Harrogate and District NHS Foundation Trust

The meeting of the Board of Directors held in public will take place at 9.00am on Wednesday 29 May 2019 in the Boardroom, Trust HQ, Harrogate District Hospital, HG2 7SX

AGENDA			
Item No.	**Item**	**Lead**	**Paper No.**
	9.00am – 9.20am		
	Patient Story – an edited audio recording from a patient meeting, presented by David Britton, Head of Nursing, Planned and Surgical Care and Mel Jackson, Patient Safety Manager		
	9.20am – 10.30am		
1.0	**Welcome and Apologies for Absence** *To receive any apologies for absence:* **Mr Harrison**	Mrs A Schofield, Chairman	-
2.0	**Declarations of Interest and Register of Interests** *To declare any interests relevant to the agenda and to receive any changes to the Register of Interests*	Mrs A Schofield, Chairman	2.0
3.0	**Minutes of the Board of Directors meeting held on 27 March 2019** *To review and approve the Minutes of the meeting*	Mrs A Schofield, Chairman	3.0
4.0	**Review Action Log and Matters Arising** *To provide updates on progress of actions*	Mrs A Schofield, Chairman	4.0
Overview by the Chairman		Mrs A Schofield, Chairman	-
5.0	**Report by the Chief Executive including Integrated Board Report and Finance Report**	Mr S Russell, Chief Executive	5.0
	To deliver high quality health care		
6.0	**6.0 Summary from Quality Committee meeting of 1 May 2019**	Ms L Robson, Chairman Quality Committee	6.0
	6.1 Annual Efficiency Programme Quality Impact Assessment	Mrs J Foster, Chief Nurse / Dr D Scullion, Medical Director	Verbal
	6.2 Guardian of Safe Working Hours Report	Dr D Scullion, Medical Director	6.2
	6.3 Annual Patient Experience and Complaints Report 2018/19	Mrs J Foster, Chief Nurse	6.3
	6.4 Learning from Deaths Quarterly Update	Dr D Scullion, Medical Director	6.4
	6.5 Consideration of IBR metrics relating to quality		6.5

	To work with partners to deliver integrated care		
7.0	**7.0 WYAAT Report**	Mr S Russell, Chief Executive	Verbal
	10.30am – 10.40am		
	Break		
	10.40am – 12.30pm		
	To ensure clinical and financial sustainability		
8.0	**8.0 Summary from Resources Committee meetings of 23 April 2019 (attached) and 28 May 2019 (to follow)** *To be considered and discussed*	Mrs M Taylor, Chairman of Resources Committee	8.0
	8.1 Business Planning Update – Operational Plan 2019/20 *To be considered and discussed*	Mr J Coulter, Director of Finance	8.1
	8.2 ICS Financial Framework *To confirm approval of the decision to adopt the Framework*	Mr J Coulter, Director of Finance	8.2
	8.3 Consideration of IBR and other metrics related to workforce and other HR matters	Ms A Wilkinson, Director of Workforce and Organisational Development	8.3
	8.4 Consideration of IBR and other metrics related to financial performance and contracts	Mr J Coulter, Director of Finance	8.4
	Governance		
9.0	**9.0 Summary from Audit Committee meetings of 8 and 21 May 2019** (written and oral) *To be considered and discussed*	Mr C Thompson, Chairman of the Audit Committee	9.0
	9.1 Minutes of the Council of Governors' meeting on 26 January 2019 *For information*	Mrs A Schofield, Chairman	9.1
	9.2 Resources Committee Annual Report	Mrs M Taylor, Chairman of Resources Committee	9.2
	9.3 Quality Committee Annual Report	Ms L Robson, Chairman Quality Committee	9.3
	9.4 Audit Committee Annual Report	Mr C Thompson, Chairman of the Audit Committee	9.4
10.0	**Any other relevant business** *By permission of the Chairman*	Mrs A Schofield, Chairman	-
	Board Evaluation	Mrs A Schofield, Chairman	-
Confidential Motion – the Chairman to move: *Members of the public and representatives of the press to be excluded from the remainder of the meeting due to the confidential nature of business to be transacted, publicly on which would be prejudicial to the public interest.*			

Harrogate and District NHS Foundation Trust

BOARD OF DIRECTORS – REGISTERED DECLARED INTERESTS

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

The register is maintained by the Company Secretary and was last updated in May 2019.

Name	Position	Interests Declared
Mr Andrew Alldred	Clinical Director LTUC	1. Chair of the Yorkshire and Humber Medicines Optimisation and Procurement Committee 2. Member of the Yorkshire and Humber Chief Pharmacist group 3. Member of the West Yorkshire and Harrogate ICS Pharmacy Leadership Group 4. Chair of the Procurement sub-committee of the West Yorkshire and Harrogate ICS and Regional Partners Regional Store Project and a member of the project board
Ms Sarah Armstrong	Non-Executive Director	1. Company director for the flat management company of current residence 2. Chief Executive of the Ewing Foundation
Mr Jonathan Coulter	Deputy Chief Executive/ Finance Director	1. Non-Executive Director of Harrogate Healthcare Facilities Management Limited t/a Harrogate Integrated Facilities (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust)
Mrs Jill Foster	Chief Nurse	None
Mr Robert Harrison	Chief Operating Officer	1. Appointed Voluntary Member of the Strategy and Resources Committee of the Methodist Church 2. Charity Trustee of Acomb Methodist Church, York
Dr Kat Johnson	Clinical Director PSC	None
Dr Natalie Lyth	Clinical Director CCCC	None
Ms Laura Robson	Non-Executive Director	1. Familial relationship with Alzheimer's Society
Mr Steve Russell	Chief Executive	None
Mrs Angela Schofield	Chairman	1. Member of WYAAT Committee in Common 2. Volunteer with Supporting Older People (charity). 3. Chair of NHS Northern Region Talent Board
Dr David Scullion	Medical Director	1. Member of the Yorkshire Radiology Group 2. Familial linkage with Freedom to Speak Up Guardian

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Mr Richard Stiff	Non-Executive Director	1. Director of (and 50% owner) Richard Stiff Consulting Limited 2. Director of NCER CIC (Chair of the Board from April 2019) 3. Director and Trustee of TCV (The Conservation Volunteers) 4. Vice Chair of the Corporation of Selby College 5. Member of the Association of Directors of Children's Services 6. Member of Society of Local Authority Chief Executives 7. Local Government Information Unit Associate 8. Local Government Information Unit (Scotland) Associate 9. Fellow of the Royal Society of Arts
Mrs Maureen Taylor	Non-Executive Director	None
Mr Christopher Thompson	Non-Executive Director	1. Non-Executive Director of Harrogate Healthcare Facilities Management Limited (a wholly owned subsidiary company of Harrogate and District NHS Foundation Trust) 2. Director – Neville Holt Opera Limited 3. Deputy Treasurer and Member – Council of the University of York 4. Chair – NHS Audit Yorkshire Consortium 5. Chair – Tissue and Organ Donation Committee HDFT
Mrs Lesley Webster	Non-Executive Director	None
Ms Angela Wilkinson	Director of Workforce and Organisational Development	None

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Deputy Directors attending Board meetings as substitutes

Dr David Earl	Deputy Medical Director	1. Private anaesthetic work at BMI Duchy hospital
Dr Claire Hall	Deputy Medical Director	1. HDFT representative on WYAAT Pathology group 2. HDFT representative on WYAAT Non-Surgical Oncology group 3. Member, HDFT Transfusion Committee 4. Principal Investigator for haematology trials at HDFT
Mrs Joanne Harrison	Deputy Director of Workforce and Organisational Development	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
Dr Sylvia Wood	Deputy Director of Governance & Freedom to Speak Up Guardian	1. Familial relationship with Medical Director

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 27 March 2019 at 9.00am in the Boardroom at Harrogate District Hospital

Present:
Ms Sarah Armstrong, Non-Executive Director
Mr Jonathan Coulter, Deputy Chief Executive/Finance Director
Mrs Jill Foster, Chief Nurse
Mr Robert Harrison, Chief Operating Officer
Mrs Angela Schofield, Chairman
Dr David Scullion, Medical Director,
Mr Richard Stiff, Non-Executive Director
Mrs Maureen Taylor, Non-Executive Director
Mr Chris Thompson, Non-Executive Director/Vice Chairman
Dr Ros Tolcher, Chief Executive
Mrs Lesley Webster, Non-Executive Director
Ms Angela Wilkinson, Director of Workforce and Organisational Development

In attendance:
Mr Andrew Alldred, Clinical Director, Long Term and Unscheduled Care
Mr Andrew Forsyth, Interim Company Secretary
Dr Claire Hall, Deputy Medical Director
Mrs Melanie Jackson, Patient Safety Manager (Patient story only)
Dr Kat Johnson, Clinical Director, Planned and Surgical Care
Dr Natalie Lyth, Clinical Director for Children's and County Wide Community Services
Mr Steve Russell, Chief Executive (designate)
Dr Matthew Shepherd, Clinical Lead, Emergency Department (Patient story only)
Dr Sylvia Wood, Freedom to Speak Up Guardian (item 9 only)

Patient Story

Mrs Schofield welcomed Dr Shepherd and Mrs Jackson to the meeting.

Dr Shepherd outlined the circumstances surrounding an edited audio recording of part of the patient conference which had taken place following the death of a patient who had been brought into the Emergency Department.

The patient (an 82-year old female) had been brought in by ambulance and her condition had deteriorated such that she was moved in to Resus. Her family had arrived before the ambulance and had been asked to wait in the waiting room, but no connection had been made between the family and the patient when the latter arrived, despite the family asking about their relative. The patient suffered a cardiac arrest and, despite efforts to revive her which included CPR, unfortunately she died. The patient had a DNACPR in place but the Emergency Department team had been unaware of this.

Sadly, the first that the family knew of what had happened to their relative was when they were invited into the Department to be told that the patient had died.

The Board was then played the audio recording, which lasted for some six minutes.

Following the recording Dr Shepherd said that he had apologised to the family for what had happened. A number of changes have been made to communicating with family members, to ensure that they are aware when a patient arrives if it is after their own arrival. The lack of visibility of DNACPR is being addressed through the new WebV patient record - DNACPR will be a patient alert which will alert teams to the presence (or need to ask about) a DNACPR.

He said that the incident had a big impact on the team. The handover from the ambulance crew had been a standard process but they had not been aware of the DNACPR and had therefore not been able to follow the wishes of the patient. Dr Shepherd said that the incident had been discussed at the departmental Quality meeting and with doctors in training and SAS doctors and the revised processes were embedded through the department's safety huddles. The Emergency Department receptionists now routinely direct families to go through to their relatives with the ambulance crew as soon as they have booked in the patient.

Mrs Schofield thanked Dr Shepherd. She said that the circumstances were very distressing for all, particularly the family. Dr Tolcher noted that it was impossible to make the situation good, but that by listening and learning the Trust could improve practices. Mr Harrison said that patients were also received direct in other places (eg CAT/MAU/Littondale and Nidderdale Wards) and asked how the same lessons had been embedded in them. Mr Alldred said that the incident had been discussed as the Directorate Board and been picked up particularly in CAT and MAU. He had chaired the complaint resolution meeting and considered that the audio that the Board had heard was very powerful in conveying the emotion felt by the family. He emphasised that this had a profound the impact on the staff involved, and more widely in the department.

Mrs Webster reminded the Board that the Quality Committee was already considering the Respect programme and DNACPR and whether or not the national format should be used. The work had not yet moved forward and she felt that an early decision was needed about the Trust's approach. Mrs Forster agreed to update the Quality Committee at the next meeting, noting that there were two separate issues, one of DNACPR and the second in respect of Respect which was about much more advanced care planning.

Mrs Schofield said that it had been a very powerful story and lessons had clearly been learnt. Dr Tolcher was clear that hearing the relatives or patients in their own words provided a more compelling patient story and that the greater emotion provided a greater impact on the Board.

Whilst Dr Shpeherd was present, Mrs Schofield congratulated Dr Shepherd on the improvement in the timely treatment of patients attending the department and his leadership of the team. He responded by praising the increased engagement across the hospital which had improved patient flow.

1.0 Welcome and Apologies for Absence

1.1 Mrs Schofield noted there were apologies for absence from Ms Laura Robson, Non-Executive Director.

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

1.3 Mrs Schofield welcomed Mr Steve Russell, Chief Executive (designate) of the Trust, and said that he would be taking a full part in the meeting. She also welcomed to the meeting Mr Cowans and Mr Dennys (members of the Council of Governors of the Trust) two members of the public and two members of Trust staff.

2.0 Declarations of Interest and Board Register of Interests

2.1 It was noted Mr Coulter and Mr Thompson were Directors of Harrogate Integrated Facilities (HIF). 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 HIF.

2.2 Mr Harrison wished it to be recorded that he was a member of the WYAAT Strategy and Operations group and WYAAT Pathology Board whilst Ms Wilkinson declared that she was a member of the WYAAT Pathology Board.

3.0 Minutes of the meeting of the Board of Directors on 30 January 2019

The draft minutes of the meeting held on 28 November 2018 were approved subject to the following amendments:

Minute 5.10 – **Delete** *in toto*
Insert: 'Mrs Webster noted that the Audit Committee had discussed the RTT data in the Integrated Board Report and noted that the way it was presented did not make clear for how much longer beyond the standard patients had been waiting, how many patients were involved and whether the waits were unreasonable. Mr Coulter said that there was now a national focus on waiting list numbers and agreed that it was important to understand by how much longer patients were waiting.'

Minute 9.4 – line 7 **Delete: '**Mrs Coulter'
Insert: 'Mr Coulter'

Minute 12.2 – line 8 **Delete:** 'they were'
Insert: 'Oakdale Ward was'

Minute 12.2 – line 10 **Delete:** 'she saw no benefit in more staff.'
Insert: 'she saw no benefit in more staff until a new staffing model was developed and in place.'

Minute 15.7 – line 5 **Delete:** 'Mrs Harrison'
Insert: 'Mr Harrison'

Minute 18.3 - line 5 **Delete:** 'approved the'

Minute 18.3 – last line Following 'risks' **insert:** 'relating to the 2018/19 audit of accounts'

APPROVED:
The Board of Directors approved the minutes of the meeting held on 30 January 2019 as an accurate record of proceedings, subject to the agreed amendments.

4.0 Review of Action Log and Matters Arising

4.1 Action 122: Ms Wilkinson said that it had been agreed that the reports would be made to the Resources Committee. Board action completed.

4.2 Action 123: action completed.

4.3 Action 125: Dr Scullion explained that this was a normal variation, and was likely to refer to orthogeriatric patients. A large mortality review around 18 months ago had identified very good practice and given assurance. The numbers involved were small and so it was important to distinguish between 'norma;l variation' and outlier alerts. Mr Harrison reported that Trauma and Orthopaedic deaths were now back within the expected range. There had been a recent alert through the other measure of mortality (SHMI) around pathological fractures and a clinical review was planned to identify any learning.. He noted thatthe categories under the Learning from Deaths report were being reviewed. The Trust always reviewed some deaths as a quality assurance measure but a Structured Joint Review was not currently undertaken for all deaths, in common with most Trusts.

4.4 Actions 126, 127 and 129 action completed.

4.5 Action 128 – Mrs Foster stated that there was now a nurse specialist who had been identified to manage the transition of patients from children's services into adult services with a focus on diabetes, asthma and epilepsy. Board action completed.

4.6 There were no other matters arising.

APPROVED:
The Board of Directors noted completed actions.

