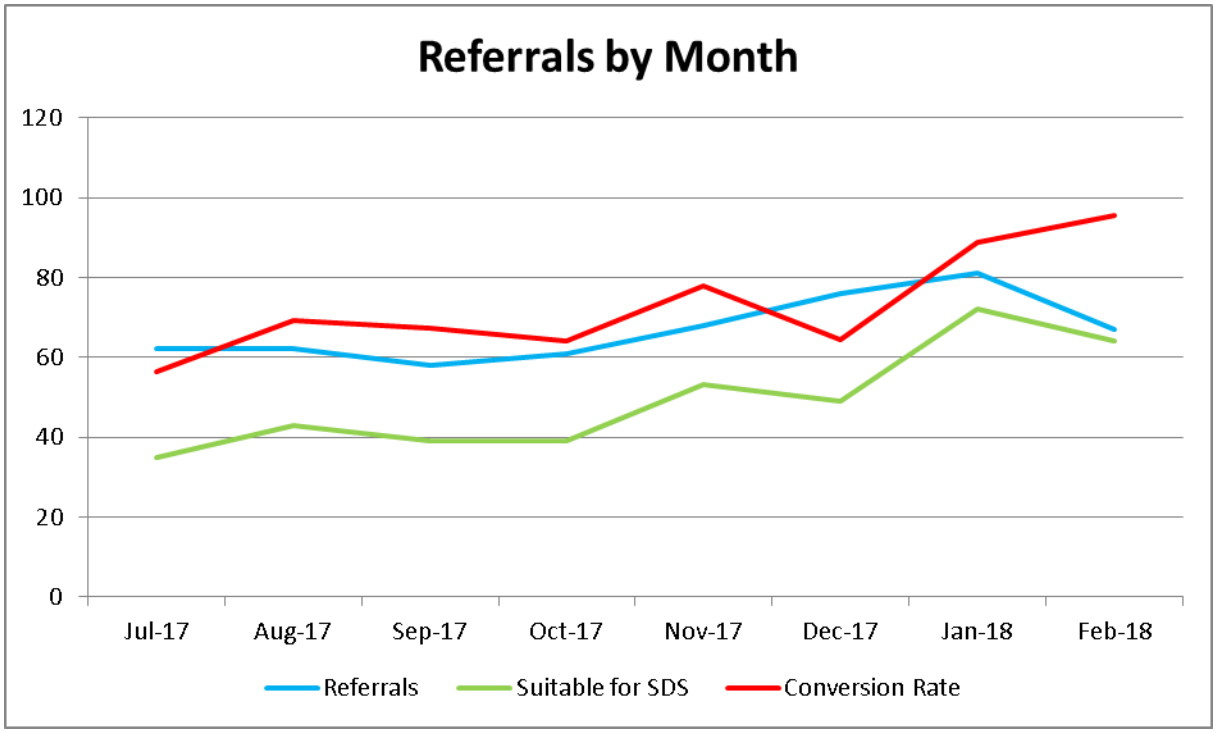
| Opportunities | Threats |
|---|---|
| Developing SDS skill base to help reduce impact on other services.<br><br>Further development of the MDA role within the team.<br><br>Support further development of Integrated Discharge Hub and D2A discharge pathways<br><br>Co-locate with Discharge Liaison Team - Office<br><br>Avoid duplication of assessment if SDS paperwork follows patient<br><br>Ideally placed to develop Trusted Assessor role<br><br>Further develop links with partners, outside agencies and charitable/private organisations.<br><br>Develop Screen tool and assessment to reduce time wasted in the initial screening process<br><br>Develop Well being check list and signposting – support necessary readmissions and referrals to community services.<br><br>More detailed learning by linking in with similar<br><br>teams established in other Trusts<br><br>Develop team further with learning gained from winter funded beds – appendix<br><br>ED assessment? | Cultural resistance to change<br><br>Reduction in team capacity following end of winter funded and Vanguard posts – especially around supporting Greenfield Court Beds<br><br>SDS capacity when bridging Long term POC or when hand overs to other agencies are delayed.<br><br>Pressure on other services financial targets/objectives.<br><br>Readmissions<br><br>Not making the service Substantive<br><br>Loosing the split post Band 6 secondment |

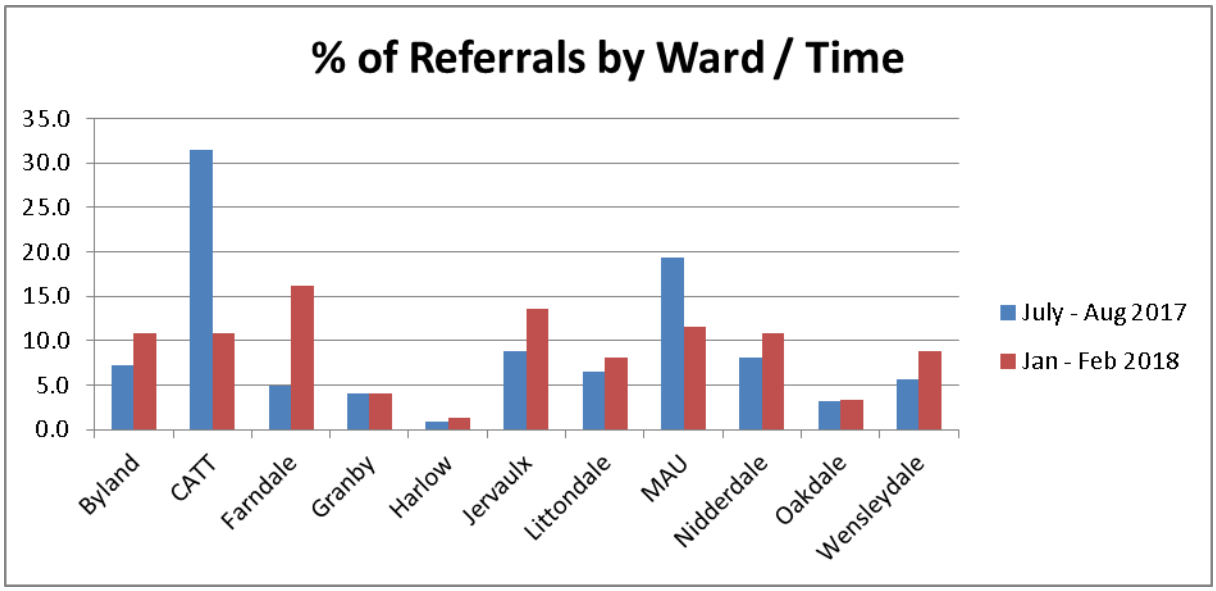
**Appendix 2**

# Data analysis for SDS ahead for use in Business Case March 2018

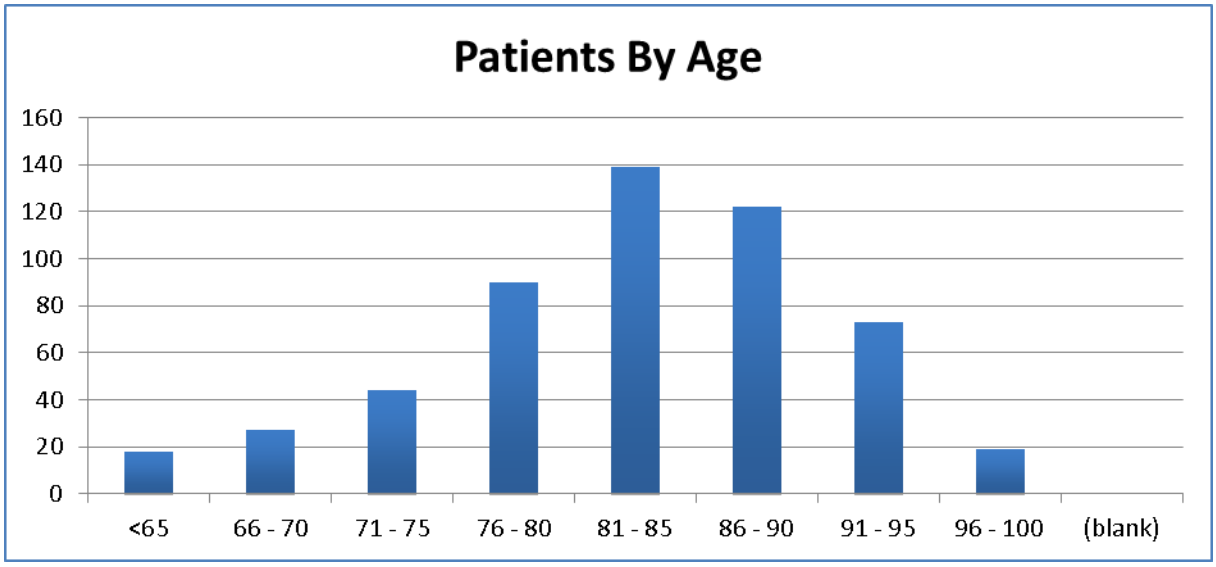
- The first patients were referred to SDS on 10th July 2017.
- Data analysis covers the period between 10.07.17 – 27.02.18
- The number of referrals by month has remained broadly consistent, although a reduction in September 2017 is largely reflective of staffing issues and the spike in December and January stems from increased staffing resource.
- But of particular note is the continual improvement in the conversation rate as the service has become more embedded and staff better understand the role it plays. This figure has risen by 69% since July 2017, when just over half (56.5%) of patients were deemed suitable, to February, where 95.5% of referrals were appropriate for supported discharge.
- This inevitably means that time and staff resource is being used far more efficiently and effectively as the majority of patients referred and assessed can be supported, rather than being assessed as inappropriate for SDS.

| | Referrals | Suitable for SDS | Conversation Rate (%) |
|---|---|---|---|
| July 2017 (from 10th) | 62 | 35 | 56.5 |
| August 2017 | 62 | 43 | 69.4 |
| September 2017 | 58 | 39 | 67.2 |
| October 2017 | 61 | 39 | 63.9 |
| November 2017 | 68 | 53 | 77.9 |
| December 2017 | 76 | 49 | 64.5 |
| January 2018 | 81 | 72 | 88.9 |
| February 2018 | 67 | 64 | 95.5 |
| **Total** | 535 | 394 | |
| **Monthly Average** | 67% | 50% | 73.0 |



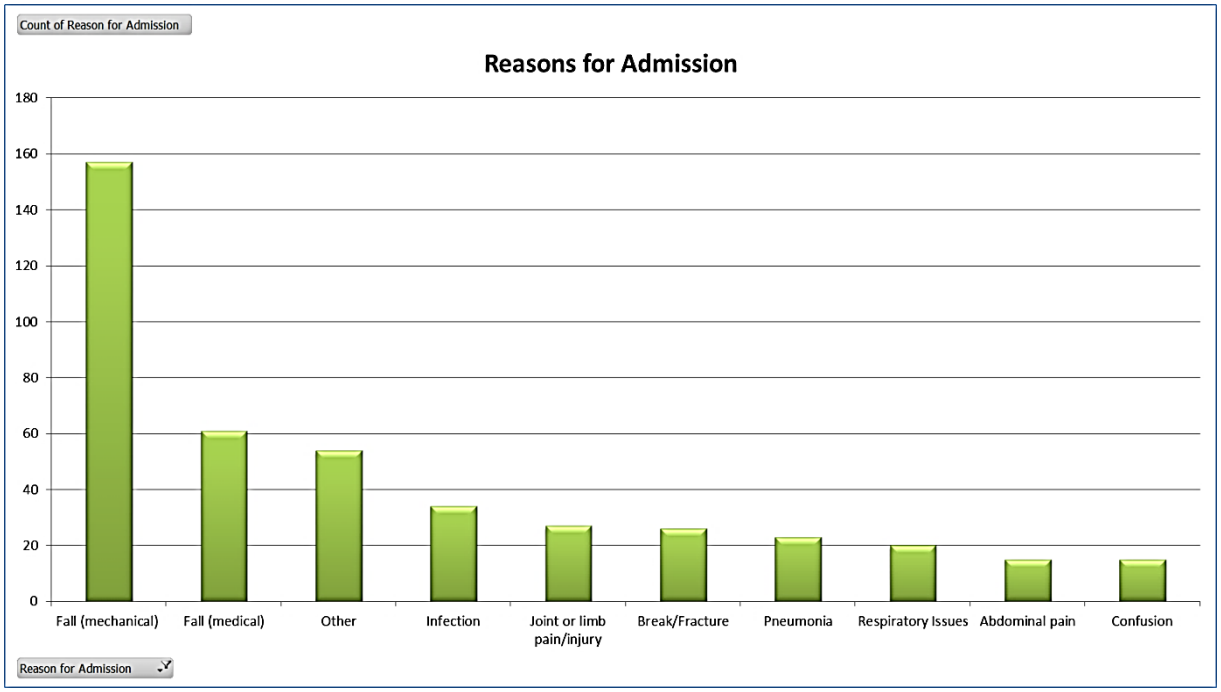




- Patient demographics haven't shifted much since the service began and the majority of patients supported are aged between 76 – 95, with the largest cohort being those aged 81-85.



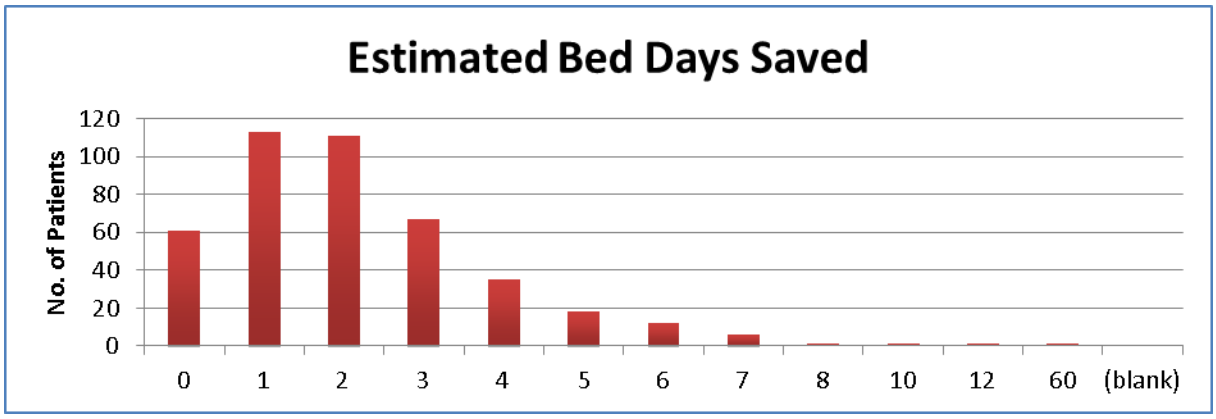

- We have in excess of 30 categories for "Reason for Admission" but the Top 10 most common are illustrated below.

- Although "other" remains a large category, we have continually attempted to refine this when frequently occurring reasons for admission arise. However, there are a significant number of patients whose unique presentation means there is little point establishing a category for just one-off instances.




- Although not an exact science, the SDS team have continually attempted to quantify the positive impact they have had by estimating how long the patients might have otherwise remained in an acute bed, were it not for their intervention.

- These figures are usually based upon the original EDD (Estimated Date of Discharge), plus discussions with the ward staff and complex discharge team.
- The general pattern of these (i.e. and average reduction in LoS of 1-2 days) has remained consistent.




- Assuming these are broadly accurate, we can estimate that to date, the SDS team have reduced bed occupancy by 975 days, which is comfortably in excess of 100 bed days per month.

- Data capture records the number of "units" i.e. clinical input, that each patient receives, either in person or otherwise. This can then be quantified in hours that illustrate Multidisciplinary Assistants provide almost half of the overall provision to patients.

| | Face to Face | | | Non- Face to face | | |
|---|---|---|---|---|---|---|
| | **OT** | **Physio** | **MDA** | **OT** | **Physio** | **MDA** |
| **Hours to date** | 324.5 | 294.75 | 592.25 | 316.75 | 301.75 | 490 |
| **As a percentage of input** | 26.8 | 24.3 | 48.9 | 28.6 | 27.2 | 44.2 |

- We are also able to confirm that based upon the number of patients supported by SDS, the average number of hours input per individual equates to 5.9 hours.
- Data demonstrates that most referrals are assessed within less than four hours.
- The average lead time between assessment and discharge varies between 3-5 days.
- We also keep track of the onward referrals to third party agencies, even though they make a comparatively small proportion of overall. These presently look like this:

| Row Labels | Count |
|---|---|
| CCT Rehab | 29 |
| Integrated Reablement Service | 11 |
| Other | 20 |
| Other voluntary sector | 6 |
| Redcross | 2 |
| (blank) | |
| Independence Co-ordinators | 3 |
| SS Reablement | 17 |
| **Grand Total** | **88** |

## Appendix 3

**Patient Satisfaction**

Patient satisfaction questionnaire a simple format has been adopted by the team - the intention of the questionnaire is to gain information about what the service does well and not so well and is used alongside The Therapy Outcome Measure (TOMS) – to be discussed in Key performance indicators;

Below are key positive patient feedback comments following SDS input.