Overview by the Chairman

Mrs Schofield noted a number of items:

- She reported, with regret, the death of Mrs Rosemary Marsh, who had had a long association with the Trust, latterly through the Patient Voice Group and, since January 2008, as a Public Governor. Mrs Schofield said that Rosemary had been an excellent supporter of the Trust over many years and it was very sad to have learnt of her death. Details of the arrangements for her funeral would be sent out once they were received.
- Board members had already been made aware of the outcome of the CQC inspection. She was delighted that the Trust's services had been rated as 'Good' overall, the highest rating possible under the process, which had not inspected the services which had been below 'Good' at the previous inspection in 2016. Feedback on this apparent flaw in the inspection had been shared with the CQC. All areas which had been inspected had improved and a number of services had been rated 'Outstanding'. She said that every member of the Trust should be incredibly proud of this achievement which reflected their hard work each and every day.
- Mrs Schofield welcomed the constructive dialogue with the Board of HIF at the Board

to Board meeting on 30 January and she expected the dialogue to continue. A second meeting would be convened in September.

- The Board to Forum meeting with the Youth Forum on 19 March had been a very good meeting and she looked forward to continuing to work with the Youth Forum to ensure their experience and expertise was used to help shape our services. There would be an annual meeting with the Forum and she had written thank you letters to members of the Forum.
- The breadth of items discussed at the Board workshop in Ripon had included an update on operational planning for 2019-20, a discussion about risk appetite (building on the session in Scarborough last October), a presentation on claims by DAC Beachcroft and Mrs Leng, and a preliminary discussion around the maternity self-assessment, which was also on the Board agenda for the meeting.
- Dr Tolcher had presented early work around diversity in the Trust, and Mrs Schofield said that this was important work as both the CQC report and the WRES had indicated that that Trust should be pursuing greater diversity, especially at senior levels.
- The workshop had also discussed a seven-day working self-assessment and the WYAAT Pharmacy business case.
- A number of Board members had subsequently visited Trinity Ward and the Minor Injuries Unit at Ripon Hospital.
- Before inviting Dr Tolcher to present her last Board report, Mrs Schofield said that Ros had been an inspiring and transformational leader and the Trust and the wider NHS owed her a huge thank you. She had been open and transparent at both Board and Council of Governors' meetings, with magnificent presentations. Her last year, 2018-19 had seen strong performance, new services and positive feedback from patients about services provided by the Trust. She had lived up to and beyond the Trust Values and put patients at the very centre of decision-making. Mrs Schofield said that she and the Board knew that Dr Tolcher had great plans for her retirement and wished her the very best for her future.

5.0 Report by the Chief Executive

5.1 The report and IBR had been circulated in advance of the meeting and was taken as read. Dr Tolcher drew out some specific issues from her report.

5.2 Dr Tolcher opened her remarks by saying that the Trust had worked hard to achieve the best year-end performance possible. Care quality was very positive; mortality, falls and infection control had all improved and work to reduce the waiting had continued. She said that the thanks for the excellent CQC outcome absolutely lay squarely with the staff, and that everyone should be proud of their efforts. The NHS Staff Survey results had shown better engagement and an improvement in clinical safety and was overall a a good report.

5.3 Moving to the financial position, Dr Tolcher noted that the Trust had achieved a surplus in January and February, but the latter had been written-off by the accrual for Emergency Department Provider Sustainability Fund monies for Q1-Q3 which the Trust did now not think would be made available to the Trust. The deficit against the control total remained at around £3m.

5.4 The North Yorkshire and York Integrated Care Partnership was a new and important strategic development in the system. The Trust was embedded with the West Yorkshire and Harrogate system which had been very positive for the Trust. North Yorkshire County Council found strategic co-ordination difficult given it played into 3 STPs

and the NYYICP was a proposed approach to better approach strategic coherence at a North Yorkshire and York 'place'. Principles and a draft Memorandum of Understanding were being worked up and would be brought to the Board in due course. It would be important to understand the relationship between this, WYAAT and WYH HCP.

5.5 Dr Tolcher reported that, in addition to those documents recorded in her report, she and the Chairman had signed and sealed a document relating to the premises of the Renal Dialysis Unit leased by York NHS FT. Mrs Taylor queried the Design and Build contract for the Endoscopy Unit which she had reported as signing and Dr Tolcher clarified this had been an agreed amendment to the original contract for the building.

5.6 Mr Thompson asked about the imminent transfer of HASU services from the Trust to Leeds and York, and whether thrombolysis would continue to be provided at Harrogate District Hospital. Mr Harrison confirmed that this would not be the case - patients would be transferred rapidly to Leeds General Infirmary or York District Hospital. Dr Scullion said that, ideally, patients would not present at the Trust but taken straight to other units if the system worked well. The Trust would no longer give thrombolysis, but if patients presented there was an agreed rapid transfer protocol to Leeds or York by blue light. He advised that the time window for thrombolysis was 4 hours from onset of symptoms and so expected even with such a transfer most patients would be within this.

5.7 Mrs Schofield thanked Dr Tolcher for her report. In response Dr Tolcher said that she was most grateful for the support which she had received from and at the Board. She wished to thank Executive and Non-Executive Board members, as well as Clinical Directors, for their support, challenge and encouragement over the last almost five years. She also wished to place on record her sincere thanks to colleagues across the organisation for their hard work and commitment to the Trust under her tenure, and passed her very best wishes to Steve Russell as he took over the leadership of the Trust.

To deliver high quality healthcare

6.0 Quality Committee Report – 6 March 2019

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

6.2 Mrs Schofield noted that the hot spot was clearly around acute medical staffing issues and invited Mr Alldred to outline the current position. The acute medical unit was staffed by one consultant, working single-handedly. A new job plan was currently being agreed with him for the medium and long-term. There had been interest from other consultants and those in the training pipeline and three or four physicians had expressed interest informally. There were more options than when the subject had been discussed previously and the service had stabilised. Mr Alldred said that solutions to what was the highest priority in his Directorate were being worked through.

6.3 Mrs Foster and Dr Lyth reassured Board members that the absence of the Safeguarding lead in Children's Services was being managed.

6.4 Dr Tolcher was concerned about how the Trust should use the data from the Friends and Family Tests. Her ambition was for the Trust to be in the upper quartile when benchmarking against peers but at present it was the least well performing for inpatient and staff responses against that group. There was a good rate of returns but it was important to examine and understand the underlying issues. She suggested that the

Quality Committee should to consider issues underlying FFT results with a view to improving the outcomes.

ACTION:
Quality Committee to consider issues underlying FFT results

7.0 Nurse and Midwifery (Safe) Staffing Assurance Report

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

7.2 Mrs Foster reminded the Board that in January it had approved the improvement plan based on the NHSI review. The review of establishments had been agreed with senior staff and they were content with the arrangements. Myths around the requirement for enhanced care had been dispelled and Mr Alldred assured the Board that robust arrangements were in place where this was required. The Nurse Staffing Review had only examined acute settings, whilst the report included staffing across all areas of nursing and midwifery, and broader staff groups. Mrs Foster confirmed that in future the report would be brought to the Board in March and September. She said that this report assured the Board that the Trust had a safe and effective nursing and midwifery workforce.

7.3 Mr Thompson was concerned about the caseload for Knaresborough and Boroughbridge community nursing team, which was significantly higher than others. Mrs Foster and Mr Alldred agreed to investigate why this was.

7.4 Mrs Taylor enquired whether Expectation 1 included further enhanced care and was this different to 1:1 care. Mrs Foster replied that enhanced care covered a broad range of care interventions including line of sight and cohorting and 1:1 care was above this level and a specific intervention. This safer culture had been introduced successfully with reduced spending as a result. Mr Alldred added that a risk assessment was undertaken and then escalation put in place if required – it was usually possibly to manage patients within the establishment.

7.5 Moving to the Health Visitor/School Nurse establishment, Mr Stiff asked about the differences in staffing across the areas in which the Trust provided these services. Mrs Foster acknowledged the differences and said that commissioners were content with the delivery of services despite the differences, and that the difference was often due to the specification of different commissioners. Neither delivery nor finances were being compromised. Mr Coulter said that the situation was being managed well within Directorates whilst Mr Harrison added that the roll-out of VPN would enhance the capability of Health Visitors. Some vacancies were being held purposefully awaiting these improvements. The School Nurse workforce position was different and there were continuing discussions. Mrs Webster was surprised at the number of cases for Health Visitors in County Durham (1560) and how they were being managed; Dr Lyth noted that they had lower sickness rates and Mr Harrison said they were being well managed locally. Finally Mr Coulter noted that the North Yorkshire caseload was an outlier and would be the subject of discussion with North Yorkshire County Council.

ACTION:
Mrs Foster and Mr Alldred to investigate high caseload of Knaresborough Community Care team.

8.0 NHS Resolution Final Report

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

8.2 Mrs Schofield reminded Board members that this had been examined at the Board workshop in February. Mrs Foster noted that the deadline for submission was not until August and that there was thus no need for the Board to approve it at this stage.

The Board of Directors noted the report

9.0 Freedom to Speak Up Guardian Biannual Report

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

9.2 Mrs Schofield welcomed Dr Wood to the meeting and emphasised the importance of her having direct access to the Board of Directors. Prior to the discussion, Dr Scullion noted his conflict of interest and offered to absent himself from the discussion. He was invited to remain but it was noted that if appropriate during the discussion he would absent himself.

9.3 Dr Wood said that she had applied learning from the national guardians office to her work at the Trust. There had been an increase in cases reporting to her during 2018 and she believed that was in part due to the raising of her profile and in part to an underlying need for her role. Themes which were raised were similar in many cases. She was working to promote the Fairness Champions in the context of the Trust developing the Fair and Just culture. There were now 34 Fairness Champions across the Trust, although there were still some staff groups (eg Doctors in Training) lacking them and these would be the subject of specific focus. She noted the results of the NHS Staff Survey which indicated that staff had positive confidence to raise issues.

9.4 Work on Conflicts of Interest policy had continued following a question from the National Guardian – this work centred around how best to manage real or perceived conflicts of loyalty. Part of this involved the appointment of a second Freedom to Speak Up Guardian, the process for which was underway.

9.5 Mrs Schofield thanked Dr Wood for her report and remarks. She asked what was included in the job description for the Fairness Champions. Dr Wood replied that they were expected to promote a learning culture around speaking up and provide a listening ear – they were not min-Freedom to Speak Up Guardians. They were expected to listen, support and signpost staff. The first group had already produced a number of ideas to make the role more visible and effective. Mrs Webster suggested that they would model good behaviour and encourage confidence amongst staff.

9.6 Addressing the potential perception of a conflict of loyalty around Dr Wood and Dr Scullion, Dr Tolcher said that this was not seen as a problem. The higher profile of both was generally understood and only if every issue was perceived to go to the Guardian's office then the mitigations in place would not work. Work on communications around this would improve understanding of the position; the National Guardian had been reassured that other routes for resolution were available and many cases would not reach the Guardian.

9.7 Mr Stiff was pleased to see the fairness work moving forward and particularly the CPD for Trade Union colleagues. Mr Thompson, having declared his interest as a member of the HIF Board, asked whether the figures included HIF staff and asked that a separate report be produced for HIF; this would be able to identify the extent of bullying and harassment in HIF; Dr Tolcher said that HIF may wish to consider appointing a dedicated Guardian.

ACTION:
Mrs Foster/Dr Wood to prepare a separate Freedom to Speak Up Guardian report for HIF staff

9.8 Dr Hall asked whether Dr Wood had been aware of any misuse of the process and whether there was evidence of threats or intimidation causing staff not to contact her. Dr

Wood said she had no evidence and therefore assumed not. The fairness champions were also intended to assist by more broadly supporting staff and signposting them. Mr Alldred said that from his Directorate's point of view, the role of the Guardian was clear and balanced and about signposting and follow-up. He believed it was gaining traction and was a positive initiative.

9.9 Summarising the discussion, Mrs Schofield said that in future there would be quarterly meetings between the Chairman, Chief Executive and the Guardian to take the temperature of the Trust and identify trends. She thanked Dr Wood for acting with sensitivity and tact in the post.

10.0 Consideration of IBR metrics relating to quality

10.1 Mrs Schofield invited the Executive and Clinical Directors to outline any risks that they felt the Board should be aware of in respect of quality.
10.2 Mr Harrison said that he was concerned about performance against RTT standards and the size of the waiting list, and noted that this may be an increasing risk depending on the Operating plan that would be agreed with commissioners for 2019/20.. Whilst cancer standards had been met this was not without significant effort and ongoing performance remained a risk, and breast symptomatic was a particular concern. The latter was common across WYAAT and had been discussed at the recent WYAAT Strategy and Operations meeting, with a review commissioned around capacity and demand.

10.3 Mrs Foster said that she was very pleased with the standards of care being provided by the Trust. Whilst there had been an increase in the number of complaints year on year there were no identifiable 'hot spots'. On complaints, the Trust needed to improve time taken to respond, as had been identified in the recent CQC report.

10.4 Dr Scullion was also concerned about RTT and the contract for 2019-20. The position with acute medical care was being addressed but staffing pressures in oncology and gastroenterology had changed little over the year. On complaints he echoed Mrs Foster's comments about timeliness but also raised the quality of responses. He considered that the process was working as well as it could as it was currently designed and the Trust may need to take a different approach to clinical complaints. He was also concerned about the impact of the taxation changes relating to NHS Pensions, in particular the annual allowance.

10.5 Dr Johnson shared the concern over RTT and complaints. She said that the quality and rigour of responses needed to be reviewed and the Trust must become better at learning from complaints. She used the patient story at Board meetings of an example of a learning culture. Dr Johnson also noted the challenging situation over pensions, which was beginning to hamper planning in her Directorate. Dr Tolcher noted that the taxation of pension savings was a national issue, currently without a solution.

10.6 Dr Lyth was concerned about the reduced Public Health grants, which might necessitate developing different ways of delivering services. The grants were no longer ring-fenced and had been recalculated which resulted in less funding being available

10.7 Mr Alldred's main concern was the acute oncology service, whilst the transition of the HASU service on 3 April was expected to go well. Those suffering a Transient Ischaemic Attack (TIA) would continue to be treated at Harrogate. Mr Harrison added that reporting would continue through SNAP and TIA reports to the Senior Management Team. There were good communication arrangements in place between services at Leeds, York and Harrogate and patients would be discharged as soon as possible, with most to return to Harrogate for further treatment and rehabilitation.

To work with partners to deliver integrated care

11.0 West Yorkshire Association of Acute Trusts report

11.1 Dr Tolcher gave a verbal report, At the last meeting a proposed change to the Pharmacy Supply Chain, in which Mr Alldred had been instrumental, had been discontinued and a change of approach agreed. The final Business Case would be considered by WYAAT in due course. The sustainability of dermatology services across WYAAT had been discussed as had challenges to the microbiology services across West Yorkshire and Harrogate, where an opportunity to network services was under consideration. Mrs Schofield and Mr Harrison had attended an organisational development session following the WYAAT meeting.

To ensure clinical and financial sustainability

12.0 Report of the Resources Committee

12.1 The February and March reports of the Resources Committee had been circulated in advance of the meeting and were taken as read.

12.2 Mrs Taylor said that she would not comment on the February report as matters had moved on significantly. In the March report she noted that the Trust had been £467,000 in deficit. The Cost Improvement Programme (CIP) was looking likely to hit 100% achievement and income was on track. All activity against the contract with Harrogate and Rural District Clinical Commissioning Group (HaRD CCG) was all ahead of plan with exception of elective inpatients. The Trust would achieve the Control Total set for it. Cash remained an issue and paying of bills in accordance with the better payments practice code (BPPC) was challenging.

12.3 The Committee had discussed the operational plan for 2019-20, which had not yet been agreed. Model Hospital data indicated areas in which efficiency could be improved and the committee had requested increased oversight of the Trust's approach to these opportunities

12.4 Mr Coulter said that agency spending was beginning to rise slowly and there was triangulation between this and sickness absence underway. Looking forward he said that the run rate had improved from September onwards and the Trust must live within its means, deliver the CIP and not fall behind in future, as had happened in 2018-19. He expected March to be similar to February, although control of agency spending, which had been improving until then, had slipped a little. The psychology must be to continue the focus on this in February and March and importantly through into the new financial year and not lose the momentum that had been gained. The current Use of Resources score was 2 which would improve to 1 at year end if the Control Total was achieved.

12.5 Continuing, Mr Coulter said that extra resources to support elective activity had been available for the final period of the year and Local Authority Commissioners had paid in advance, which had helped to improve the cash position.

12.6 Mrs Schofield congratulated colleagues and their teams on achieving 100% of the CIP, with around 25% non-recurring, and noted that this was a strong performance

relative to many other organisations. It was a significant achievement to reduce costs by 4.7% and she thanked the Directorates for their efforts, as this meant it was likely the Trust would achieve the control total for FY19, and for the planning that they had already made for the CIP in 2019-20Mr Coulter confirmed that the final element to be agreed was in respect of the £1.2m Provider Sustainability Fund.. He expected that there would also be unclaimed funding from this source which would be allocated after year end. If the Trust achieved the Control Total then it would be well-placed to receive an element of this – decisions were expected on 17 April.

13.0 Consideration of IBR and other metrics related to workforce and other HR matters

13.1 Ms Wilkinson highlighted that sickness absence had risen to above 5% against the 3.9% target figure. Within this, long-term sickness rates were static and whilst short term sickness was following a seasonal trend it was important to understand the causes and to identify how best to support staff. A 'deep dive' review was underway in each of the three operational Directorates. It was noted that sickness absence rates in community staffing (Health Visitors and School Nurses) could be linked to looming contract changes and the anxiety that this naturally caused staff members. Dr Tolcher noted that the sickness rate in February 2018 had been 5.34% and she suggested sharing data on days lost to sickness absence across the Directorates as a powerful lever. Dr Lyth added that a look at teams with low sickness absence rates, and examining why they had greater resilience, could be valuable and Mrs Schofield echoed this saying that often more could be learned from good practice than analysing poor outcomes. Mr Alldred said that medical workforce sickness absence was a particular focus for him as an area for improvement.

Governance

14.0 Summary of the Audit Committee meeting – 6 March 2019

14.1 Mr Thompson's report had been circulated in advance of the Board meeting and was taken as read.

14.2 Mr Thompson said that the Committee had looked at the arrangements for year end and confirmed that the Trust should be considered to be a "Going Concern" for the purposes of the preparation of year-end financial statements and approved the revised Accounting Policies for the Trust. There had been concern that Payroll was not being informed in a timely manner of staff changes affecting pay, leading to some overpayments. Mr Coulter confirmed that such overpayments were always recovered in full, although there were some associated opportunity costs. The Committee had been pleased to note the improvement in the submission of Post Project Evaluations.

The Board of Directors noted the Actions in the approved the Summary of the Audit Committee meeting – 6 March 2019

15.0 Minutes of the Council of Governors' Meeting on 1 August 2018

15.1 The Board of Directors noted the Minutes of the Council of Governors' Meeting held on 6 November 2018.

16.0 Freedom of Information Act 2000 Annual Report

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

16.2 Mr Forsyth highlighted the challenge which both the volume and complexity of some enquiries presented to what was a relatively small number of staff who supplied responses. He thanks Mrs Parsons who administered the process.

16.3 Mr Forsyth noted that the number of enquiries had risen again year on year and that the number which had not been answered within the statutory 20 working day deadline had again fallen. In the case of the three appeals to the Information Commissioner, the Trust had been directed to release the redacted information in each case, including one which involved detailed financial information contained in the Business Case for the creation of the Wholly Owned Subsidiary (HIF), despite this being considered by the Trust as commercially confidential.

16.4 Mrs Taylor suggested that a review of the Publication Scheme would be timely.

The Board of Directors received and noted the Freedom of Information Act 2000 Annual Report

17.0 Any other relevant business not included on the Agenda

17.1 There was no other business not included on the Agenda.

18.0 Board Evaluation

Board members agreed that the pace of the meeting had been appropriate and that they had been given an opportunity to talk about the right things. Ms Armstrong had found the reflections of the Executive Directors to have been valuable.
Mr Stiff noted that there had been positive coverage (running to several column inches) of the Trust, post-CQC report, in the Selby Times and Mrs Schofield said that the Ripon Gazette had featured the report on its front page, and the Harrogate Advertiser, Stray FM and BBC Radio York had also featured positive stories.

Dr Tolcher said that the Patient Story had been brilliant and Mrs Schofield said that the fact that it had been uncomfortable had been a positive element. She encouraged the use of different media to convey the Patient Story if the patient or relative was not willing or able to attend in person. Mrs Forsyth was requested to discuss this with the Patient Safety Manager.

ACTION:
Mr Forsyth to confirm value of different media for Patient Story to the Patient Safety Manager

19.0 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 11.20am.

4

HDFT Board of Directors Actions Schedule
Action Log
May 2019

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
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 CCWCC	**May** 2019	*From January 2019*
130	January 2019 (minute 17.2)	Post Project Evaluation of Supported Discharge Service to be considered by Board of Directors	Mr Harrison, Chief Operating Officer	November 2019	
131	March 2019 (minute 6.4)	Quality Committee to consider issues underlying FFT results	Ms Robson, Non-Executive Director, Chair of Quality Committee	May 2019	
132	March 2019 (minute 7.5)	Investigate high caseload of Knaresborough Community Care team	Mrs Foster, Chief Nurse/Mr Alldred, Clinical Director LTUC	May 2019	Complete
133	March 2019 (minute 9.7)	Prepare separate Freedom to Speak Up Guardian report for HIF staff	Mrs Foster, Chief Nurse/Dr Wood, FTSUG	June 2019	
134	March 2019 (minute 18.0)	Confirm value of different media for Patient story	Mr Forsyth, Interim Company Secretary	May 2019	Complete

Introduction

1. This is my first formal report to the Board of Directors. I wanted to thank members of the Board and, in particular the executive team, for their support. I'd also like to place on record my thanks to our amazing #teamHDFT colleagues across our 0-19 community children's services, our adult community services and those in our hospitals who have given me an incredibly warm welcome, their time, and great advice.

2. It will come as no surprise that I have spent much of my time learning about our services, our places, and our people, and listening to views about key issues, having the opportunity to share some of my early thoughts and reflections, and meeting key partners locally, and across North Yorkshire and York and West Yorkshire and Harrogate.

3. Many colleagues across HDFT use social media, and I have enjoyed learning from those on Twitter in particular about their work. I have found it a great additional way to connect with colleagues and hope many more colleagues may join up to share their great work and ideas. One of our Matrons used Twitter to ask for musicians to volunteer to play on one of our wards at HDH to encourage social interaction and lift spirits; she received many offers by return – and a huge thank you to Sophie who played on Byland ward in April. We're exploring options for a workplace-based social media platform to encourage connection across teams and geographies.

4. My early discussions have focused on how we secure the best possible care for our communities through caring for our people and making HDFT one of the very best places to work. I firmly believe that a focus on the health and wellbeing of our colleagues, supporting teams to do their work easily, and supporting colleagues to improve their work will lead to the best possible care for our communities. Alongside this I have reflected with colleagues about the importance of every role in HDFT, learning from each other within and across teams, and promoting kind, compassionate and respectful behaviour.

5. In general, this resonates with colleagues and builds on the good work that has already been done on culture. Colleagues have given good advice about the importance of the senior leadership team being connected and visible, about listening to the voice of those who do the work, and empowering them and supporting them to make improvements to their work. Colleagues have also reflected that the Trust's scope of services and locations are very different and want to see our focus, identity, communication and way of thinking reflecting the new breadth and scope. There has also been strong feedback about the issues which make it harder for them to do and improve their work, and whilst these vary from place to place, there are some common themes.

6. Through the executive team and the senior management team we are currently reflecting on the learning and feedback, and refreshing our priorities and our way of working for 2019/20 which we would propose to discuss with other Board colleagues at an upcoming workshop and with our colleagues across HDFT.

7. In the next section, I have set out some of the key issues that we have been working on in the last seven weeks which I think it would be helpful for the Board to be aware of.

2019/20 Operating Plan agreement

8. In May, Board members agreed that we should sign up to the ICS financial framework which places 15% of the Trust's Provider Sustainability Funding (PSF) at risk, in order to qualify for Flexible Transformation Funding. The framework incentivises members of the ICS to work together to ensure the aggregate control total for the ICS is met. The deadline for a response meant we had to consider this in a Board workshop, and it was duly agreed we should sign up to the framework.

9. The 'Harrogate place' faces a considerable financial pressure in 2019/20 and beyond and developing an approach to this has been a key area of focus. This is in the context of a relatively efficient commissioning system and provider sector in Harrogate, with the key challenge being an affordability issue to our local CCG, which results in insufficient funds being available to support the current level of secondary care activity.

10. Resolution of this issue has occupied a considerable amount of leadership effort and time for both the Trust team and the CCG team and despite very challenging circumstances there has been a constructive and positive working relationship between the teams.

11. This has included discussions with the ICS and NHS England and NHS Improvement (NHSE/I) and in return for some non-recurrent support to our commissioners, we were jointly asked to take on additional risk. This in effect asks the system to avoid growth, or to manage growth within the existing cost base. This is a material ask of the system, and after detailed discussions we have agreed to share the financial and performance risk associated with this between the Trust and the CCG and we will be carefully reviewing any risks to the quality of patient or staff experience.

12. We have reached an agreement in principle, which will require a significant shift in our way of working, and also involves us as an organisation taking a significant stake and share of the risk in our system which may not ordinarily or immediately fall to us. However, we believe this is the right thing to do for the communities we serve and because we recognise we are part of a system. The Board will receive an update on this in more detail as part of the meeting.

NHS Pension Scheme

13. Whilst for the majority of NHS staff the NHS pension scheme provides a valued set of benefits, there is a very significant and growing impact on medical staff, in particular in respect of the impact of the annual allowance. This exposes colleagues to a risk of a high tax charge (which in some cases is greater than the pay received), particularly where additional clinical work or leadership roles are undertaken, and as such clinicians are understandably reluctant to take these on which is a clear concern to us. This is also a significant morale issue for some colleagues, albeit it is a consequence of national policy, rather than a local Trust decision.

14. There continues to be national discussions about potential scheme flexibility but as yet there is no clarity on the timescale for any proposals.

15. Locally, there is a desire for clarity about the actions the Trust may or may not take and the Board is scheduled to consider this matter in the private part of the meeting. This has also been discussed across WYAAT as we feel it is important not to inadvertently destabilise the labour market between organisations.

Summary of Month One

16. The adverse variances in the Integrated Board Report (IBR) relate to harm free care, reporting of low/no harm incidents (Safe), waiting times for A&E, elective care, and the first outpatient appointment for suspected cancer referrals (Responsive), sickness (Workforce), and a deficit run rate (Finance).

17. We have agreed a challenging and significant ambition to reduce activity in hospital based settings where clinically appropriate as I referenced in the previous section.

18. At the end of April, compared with last year, referrals were 3.5% above the same period, outpatient activity was 2.6% above plan and elective activity was 8.5% above plan. The total waiting list size is 14,469 compared to 13,509 at the end of March and performance against the incomplete standard is 88.5%, with the 92nd percentile wait in weeks at 21 weeks, instead of 18 weeks.

19. Across our emergency pathways we saw 6.4% more A&E attendances than in April 2018, and there were 18.1% more emergency admissions. This has placed pressure on our teams with an average of nine escalation beds being open across the month with percentage occupancy remaining high throughout the month. We are undertaking further review to confirm the initial analysis given the apparent scale of increase.

20. Our community teams have continued to work hard throughout the month of April providing care for patients in their homes and the community. To help reduce the pressure on the service a number of the Adult Service teams are now working in different ways, for example, patients that may have been on the continence service caseloads for long periods of time are now receiving care and where appropriate, discharged, and provided with a contact number if their position changes. Historically we would have kept all these patients on our caseloads.

21. This is to be expected in part, as the schemes to change pathways are in the process of being developed and so we would not expect to see impact until later in the year, but nonetheless this demonstrates the scale of change we need to secure working with our colleagues in primary care and with local government.

22. Fifty three people joined HDFT, and we bid farewell to 58 people, and overall had 3532 full-time equivalent (FTE) people in post against a plan of 3530. Sickness absence (4.6%) and stability continue to be areas of concern. The Board will receive a fuller update from the Director of Workforce & Organisational Development.

23. We are slightly ahead of our financial plan at month one, with a deficit of £1.6m against a planned deficit of £2.1m. However, our aggregate plan for the year is a deficit of £0.8m before Provider Sustainability Funding (PSF) and Marginal Rate Emergency Tariff

(MRET) and consequently further improvements to the run rate are required. The plan contains risks which are yet to be mitigated and delivery of the agreed Cost Improvement Programme is a key area of focus for us. The Board will receive a fuller update in the finance report from the Director of Finance.

25. A&E performance was 93.6%. 87.9% of patients who received treatment in the month were waiting under 18 weeks, which is at the same level as March. 88.5% of patients waiting for treatment have been waiting under 18 weeks; this has improved from our March position of 87.8%. Cancer performance was of significant concern with 86.9% of patients seen within 2 weeks of referral. This has been caused by a growth in breast referrals of 4.0% in the period January to April, compared to the same period last year and a reduction in capacity because of the pension issue. We are working closely with our WYAAT colleagues as well as the CCG and primary care to resolve the issue in the short term as well as develop a longer term plan.

Making experiences count

24. Improving how we learn from the experiences of patients remains a priority and during April and May we have increased our focus on providing a timely response which addresses concerns raised by patients. The 95th centile time to respond to a complaint is currently 78 days, with an average of 38 days.

25. Because there are a large number of complaints already overdue (13 on 23 May) it will take some time to improve reported performance.

26. Clinical directorates are working very hard and there has been an improvement in the quality of responses. We recognise that the way we approach this from both a process and learning perspective can be improved and we have scheduled an Improvement event to focus on this. It is expected to take place by the end of the summer. We will continue to report this to the Quality Committee for scrutiny and challenge.

Celebrating success

27. In March and April, 51 colleagues were nominated for a Making a Difference award, with 18 being recognised formally with one. Because of the volume received, 13 have been carried forward to May. It is a great opportunity for us to learn about, support and recognise the outstanding discretionary effort people make and is increasingly hard to decide on winners! In addition Nidderdale Ward and the Knaresborough Community Care Team were recognised as March and April's Team of the Month Award winners respectively.

28. In addition to this, other colleagues have received external recognition for their contributions. Jane Jones, a Health Visitor in North Yorkshire was made a Queen's Nurse, Andy Dennis won Stray FM's Charity Fundraiser of the Year for his fundraising support to Médecins Sans Frontieres and Philip Bremner won the Advancing Healthcare Macmillan cancer award for leadership and innovation following his work on an NHS welfare and benefit service.

29. The Endoscopy service received Joint Accreditation Group accreditation and the team were highly commended by the review team, and through the work of the falls improvement huddles our teams in Medicine have seen a significant reduction in falls, with Oakdale ward seeing a reduction of 70%. In April across the Trust there were no falls resulting in moderate or severe harm.