*'treated as human beings not commodities.....we found no faults at all, so you cannot improve on the best'*

*'the team were encouraging throughout and they taught 'her' to be patient with herself'*

*'Thank you for the discharge service my husband received coming into hospital, ...everybody has been kind and caring and catered for our every need. Wonderful staff excellent'*

*'When my husband was discharged from hospital everyone was so kind and helpful to him and got things for him to help with day to day things and we could not have managed without them'*

*'I am very pleased with everything the support team have done for me, they are all lovely and very kind'*

*'Am very pleased this was very helpful and encouraging'*

*'you (SDS) got my mother out of the hospital where she was getting very 'lazy' and got her back to her own home where she wants to be'*

*'most helpful and considerate in all areas'*

*'provide assistance with cheerfulness at time stated. This is so helpful and reassuring. My husband's discharge was painless'*

**Appendix 1**

# Clinical Workforce Strategy
# Year 1 Review and Year 2 Planning Update – June 2018

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

*Key Performance Indicators:*

Growing our Capability – develop a sustainable, high quality, competent workforce

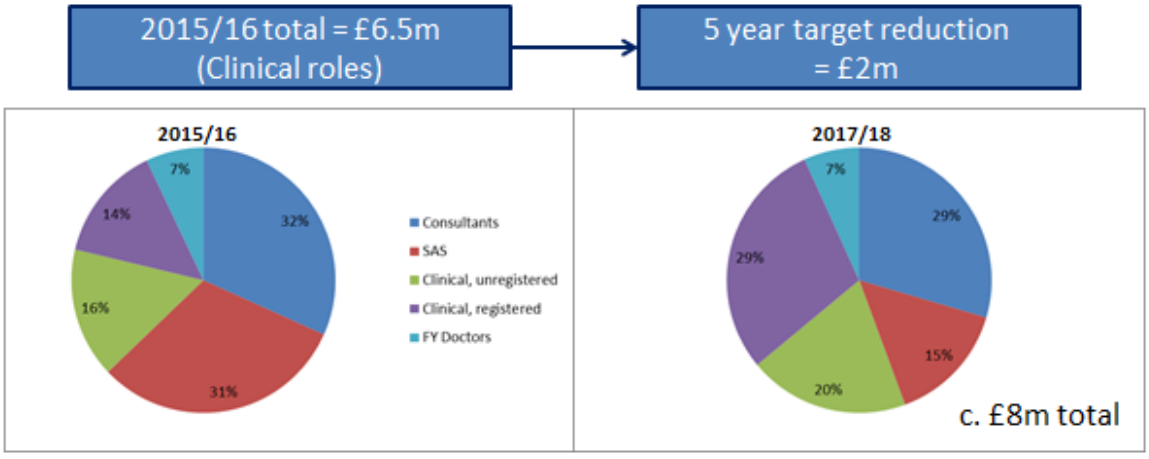
Staff Engagement – create an engaged and motivated workforce and a performance improvement culture; to be an employer and provider of choice

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

A year into the strategy we have developed the foundations of our key performance indicators within the Clinical Workforce Strategy; with a particular focus on the 'Growing our Capability' performance indicator. This was demonstrated by the schemes and initiatives shared in last month's Workforce and Organisational Development report to Board.

We held workshops in May and June with the three Clinical Directorates with the intention of reviewing our progress against the delivery of the strategy, the development of our year 2 priorities, as well as he identification of any new or emerging challenges. As part of these workshops the Workforce & Organisational Development team presented 'the story so far!' and shared some key insights;

Diagram 1.1. Temporary Staffing Spend




- The overall clinical temporary workforce spend from 2015/16 to 2017/18 increased by c.£1.5m
- Significant decrease in temporary spend on Specialty and Associate Specialty (SAS) Doctors - down 42.2% from 2015/16 (reduction of £863k), which has

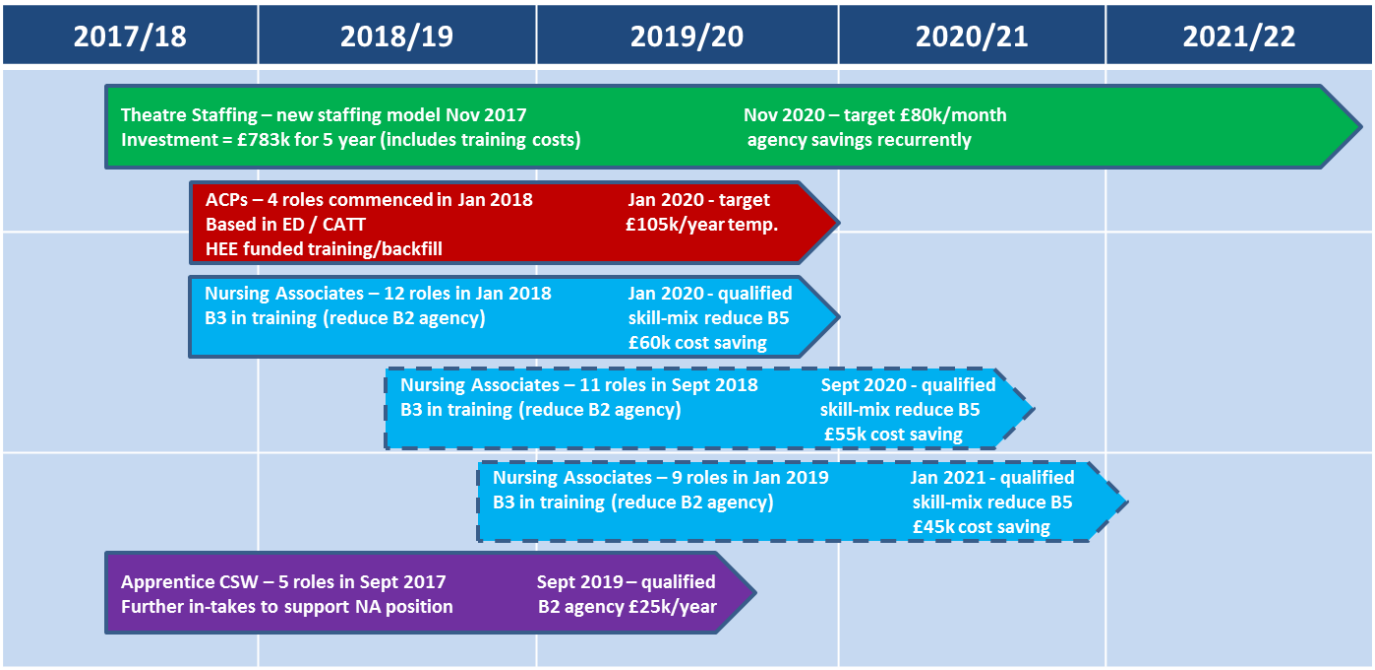
been impacted by successfully recruiting to permanent roles and the introduction of a rotation and development programme to support career progression.

- Significant increase in temporary registered workforce spend - up 150% from 2015/16 (increase of £1.4m)
- Significant increase in temporary unregistered workforce spend - up 50% from 2015/16 (increase of £522k)

In light of this changing position, it has been identified that the original £2million reduction target for temporary spend should now be adjusted to reflect the increases seen and the new target for delivery will be £3.5million.

The current planned schemes already target a reduction of temporary staffing spend by £2million to the end of the strategy in 2022 (shown in diagram 1.2.). It is critical that more schemes are identified and developed in order to address the remaining £1.5million gap.

Diagram 1.2. Planned CWS schemes



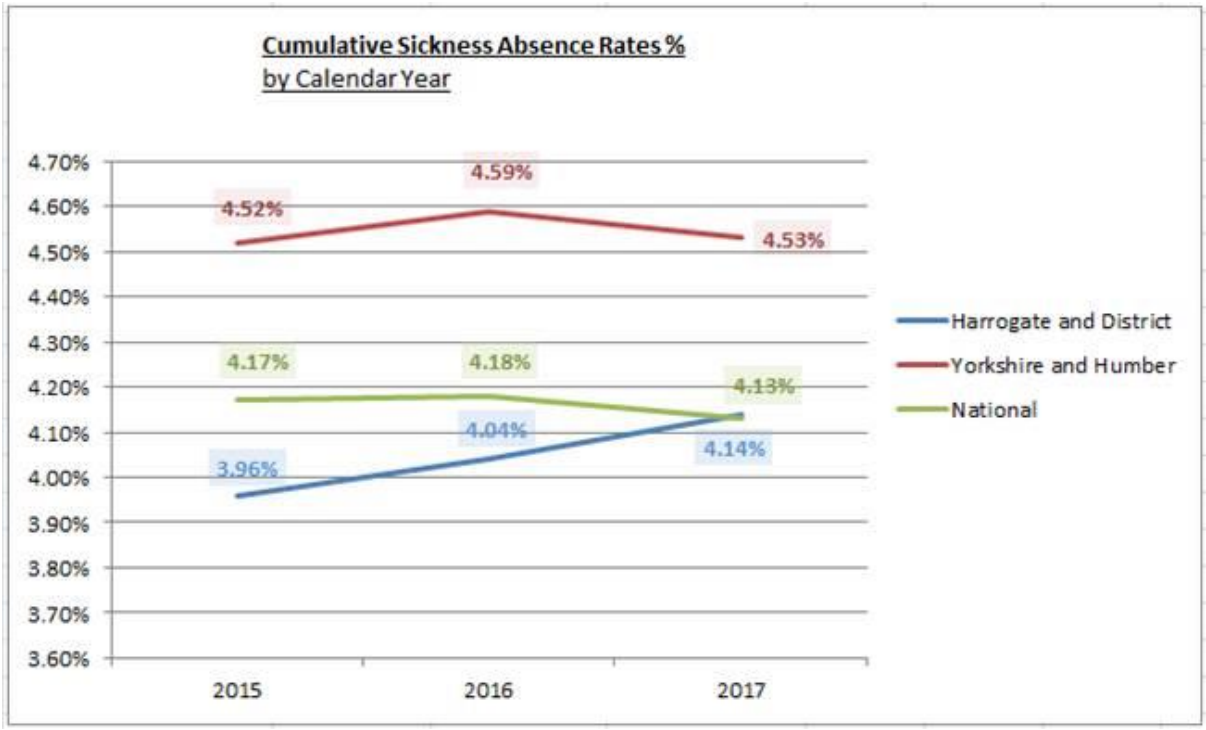

The Trust launched an Agency Master vend for Medical and Dental staff with Medacs, and a Direct Engagement Platform with Liaison 2017. Significant benefits have already been seen since implementation:

- Fill rates have improved significantly from 39% (under the previous Neutral Vend model) to 70% year to date.
- Direct Engagement generated savings of £20k in 2017/18 with future bookings up October 2018 already projecting savings of over £50k.
- 75% of all Medical and Dental agency bookings are going through the Direct Engagement Platform since its launch in 2017, in the last three months this has consistently been at 95% or above.

In addition, the overall Trust sickness absence has increased from 3.96% in 2015 to 4.14% in 2017 (at a cost of £3.9million); this is in line with the National picture and benchmarks significantly lower than other Trusts in the Yorkshire and Humber region. The two main reasons for sickness absence within the Trust with the highest associated cost remain stress, anxiety and depression (25% of overall Trust absence) and Musculoskeletal absences (20% of overall Trust absence). As such, the continued development of our Staff Health and Wellbeing offer is a key enabler to the delivery of the clinical workforce strategy.

Failure to achieve the targeted increases in the staff survey for the Health and Wellbeing initiatives in this area, in line with the CQUIN targets for 2017/18, indicate that there is an opportunity for us to do more in this area and we need organisational support to deliver invest to save schemes in these areas.

Diagram 1.3 – Sickness Absence for a rolling 12 months Jan-Dec




During the workshops a number of priority areas were identified as areas of focus for the year two priorities and we are currently working with the Directorates to agree the priority actions for 2018/19 under each of the key performance indicators, highlights of these include:

Growing our Capability

- Further development of our Nursing Associates programme for Planned & Surgical Care and Long Term and Unscheduled Care in September 2018 and January 2019
- Establish and implement a robust approach to reducing temporary workforce spend on enhanced care requirements within in-patient wards

- Expansion of our apprenticeship programmes to maximise our return on the Trusts contribution to the Apprenticeship levy
- Testing and evaluating Physicians Associate roles within Planned & Surgical Care – roles to commence in September 2018
- Review of medical staffing models in key medical staffing specialities to develop sustainable workforce models i.e. Paediatrics, Acute Medicine, Gastroenterology, Oncology
- Progression model for ACPs being developed as we look to increase the pipeline of these now established roles
- Maximising our efforts to fill all the registered nurse places on the Harrogate BSc Adult Nursing pathway programme and tie in our future registered nurse workforce

Staff Engagement

- Promotion of the Trust's staff Health & Well-Being strategy and communication plan to feedback on "You said, we did…"
- Development of more 'invest to save' schemes to target high absence reasons
- To get back to basics in understanding what would improve the working lives of our staff
- Ensuring sufficient engagement with staff relating to new schemes within the Trust and to include lessons learned from previous staff consultations

Productivity & Efficiency

- Implement internal bank system for medical and dental staff and develop collaborative approach across the ICP
- Review approach to attendance management within the Trust and refresh
- Develop career pathways and reward packages for staff in key clinical staff groups, that is sufficient to fill our workforce gaps substantively, with key focus on CSW and Registered Nursing roles within inpatient wards and Theatres
- Review flexible working opportunities to ensure we can respond to the changing needs of staff throughout their working lives, with a particular focus on working longer

The identified priorities and detailed plans for each clinical Directorate will be finalised in July. It is suggested that these are likely to be monitored going forward on a quarterly basis through the Workforce Efficiency Group and Workforce and Organisational Development Steering Group, where appropriate, as previously this was part of the Clinical Transformation Board.

**Joanne Harrison, Deputy Director of Workforce and Organisational Development**
**John Haigh, Project Manager, PMO**

Harrogate and District
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Date of Meeting:** | 27 June 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:** | 1. Pay Award to Agenda for Change staff agreed by Trade Unions<br>2. Tier 2 Visas for medical staff blockage removed by Home Office<br>3. NHS North Talent Board established | | |
| **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:<br>• **Note** the content of the report and comment as required | | | |

**Key messages for June 2018**

### a) Clinical Workforce Strategy Update

Following the brief report given at the May meeting of the Board of Directors, and workshops which have taken place since, I attach the detailed review and planning update report on the Clinical Workforce Strategy at Appendix 1 to this paper.

### b) Sickness Absence

The overall sickness absence rate across the Trust for April 2018 was 4.23% which is a decrease from March of 0.28% and continues a steady decrease in the absence rates across the Trust each month from January 2018. However, this does remain above the overall Trust target of 3.9%.

During the last few months (December 2017 to March 2018) there has been a continuous increase in short-term sickness; however, short term absence has reduced in April 2018. Short- term sickness was 2% and long-term sickness was 2.23%. There has been a decrease in absence rates across three of the four Directorates (including Corporate 1.89% compared with 1.98% in March), Children's and Countrywide (4.75% compared with 5.36% in March) and Planned and Surgical Care (4.15% compared with 4.84% in March). The Long Term and Unscheduled Care Directorate experienced an increase in April to 4.59%, from 4.36% in March. The main reasons for short-term sickness absence remain cold and flu and gastro reasons; whilst the top reasons for long-term sickness absence continue to be anxiety/stress and musculo-skeletal issues.

The attendance management lead remains focused on driving down sickness absence rates across the Trust. With support for line managers in managing absence in accordance with the Managing and Promoting Health and Wellbeing Policy by actively creating action plans to support employees to maximise their attendance and where possible their return to work.

### c) Agenda for Change Pay Award

The staff side of the NHS Staff Council met on 8 June to discuss the results of the trade union consultation exercises on the proposed deal for Agenda for Change staff. It was reported that the consultation outcome was positive, and that the staff side of the NHS Staff Council has decided to accept the proposed deal. All trade unions voted in support of the proposed deal with the exception of GMB. The parties will now jointly write to the NHS Pay Review Body informing them of the ballot result.

The full NHS Staff Council will need to meet to formally ratify the deal, and this is scheduled to take place on 27 June 2018. A revised Terms and Conditions handbook will be published following this meeting, alongside pay and terms and conditions advisory notices.

Staff will be paid the new rates of pay in their July pay and where appropriate pay will be backdated to 1 April 2018; this is likely to occur in August's pay at HDFT. NHS Employers will be publishing resources to assist employers in the implementation of the deal over the next few weeks. Full details of the changes will be available on the NHS Employers website. Once these are available a full communications plan will be developed to inform Agenda for Change staff about the transitional arrangements.

### d) Staff Appraisal Rates

Following the agreement of the Senior Management Team, the appraisal window opened on 1 April and will close on 30 September. With this in mind, the majority of staff (87%) who had an appraisal in the window last year will be due for renewal during this period.

There are some infographics on the appraisal toolkit (available on the Trust intranet) to aid staff and managers, which includes the arrangements for 'Appraisal on a Page' which was introduced last year. 'Appraisal on a Page' is a quick and accessible process which assisted in the improvement of appraisal completion rates in 2017. It should be noted that the methodology of pay progression linked to satisfactory appraisal and objective setting is part of the revised national pay deal for 2018 and is due to be rolled out NHS wide as part of the changes for Agenda for Change staff.

Training and support for managers on group and individual appraisal is available.

As at 31 May 2018 the compliance rates in each Directorate were as follows:

- Corporate 8.49%
- Long Term and Unscheduled Care – 11.51%
- Children's and County Wide Community Care – 12.71%
- Planned and Surgical Care – 10.7%

There are on-going discussions regarding whether the Children's and County Wide Directorate should be included in the Appraisal period. This is still being discussed internally and, if not supported in 2018/19, plans must be made to deliver this in 2019/20. Currently all Agenda for Change staff are within the appraisal period in terms of reporting.

Medical and dental staff are excluded from the appraisal period.

### e) Compliance with timescales for notifying Doctors in Training

Trusts have received a letter from the Executive Medical Officer at NHS Improvement emphasising the importance of observing the requirements of the code of practice *'Provision of information for postgraduate medical training'*. This lays out the commitments to doctors in training that they will be provided with a generic work schedule at least eight weeks before the start of their rotation and with a duty roster at least six weeks in advance. Data on this is being collected by NHS Improvement with a target of achieving 90% compliance.

The rotation starts on 1 August and to date the Trust has provided this information to 88 of the expected 98 doctors in training coming to the Trust. Of the remainder, the Trust has yet to be notified of the names of those who will fill four posts. Forty-seven doctors in training have yet to complete their pre-employment checks and individual reminders are being sent to those doctors in training.

### f) NHS North Region Talent Board

NHS Improvement has established a North Region Talent Board, with a priority aspiration to become far more self-sufficient as a region in filling executive director

posts. As a first step the Talent Board is seeking to build a comprehensive demand and supply picture for both Board and governing body appointments and has put in place a regular quarterly collection for Board and governing body vacancy data. The deadline for the first submission of data was 15 June and I completed the return for the Trust. In the first instance the Regional Talent Board will collate responses and present some high level data at its meeting at the end of June. This will be followed by further in-depth analysis, the outputs of which will be shared with all provider Trusts in the region.

### g) Job Planning

| MAY 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 | 48 | 87.27% | 7 | 12.72% | 0 | 0.00% | 1 | 83.63% | |
| P & SC | 66 | 35 | 53.03% | 30 | 45.45% | 1 | 1.51% | 3 | 71.01% | |
| **Total** | **133** | **95** | **71.43%** | **37** | **27.82%** | **1** | **0.75%** | 0 | **76.68%** | |

| may 2018 JOB PLANNING CENTRAL REPORT - SAS GRADES | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Directorate** | **Number of SAS Doctors** | **Current Job Plans (ie < 12 months)** | **%** | **Job Plans older than 12 months** | **%** | **Number of SAS Doctors with no Job Plans recorded** | **%** | **In progress** | **Previous month current JPs** | **RAG** |
| C & CWCC | 6 | 2 | 33.33% | 4 | 66.67% | 0 | 0.00% | | 33% | |
| LT & UC | 12 | 6 | 50.00% | 6 | 50.00% | 0 | 0.00% | 0 | 41.67% | |
| P & SC | 39 | 15 | 38.46% | 6 | 15.38% | 18 | 46.15% | 0 | 38.88% | |
| **Total** | **57** | **23** | **40.35%** | **16** | **28.07%** | **18** | **31.57%** | 0 | **38.89%** | |

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

The May job planning figures (shown above) show a welcome improvement in the rate of completed consultant job plans across two of the three Directorates, with Children's and County Wide Community Care maintaining a 100% level from the previous month. This shows that concerted effort by the Directorate teams is paying off. As far as the rate for SAS grades is concerned, there has been an improvement in Long Term and Unscheduled Care but offset slightly by a reduction in Planned and Surgical Care. It is expected that agreement on a revised Job Planning Policy, and future arrangements for job planning using the NHS Improvement guidance, can be achieved at the Local Negotiating Committee meeting in July.

### h) Tier 2 Visa Quota Challenges

It has previously been reported that the Trust has suffered some relatively minor delays in the approval of Tier 2 visas for doctors coming to the Trust from outside the European Union. This is because the Home Office has imposed a monthly quota cap on the number of medical staff who can have their visa approved. Other Trusts have had more severe problems.

Following the appointment of Mr Sajid Javid as Home Secretary, and comments by the Secretary of State for Health and Social Care, the Home Office has agreed to review the position. In response Danny Mortimer, Chief Executive of NHS Employers, said that NHS Employers *"welcomed a Government review of the Tier 2 visa system. Many NHS*

*employers could not again get certificates of sponsorship for doctors during May. It is now six months since problems first started and the NHS is fast approaching the major August intake and changeover period for many doctors in training. A speedy, effective solution is urgently needed"*, he continued, *"to clear the backlog, account for any increase in applications linked to the August changeover and provide a sustainable approach to the management of the system."*

I am delighted to report that the Home Office confirmed on 14 June that the cap will be removed for health workers. This is a significant step forward as NHS requests comprise 40% of Tier 2 places requested.

**j) Hallett vs Derby Hospitals NHS Foundation Trust**

Dr Hallett was one of a group of junior doctors employed by the above Trust on the General Surgery F1 rota between 7 August 2013 and 3 December 2013. The doctors were employed on the Trust's Principal Terms of Contract of Employment (F1) (the Derby Contract), which follows the model contract used by all trusts and incorporates provisions of the national Terms and Conditions of Service for NHS Medical and Dental Staff (England) 2002 (the TCS).

The Contract provided that the Trust has a contractual obligation "to monitor junior doctors' New Deal compliance and the application of the banding system through robust local monitoring arrangements supported by national guidance" but neither the Derby Contract nor the TCS set out any details of the system of monitoring that must be undertaken, or how the monitoring was to be done. A different paragraph of the TCS provided that a Band 3 pay supplement will be payable in respect of posts which do not comply with relevant controls on hours and natural rest breaks and referred to three guidance documents published by the (then) Department of Health (DH).

The Trust used Allocate software to manage its monitoring exercises. In the relevant period, the Trust carried out two monitoring exercises. The first monitoring round was a valid round which found the rota to be compliant on natural rest breaks; the second, however, was an invalid round because of insufficient returns, but would have triggered Band 3 uplift had the exercise been valid.

The Trust operated a local process whereby monitoring exercises returning a valid non-compliant result would be re-monitored within six weeks and only where the second monitoring exercise also demonstrated a non-compliant rota would the Trust uplift the banding supplement for the doctors working on that rota (the 'two strikes' approach).

The junior doctors sought a declaration from the High Court that the local variations to monitoring were in breach of contract. Further, they argued that the methods used by the Trust to substitute 'artificial' data, using the Allocate software, were not consistent with the contractual monitoring requirements and/or were irrational because they skewed the results in favour of compliance. Finally, they sought a declaration that the "two strikes" approach adopted by the Trust was not compliant with the contractual banding provisions.

The High Court struck down all the claims except that concerning the 'two strikes' approach. It made a declaration that the "two strikes" approach adopted by the Trust was not consistent with the contractual banding provisions. Accordingly, junior doctors working on a rota which is found to be non-compliant in a valid monitoring exercise are entitled to an enhanced banding supplement immediately (which could be backdated to

the start date of the rota or to the latest compliant monitoring exercise). The case is a reminder however, that banding claims continue to be a real issue in the NHS and contractual clauses and local arrangements must be clear and enforced, and that local monitoring processes are robust and well-documented. The Trust has initiated a 'lookback' exercise to ensure that the arrangements prior to the introduction of the 2016 Terms and Conditions of Service for doctors in training were not in breach of the High Court ruling. This is expected to be completed once arrangements for the August rotation of doctors in training are complete. If any cases are discovered then legal advice will be sought on the potential exposure to legal claims.

**k) NMC Review of Nursing Pathway**

The introduction of the Harrogate Pathway for pre-registration nursing students applying to undertake their study with the University of York, with all placements being located within HDFT and subject to a commitment agreement, triggered a Nursing & Midwifery Council (NMC) UK-Wide Quality Assurance Framework review. This review of the degree programme with the University of York by the NMC was because the NMC considered that the alteration of a single provider of placement experience was a major modification of the programme.

The NMC review took place in March 2018, and I am delighted to advise that the Harrogate Pathway was approved, subject to the actions in the report and action plan being completed. Progress on the action plan will be monitored through the Workforce and Organisational Development Steering Group and the Quality Committee.

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

Appendix 1: Clinical Workforce Strategy – Review and Planning Update June 2018

Harrogate and District
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Date of Meeting:** | 27 June 2018 | **Agenda item:** | 10.0 |
| **Report to:** | Board of Directors | | |
| **Title:** | Chief Nurse Report | | |
| **Sponsoring Director:** | Jill Foster, Chief Nurse | | |
| **Author(s):** | Jill Foster, Chief Nurse | | |

**Report Purpose:**

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

**Executive Summary:**

- The risk remains high regarding Registered Nurse vacancies on in-patient wards. Nurse recruitment and retention initiatives continue to show a challenging but improving position.
- The actions being undertaken to maintain safe staffing levels, quality of care and reduce cost.
- HDFT is participating in the NHSi Collaborative to improve Enhanced Care.
- The total number of category 2, 3 and unstageable pressure ulcers in the community has increased in May. The total number of hospital acquired pressure ulcers has increased in May but category 3 and unstageable pressure ulcers have remained the same.
- The total number of falls has decreased in May, there has been three falls resulting in fractures.

**Related Trust Objectives**

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

**Key implications**

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

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

- Be **assured** by the work being undertaken to improve of nurse recruitment and retention and the governance process for assuring safe staffing levels
- Be **informed** of actions being undertaken to maintain safe staffing levels, quality of care and reduce cost.
- **Note** the action being taken regarding Director Inspections and Patient Safety Visits
- **Note** the increase in community and hospital acquired pressure ulcers in month
- **Note** the work around falls reduction
- Be **assured** about the monitoring of care provided by the CCT's
- **Note** the number of complaints in 2017/18
- **Note** HDFT is participating in NHSi Collaborative to improve Enhanced Care.

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

## Patient Safety

### 1. Nurse Recruitment

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

1.1 The Trust's Recruitment and Retention Working Group continues to work toward zero vacancies. Services and departments are continuously recruiting. The next recruitment event is planned for July 2018.

1.2 In April Long Term and Unscheduled Care (LTUC) had **19.28** RN Band 5 vacancies across their inpatient areas, in May there are **18.66** RN Band 5 vacancies. In April LTUC had **7.53** Care Support Worker (CSW) vacancies, in May they have **3.36**.

1.3 In April Planned and Surgical Care (PSC) had **10.24** RN Band 5 vacancies across their in-patient areas, in May they have **11.07**. In April PSC had **0** CSW vacancies, in May they have **1.61**.

1.4 In Main Theatres there are **12.58** Band 5 vacancies in May, there were **11.58** vacancies in April.

1.5 Current situation on Adult in-patient wards

| Ward | Registered Nurses | | | CSW's | | |
|---|---|---|---|---|---|---|
| | Est. | Vac. | % | Est. | Vac. | % |
| Acute Admissions Unit | 23.27 | 0.4 | 2% | 15.65 | 0.72 | 5% |
| Byland | 17.04 | 0.58 | 3% | 21.12 | 0 | 0% |
| Clinical Assessment Team | 25.03 | 10.91 | 44% | 18.22 | 1.24 | 1% |
| Granby | 12.47 | 0 | 0% | 12.51 | 0 | 0% |
| Jervaulx | 17.04 | 1.3 | 8% | 21.12 | 0.43 | 2% |
| Lascelles | 10.76 | 0 | 0% | 10.68 | 0 | 0% |
| Oakdale | 25.05 | 5.47 | 22% | 16.04 | 0 | 0% |
| Trinity | 11.01 | 0 | 0% | 13.27 | 2 | 15% |
| **Total** | **141.65** | **18.66** | **13%** | **128.61** | **3.36** | **3%** |
| Farndale | 13.92 | 3.39 | 24% | 16.32 | -0.74 | -5% |
| Wensleydale | 16.74 | 0.21 | 1% | 11.51 | 0.21 | 2% |
| Littondale | 18.17 | 0.73 | 4% | 13.44 | 0.69 | 5% |
| Nidderdale | 18.32 | 3.53 | 19% | 14.92 | 0 | 0% |
| Harlow | 10.51 | 1.45 | 14% | 3.46 | 1.45 | 42% |
| ITU | 31.53 | 1.76 | 6% | 2.4 | 0 | 0% |
| **Total** | **109.19** | **10.24** | **9%** | **62.05** | **1.61** | **3%** |
| Emergency Department | 30.52 | 6.97 | 23% | 8.25 | 0 | 0% |
| Community Care Teams (CCTs) | 52.60 | 3.23 | 6% | 33.0 | -1.14 | over |

| | | | | | | |
|---|---|---|---|---|---|---|
| Main Theatres | 43.0 | 12.58 | 29% | - | - | - |
| Maternity Unit | 66.73 | 0.18 | 0.2% | 12.05 | 0.33 | 2.7% |
| Woodlands | 19.20 | 1.46 | 8% | 6.80 | 0.16 | 2% |
| SCBU | 11.36 | 0.93 | 8% | 2.0 | 0 | 0% |

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

A '-' number (-0.74 CSW on Farndale and -1.14 CCT) indicates an over establishment.

1.6 Is the situation improving?

The nursing vacancy situation has improved in May for the in-patient areas of LTUC and has deteriorated for the in-patient areas of PSC.

In May 2018, the Band 5 vacancies in the Emergency Department remain the same. The Band 5 vacancies in Main Theatres are worse by 1.0 WTE.

Vacancies in Maternity and Paediatrics in May 2018 have improved but have deteriorated in the CCTs.

1.7 As I reported last month the current number of vacancies means there are significant gaps in the planned rosters for the wards. On a daily basis we continue to take action to mitigate the risk due to staffing gaps by:

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

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

1.9 Actions being undertaken by the Chief Nurse (CN) to maintain safe staffing levels, quality of care and reduce cost:

- Daily scrutiny of numbers of beds that need to be open;
- Staffing gaps reviewed daily;
- Participation in NHSi Enhanced Care Collaborative;
- On 6 May 2018 I met with the Ward and Department Managers, Matrons and Heads of Nursing (HoN) and Midwifery to discuss the financial situation and what action needed to be taken to avoid an overspend in ward and department budgets;
- On 12 June 2018 I again, met with the Ward and Department Managers, Matrons and Heads of Nursing (HoN's) and Midwifery to issue the challenge to 'Live within Budget'. I have since issued a communication to all ward and department teams;
- I am continuing to meet with all Ward and Department Managers with their Matrons, HoN's and Head of Midwifery to discuss their budgeted staffing;
- I am to benchmark wards at HDFT with wards at organisations identified by NHSi to compare nurse staffing levels; and
- NHSi Nurse Staffing Review being planned for July 2018.

Whilst there are a number of reasons why the wards are overspent there is particular concern about the use of staff over and above the planned staffing levels for enhanced or 1:1 care.

Below is a table comparing the average Trust fill rate for actual v planned staffing levels from April to May 2018.

| 2018 | Day | | Night | | Care Hours Per Patient Day | | |
|---|---|---|---|---|---|---|---|
| Trust Total | RN fill rate | CSW fill rate | RN fill rate | CSW fill rate | RN | CSW | Overall |
| April | 94% | 112.8% | 97.3% | 143.1% | 4.60 | 3.50 | 8.10 |
| May | 96.2% | 107.4% | 97.8% | 121.4% | 5.15 | 3.49 | 8.64 |

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

**2. Unannounced Directors' Inspections and Patient Safety Visits**

2.1 The Board of Directors is aware the current formats of Directors Inspections and Patient Safety Visits are under review. There will be a proposal at the Director Team meeting on 28th June for discussion and agreement.

## Patient Outcomes

**3. Pressure Ulcer Target 2018/19**

3.1 As I have previously discussed, the pressure ulcer reduction target in 2017/18, in both the hospital and the community, is to reduce the number of avoidable category 3 and 4 pressure ulcers to zero. I will have the final result from the remaining RCAs from 2017/18 in July.

The pressure ulcer reduction target for 2018/19 continues to be to reduce the number of avoidable category 3, 4 and unstageable pressure ulcers to zero. In addition, I have provisionally challenged the teams to reduce the total number of hospital acquired pressure ulcers by 15%.

In January 2018 I reported there had been an increase in the number of community acquired category 3 and unstageable pressure ulcers particularly in Harrogate North and South CCTs. The numbers in February 2018 remained about the same. In March and April 2018 there was a reduction in category 3 and unstageable pressure ulcers across all the CCTs. There has been an increase in May 2018.