30. Teams have continued to support causes that are close to their hearts - Our Growing Healthy team in North Yorkshire took on the Skipton Triathlon to support the breastfeeding champions' initiative, and the outpatient team and pathology teams ran a 'bake off' for Macmillan cancer and the Children's Air Ambulance respectively. Continuing the 'bake off' theme, our midwives and orthopaedic therapy team ran cake sales to support Oxfam's programme of providing education, care and support to the mums and babies overseas, and children with cancer respectively. Our Growing Healthy team in Gateshead swapped cake for knickers on International Nurses' Day to support period dignity in schools.

31. Our Growing Healthy team in Darlington ran a raffle to support St Teresa's Hospice and next month Ed Powell-Smith, one of our Orthopaedic consultants, is doing a 500 mile cycle ride across France and Germany for SSAFA and Leeds Children's Charity. There will be many others that I am not aware of. This shows the kindness and compassion of so many people across HDFT who I am proud to have as colleagues. Many members of the community are also engaged in fundraising to support services across HDFT – and we are incredibly grateful for their support.

32. Our charity has also been active promoting the Nidderdale walk and future events. Over 230 people took part in the Nidderdale walk, and 12 teams and eight staff and many others from elsewhere in the NHS are signed up to It's a Knockout and the Yorkshire 3 Peaks respectively.

33. We've also marked International Day of the Midwife, International Nurses' Day, International Research Day, World Parkinson's Day, World TB Way, Deaf Awareness Week, Dying Matters Awareness Week, Autism Awareness Week and Equality, Diversity and Human Rights Week. Alongside other public sector partners we are supporting 'Pride in Diversity' in Harrogate which takes place on 15 June.

News from partners

34. The governing bodies of Harrogate & District Care Commissioning Group (CCG), Hambleton, Richmond and Whitby CCG and Scarborough and Ryedale CCG are proposing to merge, and slightly further afield, there is a proposal to replace the three CCGs in Bradford district and Craven with one new CCG.

35. The Yorkshire Ambulance Service electronic patient record has gone live in HDH which we hope will improve the availability of information to our teams.

Risks

36. The Corporate Risk Register was reviewed at the monthly meeting of the Corporate Risk Review Group on 10 May 2019. No risks were added to the register, one risk was updated (CR35) and two risks were removed:

- CR36: Risk of critical report (and potential reputational impact) from Human Tissue Authority/UKAS/ Care Quality Commission regarding lack of bariatric fridges and inoperable post mortem tables in the mortuary.

- CR39: Risk to the delivery of clinical care by not being able to remove clinical waste from sites.

37. The Corporate Risk Register summary is as follows:

Corporate risk register summary of changes: Updated May 2019

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; reduction in trainee numbers; agency cap rate; quality control of locums; and no-deal EU Exit *(added 08/03/2019)* .	16	↔	*3*	*Mar-20*	*Progress with actions score improved from 5 to 3*
CR5	Risk to the quality of service delivery due gaps in registered nurses establishment	12	↔	*2*	*Oct-20*	
CR14	Risk of financial deficit and impact on the quality of service delivery due to failure to deliver the Trust annual plan by having excess expenditure or a shortfall in income. *NB Impact of no-deal EU Exit on annual financial plan added 08/03/2019*	12	↔	*2*	*Apr-19*	*Consider re-wording risk description to be more focused on directorates*
CR18	Risk to provision of service and not achieving national standards in cardiology due to potential for lab equipment breaking down	12	↔	*1*	*Jun-19*	*Gap in control updated*
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	↔	*4*	*Oct-19*	*Target date for risk reduction extended by 6 months*
CR27	Risk to the quality of 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	16	↔	*5*	*Apr-19*	
CR32	Financial risk from major sporting events due to cost of contingency arrangements and loss of income	12	↔	*3*	*Sep-19*	
CR34	Risk to quality of care by not meeting NICE guidance in relation to the completion of autism assessment within 3 months of referral.	12	↔	*1*	*TBC*	
CR35	Risk to Service Delivery as Microsoft ends support for Windows 7 in January 2020 resulting in no further patch or security updates from Microsoft.	8	↓	*2*	*Apr-20*	*Microsoft agreement to extend W7 Support to Dec 2020. Still awaiting licence allocation (expected mid-May) and capital cost pressure circa £600k therefore risk not removed completely*
CR36	Risk of critical report (and potential reputational impact) from HTA / UKAS / CQC regarding lack of bariatric fridges and inoperable post mortem tables in the mortuary.	8	↓	*4*	*TBC*	
CR37	Risk of negative impact on performance targets, income and potentially patient safety if individual consultants/SAS doctors reduce job plans/additional activity as a result of tax changes in 2019.	12	↔	*TBC*	*Apr-19*	
CR38`	Risk of failure to meet regulations for claims, complaints and incidents if historical outlook emails cannot be accessed following move to NHS net	12	↔	*TBC*	*TBC*	
CR39	Risk to the delivery of clinical care by not being able to remove clinical waste from sites	8	↓	*2*	*Apr-19*	

39. The Board Assurance Framework was reviewed by the Executive Directors on 8 May. No changes were made.

The Board will review the Board Assurance Framework in detail during its private meeting on 29 May.

The summary of strategic risks to the Trust, as reflected in the Board Assurance Framework, is as follows:

Ref	Description	Risk score	Progress score	Target risk score reached
BAF 1	Risk of a lack of medical, nursing and clinical staff	*Amber 9* ↔	*Unchanged at 1*	√
BAF 2	Risk of a high level of frailty in the local population	*Amber 8* ↔	*Unchanged at 1*	√
BAF 3	Risk of a failure to learn from feedback and Incidents	*Amber 9* ↔	*Unchanged at 2*	
BAF 5	Risk of maintaining service sustainability	*Amber 9* ↔	*Unchanged at 1*	
BAF 9	Risk of a failure to deliver the Operational Plan	*Red 12* ↓	*Unchanged at 2*	
BAF 10	Risk of breaching the terms of the Trust's Licence to operate	*Yellow 5* ↔	*Unchanged at 1*	√
BAF 12	Risk of external funding constraints	*Red 12* ↔	*Unchanged at 1*	√
BAF 13	Risk standards of care and the organisation's reputation for quality fall because quality does not have a sufficient priority in the Trust	*Yellow 4* ↔	*Unchanged at 1*	√
BAF 14	Risk of delivery of integrated models of care	*Amber 8* ↔	*Unchanged at 1*	√
BAF 15	Risk of misalignment of strategic plans	*Red 12* ↑	*Unchanged at 1*	
BAF 16	Risk that the Trust's critical infrastructure (including estates, diagnostic capacity, bed capacity and IT) is not fit for purpose	*Red 12* ↔	*Improved to 2*	
BAF 17	Risk to senior leadership capacity	*Amber 8* ↓	*Unchanged at 1*	

Common Seal Transaction

40. I am pleased to report that during May 2019 the Chairman and I have signed, and affixed the Trust Seal, to the contract variation to extend the Children's Services 0-19 contract between HDFT and Darlington Borough Council to March 2022.

Clinical Excellence Awards 2018

41. The Clinical Excellence Local Awards Committee (LAC) met in March to discuss the allocation of awards for 2018.

The awards allocation process changed for 2018 - 2021 which resulted in the removal of levels within the new system. The value of an award is £3,016 and the LAC was able to award multiple awards to an applicant where the committee felt the application was outstanding and stood out from other applications. The awards for CEA 2018 - 2021 are no longer consolidated or pensionable and will be awarded for three consecutive years and then cease.

The Trust complied with the national formula for the minimum annual level of investment in new awards as detailed below:-

- 123 consultants were eligible to apply which is then multiplied by 0.30 equalling the number of awards available (36.9).
- Number of awards (36.9) is then multiplied by the value of an award (£3,016) equating to £111,290, which is the minimum annual level of investment the Trust is required to award.

Applications were scored against five domains which are: delivering a high quality service; developing a high quality service; leadership & managing a high quality service; research & innovation and teaching & training.

High calibre applications demonstrated the significant amount of work undertaken, including work to demonstrate a measurable improved against quality indicators compared with national data and innovation to imbed multi-disciplinary working to benefit patient safety and care. There were also a number of examples of improved staff and public engagement as part of overall improvement methodology.

The Committee also decided to award full awards to those on less than full-time contracts rather than make an award on a pro-rata basis.

A total of 25 Clinical Excellence Awards were made during the 2018 round, as follws:

- 14 to female colleagues and 9 to male colleagues
- 6 of these colleagues can also be categorised as having protected characteristics under the Equality Act.
- There was a spread of specialties – Pediatrics (incl Community) (6), General Medicine/Stroke (4), Urology (1), Trauma and Orthopaedics (2), Emergency Medicine (1), Anaesthetics (4), Obstetrics and Gynaecology (2), Palliative Care (1), Radiology (1) and Elderly Medicine (3)

Steve Russell **23 May 2019**

Harrogate and District NHS Foundation Trust

Integrated board report - April 2019

Key points this month

1. The Trust reported a favourable variance in April of £434k. While this is positive, it is against a deficit plan and therefore it is crucial that we improve the run rate position.

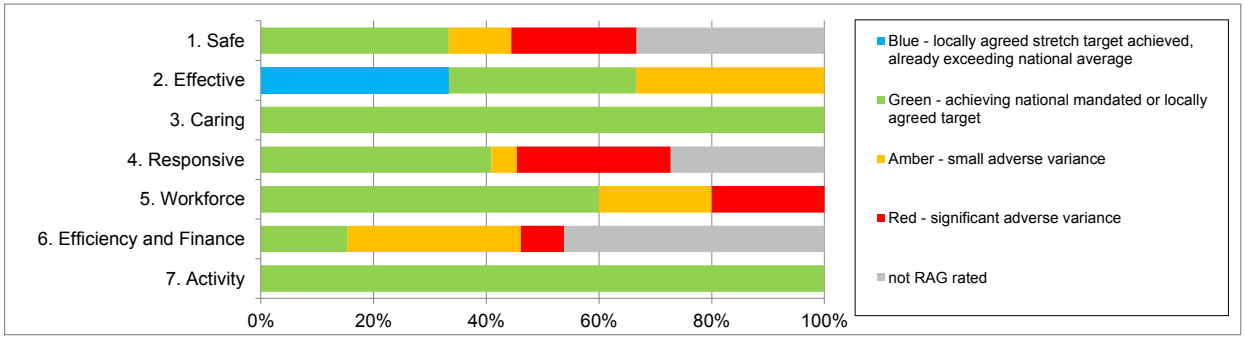
2. HDFT's performance against the A&E 4-hour standard was below 95% reported at 93.65%.

3. The Trust's 18 weeks performance remained below the 92% standard in April with performance at 88.5%.

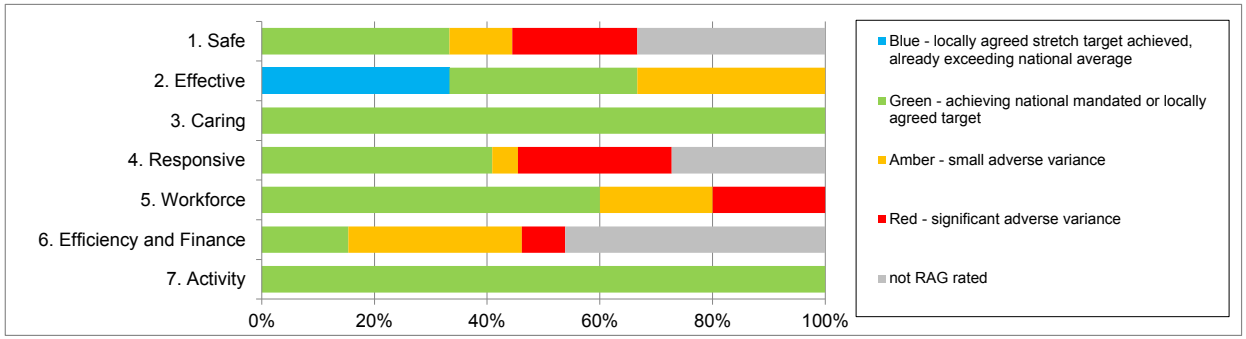
4. Provisional data indicates that all applicable cancer waiting times standards were achieved for April, with the exception of the 14 day breast symptomatic standard (28.9%), the 14 day suspected cancer standard (86.9%), and the 31 day surgcial subsequent treatment standard (90%).

5. The harm free percentage for April was 96.4%.

Summary of indicators - current month

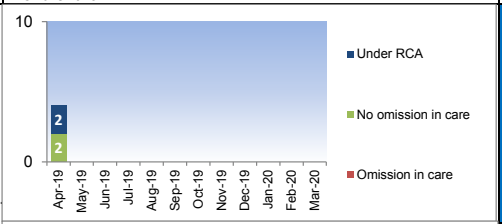
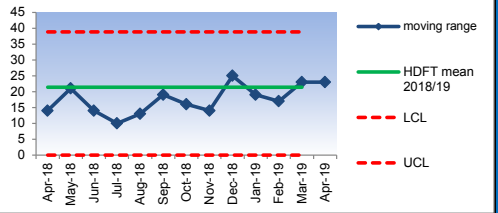
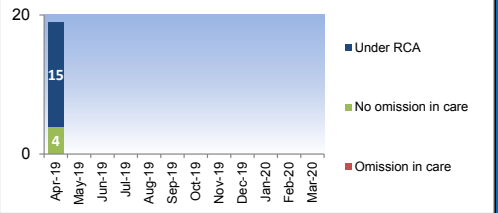
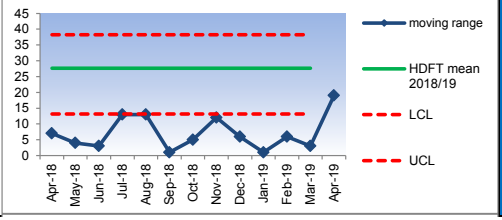


Summary of indicators - year to date

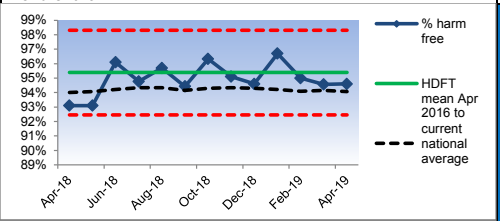
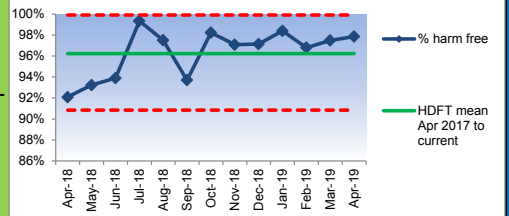
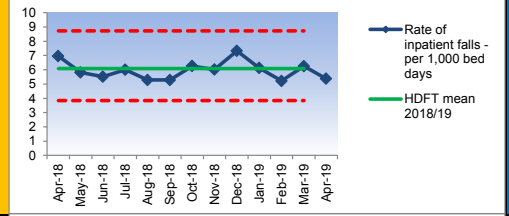
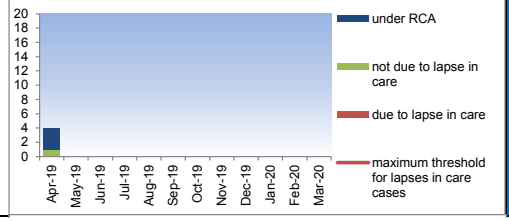


NHS Harrogate and District NHS Foundation Trust

Section 1 - Safe - April 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.1a	Pressure ulcers hospital acquired DQ		There were 4 hospital acquired category 3 and above pressure ulcers reported in April (including device related and device related mucosal). This is in slightly lower than last year with an average of 6 per month reported in 2018/19. Of the 4 reported there were 0 omission in care, 2 no omission in care and 2 under RCA.
1.1b	DQ		The number of hospital acquired category 2 and above pressure ulcers reported in April was 24. The reported number is inclusive of device related and device related mucosal pressure ulcers.
1.2a	Pressure ulcers community acquired DQ		There were 19 community acquired category 3 and above pressure ulcers reported in April (including device related and device related mucosal). The average per month reported in 2018/19 was 11. Of the 19 reported there were 0 omission in care, 4 no omission in care and 15 under RCA.
1.2b	DQ		The number of community acquired category 2 and above pressure ulcers reported in April was 44. The number reorted is inclusive of device related and device related mucolsal pressure ulcers.