January 2018 also saw a rise in hospital acquired pressure ulcers categories 2-3 and unstageable. I was pleased to report the number of hospital acquired pressure ulcers categories 2-3 and unstageable was significantly lower in February 2018 but there was an increase in March 2018. There was a significant decrease of pressure ulcers (all categories) in April 2018. In May 2018 the number of category 2 hospital acquired pressure ulcer has increased but the number of category 3 and unstageable is the same. There was no category 3 or unstageable pressure ulcers in LTUC.

**4. Falls**

4.1 I am continuing to monitor the total number of falls per month and the number of falls resulting in fracture.

In April 2018 there was a total of **68** falls compared to **63** in April 2017. In May there has been a total of **52** falls compared to **55** in May 2017. There has been **three** falls resulting in fractures in May, one was a fractured neck of femur. Falls that result in fractured necks of femur are now categorised as 'severe harm'.

**5. Quality of Care in the Community (Adult Community Care Teams in Harrogate)**

5.1 Since December 2017 to date the CCTs have been experiencing significant pressure. Demand on the service coupled with the teams' capacity has meant the community OPEL score daily, has fluctuated between 2 and 4. This continued throughout the first three months of 2018. In April 2018 the OPEL level fluctuated between 2 and 3. This has continued in May. Workload is reported as manageable.

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

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

## Patient Experience

**6. Complaints**

6.1 The number of complaints received in May 2018 is 24.

Of the complaints received in May 2018, 21 have been graded Yellow and three Green.

6.2 The number of complaints received by month, year to date (YTD) compared with the previous three years is shown below.

**Total number of complaints by month for 2018/19 compared to the previous three years.**

| | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | March | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **2018/19** | 15 | 24 | | | | | | | | | | | |
| **2017/18** | 16 | 21 | 16 | 11 | 22 | 16 | 20 | 14 | 14 | 26 | 8 | 26 | **209** |
| **2016/17** | 18 | 16 | 24 | 21 | 25 | 19 | 19 | 18 | 9 | 14 | 26 | 25 | **234** |
| **2015/16** | 26 | 18 | 30 | 15 | 17 | 26 | 11 | 9 | 12 | 12 | 21 | 16 | **213** |

**7. NHSI Collaborative for Improving Enhanced Care**

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

The objective of the project is to:

- Develop a robust Assessment Tool
- Strengthen the escalation process
- Ensure there is a review of enhanced care requirements every 24 hours
- Include relatives in providing care
- Provide better quality of care when 1:1 care is required

The project formally ends 10th July 2018. I will update the Board of the outcomes at the next Board Meeting.

**Jill Foster**
**Chief Nurse**
**June 2018**

**Appendix One**

## Actual versus planned nurse staffing - Inpatient areas

The table below summarises the average fill rate on each ward during **May 2018.** The fill rate is calculated by comparing planned staffing hours and actual staffing achieved.

In addition we are required to submit information on the total number of patients that were on each ward throughout the month – this is then used to calculate the "Care Hours per Patient Day" (CHPPD) metric. Our overall CHPPD for May was **8.64** care hours per patient per day.

| | **May-2018** | | | | | | |
|---|---|---|---|---|---|---|---|
| | **Day** | | **Night** | | **Care hours per patient day (CHPPD)** | | |
| **Ward name** | **Average fill rate - registered nurses/ midwives** | **Average fill rate - care staff** | **Average fill rate - registered nurses/ midwives** | **Average fill rate - care staff** | **Registered nurses / midwives** | **Care Support Workers** | **Overall** |
| AMU | 97.9% | 106.9% | 100.0% | 137.6% | 4.56 | 3.24 | 7.80 |
| Byland | 90.1% | 113.7% | 85.2% | 133.3% | 3.05 | 4.57 | 7.61 |
| CATT | 96.2% | 121.5% | 95.2% | 115.3% | 5.72 | 3.98 | 9.70 |
| Farndale | 86.4% | 98.9% | 100.0% | 112.9% | 3.19 | 3.50 | 6.69 |
| Granby | 100.0% | 126.6% | 100.0% | 98.4% | 3.83 | 3.78 | 7.61 |
| Harlow | 104.8% | 100.0% | 101.6% | - | 6.49 | 1.81 | 8.30 |
| ITU/HDU | 103.1% | - | 101.3% | - | 27.56 | 0.74 | 28.30 |
| Jervaulx | 96.4% | 101.4% | 92.9% | 125.8% | 2.89 | 3.67 | 6.56 |
| Lascelles | 104.7% | 100.0% | 100.0% | 164.5% | 4.67 | 4.77 | 9.45 |
| Littondale | 99.2% | 132.3% | 100.5% | 135.5% | 4.35 | 2.94 | 7.29 |
| Maternity Wards | 100.9% | 87.1% | 97.3% | 83.1% | 16.52 | 4.21 | 20.73 |
| Nidderdale | 95.4% | 85.7% | 105.6% | 103.8% | 3.95 | 3.28 | 7.22 |
| Oakdale | 92.4% | 125.8% | 92.7% | 166.1% | 4.16 | 3.50 | 7.66 |
| Special Care Baby Unit | 94.3% | 37.0% | 102.3% | - | 12.23 | 1.09 | 13.32 |
| Trinity | 114.8% | 84.5% | 101.6% | 100.0% | 3.89 | 3.60 | 7.49 |
| Wensleydale | 92.3% | 151.6% | 101.6% | 143.5% | 3.46 | 3.32 | 6.78 |
| Woodlands | 76.6% | 83.9% | 90.3% | 80.6% | 9.75 | 2.76 | 12.51 |
| **Trust total** | **96.2%** | **107.4%** | **97.8%** | **121.4%** | **5.15** | **3.49** | **8.64** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ED | 95% | 103% | 90% | 106% | | | |

## Further information to support the May data

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

The planned staffing levels on the Delivery Suite and Pannal ward (maternity wards) have been combined to reflect the close working relationship of these two areas and the movement of staff between the wards in response to fluctuating occupancy and activity levels. Some of the care staff gaps were due to vacancies and sickness in May; however a professional assessment was made on a shift by shift basis to ensure that nurse staffing numbers matched the activity.

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

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

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

Harrogate and District
NHS Foundation Trust

| | | | |
|---|---|---|---|
| **Date of Meeting:** | 27 June 2018 | **Agenda item:** | 11.0 |
| **Report to:** | Board of Directors | | |
| **Title:** | Report from the Medical Director | | |
| **Sponsoring Director:** | Dr David Scullion, Medical Director | | |
| **Author(s):** | Dr David Scullion, Medical Director | | |

**Report Purpose:**

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

**Executive Summary:**

- The crude mortality rate decreased to 0.86% in May 2018 (1.07% last month). The Trust HSMR decreased again this month and is now at 105.5 for the rolling 12 months ending There is no update of the SHMI this month on HED (for the second month running) due to a delay in receiving the data from NHS Digital. The Structured Judgment Review of Orthopaedic case notes under way.
- Two new Consultants were appointed during the month, in General and Colorectal Surgery.
- The Trust's annual organisational audit for revalidation has been completed and returned to NHS North. No significant concerns or omissions have been highlighted by the Responsible Officer.
- National funding is available for service redesign where digital advances and Artificial Intelligence are central to the project. The Yorkshire and Humber Digital Pathology Network is actively pursuing funding.
- The Trust has received its annual update on performance from NHS Blood and Transplant. From four consented donors, the Trust facilitated two organ donors resulting in seven patients receiving a life-saving or life-changing transplant during the time period.
- The new endoscopy unit is operational and the Trust received formal notification of the receipt of full JAG Accreditation for 2018.

**Related Trust Objectives**

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

**Key implications**

| | |
|---|---|
| **Risk Assessment:** | None identified. |
| **Legal / regulatory:** | None identified. |
| **Resource:** | None. |

| | |
|---|---|
| **Impact Assessment:** | None. |
| **Conflicts of Interest:** | None identified. |
| **Reference documents:** | None |
| **Assurance:** | Not applicable, this report is reserved to the Board of Directors. |
| **Action Required by the Board of Directors:** | |
| • It is recommended that the Board receives and notes the report. | |

## 1. Mortality update:

The crude mortality rate decreased to 0.86% in May (1.07% last month). The rolling twelve month rate has also slightly decreased, continuing a slow progressive trend across the NHS.

The Trust HSMR decreased again this month and is now at 105.5 for the rolling 12 months ending February 2018 (106.1 last month). This remains within expected levels. At specialty level, 3 specialties have a higher than expected standardised mortality rate – Geriatric Medicine, Respiratory Medicine and Trauma & Orthopaedics.

There is still no update of the SHMI this month on HED (for the second month running) due to a delay in receiving the data from NHS Digital. Despite this, recent SHMI remains below expected levels and I am doubtful any change is likely to have a significant impact either way. I will update the Board when data is available.

The Structured Judgment Review of Orthopaedic case notes, led by Dr Leigh is under way following last month's alert. I will update Board when this is completed.

## 2. GIRFT/Carter update:

I am attending the annual update conference in London on 20 June and will verbally update Board on any matters of importance.

## 3. Consultant appointments:

I am delighted to announce the appointment of two new Consultants in General and Colorectal Surgery. Both are established and experienced Consultants moving from other Trusts.

Miss Clare Mcnaught is currently a Consultant Surgeon in Scarborough. Miss Clare Adams is currently a Consultant in Plymouth. Both are excellent appointments.

Mr Richard Pilling has been appointed as Consultant in Trauma and Orthopaedics with a special interest in lower limb arthroplasty. Mr Pilling has until very recently worked in the department as a Hip Fellow under Mr Conroy. This is an equally impressive appointment from a strong field of candidates.

## 4. Revalidation update:

The annual organisational audit has been completed and returned to NHS North. The Framework of Quality Assurance (FQA) and the monitoring processes within it are designed to support all responsible officers in fulfilling their statutory duty, providing a means by which they can demonstrate the effectiveness of the systems they oversee. It has been carefully crafted to ensure that administrative burden is minimised, whilst still driving learning and sharing of best practice. Each element of the FQA process will feed in to a comprehensive report from the national level responsible officer to Ministers and the public, capturing the state of play of medical revalidation across the country.

The AOA is a standardised template for all responsible officers to complete and

return to their higher level responsible officer. AOAs from all designated bodies will be collated to provide an overarching status report of medical revalidation across England. Where small designated bodies are concerned or where types of organisation are small in number, these will be appropriately grouped to ensure that data is not identifiable to the level of the individual.

The AOA is designed to assist NHS England regional teams to assure the appropriate higher level responsible officers that designated bodies have a robust consistent approach to revalidation in place, through assessment of their organisational system and processes in place for undertaking medical revalidation.

I have not been made aware of any significant concerns or omissions by the Responsible Officer.

**5. Service reconfiguration update:**

National funding is available (Government and matched industry contribution) for service redesign where digital advances and Artificial Intelligence are central to the project. These lend themselves particularly well to delivery of Radiology and Pathology services. The latter in particular is verging on a manpower crisis, with numerous post unfilled nationally and training numbers dwindling.

The Yorkshire and Humber Digital Pathology Network is actively pursuing funding. The aim is for region-wide digital pathology scanning across all Trusts, serving a population of 3-5 million people. Bids up to £10M will be considered. The bid has been shared with the WYAAT pathology group and includes both York and Hull pathology departments. Decisions on allocation of funding are to be made around September 2018.

**6. Research update:**

As of 20 April the Trust is officially “Go Live” for the 100,000 Genome Project. I am indebted to Lead Clinician, Dr Daniel Scott and the support team for their hard work. I believe the Trust has already recruited its first patient into the project.

The Quality Improvement for Surgical Teams (QIST) study was opened for recruitment on 16th May 2018. This is being led locally by Dr Jenny Child and Mr David Duffy with support from infection control and the research office.

Slight changes to national performance metrics have taken place related to the 70 day benchmark. This will have no significant effect on Trust performance.

**7. Organ donation performance:**

The Trust has received its annual update on performance from NHS Blood and Transplant.

From four consented donors, Harrogate and District NHS Foundation Trust facilitated two actual solid organ donors resulting in seven patients receiving a life-saving or life-changing transplant during the time period.

The Trust referred nine potential organ donors to NHS Blood and Transplant's Organ Donation Service during the time period. There were no occasions where potential organ donors were not referred.

A Specialist Nurse was present for five organ donation discussions with families of eligible donors. There were no occasions where a Specialist Nurse for Organ Donation was not present for the organ donation discussion.

The Trust was one of the best performing Trusts for quality of care in organ donation when compared to similar Trusts. HDFT missed zero opportunities out of 14.

This is a vital service and a key NHS legacy theme. Our clinical teams, led by Dr Sarah Marsh are to be congratulated for remaining professional and vigilant at what is a most distressing time for families.

**8. Endoscopy update:**

As well as the new endoscopy unit being operational, the Trust has received formal notification that we have received full JAG Accreditation for 2018. This award was deferred until April 2018 following an improvements required notice on the last assessment. I am pleased to inform the Board that the action plan is complete, changes have been implemented and full accreditation restored. I am grateful to Mr Jon Harrison and Dr Gareth Davies for their clinical leadership and to all of the endoscopy staff who have supported them through a period of significant service upheaval. Data submission for next year begins in June!

| | | | |
|---|---|---|---|
| **Date of Meeting:** | 27 June 2018 | **Agenda item:** | 11.1 |
| **Report to:** | Board of Directors | | |
| **Title:** | Annual Report on progress against the recommendations of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) 2017/18. | | |
| **Sponsoring Director:** | Dr David Scullion, Medical Director | | |
| **Author(s):** | Michael England / Dr Sylvia Wood / Mr David Lavalette | | |
| **Report Purpose:** | **Decision** | | **Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓ |
| **Executive Summary:** | The purpose of National Confidential Enquiries is to assist in maintaining and improving standards of medical and surgical care.<br>This report clarifies the current studies and reports, and provides an update in relation to the action plans developed to meet gaps in practice at HDFT based on National Confidential Enquiry recommendations. There remain challenges in getting progress updates and there are significant delays in progressing some of the actions developed to address recommendations from these studies. We are proposing to review the action plans with the lead clinician and manager with the aim of checking whether outstanding actions are still relevant, then supporting completion of these where possible, and identifying whether others should be transferred to a risk register and the action closed. | | |
| **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 are risks associated with failure to participate in National Confidential Enquiries and with failure to implement recommendations. There are processes in place to ensure the Trust participates and implements recommendations. | | |
| **Legal / regulatory:** | Detail of participation in National Confidential Enquiries is required in Quality Accounts. | | |
| **Resource:** | None. | | |
| **Impact Assessment:** | None. | | |
| **Conflicts of Interest:** | None identified. | | |
| **Reference documents:** | None | | |
| **Assurance:** | Not applicable, this report is reserved to the Board of Directors. | | |
| **Action Required by the Board of Directors:** | | | |
| • To comment on the content of this report. | | | |

## 1. INTRODUCTION

This report outlines Harrogate and District NHS Foundation Trust's response to recommendations from National Confidential Enquiries. The enquiries covered by this report are:

- NCEPOD - National Confidential Enquiry into Patient Outcomes and Death.
- MBRRACE-UK - Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
- NCISH – National Confidential Enquiry into Suicide and Homicide by people with mental illness.

The Standards Policy describes the method for quality assuring the submission of organisational questionnaires, receipt of reports, gap analysis of recommendations and monitoring of action plans.

On publication of the results of a new enquiry, receipt of the report is recorded by the Deputy Director of Governance on the standards database, a lead is proposed and this is reported to Quality Committee. The lead for NCEPOD reports will be an identified lead clinician and the NCEPOD Ambassador. The leads for the other National Confidential Enquiries will be the local reporters.

The leads are asked to ensure that recommendations are discussed in the appropriate fora in the Trust and a gap analysis is prepared for each enquiry to establish the Trust's position in relation to the recommendations. The leads are expected to develop an action plan to address any gaps and this will be reviewed and progress monitored at the Improving Patient Safety Steering Group.

The standards database is used to record the process and to facilitate monitoring. In the event of it proving impossible to action the recommendations, the risks are added to the appropriate risk register in accordance with the Standards Policy.

## 2. REPORT METHODOLOGY

The preparation of this report has involved reviewing the standards database and Improving Patient Safety Steering Group minutes to confirm that the relevant organisation data has been prepared, reviewed and submitted, and that gap analyses and action plans have been prepared, reviewed and progressed for all relevant reports during the time period April 2017 – June 2018. The results of the gap analyses and action plans against the reports published during this period are included to provide assurance of compliance, or progress towards compliance with recommendations.

## 3. NCEPOD

The purpose of NCEPOD is to assist in maintaining and improving standards of medical and surgical care for the benefit of the public by reviewing the management of patients, by undertaking confidential surveys and research, by maintaining and improving the quality of patient care and by publishing and generally making available the results of such activities. NCEPOD is independent of the Department of Health and the professional associations.

Each year, NCEPOD invites organisations or individuals to submit original study proposals for consideration as possible forthcoming studies. Proposals should be relevant to the current clinical environment and have the potential to contribute original work to the subject.

Once a topic has been identified an expert group will identify study themes, determine what questions need to be asked and develop clinical and organisational questionnaires. These are then sent to the NCEPOD local reporter to distribute to relevant clinicians.

NCEPOD local reporters act as a link between the non-clinical staff at NCEPOD and individual hospitals. The role includes compiling and sending datasets requested by NCEPOD and acting as a named contact for information sent by NCEPOD. The HDFT local reporter is Michael England, Governance & Emergency Planning Officer.

NCEPOD ambassadors support both NCEPOD local reporters and their fellow clinicians, working alongside NCEPOD. The HDFT Ambassador is Mr David Lavalette, Consultant Orthopaedic Surgeon.

In November 2014 NCEPOD were awarded the contract by HQIP to undertake the Child Health Clinical Outcome Review Programme (previously run as a part of Centre for Maternal and Child Enquiries (CMACE) and then more recently Royal College of Paediatrics and Child Health (RCPCH)). As a result NCEPOD have undertaken additional studies that focus on children and young people with complex neuro-disability and adolescent mental health.

The Improving Patient Safety Steering Group monitors the progress of all the NCEPOD action plans.

### 3.1. Current position regarding new and open studies

| Study name | Study pack received | Organisational data submission date | Organisational data validated by | Publication date | Current status at HDFT | Notes |
|---|---|---|---|---|---|---|
| Young Person's Mental Health | Dec-15 | Sep-16 | RH | TBC | Organisational Questionnaires completed and submitted - 20/09/16.<br><br>5 Clinical Questionnaires completed and returned. 1 case excluded from study | Study now closed |
| Cancer in Children and Young People Study | Nov-16 | Aug-17 | RH/SW | Autumn 2018 | Retrospective data collection - blank return<br><br>Organisational questionnaire completed and submitted 17/08/2017 | No clinical questionnaires expected for completion due to blank return of retrospective data collection |
| Acute Heart Failure Study | Mar-17 | Jan-18 | RH/SW | Summer 2018 | Organisational questionnaire completed and submitted – 22/01/2018<br><br>5 questionnaires completed and submitted. 1 case excluded from the study | Study now closed |
| Perioperative Diabetes Study | Jun-17 | February 2018 | RH/SW | Winter 2018 | Retrospective data collection submitted- 23/06/17<br><br>5 Surgical and 5 Anaesthetic Questionnaires completed and submitted<br><br>Organisational questionnaire submitted 14/02/2018 | |
| Pulmonary Embolism study | Feb-18 | | | Summer 2019 | Retrospective data collection submitted- 12/04/2018<br><br>Awaiting clinical and organisational questionnaires | |
| Acute Bowel Obstruction study | May-18 | | | TBC | | |
| Long Term Ventilation | | | | TBC | | |

### 3.2. Progress of action plans that remain incomplete

| NCEPOD report name | Date received | Report date for Quality Committee | Lead | Assurance reports scores to Quality Committee - progress on action plans | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | June/July 2018 | February 2018 | August 2017 | February 2017 | August 2016 | Jan / Feb 2016 |
| Each and Every Need | Mar-18 | Jun-18 | Dr A Linden | 2 | N/a | N/a | N/a | N/a | N/a |
| Inspiring Change | Jul-17 | Oct-17 | Dr C Taylor | | | N/a | N/a | N/a | N/a |
| Treat as One | Jan-17 | Apr-17 | Dr D Scullion | 2 | 2 | 2 | N/a | N/a | N/a |
| Acute Pancreatitis study: Treat the cause | Jul-16 | Oct-16 | Mr J Simpson | 2 | 2 | 1 | 1 | N/a | N/a |
| Sepsis study: Just say Sepsis | Nov-15 | Feb-16 | Dr D Earl | Complete | 2 | 1 | 3 | 1 | 1 |
| GIH study: Time to get control? | Jul-15 | | Dr G Davies | 3 | 3 | 3 | 3 | 2 | 1 |
| Subarachnoid haemorrhage: Managing the flow | Nov-13 | | Dr J Smith | 2 | 2 | 2 | 2 | 2 | 1 |
| Emergency & Elective Surgery in the Elderly Report: An age old problem | Nov-10 | | J Hammond | 2 | 2 | | 2 | 2 | 2 |

The progress on action plans has been RAG rated as follows:

| Progress description | Progress score | RAG rating |
|---|---|---|
| *Not applicable (i.e. action plan not in place)* | N/a | |
| *Good – no concerns* | 1 | 1 |
| *Delayed – outline actions delayed with reasons below* | 2 | 2 |
| *Some required actions not achievable – added to risk register* | 3 | 3 |
| *No assurance received* | | |

3.2.1. Elective & Emergency Surgery in the Elderly: An Age Old Problem (2010): Update

This NCEPOD report published in 2010 highlighted the process of care of elderly patients who died within 30 days of emergency or elective surgery. The report took a critical look at areas where the care of patients might have been improved, from lack of input from Medicine for the Care of Older People, to the level of pain relief provided. Remediable factors were also identified in the clinical and the organisational care of these patients.

This report followed on from the NCEPOD Report Extremes of Age (1999) and reviewed the care received by elderly patients undergoing surgery. The report made a number of recommendations which were relevant to HDFT, falling into seven categories. Several of the recommendations cross cut with work streams relating to the National Falls and Bone Health audit reports.

Following previously reported delays, the directorate have recruited to a second surgical geriatrician post and a liaison service for surgical patients requiring geriatrician input has commenced initially as a trial following the blue slip process to understand the demand and review the service offer.

There continue to be delays with progressing some of the recommendations. The remaining actions relate to:

- Capacity for senior clinicians in surgery, anaesthesia and medicine to be involved in the decision to operate on elderly patients; surgical geriatricians providing routine daily input from to elderly patients undergoing surgery, and being part of the multidisciplinary input required to recognise comorbidities, disability and frailty which are independent markers of risk in the elderly.
- Ensuring delays in surgery for the elderly are subject to regular and rigorous audit alongside identifiable agreed standards in all surgical specialities. Delays to theatre needs further review and progress with the action plan from the National Emergency Laparotomy Audit is also required.
- Having clear protocols for the post-operative management of elderly patients undergoing abdominal surgery which include where appropriate routine review by a Medicine for the Care of Older People consultant, and nutritional assessment.

The latest action plan is at appendix 1.

3.2.2. Subarachnoid Haemorrhage: Managing the flow (2013)

This NCEPOD report highlighted the process of care for patients who are admitted with aneurysmal subarachnoid haemorrhage, looking both at patients that underwent an interventional procedure and those managed conservatively. The report took a critical look at areas where the care of patients might have been improved. Remediable factors were also identified in the clinical and the organisational care of these patients.

This report was published in November 2013 and Dr John Smith was appointed as clinical lead. Since the last report to the Board this action plan has been received at the Improving Patient Safety Steering Group in January and June 2018.

To complete the remaining actions Dr Smith will be amending the draft guidelines to include transfer of patients and the agreed changes to the scanning protocol. We are hoping this will be achieved by August 2018.

The latest action plan is at appendix 2.

3.2.3. Gastrointestinal Haemorrhage: Time to get control (2015)?

This NCEPOD report highlighted the process of care for patients aged 16 years or older that were coded for a diagnosis of gastrointestinal (GI) haemorrhage. The report took a critical look at areas where the care of patients might have been improved, with remediable factors identified in the clinical and the organisational care of these patients.

This report was published in June 2015. Dr Gareth Davies was appointed as the clinical lead, supported by the Integrated Care directorate. The action plan has been reviewed by the Improving Patient Safety Steering Group since last reported to Board, in January 2018.

The majority of actions have been completed. One recommendation for all acute hospitals to have a lead clinician responsible for local integrated care pathways for both upper and lower GI bleeding and clinical governance, including identifying named consultants, ideally gastroenterologists, who would be responsible for the emergency and on-going care of all major GI bleeds, has been added to the endoscopy risk register and closed. The outstanding actions are:

- To establish an agreement or SLA for interventional radiology with York. Whilst there are effective working arrangements in place to support our most critically ill GI bleed

patients a formal arrangement needs to be established. This has been added to the endoscopy risk register in the interim.

- Dr Davies has drafted a GI bleed management protocol which will close most of the outstanding NCEPOD issues. Whilst the principles are agreed and in place we are awaiting confirmation of implementation.

The latest action plan can be found at appendix 3

3.2.4. Sepsis: Just Say Sepsis!

This NCEPOD report highlighted the process of care for patients aged 16 years or older with sepsis. The report took a critical look at areas where the care of patients might have been improved and identified remediable factors in the clinical and the organisational care of these patients.

This report was published in November 2015. The launch was attended by Dr David Earl, Deputy Medical Director who also led on the review of the report. A gap analysis was received by the Improving Patient Safety Steering Group in January 2016. Since the last report to the Board this action plan has been received at the Improving Patient Safety Steering Group in January and June 2018 when all outstanding actions were reported as complete.

The completed action plan can be found at appendix 4.

3.2.5. Acute Pancreatitis: Treat the cause (2016)

This NCEPOD report highlighted the process of care for patients aged 16 years or older with acute pancreatitis. The report took a critical look at areas where the care of patients might have been improved. Remediable factors have also been identified in the clinical and the organisational care of these patients.

This report was published in July 2016. Mr John Simpson was appointed as the clinical lead to review the report and produce a gap analysis against the report's recommendations. Since the last report to the Board this action plan has been received at the Improving Patient Safety Steering Group in September 2017 and January 2018. An audit of the management of patients with acute pancreatitis has been undertaken to inform the two outstanding actions. The audit showed that less than 10% of patients were getting their gall bladders removed within the time frame suggested by NICE. The results related to nutritional assessments and further actions and timescales to ensure improvement with the timeliness of laparoscopic cholecystectomies are being followed up.

The latest action plan can be found at appendix 5.

3.2.6. Mental Health in General Hospitals: Treat as one (2017)

This NCEPOD report highlights the quality of mental health and physical health care for patients aged 18 years or older with a significant mental disorder who are admitted to a general hospital. The report takes a critical look at areas where the care of patients might have been improved. Remediable factors have also been identified in the clinical and the organisational care of these patients.

This report was published in January 2017. Dr Matt Shepherd completed a gap analysis which was shared at Quality Committee in April 2017. It was subsequently agreed at Improving Patient Safety Steering Group that Dr Scullion would lead and coordinate the work required to complete the associated action plan which had Trust wide implications. A task and finish group formed of representatives from key areas within the clinical directorates,

and from Tees, Esk and Wear Valleys NHS Foundation Trust have met to agree actions required and who will lead each.

The action plan has been received at Improving Patient Safety Steering Group in January and June 2018. The latest action plan can be found at appendix 6.

3.2.7. Acute Non-Invasive Ventilation: Inspiring Change (2017)

This NCEPOD report focuses on the quality of acute non-invasive ventilation clinical care for patients aged 16 years or older who are admitted to hospital. The report takes a critical look at areas where the care of patients might have been improved, with remediable factors identified in the clinical and the organisational care of these patients.

This report was published in July 2017. Dr Claire Taylor was appointed as the clinical lead to review the report and produce a gap analysis against the report's recommendations which was scheduled to come to Quality Committee in October 2017. However at the time of writing this report, the clinical team continue to have capacity issues and are facing challenges to review the document and its recommendations. The Long Term and Unscheduled Care Directorate are in the process of recruiting a third consultant respiratory physician and will support a review once appointed.

The respiratory team have provided an update:

1) A rolling audit to assess progress against NCEPOD standards is in place and an interim report has been prepared;
2) Currently neither respiratory consultant is named as NIV lead, nor has time in job plans to act as NIV lead;
3) The respiratory team are not able to provide NIV on wards other than the acute floor or HDU beyond the hours covered by the critical care outreach team. The NCEPOD report suggests that NIV should be delivered within 1 hour on the patient's ward prior to them being moved to an appropriate environment;
4) HDFT mortality figures related to NIV are out-with the recommended figures. This is likely to be due to inappropriate patient selection out of hours by non-specialist trainees, resulting in patients with frailty/end stage respiratory disease being started on NIV;
5) Non-HDU settings do not have appropriate nursing/patient ratios for NIV management. However Dr Rob Tuffin would like to move acute NIV management to the HDU setting which would mean:
    - Patient/nursing ratios will be met;
    - Patients will have their observations taken in an appropriately timed manner;
    - Discussion about the appropriateness of NIV management for each patient with the anaesthetists;
    - Patients will have access to the post ITU/HDU psychology service; NIV can cause significant psychological trauma and a post treatment debrief is a vital component of their care.

3.2.8. Chronic Neurodisability: Each and Every Need (2018)

This NCEPOD report focuses on the quality provided to children and young people with chronic disabling conditions, focusing in particular on cerebral palsies. The report takes a critical look at areas where the care of patients might have been improved and remediable factors have been identified in the clinical and the organisational care of these patients.

The report was published in March 2018. Whilst NCEPOD advised that this report is relevant to paediatrics, emergency medicine, acute medicine, nurses, critical care, surgeons, anaesthetists, physiotherapists and occupational therapists it has been agreed that the CCCC directorate should lead on undertaking a gap analysis and developing an action plan,

which will be supported by the other clinical directorates as required. Dr Anna Lindon has agreed to be the clinical lead, and has reviewed the report and undertaken a gap analysis, which was received at Improving Patient Safety Steering Group in June 2018. The action plan to address the identified gaps is in development.

### 3.3. Closed action plans

Action plans for the following reports have been closed on the standards database:

- Cardiac Arrest Procedures: Time to Intervene? (June 2012)
- Peri-operative Care: Knowing the Risk (December 2011)
- Surgery in Children: Are We There Yet? (October 2011)
- Bariatric Surgery: Too Lean a Service? (October 2012)
- Saving Mothers' Lives 2011 (March 2011)
- Alcohol Related Liver Disease: Measuring the Units (2013)
- Tracheostomy Care: On the right trach (June 2014)
- Lower Limb Amputation: Working Together (November 2014)

## 4. MBRRACE-UK

This section of the report has been co-ordinated by Alison Pedlingham, Head of Midwifery and Dr Kat Johnson, Consultant Obstetrician. It considers the National Confidential Enquiries and national reports that relate to maternity services and demonstrates how HDFT Maternity service have applied, implemented and worked towards compliance with the recommendations of each report.

The MBRRACE-UK collaboration led by the National Perinatal Epidemiology Unit continue the work investigating maternal deaths, still births and neonatal deaths carried out in the past by Centre for Maternal and Child Enquiries (CMACE), including the Confidential Enquiry into Maternal Deaths. We have a nominated senior midwife (Bereavement midwife) within the HDFT Maternity services who is the contact for MBRRACE-UK.

The MBRRACE-UK reports published since the last report are:

| Report | Published | Comments |
|---|---|---|
| Confidential Enquiry into Maternal Death 2017-Saving Lives, Improving Mothers Care | Dec 2017 | Combined action plan to be completed and progress will be monitored by Maternity Risk Management Group |
| Perinatal Mortality Surveillance Enquiry 2017 | November 2017 | Combined action plan to be completed and progress will be monitored by Maternity Risk Management Group |
| Perinatal Mortality Surveillance Report Jan - Dec 2015 | June 2017 | Information |

These reports are reviewed by the Head of Midwifery and a senior Obstetrician and any recommendations considered and implemented as appropriate, following benchmarking against current practice at HDFT. Due to the number of reports, maternity specific and the degree of overlap in some of the recommendations from these reports it has been decided to combine all actions from previous and current reports into one action plan. The key findings and recommendations relevant to HDFT from the latest reports (above) are:

## Maternal Death 2017 – Saving Lives, Improving Mothers Care

MBBRACE-UK published the latest report on maternal deaths and morbidity, 'Saving Lives, Improving Mothers' Care' in December 2017. This report, the fourth MBRRACE-UK annual report of the Confidential Enquiry into Maternal Deaths and Morbidity, includes surveillance data on women who died during or up to one year after pregnancy between 2013 and 2015 in the UK.

For women in the UK, having a baby still remains relatively safe with 8.76 women per 100,000 maternities dying in pregnancy and around the time of childbirth. More than two thirds of women who died had pre-existing physical or mental health problems, (not a direct complication of pregnancy). There has been a decrease in the number of women dying from flu and sepsis due to campaigns to raise awareness of the risks of these two conditions. A recommendation from this report is that this model be replicated to reduce the number of deaths from heart disease (leading cause of death), epilepsy and mental health problems. Maternal suicide is the third largest cause of death following delivery; the Department of health have recently awarded monies to improve perinatal mental health services across the UK.

A recurring theme of the report is forward planning for the care of women with known pre-existing medical or mental health problems and regular review of medications by specialist services and the GP prior to and during pregnancy and the postnatal period.

**Key areas for action:**

**Improving overall care** – facilitate opportunistic pre and post pregnancy counselling and advice for women. Delivery of the flu vaccine should be part of routine antenatal care rather than primary care. **At HDFT** we are reviewing this as a possible option as part of care in the antenatal clinic – careful consideration needs to be given to staffing levels, allocation of time, appropriate storage of vaccines and equipment required (fridge).