Section 1 - Safe - April 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.3	Safety Thermometer - harm free care DQ		The Trust harm free percentage for April was 94.6%. The Trust average for 2018/19 was 94.9%.
1.4	Safety thermometer - harm free care - Community Care Teams DQ		The harm free percentage in the Community for April was 96.4% and remains above 95%.
1.5	Falls DQ		The rate of inpatient falls was 5.38 per 1,000 bed days in April. This is lower than the average HDFT rate for 2018/19 (6.01)
1.6	Infection control DQ		There were 4 cases of hospital apportioned C. difficile reported in April. 1 Case is no lapse in care, and 3 cases are under RCA. No MRSA cases have been reported in 19/20. **(Annual target trajectory required)**

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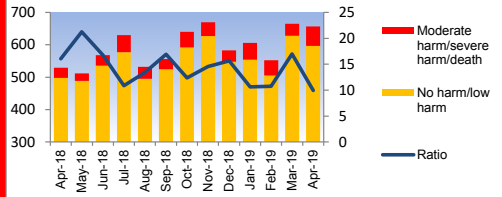
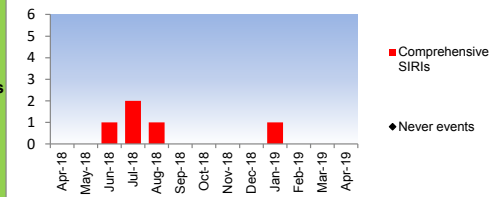
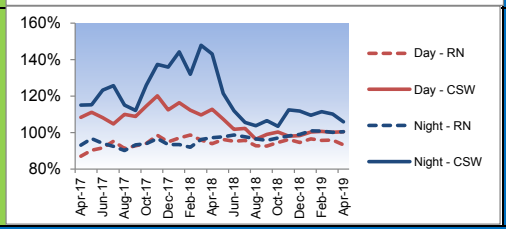
Section 1 - Safe - April 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.7	Incidents - all DQ		The latest published national data (for the period Apr 18 - Sept 18) shows that Acute Trusts reported an average ratio of 46 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 22, an increase on the last publication but remaining in the bottom 25% of Trusts nationally. HDFT's latest local data for April gives a ratio of 10, a deterioration on the March position of 17.
1.8	Incidents - SIRIs and never events DQ		There were no comprehensive SIRI or Never Events reported in April. No Never Events were reported in 2017/18 or 2018/19.
1.9	Safer staffing levels DQ		In April staff fill rates were reported as follows: Registered Nurses Day 93.3% and Night 100.5%, Care Staff Day 100.5% and Night 105.8%. Reported care hours per day per patient was 7.90 hours per day.

Narrative

Total number of hospital falls have reduced by 4% YTD compared to April to January 2017/18.

Safer staffing

The table below summarises the average fill rate on each ward during April 2019. 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 April was 7.90 care hours per patient per day.

Section 1 - Safe - April 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation

	Apr-19						
	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(MSS)	98.20%	97.60%	98.80%	118.90%	4.26	2.73	6.98
Byland	89.50%	91.70%	99.30%	116.10%	2.63	3.12	5.75
CATT(MAU)	93.40%	101.70%	103.80%	103.30%	4.69	2.75	7.45
Farndale	88.00%	92.80%	100.00%	120.00%	3.23	3.42	6.65
Granby	111.70%	138.30%	100.00%	105.00%	3.21	3.19	6.39
Harlow	103.30%	86.70%	100.00%	-	6.82	1.86	8.69
ITU/HDU	102.60%	-	110.00%	-	23.29	1.74	25.03
Jervaulx	95.20%	98.80%	94.70%	112.80%	2.78	3.33	6.12
Lascelles	103.20%	94.70%	100.00%	100.00%	4.55	3.92	8.47
Littondale	95.20%	96.70%	98.90%	106.70%	4.14	2.47	6.61
Maternity Wards	91.10%	85.80%	96.40%	80.00%	15.58	4.14	19.73
Nidderdale	91.30%	96.10%	98.90%	113.30%	3.72	2.3	6.03
Oakdale	86.90%	110.50%	106.70%	103.30%	3.68	3.84	7.51
Special Care Baby Unit	93.80%	43.30%	100.00%	-	23.86	2.95	26.82
Trinity	100.00%	106.00%	100.00%	100.00%	3.17	3.69	6.86
Wensleydale	78.60%	113.30%	100.00%	105.00%	3.95	3.15	7.1
Woodlands	81.40%	93.30%	95.60%	70.00%	10.37	2.83	13.2
Trust Total	**93.30%**	**100.50%**	**100.50%**	**105.80%**	**4.83**	**3.08**	**7.9**
ED	102.00%	146.70%	100.90%	129.60%			

Section 1 - Safe - April 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation

Further information to support the April safer staffing data

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

On Granby, Oakdale and MAU the increase in RN hours and some care staff hours was to support the opening of additional escalation beds in April when required.

The ITU/HDU staffing levels reflect periods of increased activity within the unit during April.

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

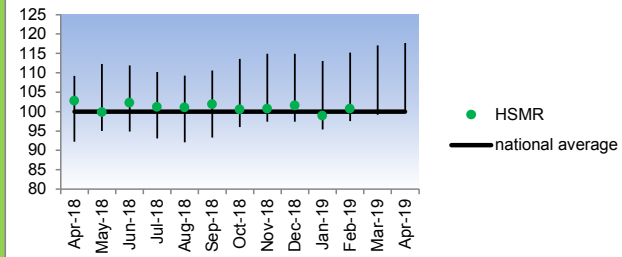
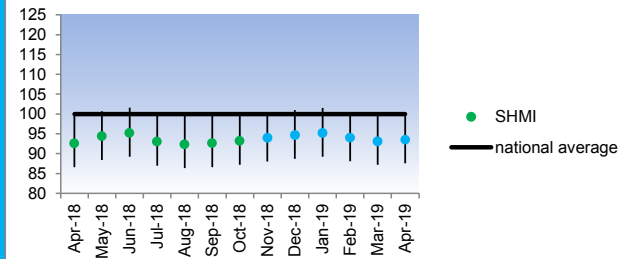
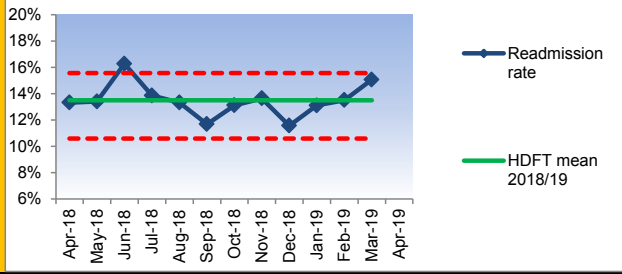
In some wards the actual care staff hours show additional hours used for enhanced care for those patients who require intensive support. In April this is reflected on the wards; MSS, Byland, Farndale, Granby, Jervaulx, Nidderdale and Oakdale.

For the Special Care Baby Unit (SCBU) although the daytime RN 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

In April on Woodlands ward the RN hours were less than planned due to sickness and the care staff hours less than planned due to vacancy and sickness, however the ward occupancy levels vary considerably which means that particularly in this area the number of planned and actual nurses is kept under constant review.

On Wensleydale ward although the daytime RN hours were less than planned in April, the occupancy levels varied in this area throughout the month which enabled staff to assist in other areas.

Section 2 - Effective - April 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
2.1	Mortality - HSMR DQ		Our HSMR has increased to 100.68 for the last 12 months up to February 2019 (98.89 the previous month). Three specialties have a higher than expected standardised mortality rate: Anaesthetics, Geriatric Medicine and General Medicine. The trust is performing above national average which is currently 99.7.
2.2	Mortality - SHMI DQ		SHMI data is now available on HED up to end of December 2018. HDFT's SHMI for the most recent rolling 12 months was 94.11. This remains below expected levels. No new SHMI data is currently available, so it is still currently sitting at 94.11 At specialty level, 5 specialties (Trauma and Orthopaedics, Gastroenterlogy, Respiratory Medicine, Geriatric Medicine, and General Medicine) have a standardised mortality rate above expected levels.
2.3	Readmissions DQ		Emergency Readmissions increased in March to 15.08% resulting in an average of 13.5% for 18/19. This is an increase of 0.4% from 2017/18 which was 13.1%.

Narrative

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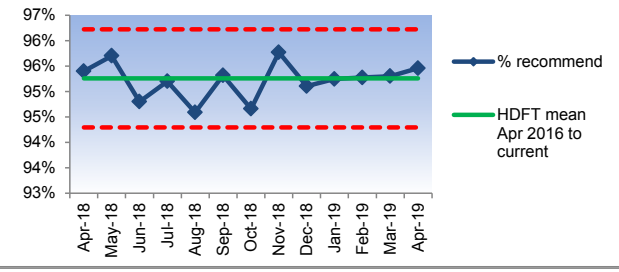
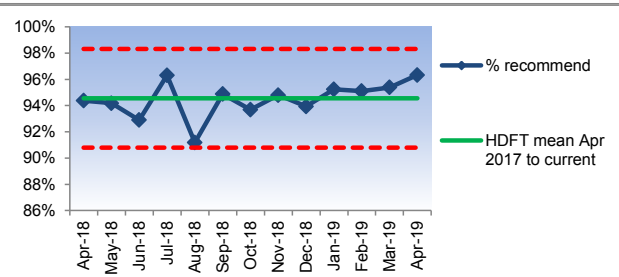
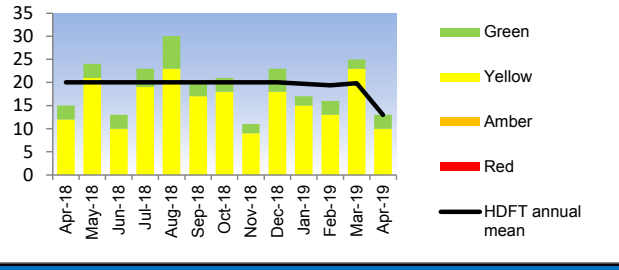
Section 3 - Caring - April 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
3.1	Friends & Family Test (FFT) - Patients DQ		95.5% of patients surveyed in April would recommend our services, an increase on last month and remaining above the latest published national average (93.6%). 4,624 patients responded to the survey this month of which 4,414 would recommend our services.
3.2	Friends & Family Test (FFT) - Adult community services DQ		96.3% of patients surveyed in April would recommend our services, an increase on last month (95.3%). Current national data (March) shows 94% of patients surveyed would recommend the services. 381 patients from our community services responded to the survey this month.
3.3	Complaints DQ		13 complaints were received in April, a decrease on March and below the average for 2018/19. No complaints were classified as amber or red this month.

Narrative

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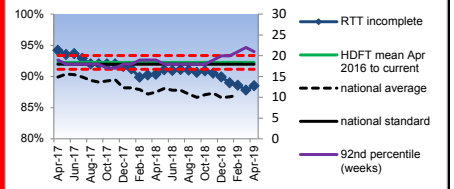
Section 4 - Responsive - April 2019

NHS Improvement Single Oversight Framework

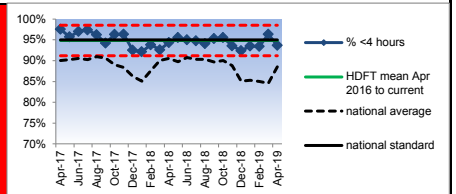
4.1 **NHS Improvement Single Oversight Framework** — DQ

Standard	Q1	Q2	Q3	Q4	YTD
RTT incomplete pathways	88.5%				88.5%
A&E 4-hour standard	93.6%				93.6%
Cancer - 62 days	86.8%				86.8%
Diagnostic waits	99.3%				99.3%
Dementia screening - Step 1	91.6%				91.6%
Dementia screening - Step 2	92.3%				92.3%
Dementia screening - Step 3	100.0%				100.0%

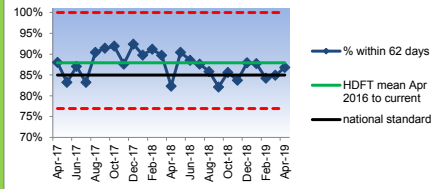
4.2 **RTT Incomplete pathways performance** — DQ



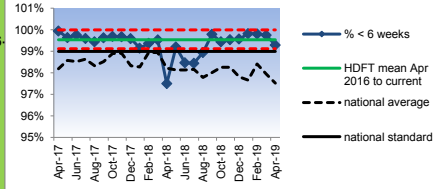
4.3 **A&E 4 hour standard** — DQ



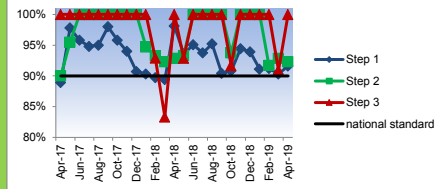
4.4 **Cancer - 62 day wait for first treatment from urgent GP referral to treatment** — DQ



4.5 **Diagnostic waiting times - 6-week standard** — DQ



4.6 **Dementia screening** — DQ



Narrative

Performance against the 62 day cancer standard was delivered in April with provisional performance at 86.8% , however the Breast symptomatic standard continues to be challenging due to a continued rise in referral rates. The COO is working with NHSI and the WY&H Cancer Alliance to review opportunities across the ICS to support the delivery of this standard by improving referral guidance and planned capacity.

Two patients waited longer than 31 days for subsequent surgical treatment (1 skin and 1 bladder) - these were due to patient choice/cancellation and two urological theatre lists being lost because of the Easter bank holiday. The current forecast denominator for April is 20 (90.0%).

The COO held a summit with the clinical team delivering the Breast Care clinics. This focussed on the specific capacity and demand issues leading to the significant drop in performance. This approach is being used across West Yorkshire and Harrogate in conjunction with the Cancer Alliance team as this is an issue across the ICS. A detailed action plan was developed and implementation of this will be managed through Operational Delivery Group. There are a number of short term measures which should stabilise the position, but it will take some months to recover to the expected standard.