Escalation policies to manage periods of raised activity with a full assessment of staffing-workload balance. At **HDFT** our local escalation policy was reviewed in December 2017, we now have fully implemented a hospital midwife on call for a period of 12 months and we have agreement from the Directorate to purchase the Birthrate Plus acuity tool to benchmark current staffing ratios against the acuity of the women we provide care to.

The report recommends improvement in care for women with epilepsy, women who present with a stroke, women with existing medical and general surgical disorders, prevention and care of sepsis, improving prevention and care of haemorrhage and amniotic fluid embolism. The key themes of the report include the importance of leadership (one person coordinating care with close communication between all specialities), regular review of medications and improved links between maternity services and specialist services with clear plans of care for pregnancy, birth and the postnatal period.

## Perinatal Mortality Surveillance Enquiry (2017)

This report represents the findings of the third perinatal confidential enquiry carried out as part of the MBRRACE- UK programme of work and focuses on term, singleton, intrapartum stillbirths and intrapartum-related neonatal deaths. Since the last confidential enquiry into intrapartum stillbirths and intrapartum-related deaths in 1993-1995, overall stillbirth rates have reduced by just over a fifth and neonatal death rates by over a third. Nevertheless, the UK rates are still high compared with other European and other high income countries.

**Key recommendations to reduce intrapartum death:** Concerns identified in this confidential enquiry about staffing and capacity issues in maternity services, particularly around the issues of induction of labour and timely transfer to delivery suite.

Multidisciplinary training in situational awareness and human factors should be undertaken by all staff who care for women in labour – **at HDFT** this forms part of local Prompt emergency skills training for all midwives and medical staff.

Adequate resource and training should be given to enable all intrapartum deaths to be systematically reviewed to facilitate organisational learning by using a standardised tool / methodology, by an appropriate multidisciplinary panel. Including the opportunity for the parents' perspectives of their care to be included in the review should be considered. Consideration should be given to including an independent external assessor on the panel. We have implemented the use of the National Perinatal Mortality tool to review perinatal deaths; this evidence is required by NHS Resolution (10 maternity safety actions) and the Saving babies Lives care Bundle.

**New initiatives to reduce intrapartum death:**

There should be national development of a standardised risk assessment tool for determining a woman's risk status on admission in presumed labour, or prior to induction, and regularly throughout labour – **at HDFT we are compliant.**

National guidance should be developed for care during the latent phase of labour once a mother accesses maternity services and this should take account of her risk status. This should include frequency, nature (intermittent auscultation or cardiotocography), and interpretation of fetal heart rate assessment – **to be completed**.

There should be a national discussion about the content of fetal monitoring training (both intermittent auscultation and continuous electronic fetal monitoring) and agreement over the content, duration and frequency of training as well as whether competency should be formally assessed for healthcare professionals caring for women in labour – at HDFT **training for all staff is almost complete, formal competency assessment is in progress.**

Due to differing local circumstances maternity services should develop local guidance that clarifies the actions that should be undertaken when serious problems arise in a home birth, either planned or unplanned – at HDFT **emergency skills training for community midwives will be implemented later this year.**

Local guidance should be developed to cover the particular circumstance of resuscitation of a baby born in extremis and out of hours in their service. This guidance should be practical and include issues around the use of volume expanders and the use of neonatal intubation – **to be discussed further with senior paediatric staff.**

National guidance is needed regarding the principles that should guide decisions to stop resuscitation and/or re-orientate care. National guidance should consider the approach to the resuscitation of a baby with prolonged bradycardia following delivery after lung aeration is confirmed - **to be discussed further with senior paediatric staff**.

A co-ordinated approach should be adopted for care following all intrapartum related deaths with good communication between maternity and neonatal care providers as relevant to ensure seamless care for parents. This should include: the development and implementation of a bereavement checklist for all intrapartum related deaths irrespective of the place of death; follow-up with input from all relevant professional groups who have been involved in the care – **to be discussed further with obstetric, paediatric and the bereavement midwife.**

**Quality improvement programmes to reduce intrapartum death**
National quality improvement and training programmes should be implemented to improve compliance with national guidance. HDFT is in wave 2 of the National Maternal and Safety Collaborative which commenced in April 2018, one or two projects to support this quality improvement work will be identified by the end of June 2018.

**Perinatal Mortality Surveillance report (2017)**

This is the third MBRRACE-UK Perinatal Mortality Surveillance Report and provides information on extended perinatal deaths in the UK and Crown Dependencies arising from births during 2015. As in previous reports, MBRRACE-UK compares rates of stillbirth and neonatal death* focusing on deaths after 24 weeks of pregnancy and excluding terminations of pregnancy. The data presented in the report summarises the stillbirth, neonatal mortality, and extended perinatal mortality rates for births in 2015 for individual Trusts and Health Boards.

**Key recommendations from the 2017 report:**

- Neonatal deaths, which have remained static for 3 years, require a renewed focus
- Stillbirths need to be investigated closely to ensure the fall in rates continues
- Improved research is needed to understand if stillbirths before 32 weeks of pregnancy are avoidable
- A national forum should be formed to decide how to report deaths before 24 weeks and those due to congenital anomalies, and their impact on overall rates
- Organisations are urged to provide improved data on deaths at all stages of pregnancy so it is possible to make better comparisons between them
- All hospitals should carry out local reviews on every death to understand what happened, why it happened and how they can improve care to prevent similar deaths in the future

**HDFT was coded as amber - up to 10% higher than the UK average.**

**Rate per 1000 births**

| Total births | Stillbirth | | Neonatal | | Extended perinatal | |
|---|---|---|---|---|---|---|
| | Crude | Stabilised and adjusted | Crude | Stabilised and adjusted | Crude | Stabilised and adjusted |
| 1906 | 3.67 | 2.44 (1.61 to 3.45) | 1.58 | 1.25 (0.57 to 2.66) | 5.25 | 3.67 (2.55 – 5.39) |

In response to national recommendations the substantive Bereavement Midwife continues to work 1 day per week to support bereaved parents during pregnancy and the immediate postnatal period. She leads on education and training in bereavement issues for staff, and is the lead on national and regional projects including the ongoing work of the national stillbirth care bundle.

Good progress has been made on some sections of the Saving babies Lives Care Bundle which provides evidence-based and policy recommendations in maternity care towards the goal of reducing stillbirth in the UK.

Harrogate currently has a lower rate than the national average of stillbirth and has made good progress on the four recommendations within the care bundle. The maternity unit will be focusing on completion of audits to assess compliance and will continue to work on a business case to support serial ultrasound assessment of fetal growth throughout the third trimester of pregnancy in line with the Royal College of Obstetricians and Gynaecologists Green-top Guideline.

We continue to participate in all of the regional work streams as well as the work of the WY&H LMS including perinatal mental health, stillbirth care bundle and maternal critical care. Due to the Perinatal mental health midwife going on secondment to NHS England for 12 months we have reviewed this role and recruited a Public health midwife/named midwife for safeguarding (1.0 WTE). Her role is to review and ensure effective pathways for women with obesity, perinatal mental health and smoking and to continue to educate midwives and medical staff on public health issues specific to maternity services.

## 5. NCISH

The latest NCISH annual report was published in October 2017 and presents findings from 2005 to 2015. It provides the latest figures on suicide, homicide and sudden unexplained deaths and highlights the priorities for safer services. There is an infographic available, illustrating the key messages which include:

- There is evidence of improved patient safety with patient suicide down overall and in in-patient suicides; following hospital discharge; and after non-adherence to treatment
- The longstanding downward trend in inpatient suicides is slowing from 39% reduction between 2005-2010 to 10% reduction between 2010-2015
- The first week post-discharge period remains a time of high risk
- During the study period there has been a rise in the number of suicides amongst eating disorder, autism spectrum disorder and dementia specific diagnostic groups. It is recognised that the rise is likely to reflect increasing diagnosis however access to specialist support is needed in these conditions
- 424 self-poisoning deaths were recorded on average per year. Opiates are most frequent type of drug used in fatal overdose however figures have fallen in England, Scotland and Wales
- Between 88%-100% of patients in the UK convicted of homicide have a history of alcohol or drug misuse
- 41% of patients with schizophrenia convicted of homicide offences were sent to prison rather than hospital. Further understanding of sentencing decisions needed.

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

## 6. CONCLUSIONS

The recommendations from the confidential enquiry reports and gap analyses have been reported to the Board of Directors for several years. This report clarifies the current studies and reports and includes the action plans that are currently being progressed to meet gaps in practice at HDFT based on the recommendations.

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

Meeting the initial submission deadlines set by NCEPOD for contributions to studies continues to be a challenge, particularly for clinical questionnaires and photocopied case note extracts. Clinicians report limited capacity to complete questionnaires as well as limited capacity within in secretarial/administrative support teams to undertake the necessary photocopying of case note extracts which usually accompanies a clinical questionnaire submission request.

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

The Improving Patient Safety Steering Group continues to monitor progress with all NCEPOD action plans, and presents an update to the Quality Committee every 6 months. There remain challenges in getting progress updates from the leads of some action plans, and delays in progressing the actions developed to address recommendations from these studies. We promote the development of actions that are deliverable in a reasonable time frame with the support of clinicians and managers within directorates. If recommendations cannot be addressed in this way, we suggest that they are added to the most appropriate risk register for ongoing management of the gap in compliance.

We are proposing to review the older action plans with the lead clinician and manager, with the aim of agreeing whether there are outstanding actions that can or should be addressed rapidly, and whether some should be transferred to a risk register and the action closed.

## 7. APPENDICES

Appendix 1: Elective & Emergency Surgery in the Elderly: An Age Old Problem (2010)
Appendix 2: Alcohol Related Liver Disease: Measuring the Units (2013)
Appendix 3: Subarachnoid Haemorrhage: Managing the flow (2014)
Appendix 4: Gastrointestinal Haemorrhage: Time to get control? (2015)
Appendix 5: Sepsis: Just say Sepsis! (2015)
Appendix 6: Mental Health in General Hospitals: Treat as one! (2017)

# Appendix 1: Elective & Emergency Surgery in the Elderly: An Age Old Problem (2010): Current action plan

**Action plan:** ***NCEPOD - An Age old Problem (2010)***
**Date: 16/03/2016**
**Action plan owner: Jonny Hammond / Kat Johnson**
**Monitoring group / committee: Improving Patient**

**Action plan progress June 2018**

| ID no. | Issue / Audit Finding / Theme | Initial risk | Action/s | Operational Lead | Responsible Lead | Target Date | ID no. | Risk at review | Progress made | Further action/s to ensure completion | Operational Lead (if changed) | Responsible Lead (if changed) | New target date if original passed |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Routine daily input from Medicine for the Care of Older People should be available to elderly patients undergoing surgery and is integral to inpatient care pathways in this population. | High | Proposal to be brought to SMT and included in the planning process | Dr Hammond / Mr Conroy / Clinical Lead for Elderly Medicine | Dr Hammond / Mr Conroy / Clinical Lead for Elderly Medicine | Mar-12 | 1 | medium | Oct 18 - Recruitment of 2nd substantive ortho/surgical geriatrician August 17. 4 days cover which combined with 1st ortho/Surgical geriatrician provides 5 day service. Trial started Oct 17 to provide surgical geriatrician input on the general surgical wards. Initially as a trial this is being done by taking blue slip referrals, in order to understand the demand. The aim is to review this at 3 months, to understand next steps in order to progress this service offer.<br><br>1C3983D6.pdf | Review of trial surgical geriatrician input and progress model.<br>For risk to be low - need fully proactive model of assessment prior to blue slip referral.<br><br>**Update June 18** - trial demonstrated that referrals are present which would benefit from input from Surgical geriatrician. However workload pressures impacted on the ability for the 2 current ortho/surgical geriatricians to see patients in timely way as the number of patients on Farndale and Wensleydale also requiring input was high, and their time was taken seeing medical outliers<br><br>In 2017 a bid was put forward for an ACP to be attached to the ortho/surgical geri team, which would improve capacity, however this was not prioritised for investment.<br><br>A plan being explored between PSC and LTUC is increasing capacity for surgical geriatrician review by moving consultant funding from the gastro medical team to the elderly team on the basis that medical outlying patients on Littondale and Nidderdale are transfered to the geriatric team. If this were the case, then it is possible that as well as seeing outlying medical patients, the individual could also see surgical patients requiring geriatrician input. Further work is being done on this plan, which is being led by Mike Forster as part of the plan for medical outliers. | Rebecca Leigh /Jo Parker | Jonny Hammond | Sep-20 |
| 3 | Comorbidity, disability and frailty need to be clearly recognised and seen as independent markers of risk in the elderly. This requires skill and multidisciplinary input including early involvement of Medicine for the Care of Older People | High | Appointment of orthogeriatrician. Ward rounds on all surgical wards by CoE physicians. | Dr Hammond / Mr Conroy / Clinical Lead for Elderly Medicine | Dr Hammond / Mr Conroy / Clinical Lead for Elderly Medicine | Mar-12 | 3a | medium | Oct 18 - Recruitment of 2nd substantive ortho/surgical geriatrician August 17. 4 days cover which combined with 1st ortho/Surgical geriatrician provides 5 day service. Trial started Oct 17 to provide surgical geriatrician input on the general surgical wards. Initially as a trial this is being done by taking blue slip referrals, in order to understand the demand. The aim is to review this at 3 months, to understand next steps in order to progress this service offer.<br><br>Oct 17 Discussion with the CCG regarding frailty service which would enable the identification of some frail elderly which may then go on to receive elective procedures. Business case with the CCG currently for review as commisioning of the service would be required.<br><br>Multiprofessional assessment for patients undergoing a planned procedure is completed at pre-assessment. Any patients identified as to requiring geriatrician input would require a blue referral to the geriatrician team. | Develop protocol / processes to ensure early involvement of Medicine for the Care of Older People for all relevant elderly surgical patients<br><br>Data analysis required to understand which patients require early involvement of Medicine for the Care of Older People<br><br>Explore with D Earl and D Carter potential to develop the pre-assessment service<br><br>**June 2018 update** - As above. Re: frailty service. Business case still being developed. Investment likeley required re: radiology which may make prohibative.<br>Pre-assessment service still being explored. | Rebecca Leigh /Jonny Hammond | Beth Barron | tbc |
| 5 | Delays in surgery for the elderly are associated with poor outcome. They should be subject to regular and rigorous audit in all surgical specialities, and this should take place alongside identifiable agreed standards. | Medium | Delays to be monitored and audited for all surgical specialties. Process to commence October 2011. | Audit Leads for Surgical Specialties in Gynaecology, Urology, General Surgery and Orthopaedics. | Audit Leads for Surgical Specialties in Gynaecology, Urology, General Surgery and Orthopaedics. | Mar-12 | | Low | Oct 17 - delay to theatre for # NOF picked up within BPT reports which are reviewed through the # NOF steering group run by Rebecca Leigh.<br><br>As part of the Trauma Peer review - audit undertaken regarding delays to theatre - full year from Sept 16 to end August 17. Cancelations in line with standard and peer review satisfied that delays are within the norm. This is to be monitored on an ongoing basis through the Trauma Steering group.<br><br>Mortality reviews undertaken through the M and M group.<br><br>National Laparotomy audit data is being reviewed to understand length of time to theatre and outcome | Data analysis required to understand delays against defined standards and outcomes<br><br>**June 2018 update** - the input of the 2nd Ortho geriatrician has significantly improved the timeley input which has been consistently >90%<br>Limitation in reaching full BPT is now predominatly delays to theatre, which although has not significantly increased, needs further review and including in the business case for a new main theatre.<br><br>National lap audit update required from Gen Surgeons | Audit Leads for Surgical Specialties in Gynaecology, Urology, General Surgery and Orthopaedics. | Kat Johnson | Sep-16 |
| | | | | | | | | Low | Undertake a data analysis for all surgical specialties split by Acute and planned procedures identifying number of patients treated for those 80 years and older, understand those that were<br><br>Review and understand the mortality rate 30 days post surgery.<br><br>What is happening about this? | | Rachel McDonald | Beth Barron | Jun-16 |

| ID no. | Issue / Audit Finding / Theme | Initial risk | Action/s | Operational Lead | Responsible Lead | Target Date | ID no. | Risk at review | Progress made | Further action/s to ensure completion | Operational Lead (if changed) | Responsible Lead (if changed) | New target date if original passed |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 6 | Senior clinicians in surgery, anaesthesia and medicine need to be involved in the decision to operate on the elderly. Risk assessment must take into account all information strands, including risk factors for acute kidney injury. | High | Regular ward rounds by Care of Elderly Physician are not in place. This will be resolved with appointment of ortho-geriatrician / surgical-geriatrician which has been agreed between Elective and Integrated Care Directorates. | Dr Hammond / Mr Conroy | Dr Hammond / Mr Conroy | Nov-11 | | medium | O[1C3983D6.pdf]nt of 2nd substantive ortho/surgical geriatrician August 17 [illegible]ich combined with 1st ortho/Surgical geriatrician pr[illegible]ce. Trial started Oct 17 to provide surgical geriatrician input on the general surgical wards. Initially as a trial this is being done by taking blue slip referrals, in oredr to understand the demand. The aim is to review this at 3 months, to understand next steps in oredr to progress this service offer.<br>Multiprofessional assessment for patients undergoing a planned procedure is completed at pre-assessment. Any patients identified as to requiring geriatrician input would receive a referral to an aneasthetist for further assessment, there would also be communication to the ward regarding any additional needs - equipment, social needs etc.... This would then be picked up by the ward with surgical geri assessment as required. | **June 2018 update** - updated as above | Chris Mahon<br>Anne-Marie Davies<br>Tracy Jackson<br>Jeremy Childs<br>Mark Farndon | Kat Johnson | Jul-17 |
| 10 | Clear protocols for the post-operative management of elderly patients undergoing abdominal surgery should be developed which include where appropriate routine review by a MCOP consultant and nutritional assessment. | Medium | Clear protocols to be developed between surgery and medicine (Elective and Integrated Care Directorates) | General Managers in Elective and Integrated Care | General Managers in Elective and Integrated Care | Mar-12 | | Medium | Review of the hip fracture handbook to see if it can be updated to become an acute abdo handbook.<br><br>Handbook reviewed at Directorate Governance Group for agreement.<br><br>What is happening about this? Update needed and new target date | Was marked as complete September 2012 but re-opened as this requires review<br><br>**June 2018 update** - continues to require review | Chris Mahon | Kat Johnson | Jun-16 |

# Appendix 2: Subarachnoid Haemorrhage: Managing the flow (2014)

| NCEPOD SAH<br>April 2014 | | | | | Action Plan Progress Monitoring - Update May 2018 | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ID number | Issue / Audit Finding / Theme | Initial Risk (H/M/L) | Action/s | Operational Lead | ID number | Risk at review | Progress on actions | Further action/s to ensure completion | Operational Lead (if changed | Responsible Lead (if changed | Target Date |
| O1 | Formal networks of care should be established. linking all secondary care hospitals receiving subarachnoid haemorrhage patients to a designated regional neurosurgical/neuroscience centre. | Low | Formal links already in place with LGI and Leedsneurosurgery.com. These need to be incorpartaed into common care pathway. There is still scope to agree criteria for referal with Leeds and responsibility for further imaging ie CTA | Dr J Smith | O1 | Complete | We have now forming a local network to drew a ccommon response to all NCEPOD SAH issues. This is being co-ordinated by Mr Ross, Neurosurgeon in LGI and the first meeting is in October - There will not be any further development of these pathways locally until a regional approach is dicted. | Meetings are now established and regular and will develeope to include audit and M&M | | | |
| O2 | All hospitals should undertake regional audit or multi-disciplinary team meetings, in order to share learning that could improve the care provided to aneurysmal subarachnoid haemorrhage patients. | Low | No regular audit has been undertaken. First initial updit has been initiated. Alter and complete initial audit and set tine for annual re-audit. It would be difficult to organise MDT - rolling audit a better option. | Dr J Smith | O2 | Complete | First audit done and results awaited - plan yearly audit of target number. Suggest this is a rolling audit to be completed by CAT junior Doctor allocated on a yearly basis. Nature of audit likely to be dictated by regional response | Yearly on-going SAH audit. Likley to feed into regional data. M&M style audit at SAH regional meetings | | | |
| O3 | The availability of interventional neuroradiology services should be such that hospitals can comply with the 'National Clinical Guideline for Stroke' stating that patients should be treated within 48 hours of their aneurysmal subarachnoid haemorrhage. | Low | Baseline data needs to be obtained via audit. Transfer to Leeds is usually pormpt but the service is not consistent. | Dr J Smith | O3 | Complete | Inherent variability in transfer - usually within target - will need to be monitored via annual audit. Formal criteria will need to be finalised with regional approach. | Yearly on going SAH audit. Likely to remain ongoing low risk. The condition of this is likely to remain unchnaged for the forseebale future. Low risk however as base line service is excellent. | | | |
| S1 | The clinical presentation of aneurysmal subarachnoid haemorrhage should be highlighted in primary and secondary care education programmes for all relevant health care professionals, including the guidelines for the management of acute severe headache published by the College of Emergency Medicine. | Medium | | Dr J Smith | S1 | Complete | Headache included in both ED and CMT training programs. Common presentation core competency in ACCS and CMT | | | | |
| S2 | All patients presenting with acute severe headache in a secondary care hospital should have a thorough neurological examination performed and documented. A CT scan should be performed immediately in this group of patients as defined by the 'National Clinical Guideline for Stroke'. | Medium | This should be standard practice but documentation of such needs to be auditted. Need agreement from radiology on avaialbility of cross sectional imaging both in and out of hours. | Dr J Smith | S2 | Low | Deviation in out of hours CT scanning of low risk presentation needs to be explored. May need to allow case by case variation and dicussion with on call radiology. Likely to remain low risk.<br><br>High risk factors for acute severe headaches developed | It has been accepted locally that patients wil be imaged urgently along the new trust guidelines (CAT,ED and radiology) | | | Aug-2018 |
| S3 | Standard protocols for the care of aneurysmal subarachnoid haemorrhage patients in secondary care should be developed and adopted across formal networks. These should cover, as a minimum, initial assessment and diagnosis, management, referral, transfer to a neurosurgical/neuroscience centre and subsequent repatriation to secondary care, including rehabilitation. These protocols should take into account existing guidelines where relevant. | Medium | This is not in place although aspects are available there is no universal protocol. This should include multiple patient entry points (ED and AMU), Initial management and risk assessment; agreements for cross sectional imaging both in and out of hours; agreement on suitability of referal to tertiary centers, requirement for supported transfer, agreement on criteria for re-location from tertiary care and rehabilitation | Dr J Smith | S3a | Low | Secondary care pathway bundle completed by J Smith in HDFT. | Agreed by network. To include transfer as not developed by network, complete internal ratification and implement | | | Aug-2018 |
| | | | | | S3b | Low | Others in the network are developing the other care pathways | Network to ratify the entire set of protocols / pathways | SAH network group | | Aug-2018 |
| S4 | All patients diagnosed with a subarachnoid haemorrhage should be commenced on nimodipine immediately as recommended in the 'National Clinical Guideline for Stroke', unless there are contraindications to its use. | Medium | This is not current initial practice. Nimodipine is not available on the wards or within the Emrgency Department | Dr J Smith | S4 | Complete | Nimodipine is now stocked in ED, CCU and AMU Fountains. Its use will be highlighted in guidelines | Nimodipine easily available now for routine use | | | |
| P1 | Organ donation rates following fatal aneurysmal subarachnoid haemorrhage should be audited and policies adopted to increase the frequency with which this occurs. | Low | Occurs under the unbrella of organ transplation on going audit - needs to be flagged as specific issue | Dr J Smith | P1 | Complete | This is included as part of on going organ donation audits | | | | |

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

**Action plan:** ***NCEPOD Gastroenterology Haemorrhage - time to get control***
**Date: March 2016**
**Action plan owner: Sharon Bilbrough**
**Monitoring group / committee: Planned & Surgical Care**

**Action plan progress: June 2018**

| ID no. | Issue / Audit Finding / Theme | Initial risk (H/M/L) | Action/s | Operational Lead | Responsible Lead | Target Date | ID no. | Risk at review (H/M/L or complete) | Progress made | Further action/s to ensure completion | Operational Lead (if changed) | Responsible Lead (if changed) | New target date if original passed |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2 | Interventional radiology (on-site or covered by a formal network) | Medium | Network with York currently exists, however requires formalisation with specific relation to this NCEPOD | David Scullion | Sharon Bilbrough, Service Manager | Nov-15 | | Medium | Not able to locate an agreement /SLA<br>There are effective working arrangements in place to support our most critically ill GI bleed patients. To add to alliance documentation.<br><br>Was on agenda to discuss at York / HDFT Alliance meeting June 2017, but meeting was cancelled. Next meeting scheduled for 14 December. Operational meeting scheduled in November for the clinical teams to meet to discuss further the upper GI bleed rota.<br><br>Added to endoscopy risk register | To be discussed at next York/HDFT alliance meeting When ??? | | | ??? |
| 6 | All acute hospitals should have a Lead Clinician who is responsible for local integrated care pathways for both upper and lower GI bleeding and their clinical governance, including identifying named consultants, ideally gastroenterologists, who would be responsible for the emergency and on-going care of all major GI bleeds. | Medium | Work underway to produce agreed overarching pathway document which will be replaced by bespoke care pathway to replace the generic medical admissions document for GI bleeds. | Gareth Davies | Sharon Bilbrough, Service Manager | Oct-15 | | Complete | Upper GI bleeding management protocols drafted March 2016<br><br>Agreement from all gastroenterology colleagues that they will look after all significant upper GI bleeds.<br><br>Regarding lower GI bleeds - gastroenterologists and GI surgeons do not think useful at this time to combine upper and lower GI bleeds under 1 team. Feeling that there would need to be major movement from specialist societies and retraining of a generation of doctors before the NCEPOD recommendation can be rolled out. Harrogate not alone in this.<br><br>G Davies - EUG Lead<br><br>Added to endoscopy risk register to manage appropriately. | | | | |
| 7 | All patients who present with a major upper or lower GI bleed, either on admission or as an inpatient, should be discussed with the duty or on-call (out-of-hours) consultant responsible for major GI bleeds, within one hour of the diagnosis of a major bleed | Medium | Work underway to highlight need for staff to notify within an hour, this includes development of problem-specific admission paperwork, which would trigger the call. | Gareth Davies | Sharon Bilbrough, Service Manager | Feb-15 | | Medium | Advice included in GI bleed management protocol. Principles agreed and in place. Paperwork needs fine tuning when the model of care is finalised.<br><br>Now achieved with current COF system and established OOH GI bleed service - audit currently underway | GI bleed management protocol to be implemented | | | ??? |

# Appendix 4: Sepsis: Just say Sepsis! (2015)

**Action plan:** NCEPOD: Sepsis study: Just say sepsis (Nov 2015)
**Date:** December 2015
**Action plan owner:** David Earl
**Monitoring group / committee:** Improving Patient safety Steering Group

**Action plan progress May 2018**

| ID no. | Issue / Audit Finding / Theme | Indicator (if relevant - remove column if not) | Initial risk (H/M/L) | Action/s | Operational Lead | Responsible Lead | Target Date | ID no. | Risk at review (H/M/L or comple | Progress made | Further action/s to ensure completion |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | All hospitals should have a formal protocol for the early identification and immediate management of patients with sepsis. The protocol should be easily available to all clinical staff, who should receive training in its use. Compliance with the protocol should be regularly audited. This protocol should be updated in line with changes to national and international guidelines and local antimicrobial policies. | Trust protocol, created from the national and international guideline, is in place. This is now included in all admission proformas and extra copies are available for septic episodes post admission. All FY1s have a teaching session in their first few weeks. Currently monthly audits as part of CQUINs. | Low | Current audits do not look at compliance with the protocol (just 1 hour antibitoic administration).<br><br>Establish an annual audit of compliance | CCOT | CCDG | Oct-16 | 1 | Complete | CQUIN screening audit looks at compliance with antibiotics, which is the one component of the sepsis six with a strong evidence base. We are about to launch a revised sepsis six bundle alongside a record of blood cultures, both of which will be audited once launched. | No specific plans except continual education on Patientrack screening and continuing CQUIN audits |
| 4 | Trusts/Health Boards should use a standardised sepsis proforma to aid the identification, coding, treatment and ongoing management of patients with sepsis (some examples are available at sepsistrust.org and survivingsepsis.org). To ensure continuity of care, this proforma should be compatible, where possible with any similar proforma or system used in primary care and should permit the data to be shared electronically. | Proforma as described in use. Not currently in electronic format. | Low | Patientrack sepsis module planned for 2016 | Robin Pitts | Patientrack Steering Group | Jun-16 | 4 | Complete | Due for launch 12th December 2016 | |
| 7 | Where sepsis is suspected, early consideration should be given to the likely source of infection and the ongoing management plan recorded. Once identified, control of the source of infection should be undertaken as soon as possible. Appropriate staffing and hospital facilities (including theatre/interventional radiology) should be available to allow this to occur. | 24 hour emergency theatre avaialble, and interventional radiology available via local networks. Need some staff education about early source control for deep collections | Low | Education of senior medical staff required | | D Earl | Apr-16 | 7 | Complete | Part of mandatory training | |
| 8 | The importance of early identification and control of the source of sepsis should be emphasised to all clinicians, and be reinforced in any future guidelines or tools for the management of sepsis. | As in section 7. | Medium | On-going education a priority. Essential learning package is in place for fluid balance / sepsis, and this is part of medical school curriculum.<br>To add to the next update of annual elearning requirement | | D Earl | Nov-16 | 8 | Complete | Now part of mandatory e-learning for all doctors with fluid-prescribing duities. Continuing education will be necessary for the forseeable future until the topic is firmly part of the healthcare community | |
| 9 | In line with previous NCEPOD and other national reports' recommendations on recognising and caring for the acutely deteriorating patients, hospitals should ensure that their staffing and resources enable:<br>a. All acutely ill patients to be reviewed by a consultant within the recommended national timeframes (max of 14 hours after admission)<br>b. Formal arrangements for handover<br>c. Access to critical care facilities if escalation is required; and<br>d. Hospitals with critical care facilities to provide a Critical Care Outreach service (or equivalent) 24/7. | Section a and b in other work streams. C and D in place, although CCOT is not 24/7 (currently 9am-10pm, 7 days) | Medium | Outreach not 24/7. Consultant reviews not timely (part of 7 day working workstream)<br><br>Provision of CCOT 24/7 is not a high priority - to include on Critical Care risk register, scored as the higher of risk to patient safety or risk to reputation | | D Earl | Feb-16 | 9 | Complete | Provision of CCOT 24/7 is on risk register but no plans to achieve 24/7 coverage | |

| ID no. | Issue / Audit Finding / Theme | Indicator (if relevant - remove column if not) | Initial risk (H/M/L) | Action/s | Operational Lead | Responsible Lead | Target Date | ID no. | Risk at review (H/M/L or comple | Progress made | Further action/s to ensure completion |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 10 | All patients diagnosed with sepsis should benefit from management on a care bundle as part of their care pathway. The implementation of this bundle should be audited and reported on regularly. Trusts/Health Boards should aim to reach 100% compliance and this should be encouraged by local and national commissioning arrangements. | Part of the sepsis screen in all medical proformas. Annual audits via CCOT to continue | Medium | Bundle in place but compliance not audited - see section 1. | | | | 10 | Complete | Electronic screening has replaced paperbased model (with updated parameters). Continually monitored as part of CQUIN. Ongoing efforts by senior nursing staff to improve compliance rates.<br><br>No specific issues highlighted - occasional care lapses communicated directly to clinical teams | |
| 14 | A booklet that provides patients and their relatives with easy to understand information on the recognition of sepsis, its long-term complications, recovery and risk of recurrence should be available from all healthcare providers and be provided to patients with sepsis at discharge from hospital. Some examples can be found at the UK Sepsis Trust (sepsistrust.org) and ICU Steps (icusteps.org). | Not yet in place | Medium | Not yet established. To discuss at next Critical Care Consultants' Meeting | D Earl | R Tuffin | Apr-16 | 14 | Complete | In place but compliance unclear. | |
| 16 | All patients discharged following a diagnosis of sepsis should have sepsis recorded on the discharge summary provided to the general practitioner so that it can be recorded in the patient's GP record. | No firm system in place | Low | No formal reporting structyure in place for sepsis (unlike AKI)<br><br>Include in audit - see section 1 | | | | 16 | Complete | National coding guidelines have been introduced and implemented.<br><br>Compliance now communicated to clinical teams, with green, amber or red awards. Red awards logged on Datix. | |
| 18 | When diagnosed, sepsis should always be included on the death certificate, in addition to the underlying source of infection. | Needs to be dissemintaed to juniors | Medium | Not yet disseminated to Juniors<br><br>To discuss with DoME for inclusion in teaching on death certification | D Earl | | | 18 | Complete | Part of the induction training for all juniors. | |