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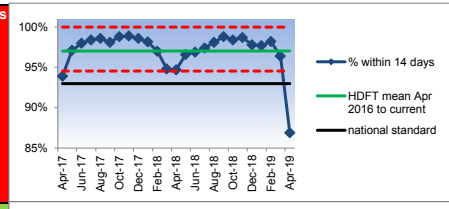
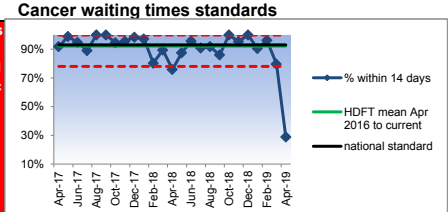
Cancer waiting times standards

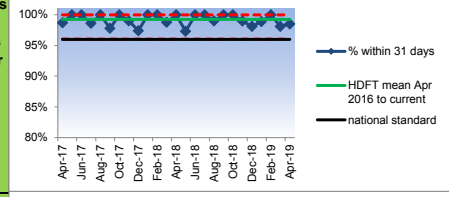
4.7 Cancer - 14 days max wait from urgent GP referral for suspected cancer (DQ)



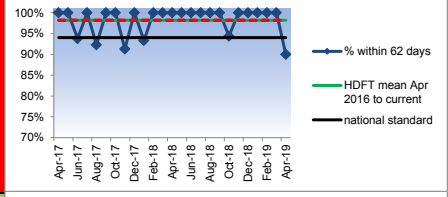
4.8 Cancer - 14 days maximum wait from GP referral for symptomatic breast patients (DQ)



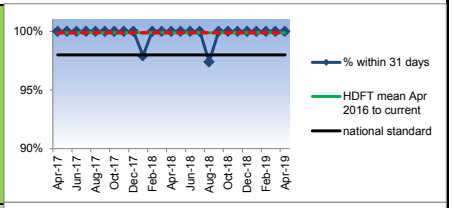
4.9 Cancer - 31 days maximum wait from diagnosis to treatment for all cancers (DQ)



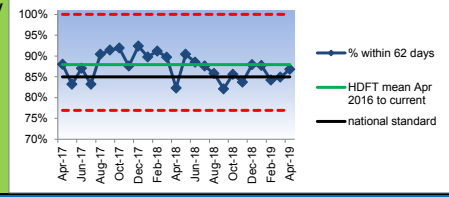
4.10 Cancer - 31 day wait for second or subsequent treatment: Surgery (DQ)



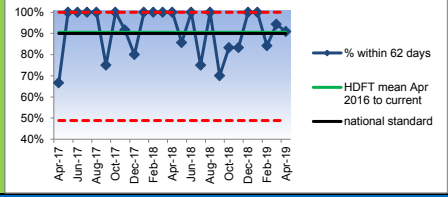
4.11 Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug (DQ)



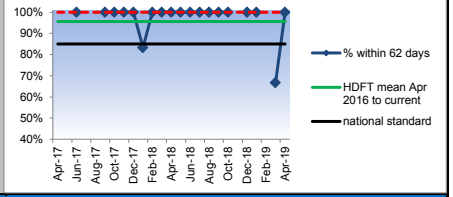
4.12 Cancer - 62 day wait for first treatment from urgent GP referral to treatment (DQ)



4.13 Cancer - 62 day wait for first treatment from screening service (DQ)



4.14 Cancer - 62 day wait for first treatment from consultant upgrade (DQ)



Narrative

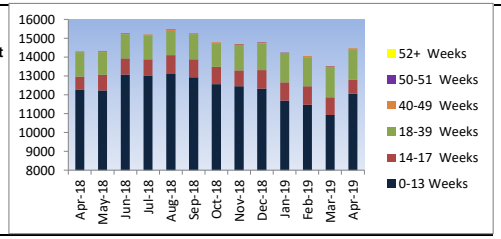
Provisional data indicates that all cancer waiting times standards were achieved in April, with the exception of both 14 day standards. The were 38.0 accountable 62 day treatments in the month with 5.0 breaches, meaning performance was above the standard of 86.8%.

There were 45 non-cancer related breast symptomatic attendances in April, with 32 patients seen after day 14 (28.9%). The denominator for the 14 day suspected cancer standard was 739 in April with 97 patients first seen outside 14 days (86.9%). Of these 97 patients, 86% (83) were breast referrals.

For the main 62 day standard, of the 11 tumour sites, 2 had performance below 85% in April - Gynaecology (2.0 breaches) and Urological (3.0). 2 patients waited over 104 days for treatment in April - both were complex pathways.

RTT waiting list metrics

4.15 RTT waiting list split by weeks (DQ)



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Narrative

Of the 14469 patients on the waiting list at the end of April, 12049 have been waiting 0-13 weeks, 754 for 14-17 weeks, 1578 for 18-39 weeks and 88 between 40-49 weeks. No patients have been waiting 50 weeks or over.

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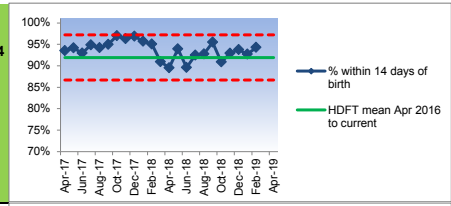
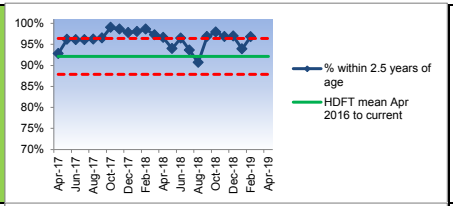
Section 4 - Responsive - April 2019

Children's Services metrics

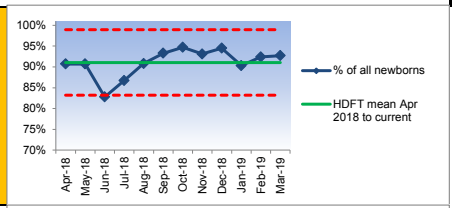
4.16 Children's Services - 10-14 day new birth visit — DQ



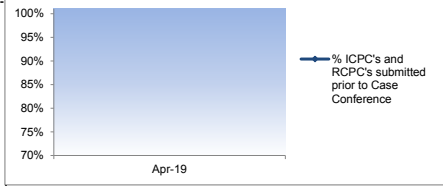
4.17 Children's Services - 2.5 year review — DQ



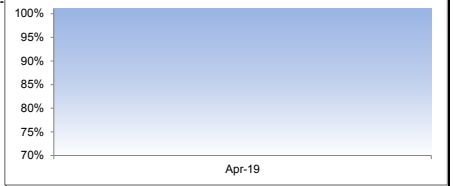
4.18 Children's Services - Use of the Home Environment Assessment Tool — DQ



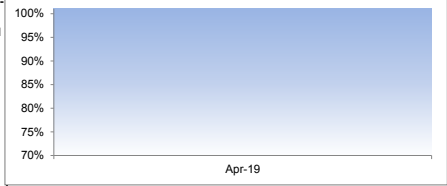
4.19 Children's Services - Reports for Initial and Review Child Protection Case Conferences — DQ



4.20 Children's Services - Staff compliance with Safeguarding Supervision. — DQ



4.21 Children's Services - Reports for Achievement of KPI for Breast Feeding Prevalence. — DQ



Narrative

10-14 day new birth visits is reported one month behind. For February 2019, 94% of newborns received a new birth within 10-14 days. This is an improvement on January where 91.9% was reported.

2.5 year review is reported one month behind. For February 2019, 96.% of children due a 2.5 review received their review in timescale. This again is an improvement on January where 93.9% was reported.

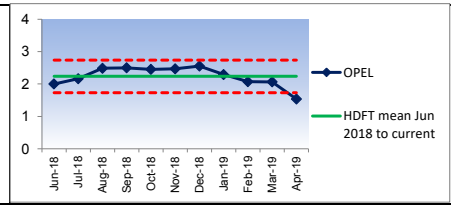
New Metric - this is reported one month behind._Use of the Home Environment Assessment Tool. The Home Environment Assessment Tool enables an assessment of the suitability of the home in relation to basic amenities, health and safety issues, supervision etc. This tool is used by HDFT's Durham 0-19 team. HDFT aim for 95% of eligible children to receive an assessment. For March 2019 91% of eligible children were assessed.

3 new metrics will be reported monthly/quarterly in arrears for 2019/20.

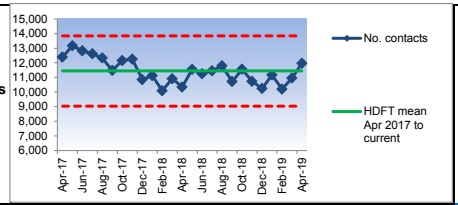
4.19 will be reported on quarterly in arrears for 2019/20. HDFT provide Initial and Review Reports for Child Protection Case Conferences. HDFT aim for 95% of reports to be submitted prior to the CPCC.
4.20 will be reported on quarterly in arrears for 2019/20. HDFT provide Safeguarding Supervision to all staff. Supervision compliance of 80% is required for all staff receiving supervision. % of staff achieving the 80% compliance will be reported quarterly.
4.21 6-8 weeks breast feeding will be reported on monthly in arrears for 2019/20. All Children's Services share a joint KPI for breast feeding prevalence at 6-8 weeks. % achieved against the prevalence KPI will be reported monthly.

Adult Community Services metrics

4.22 OPEL level - Community Care Teams — DQ

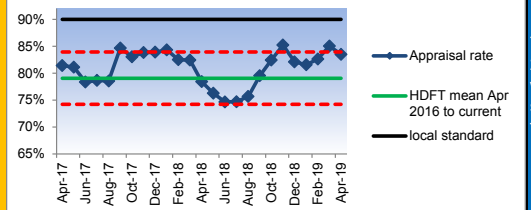
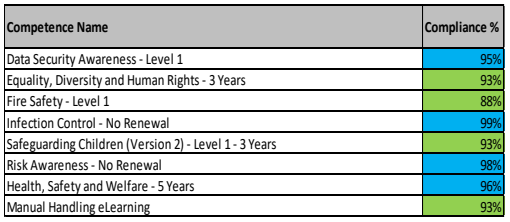
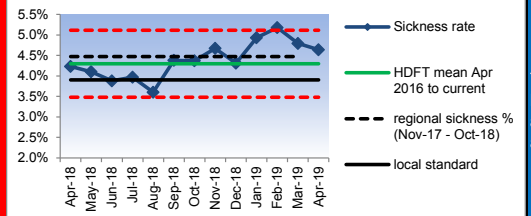
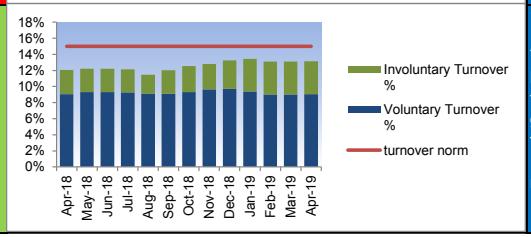


4.23 Community Care Teams - patient contacts — DQ



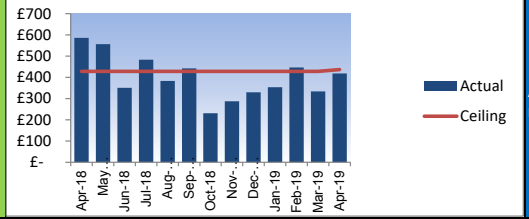
Narrative

Section 5 - Workforce - April 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
5.1	Staff appraisal rates DQ		There has been a slight reduction in appraisal rates to 83.48% in April from 84.77% in March 2019. The Appraisal window opened on the 1 April 2019 and closes on 30th September 2019, with the aim of ensuring 90% of staff are appraised during this period. Communications with staff have commenced to highlight the launch of this year's appraisal window which offers tips for managers and signposts staff to the relevant appraisal resources in the HR Toolkit.
5.2	Mandatory training rates DQ		Mandatory % Report – Trust exc HIF 01.04.19 The data shown is for the end of March and excludes the Harrogate Integrated Facilities (HIF) staff who transferred into the new organisation on the 1st March 2018. The overall training rate for mandatory elements for substantive staff is 94% and has increased since the last reporting cycle.
5.3	Sickness rates DQ		The Trust sickness absence rate for April 2019 is 4.64% which is a further reduction from March's rate of 4.79%. This remains above the Trust target of 3.9%. A review of sickness absence data has been undertaken and shared at Directorate Boards in April. The report and associate recommendations will be provided to SMT in May.
5.4	Staff turnover rate DQ		Turnover has seen a marginal decrease from January into March 2019, with combined turnover being reported as 13.10% (13.26% in January). A gradual upward trend can be seen with turnover at the beginning of the financial year being reported as 12.08%. Turnover for key staff groups and departments is reported through the Workforce Efficiency Group and has been factored into ongoing recruitment plans for 2019/20 and beyond. In addition, the Nurse Recruitment and Retention Group is working through a number of initiatives to help increase retention across the Trust.

Harrogate and District NHS Foundation Trust

Section 5 - Workforce - April 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
5.5	Agency spend in relation to pay spend DQ		Agency expenditure is within the ceiling set for the Trust, however, there remains pressures in a number of areas which will need careful management throughout the year.

Narrative

Sickness Absence

The Trust sickness absence rate for April 2019 is 4.64% which is a further reduction from March's rate of 4.79%. This remains above the Trust target of 3.9%. A review of sickness absence data has been undertaken and shared at Directorate Boards in April. A review of the sickness absence policy is underway to ensure the process supports effective management of absence.

Turnover

Turnover for April shows a slight increase to 13.14% in April from 12.97% in March 2019. This has remained fairly static and the recruitment and retention group continue to meet on a monthly basis to discuss a number of initiatives.

Appraisal Rate

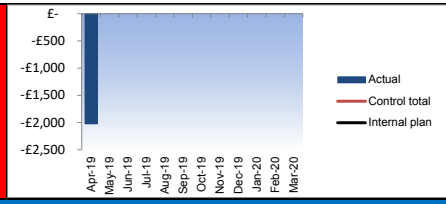
There has been a slight reduction in appraisal rates to 83.48% in April from 84.77% in March 2019. The Appraisal window opened on the 1 April 2019 and closes on 30th September 2019, with the aim of ensuring 90% of staff are appraised during this period. Communications with staff have commenced to highlight the launch of this year's appraisal window which offers tips for managers and signposts staff to the relevant appraisal resources in the HR Toolkit.

NHS Harrogate and District NHS Foundation Trust

Section 6 - Efficiency and Finance - April 2019

Finance

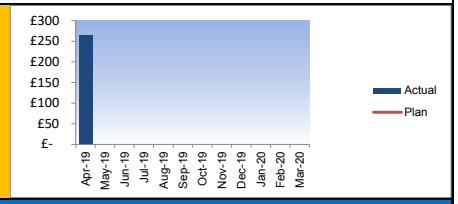
6.1 Surplus / deficit and variance to plan DQ



6.2 NHS Improvement Single Oversight Framework - Use of Resource Metric DQ

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

6.3 Capital spend DQ



Narrative

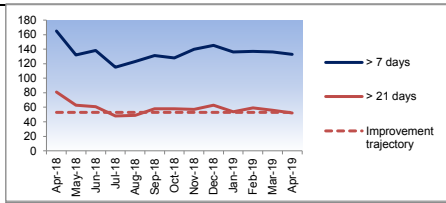
Surplus/deficit and variance to plan - The Trust reported a favourable variance in April of £434k. While this is positive, it is against a deficit plan and therefore it is crucial that we improve the run rate position. The information below outlines Trust overall performance, performance against the control total and the drivers for the current month variance.

NHS Improvement Use of Resource Metric - The Trust reported a UoR rating of 3 in April.

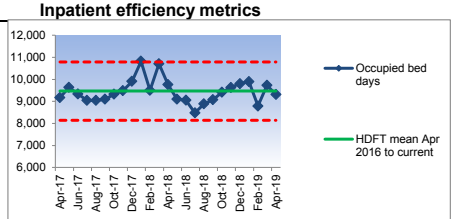
Capital Spend - Discussions continue at a national level regarding the availability of capital resource. The Trust will look to manage pressures through the year and the position is currently balanced to plan.