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

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

**Action plan progress: June 2018**

| ID no. | Issue / Audit Finding / Theme | Initial risk (H/M/L) | Action/s | Operational Lead | Responsible Lead | Target Date | ID no. | Risk at review (H/M/L or complete) | Progress made | Further action/s to ensure completion | New target date if original passed |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Ensure that all patients admitted to HDFT with a diagnosis of pancreatitis are assessed for their overall risk of malnutrition. | Medium | All ward admissions are screened for nutritional risk and referred to the dietitians based on their nutrition risk score - but the current screening tool may not pick up this particular group.<br><br>To undertake an audit over 6 months to determine if these patients are at nutritional risk and to determine if they will benefit from nutritional advice. All patients admitted with acute pancreatitis to be referred to the dietitians for assessment of their nutritional screening tool score and dietetic intervention required. If the audit demonstrates these patients are at risk - to add acute pancreatitis to automatic dietetic referral criteria. | Jeanie Ferguson Macmillan Specialist Dietitian | Jill Gale Senior Specialist Dietitian/Team Leader | Sep-17 | | Medium | Retrospective data for patents presenting with pancreatitis not possible to get. Started prospective data collection May 2017. Daily emails from iCE reporting system about patients with high amylase. Need 6 months data before collating the results as the numbers are quite small.<br><br>Results relating to nutritional assessment awaited | | Nov-17 |
| 2 | Increase the number of patients with acute gallstone pancreatitis having surgery to remove their gall bladder within 2 weeks on their index admission. | Medium | Implementation of the Consultant of the week model will enable progress towards this target.<br><br>HDFT has a good and supportive relationship with the pancreatic unit in Leeds which facilitates the management of the more complex cases. | John Simpson Consultant Surgeon | John Simpson Consultant Surgeon | Sep-17 | | Medium | Local audit shows: Less than 10% of patients had gall bladders removed within the time frame suggested by NICE. Results presented at surgical audit meeting along with the guidelines and suggested that any patient who needs a lap chole urgently should either<br>1) be done urgently<br>2) referred / discussed with JS<br>3) put in one of JS urgent clinic slots. | To be confirmed | Nov-17 |

# Appendix 6: Mental Health in General Hospitals: Treat As One (2017)

**Action plan: NCEPOD: Mental Health in General Hospitals: Treat As One**
**Date: 23/11/2017**
**Action plan owner: Dr David Scullion**
**Monitoring group / committee: Improving Patient Safety Steering Group**

**Action plan progress: May 2018**

| ID no. | Issue / Audit Finding / Theme | Indicator (if relevant - remove column if not) | Current situation | Initial risk (H/M/L) | Action/s | Operational Lead | Responsible Lead | Target Date | ID no. | Risk at review (H/M/L or complete | Progress made | Further action/s to ensure completion |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Presentation to Hospital | Patients who present with known co-existing mental health conditions should have them documented and assessed along with any other clinical conditions that have brought them to hospital. These should be documented:<br>a. In referral letters to hospital<br>b. In any emergency department assessment<br>c. In the documentation on admission to the hospital Existing guidance in these areas for specific groups should be followed which includes but is not limited to NICE CG16 and CG113 | Not universally complied with | Medium | Include prompt on clerking proformas i.e. ED CAS Card for mental health diagnoses | Robin Pitts | Matt Shepherd / Helen Law | Apr-18 | | Complete | Mental Health history prompt added to ED CAS Card | |
| | | | | | Admission proforma - nursing. Add prompt to ask and actions to be taken | Tammy Gotts / Alison Mayfield / R Pitts | Jill Foster | Aug-18 | | | | |
| | | | | | Web-V can bring through known information from other patient systems including GP systems.<br>Consider incorporating a prompt on the Web-V admission screen. | Robin Pitts / Web-V Clinical Board | Matt Shepherd | Feb-19 | | Medium | Action ongoing | Development of WebV admission documents |
| | | | | | Depending on the reason for presenting at MIU, ensure reason for current injury and any associated MH needs are addressed. Add into MIU documentation | Steph Davis | Matt Shepherd | Apr-18 | | Complete | Unable to introduce mental health history prompt to SystemOne used by MIUs. However summary care record lists all diagnosis recorded for the patient by primary care. | |
| 4 | Liaison Psychiatry review | As recommended by the Psychiatric Liaison Accreditation Network, mental health liaison assessments should be made in an appropriate timeframe, and by a mental health professional of appropriate seniority to meet the needs of the patient. | Formal liaison psychiatry in HDFT commissioned.<br><br>Ward staff not clear about how to access the service and MH support<br>Lack of training about mental health<br>Delays in getting review<br>Lack of clarity about Cygnet and Leeds patients<br>Difficulty and delays in accessing MH beds<br>Lack of clarity about how to manage patients with Korsakoff's syndrome<br>Yellow form developed for MH Liaison assessments after SI - was good. Not used now. | Medium | Develop SOP document to clarify and agree expectations of Psychiatric Liaison service:<br>How to access the service; Expectations regarding timeliness of review; Expectations of MH support (including for Cygnet and Leeds patients); Process for accessing MH beds; Management of common conditions e.g. Korsakoff's syndrome;<br>Documentation of assessment / treatment plan etc by MHLS in medical record - improving visibility of MH liaison documentation in HDFT notes will help ensure MH issues (and diagnoses if documented) during admission are picked up by coders; If the primary clinical team has concerns about mental capacity in patients who have a mental health condition, they should involve liaison psychiatry to assist in decision making | Liz Baker Clinical Team Lead, Acute Hospital Liaison Service / Sylvia Wood / Jane Paisley | Sylvia Wood | Jul-18 | | | | |
| | | | | | Improve staff awarness around Mental Health Act by reviewing current MH training needs and consider the use of ward posters to summarise common detention powers under MH act. | Fran Bowden / Mike England / Steph Davis | | Jul-18 | | | | |
| 7 | Supporting Care issues | All healthcare professionals must work together to eradicate terms such as 'medically fit' or 'medical clearance'. The terms 'fit for assessment', 'fit for review' or 'fit for discharge' should be used instead to ensure parallel working. | | Low | Adopt term "fit for assessment" and include in pychiatric liaison SOP document and communicate to HDFT and TEWV staff | Liz Baker / Sylvia Wood | Liz Baker / Sylvia Wood | Jul-18 | | | | |
| | | | | | Include "FFA" flag on ward whiteboards (Web-V) | Robin Pitts | M Shepherd | Aug-18 | | | | |
| 11 | Mental Health legislation | Mental capacity assessments should be documented in the case notes using the language of the relevant Act, and regular audits of the quality of the documentation undertaken. | Capacity assessment proforma available - reinforces correct language and aspects to be covered<br>MCA / DOLS audit planned for 2018 | Low | Plan audit in conjunction with mental health colleagues. TEWV to be copied into report | R Wixey / Liz Baker | R Wixey | May-18 | | | | |
| 13 | | General hospitals must have a robust centralised hospital system for the management of mental health legislation processes whether by themselves or with their local mental healthcare providers. This should be audited regularly to ensure that the law is complied with. | M England holds central register of DOLS applications<br>TEWV hold register of sections - is this complete for all sections?<br>TEWV annual report<br>Leeds patients / Cygnet patients - transfer of section | Medium | Check what happens about sectioned Leeds / Cygnet patients | S Wood / M Wilkinson | S Wood | May-18 | | Complete | Update from Mel Wilkinson 21.02.2018<br>The MHA administration service provided by TEWV is for any patients who are detained in HDH where we are the detaining authority, regardless of where the patient is resident.<br><br>If TEWV had a detained patient in Briary Wing or any other of our TEWV hospitals, who was admitted to HDH for physical healthcare they would come on s17 leave and still be a TEWV patient for MHA purposes. TEWV would provide an escort of TEWV staff if it was jointly agreed that was required.<br><br>If a patient is already detained under the MHA in Cygnet Hospital or a Leeds hospital, and is admitted to HDH for physical healthcare, they should also usually come on s17 leave, and Leeds or Cygnet, whoever is the detaining authority, would retain MHA responsibility. If Cygnet or Leeds want to *transfer* an already detained patient for physical healthcare, their mental health needs should be transferred to TEWV, to take over responsibility for MHA and provision of RC, under section 19, rather than on s17 leave.<br><br>Confirmed that we do have a robust centralised hospital system for the management of mental health legislation processes provided by our mental healthcare providers and this is audited regularly to ensure that the law is complied with - results included in the TEWV Annual Report. This is for the patients for whom we are appropriately the detaining authority. Short term admissions of detained patients from other areas remain the responsibility of the originating Trust/Ind hospital and they will have the required MHA processes in place. | |

**Action plan: NCEPOD: Mental Health in General Hospitals: Treat As One**
**Date: 23/11/2017**
**Action plan owner: Dr David Scullion**
**Monitoring group / committee: Improving Patient Safety Steering Group**

**Action plan progress: May 2018**

| ID no. | Issue / Audit Finding / Theme | Indicator (if relevant - remove column if not) | Current situation | Initial risk (H/M/L) | Action/s | Operational Lead | Responsible Lead | Target Date | ID no. | Risk at review (H/M/L or complete | Progress made | Further action/s to ensure completion |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 14 | Ongoing patient care | Mental healthcare should be routinely included in stepup and step-down documentation to critical care, with appropriate involvement from liaison psychiatry. | Should be included in medical handover | Low | Consider adding prompt to critical care step down documentation - "was there a MH condition / addressed?" | R Tuffin | R Tuffin | | | | | |
| 15 | | Discharge planning for patients with mental health conditions should involve multidisciplinary input, including liaison psychiatry where appropriate and in all cases where the patient has been under the care of liaison psychiatry. The discharge letter should be copied to all specialties providing ongoing mental and physical healthcare outside of the general hospital. Sharing of clinical information between care providers using a Summary Care Record or equivalent should be utilised. | MH teams involved in relevant discharges | Low | Add to discharge summary - whether MH have been involved, ongoing plans, prompt to ensure copies to all specialties providing ongoing mental and physical healthcare. This will also help ensure MH issues during admission are picked up by coders. | R Pitts | M Shepherd | May-18 | | | | |
| 16 | Training | All hospital staff who have interaction with patients, including clerical and security staff, should receive training in mental health conditions in general hospitals. Training should be developed and offered across the entire career pathway from undergraduate to workplace based continued professional development. | Yes- need training to be developed and agreed, but not possible to train all staff. Aim to develop a network of champions<br><br>TEWV delivering bite sized training / extended training | Medium | Focus on clinical staff and develop network of MH champions - and ensure other staff know who to ask | Supporting Vulnerable People Steering group | Jill Foster | Jul-18 | | | | |
| | | | | | Develop TNA for the MH champions, and staff who might provide one-to-one care. TEWV can support training | Supporting Vulnerable People Steering group | Jill Foster | Jul-18 | | | | |
| | | | | | Extend buddying of HDFT CSWs on Rowan / Cedar from acute wards. | Steph Davis / Liz Baker | Jill Foster | May-18 | | | | |
| | | | | | Include MHLS / Crisis Team in FY1 and FY2 doctors induction / training programme | Dawn Martin / Shakeel Rahman / Liz Baker | D Scullion | Jul-18 | | | | |
| | | | | | Development of Basic Awareness e-learning module for all staff. Options available on ESR | Liz Baker / Paul Hogarth / Emily Caldecott | D Scullion | Jul-18 | | | | |
| 21 | Coding | Diagnostic coding of mental health conditions must be improved. Liaison psychiatrists should enter the diagnosis in the general hospital notes so that they can be coded appropriately and included in discharge summaries made by general hospital doctors. This will help with local and national audit. | Yes- training of MH teams and coders to write diagnoses in and then pick them up for coding. | Low | Work to standardise coding with ECDS between MHLS and ED | Paul Hogarth / M Shepherd / H Law | M Shepherd | May-18 | | | | |

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:** | 6 June 2018 |
| **Date of Board meeting for which this report is prepared** | 27 June 2018 |

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

**Hot Spots:** No issues reported

**Board Request for QC to seek assurance:** scrutiny on patient falls and pressure ulcers continues and annual reports on both areas will be received at the next QC meeting.

**Reports Received:**
QC gained assurance from the following reports:

- Patient Safety Report – Qtr4
- Planned & Surgical Care Directorate Annual Governance Groups Report
- Adult Safeguarding Annual Report – an excellent report showing a significant amount of work conducted in this important area, giving good assurance.

The following reports highlighted some areas for future scrutiny by QC:

- **Patient Experience Report** – Qtr 4, an increase in complaints related to discharge process.
- **NICE Compliance Report** Qtr4 – this team is currently working with reduced capacity, however 41 of the 55 documents published have been reviewed and of these several have been highlighted as a concern. QC debated and challenged the Trust in both time capacity and financial availability in continuing to commit to supporting external audits.
- **External Audit Reports** – Chronic Obstructive Pulmonary Disease, whilst we are complying with the audits recommendations the Trust is not achieving best practice tariff in this area. *See note above under NICE.*

**Other Items**
**Quality Priorities (QP) for 2018-2019**
The baseline reports were received for all five of this year's QP's.
QC requested that the QP for *Improving the Clinical Model of Care for Acute Services* be discussed at SMT to revisit the scoping of this new priority.

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

**Quality Impact Assessments (QIA) –** An audit outcome of limited assurance, relating to the impact of transformational savings on quality of care has been received.
QC heard that currently there is no Trust wide process embedded within the Trust to

highlight the risks in this area.
There is however a Cost Improvement Quality Impact Screening tool which provides oversight and assurance of schemes at directorate level.
QC debated what information would be required to provide oversight and assurance at Trust wide level and a project to implement this is in progress and updates will be reported in subsequent reports.

**Matters for decision**

**None**

**Action Required by Board of Directors:**

1. Note QC action to gain assurance re Quality Impact Assessments;
2. Note QC request for SMT to reconsider scope of new Quality Priority related to *Improving the Clinical Model of Care for Acute Services*;
3. Note QC challenge about the Trust's capacity to support external audits.

Harrogate and District
NHS Foundation Trust

# Board Committee report to the Board of Directors

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|---|---|
| **Committee Name:** | Finance Committee |
| **Committee Chair:** | Maureen Taylor |
| **Date of last meeting:** | 14 June 2018 |
| **Date of Board meeting for which this report is prepared** | 27 June 2018 |

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

1. The Committee received an update on the latest financial position for 2018/19. Mr Coulter confirmed that the Trust was meeting its external plan (a deficit of £2,362k against a planned deficit of £2,889k) but was not meeting the internal plan (a planned deficit of £1,117k). Activity was largely on track but expenditure on ward staffing, theatres, CIP delivery and corporate non-pay were overspent at month 2.
2. A CIP of £10.7m is required in 2018/19 to achieve our internal plan. The risk adjusted CIP at month 2 stands at 87%. The risk areas are within Corporate, Central schemes and Long Term and unscheduled care.
3. The cash position continues to be a concern. STF funding relating to 2017/18 has not been received yet. Information presented showed that the Trust had £5m of receivables outstanding for more than 90 days and this includes £1.5m of over-trade income from 2017/18. The consequence of this is that creditor payments are delayed.
4. A report on activity was presented. Month 2 activity exceeds month one and overall, activity is slightly ahead of plan.
5. A report on workforce for month 1 was presented and discussed. Ward and theatre staffing are overspent and these variances continue into month 2. Mr Coulter reported on actions being taken by the Chief Nurse to control additional ward staff for one to one support in order to curb this overspend.
6. The provisional Financial Sustainability Risk Rating for Q1 is likely to be 2.
7. Benchmarking Initiatives – Mr Coulter reported there would be a nurse staffing review in July which would compare staffing levels with other Trusts. In addition, corporate data comparisons would also take place, comparing a number of “back office” functions with peer organisations. A recent Model Hospital presentation was well attended and raised some questions for specific specialities (e.g. diabetes and endocrinology).
8. The committee received a very informative update on progress with the Aligned Incentive Contract and in particular about measures that would need to be taken during winter pressures to keep the contract within the £94m agreed.

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|---|
| 9. Mr Coulter updated the committee on a letter received from NHSI giving feedback on the Operational Plan 2018/19. A response is being prepared to the questions raised and these will be discussed on 18th June. |
| **Are there any significant risks for noting by Board? (list if appropriate)** |
| • Ward staffing is overspending by £200k each month and needs to be contained if the Plan is to be achieved.<br>• Focus on outstanding debts from 2017/18 is needed to improve the Trust's cash position. |
| **Matters for decision** |
| |
| **Action Required by Board of Directors:** The Board of Directors is asked to note the contents of this report. |

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

| | |
|---|---|
| **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

| | |
|---|---|
| **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

| | |
|---|---|
| **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* |

| | |
|---|---|
| **NYCC** | *North Yorkshire County Council* |

# O

| | |
|---|---|
| **OD** | *Organisational Development* |
| **ODG** | *Operational Delivery Group* |
| **ODP** | *Operating Department Practitioner* |
| **OPEL** | *Operational Pressures Escalation Levels* |
| **OSCE** | *The Objective Structured Clinical Examination* |

# P

| | |
|---|---|
| **PACS** | *Picture Archiving and Communications System – the digital storage of x-rays* |
| **PbR** | *Payment by Results* |
| **PEAT** | *Patient Environment Action Team* |
| **PET** | *Patient Experience Team* |
| **PET SCAN** | *Position emission tomography scanning system* |
| **PHSO** | *Parliamentary and Health Service Ombudsman* |
| **PMO** | *Project Management Office* |
| **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

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

# R

| | |
|---|---|
| **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* |

| | |
|---|---|
| **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

| | |
|---|---|
| **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

| | |
|---|---|
| **YTD** | *Year to Date* |

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

**June 2018**