Inpatient efficiency metrics

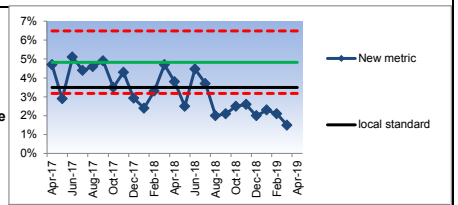
6.4 Long stay patients



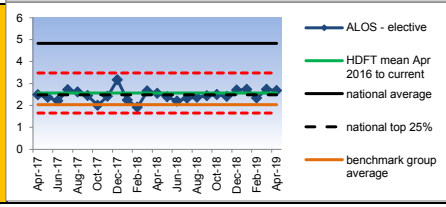
6.5 Occupied bed days



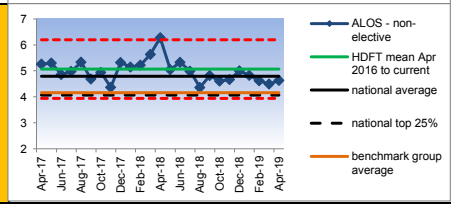
6.6 Delayed transfers of care DQ



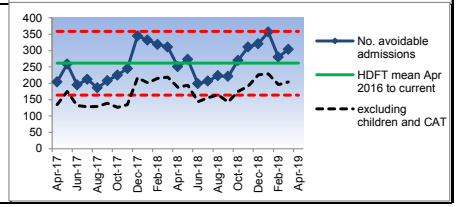
6.7 Length of stay - elective



6.8 Length of stay - non-elective



6.9 Avoidable admissions DQ



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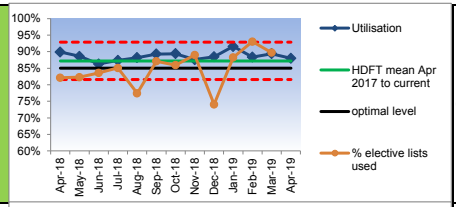
Section 6 - Efficiency and Finance - April 2019

Narrative

Non Elective Length of stay continues to be below the long term Trust average and below the national average. Work continues through the Discharge programme to seek to further reduce long stay patients with a trajectory set through the year to make further reductions (which will be included in the next IBR). The continued stable low level of DTOCs is supporting the delivery of this.

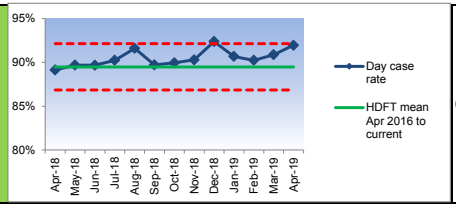
Productivity metrics

6.10 Theatre utilisation



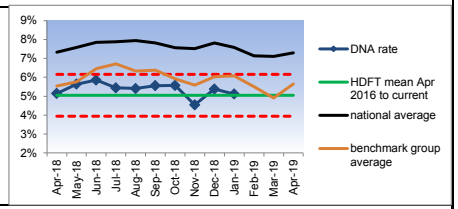
6.11 Day case rate

DQ



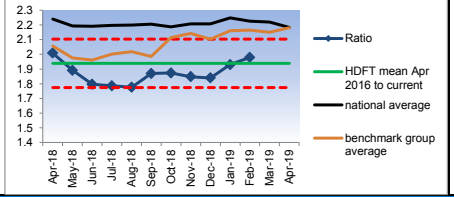
6.12 Outpatient DNA rate

DQ



6.13 Outpatient new to follow up ratio

DQ



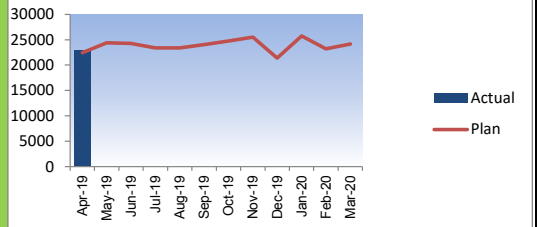
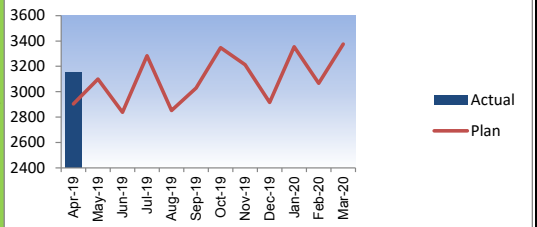
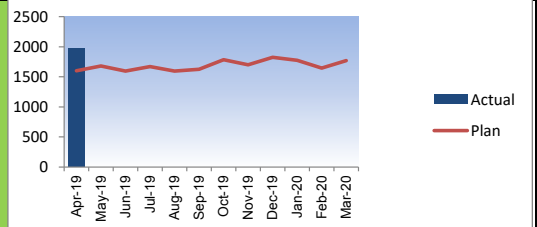
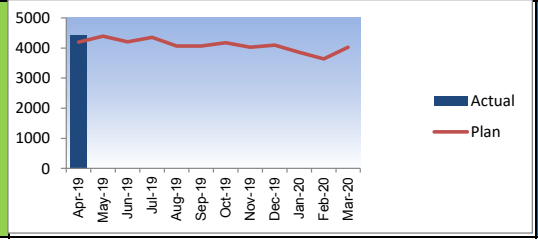
Narrative

New to Follow-up ratio's have risen back up to April 18 levels, the planned care group have plans to continue to focus on this through different elements of the programme and therefore it is expected they will begin to fall again.

Theatre utilisation levels remain stable and therefore more work is needed to review further opportunities to increase this.

Harrogate and District NHS Foundation Trust

Section 7 - Activity - April 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
7.1	Outpatient activity against plan DQ		Outpatient activity was 2.6% above plan for April.
7.2	Elective activity against plan DQ		Elective activity was 8.5% above plan for April.
7.3	Non-elective activity against plan DQ		Non-elective activity was 22.7% above plan for April.
7.4	A&E activity against plan DQ		A&E attendances were 5.3% above plan for April. The figures presented include patients streamed to primary care.

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Section 7 - Activity - April 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation

Narrative

The rate of Non Elective activity in April is concerning, this has continued into May and is causing the requirement for escalation beds to be open. Teams continue to focus on reducing occupancy in order to de-escalate the bed situation. There remains work to do on all planned levels based on the final contract agreement with HaRD CCG and therefore plans will be updated next month. However, comparing actuals from April 18 to April 19 shows significant additional pressure in NEL pathways in particular.

Activity Summary - Trust total

	Apr-18 YTD			Mar-19			Apr-19			Apr-19 YTD		
Activity type	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
New outpatients	7679	7779	-1.3%	8424	8273	1.8%	7719	7819	-1.3%	7719	7819	-1.3%
Follow-up outpatients	15493	15630	-0.9%	16249	16435	-1.1%	15307	14633	4.6%	15307	14633	4.6%
Elective inpatients	295	291	1.4%	283	315	-10.0%	254	271	-6.3%	254	271	-6.3%
Elective day cases	2440	2602	-6.2%	2813	2944	-4.4%	2897	2633	10.0%	2897	2633	10.0%
Non-electives	1665	1809	-7.9%	2003	1982	1.1%	1966	1602	22.7%	1966	1602	22.7%
A&E attendances	4153	4108	1.1%	4306	4245	1.4%	4419	4196	5.3%	4419	4196	5.3%

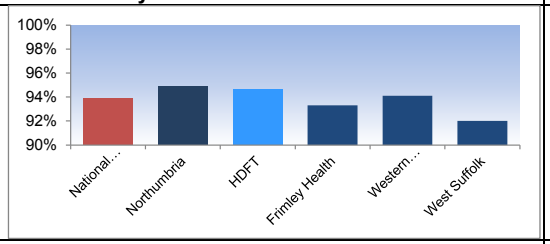
Activity Summary - HARD CCG

	Apr-18 YTD			Mar-19			Apr-19			Apr-19 YTD		
Activity type	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
New outpatients	5214	5135	1.5%	5975	5471	9.2%	5369	4454	20.5%	5369	4454	20.5%
Follow-up outpatients	10913	10307	5.9%	11536	10844	6.4%	10867	9801	10.9%	10867	9801	10.9%
Elective inpatients	175	178	-1.8%	183	198	-7.6%	154	169	-8.7%	154	169	-8.7%
Elective day cases	1604	1540	4.1%	1775	1730	2.6%	1799	1475	21.9%	1799	1475	21.9%
Non-electives	1274	1343	-5.1%	1551	1471	5.4%	1480	1087	36.1%	1480	1087	36.1%
A&E attendances	2949	3033	-2.8%	3202	3134	2.2%	3205	2941	9.0%	3205	2941	9.0%

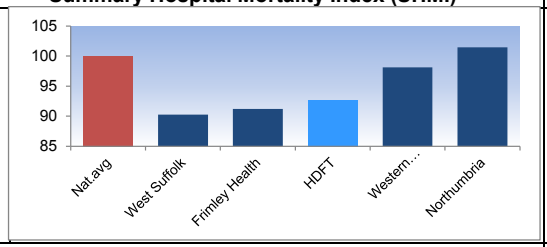
Harrogate and District NHS Foundation Trust

Section 8 - Benchmarking - April 2019

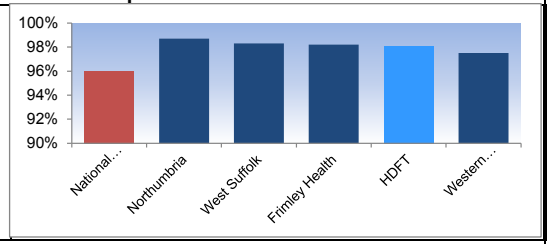
8.1 Safety thermometer - % harm free



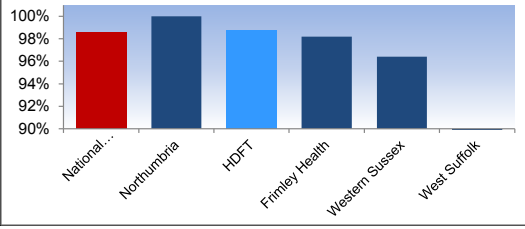
8.2 Summary Hospital Mortality Index (SHMI)



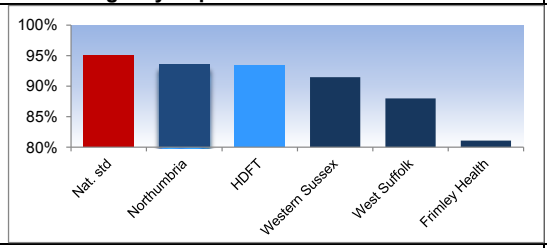
8.3 Inpatient FFT - % recommend



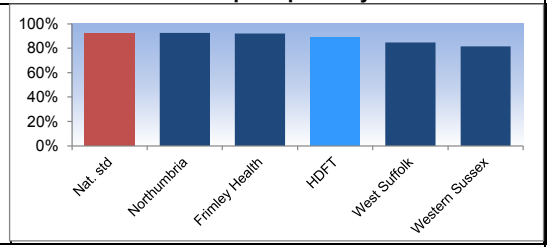
8.4 Maternity FFT - Q2 Birth - % recommend



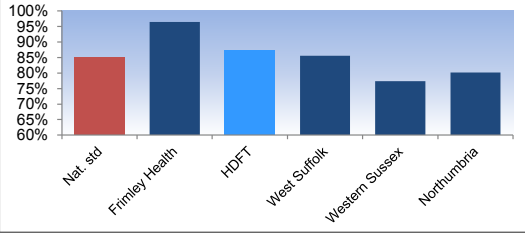
8.5 Emergency Department 4 hour standard



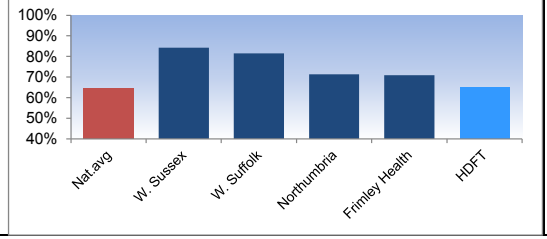
8.6 RTT incomplete pathways



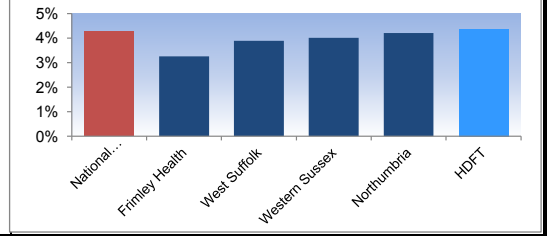
8.7 Cancer 62 days



8.8 Staff FFT - % recommend (place to work)



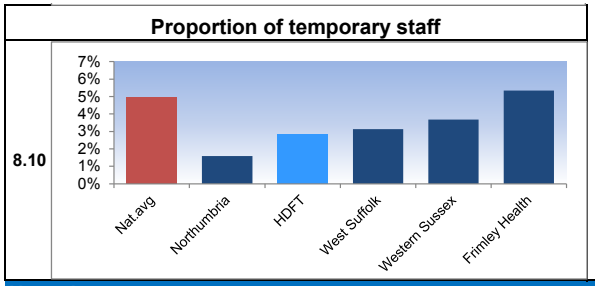
8.9 Sickness absence



Harrogate and District NHS Foundation Trust

Section 8 - Benchmarking - April 2019

8.10



Narrative

The charts above show HDFT's latest published performance benchmarked against small Trusts with an outstanding CQC rating. The metrics have been selected based on a subset of metrics presented in the main report where benchmarking data is readily available. For the majority of metrics, the data has been sourced from NHSE Website, Data Statistics.

Data Quality - Exception Report

Harrogate and District NHS Foundation Trust

Domain	Indicator	Data quality rating	Further information
Safe	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.
Caring	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.
Efficiency and Finance	Theatre utilisation	**Amber** 	This metric has been aligned with the new theatre utilisation dashboard from December 2017. Further metrics from the new dashboard are being considered for inclusion in this report from April 2018. The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. There are some known data quality issues with the utilisation data but it is anticipated that increased visibility of the data via the new dashboard will help to resolve these in the coming months.
Responsive	OPEL level - Community Care Teams	**Amber** 	This indicator is in development.
Activity	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.

Indicator traffic light criteria

Indicator number	Domain	Indicator	Description	Traffic light criteria	Rationale/source of traffic light criteria
1.1	Safe	Pressure ulcers - hospital acquired	The chart shows the number of category 2, 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.	tbc	tbc
1.1	Safe	Pressure ulcers - hospital acquired	The chart shows the number of category 2, category 3, category 4, unstageable and DTI hospital acquired pressure ulcers, including device related and device related mucosal for 2019/20. The data includes hospital teams only.		
1.2	Safe	Pressure ulcers - community acquired	The chart shows the number of category 2, 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.	tbc	tbc
1.2	Safe	Pressure ulcers - community acquired	The chart shows the number of category 2, category 3, category 4, unstageable and DTI community acquired pressure ulcers, including device related and device related mucosal for 2019/20. The data includes community teams only.		
1.3	Safe	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.	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%.
1.4	Safe	Safety thermometer - harm free care - community care teams	As above but including data for community teams only.		
1.5	Safe	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.	Blue if YTD position is a reduction of >=50% of HDFT average for 2018/19, Green if YTD position is a reduction of between 20% and 50% of HDFT average for 2018/19, Amber if YTD position is a reduction of up to 20% of HDFT average for 2018/19, Red if YTD position is on or above HDFT average for 2018/19.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
1.6	Safe	Infection control	HDFT's C. difficile trajectory for 2019/20 is 19 cases, an increase of 8 on last year's trajectory. This increase takes into account the new case assignment definitions. Cases where a lapse in care has been deemed to have occurred would count towards this. Hospital apportioned MRSA cases will be reported on an exception basis. HDFT has a trajectory of 0 MRSA cases for 2019/20. The last reported case of hospital acquired MRSA at HDFT was in Oct-12.	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
1.7	Safe	Incidents - all	The number of incidents reported within the Trust each month. It includes all categories of incidents, including those that were categorised as "no harm". The data includes hospital and community services. A large number of reported incidents but with a low proportion classified as causing significant harm is indicative of a good incident reporting culture	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.
1.8	Safe	Incidents - comprehensive SIRIs and never events	The number of Serious Incidents Requiring Investigation (SIRIs) and Never Events reported within the Trust each month. The data includes hospital and community services. Only comprehensive SIRIs are included in this indicator, as concise SIRIs are reported within the presure ulcer / falls indicators above.	Green if none reported in current month; Red if 1 or more never event or comprehensive reported in the current month.	
1.9	Safe	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 provided in the narrative section and published on the Trust website.	Green if latest month overall staffing >=100%, amber if between 95% and 100%, red if below 95%.	The Trusts aims for 100% staffing overall.
2.1	Effective	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.	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.
2.2	Effective	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.		
2.3	Effective	Readmissions	% of patients readmitted to hospital as an emergency within 30 days of discharge (PbR exclusions applied). To ensure that we are not discharging patients inappropriately early and to assess our overall surgical success rates, we monitor the numbers of patients readmitted. A low number is good performance. This data is reported a month behind so that any recent readmissions are captured in the data.	Blue if latest month rate < LCL, Green if latest month rate < HDFT average for 2018/19, Amber if latest month rate > HDFT average for 2018/19 but below UCL, red if latest month rate > UCL.	Locally agreed improvement trajectory based on comparison with HDFT performance last year.
3.1	Caring	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.	Green if latest month >= latest published national average, Red if < latest published national average.	Comparison with national average performance.
3.2	Caring	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.		

Indicator number	Domain	Indicator	Description	Traffic light criteria	Rationale/source of traffic light criteria
3.3	Caring	Complaints	The number of complaints received by the Trust, shown by month of receipt of complaint. The criteria define the severity/grading of the complaint with green and yellow signifying less serious issues, amber signifying potentially significant issues and red for complaints related to serious adverse incidents. The data includes complaints relating to both hospital and community services.	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.
4.1	Responsive	NHS Improvement governance rating	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.	As per defined governance rating	
4.2	Responsive	RTT Incomplete pathways performance	Percentage of incomplete pathways waiting less than 18 weeks. The national standard is that 92% of incomplete pathways should be waiting less than 18 weeks. A high percentage is good.	Green if latest month >=92%, Red if latest month <92%.	NHS England
4.3	Responsive	A&E 4 hour standard	Percentage of patients spending less than 4 hours in Accident & Emergency (A&E). The operational standard is 95%. The data includes all A&E Departments, including Minor Injury Units (MIUs). A high percentage is good.	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%.
4.4	Responsive	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.	Green if latest month >=85%, Red if latest month <85%.	NHS England, NHS Improvement and contractual requirement
4.5	Responsive	Diagnostic waiting times - 6-week standard	Percentage of patients waiting 6 weeks or less for a diagnostic test. The operational standard is 99%. A high percentage is good.	Green if latest month >=93%, Red if latest month <93%.	NHS England, NHS Improvement and contractual requirement
4.6	Responsive	Dementia screening	The proportion of emergency admissions aged 75 or over who are screened for dementia within 72 hours of admission (Step 1). Of those screened positive, the proportion who went on to have an assessment and onward referral as required (Step 2 and 3). The operational standard is 90% for all 3 steps. A high percentage is good.	Green if latest month >=90% for Step 1, Step 2 and Step 3, Red if latest month <90% for any of Step 1, Step 2 or Step 3.	NHS England, NHS Improvement and contractual requirement
4.7	Responsive	Cancer - 14 days maximum wait from urgent GP referral for all urgent suspect cancer referrals	Percentage of urgent GP referrals for suspected cancer seen within 14 days. The operational standard is 93%. A high percentage is good.	Green if latest month >=93%, Red if latest month <93%.	NHS England, NHS Improvement and contractual requirement
4.8	Responsive	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.	Green if latest month >=93%, Red if latest month <93%.	NHS England, NHS Improvement and contractual requirement
4.9	Responsive	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.	Green if latest month >=96%, Red if latest month <96%.	NHS England, NHS Improvement and contractual requirement
4.10	Responsive	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.	Green if latest month >=94%, Red if latest month <94%.	NHS England, NHS Improvement and contractual requirement
4.11	Responsive	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.	Green if latest month >=96%, Red if latest month <96%.	NHS England, NHS Improvement and contractual requirement
4.12	Responsive	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.	Green if latest month >=85%, Red if latest month <85%.	NHS England, NHS Improvement and contractual requirement
4.13	Responsive	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.	Green if latest month >=90%, Red if latest month <90%.	NHS England, NHS Improvement and contractual requirement
4.14	Responsive	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.	Green if latest month >=85%, Red if latest month <85%.	NHS England, NHS Improvement and contractual requirement
4.15	Responsive	RTT waiting list split by weeks	Number of referred patients waiting for treatment broken down into weeks.	tbc	tbc
4.16	Responsive	Children's Services - 10-14 day new birth visit	The percentage of babies who had a new birth visit by the Health Visiting team within 14 days of birth. A high percentage is good. Data shown is for North Yorkshire, Darlington, Co. Durham, Middlesbrough, Stockton, Gateshead and Sunderland. A high percentage is good.	Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%.	Contractual requirement
4.17	Responsive	Children's Services - 2.5 year review	The percentage of children who had a 2.5 year review. A high percentage is good. Data shown is for North Yorkshire, Darlington, Co. Durham, Middlesbrough, Stockton, Gateshead and Sunderland. A high percentage is good.	Green if latest month >=90%, Amber if between 75% and 90%, Red if <75%.	Contractual requirement
4.18	Responsive	Children's Services - Use of the Home Environment Assessment Tool	The % of eligible children in Durham who had a HEAT assessment. The performance target is 95%.	Green if latest month >=95%, Amber if between 90% and 94%, Red if <90%.	Contractual requirement
4.19	Responsive	Children's Services - Reports for Initial and Review Child Protection Case Conferences	The % of reports submitted prior to Case Conferences (where reports are reqeusted earlier than 48 hours before Case Conference.)	Green if latest month >=95%, Red if <95%.	Contractual requirement
4.20	Responsive	Children's Services - staff compliance with Safeguarding Supervision.	% of community staff achieving 80% compliance for Safeguarding Supervision.	Green if latest month >=100%, Red if <100%.	Locally agreed metric
4.21	Responsive	Children's Services - % achievement against KPI for Breast Feeding Prevalence at 6-8 weeks.	% of children breast fed at the 6-8 week review. Charted against Prevalence targets for all 0-5 services.	Green if latest month >=100%, Amber if between 90% and 99%, Red if <90%.	Contractual requirement
4.22	Responsive	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 will show the average level reported by adult community services during the month.	tbc	Locally agreed metric
4.23	Responsive	Community Care Teams - patient contacts	The number of face to face patient contacts for the community care teams.	tbc	Locally agreed metric
5.1	Workforce	Staff appraisal rate	Latest position on no. staff who had an appraisal within the last 12 months. The Trusts aims to have 90% of staff appraised. A high percentage is good.	Annual rolling total - 90% green. Amber between 70% and 90%, red<70%.	Locally agreed target level based on historic local and NHS performance
5.2	Workforce	Mandatory training rate	Latest position on the % substantive 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
5.3	Workforce	Staff sickness rate	Staff sickness rate - includes short and long term sickness. The Trust has set a threshold of 3.9%. A low percentage is good.	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

Harrogate and District NHS Foundation Trust

Indicator number	Domain	Indicator	Description	Traffic light criteria	Rationale/source of traffic light criteria
5.4	Workforce	Staff turnover	The staff turnover rate excluding trainee doctors, bank staff and staff on fixed term contracts. The turnover figures include both voluntary and involuntary turnover. Voluntary turnover is when an employee chooses to leave the Trust and involuntary turnover is when the employee unwillingly leaves the Trust. Data from the Times Top 100 Employers indicated a turnover rate norm of 15%, i.e. the level at which organisations should be concerned.	Green if remaining static or decreasing, amber if increasing but below 15%, red if above 15%.	Based on evidence from Times Top 100 Employers
5.5	Workforce	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.	Green if <1% of pay bill, amber if between 1% and 3% of pay bill, red if >3% of pay bill.	Locally agreed targets.
6.1	Efficiency and Finance	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.	Green if on plan, amber <1% behind plan, red >1% behind plan	Locally agreed targets.
6.2	Efficiency and Finance	NHS Improvement Financial Performance Assessment	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.	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
6.3	Efficiency and Finance	Capital spend	Cumulative Capital Expenditure by month (£'000s)	Green if on plan or <10% below, amber if between 10% and 25% below plan, red if >25% below plan	Locally agreed targets.
6.4	Efficiency and Finance	Long stay patients	This indicator shows the average number of patients that were in the hospital with a length of stay of over 7 days (previously defined as stranded patients by NHS Improvement) or over 21 days (previously super-stranded patients). The data excludes children, as per the NHS Improvement definition. A low number is good.	tbc	as defined by NHS Improvement
6.5	Efficiency and Finance	Occupied bed days	Total number of occupied bed days in the month.	tbc	Locally agreed targets.
6.6	Efficiency and Finance	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. The maximum threshold shown on the chart (3.5%) has been agreed with HARD CCG.	Red if latest month >3.5%, Green <=3.5%	Contractual requirement
6.7	Efficiency and Finance	Length of stay - elective	Average length of stay in days for elective (waiting list) patients. The data excludes day case patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.	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.
6.8	Efficiency and Finance	Length of stay - non-elective	Average length of stay in days for non-elective (emergency) patients. A shorter length of stay is preferable. When a patient is admitted to hospital, it is in the best interests of that patient to remain in hospital for as short a time as clinically appropriate – patients who recover quickly will need to stay in hospital for a shorter time. As well as being best practice clinically, it is also more cost effective if a patient has a shorter length of stay.		
6.9	Efficiency and Finance	Avoidable admissions	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.	tbc	tbc
6.10	Efficiency and Finance	Theatre utilisation	The percentage of time utilised during elective theatre sessions (i.e. those planned in advance for waiting list patients). The utilisation calculation excludes cancelled sessions - operating lists that are planned not to go ahead due to annual leave, study leave or maintenance etc. A higher utilisation rate is good as it demonstrates effective use of resources. A utilisation rate of around 85% is often viewed as optimal.	Green = >=85%, Amber = between 75% and 85%, Red = <75%	A utilisation rate of around 85% is often viewed as optimal.
6.11	Efficiency and Finance	Day case rate	The proportion of elective (waiting list) procedures carried out as a day case procedure, i.e. the patient did not stay overnight. A higher day case rate is preferable.	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.
6.12	Efficiency and Finance	Outpatient DNA rate	Percentage of new outpatient attendances where the patient does not attend their appointment, without notifying the trust in advance. A low percentage is good. Patient DNAs will usually result in an unused clinic slot.		
6.13	Efficiency and Finance	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.		
7.1	Activity	Outpatient activity against plan (new and follow up)	The position against plan for outpatient activity. The data includes all outpatient attendances - new and follow-up, consultant and non-consultant led.	Green if on or above plan in month, amber if below plan by < 3%, red if below plan by > 3%.	Locally agreed targets.
7.2	Activity	Elective activity against plan	The position against plan for elective activity. The data includes inpatient and day case elective admissions.		Locally agreed targets.
7.3	Activity	Non-elective activity against plan	The position against plan for non-elective activity (emergency admissions).		Locally agreed targets.
7.4	Activity	Emergency Department attendances against plan	The position against plan for A&E attendances at Harrogate Emergency Department. The data excludes planned follow-up attendances at A&E and pateints who are streamed to primary care.		Locally agreed targets.

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

Finance Report – April 2019

Summary:

- Favourable variance against plan for April
- Positive performance across all Directorates
- Risks in relation to CIP delivery and NHS Property Services
- Ward / theatre spend in line with plan

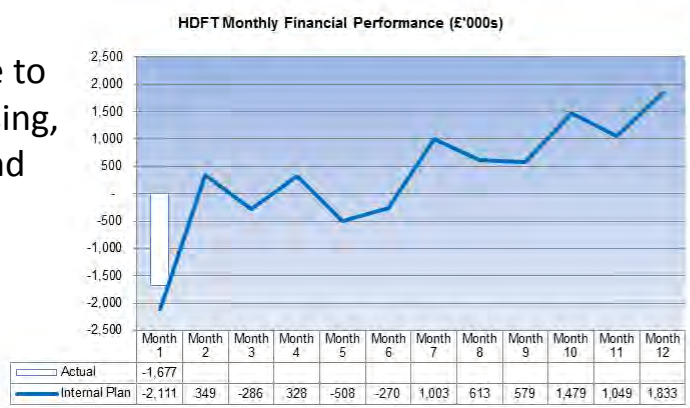
- Cash remains a constraint, and will do until PSF funding received
- Use of Resources rating of 3, in line with plan

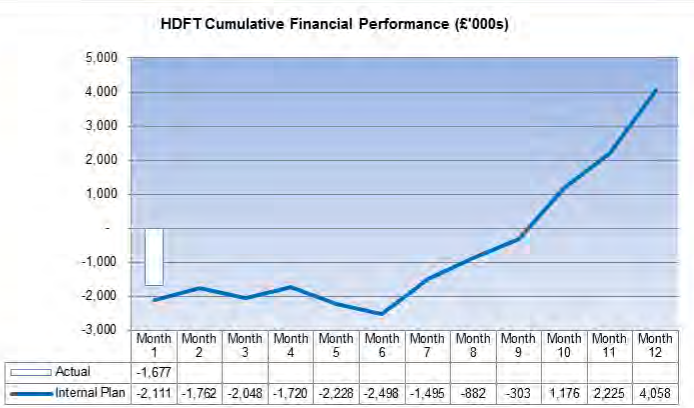
- Will develop reporting going forward to take account of the contract agreement with HaRD CCG

April 2019 Financial Position

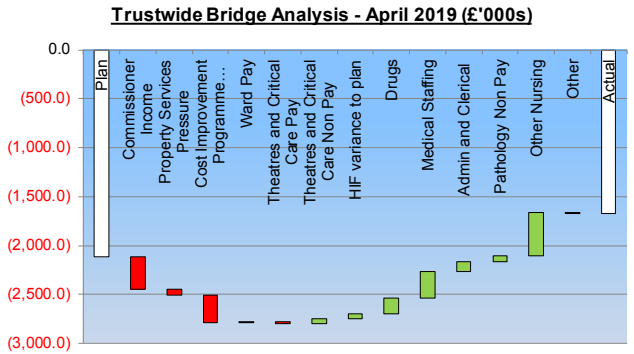
The Trust reported a favourable variance in April of £434k. While this is positive, it is against a deficit plan and therefore it is crucial that we improve the run rate position. The information below outlines Trust overall performance, performance against the control total and the drivers for the current month variance.

Deficit plan due to pay award phasing, activity plan, and CIP profile.





Variance to Budget	£'000s
Plan	**(2,111)**
Commissioner Income	(333)
Property Services Pressure	(60)
Cost Improvement Programme Pressure	(284)
Ward Pay	7
Theatres and Critical Care Pay	(13)
Theatres and Critical Care Non Pay	45
HIF variance to plan	54
Drugs	161
Medical Staffing	270
Admin and Clerical	95
Pathology Non Pay	67
Other Nursing	436
Other	(11)
Actual	**(1,677)**



April 2019 Financial Position

- The directorate forecast position for Q1 is highlighted to the right. Further work is happening to mitigate the emerging risks this position highlights.

Forecast Directorate Position						
	April		May		Q1	
£'s	Actual	Variance (-ve = underspent)	Actual	Variance (-ve = underspent)	Actual	Variance (-ve = underspent)
CCCC	4,727,685	- 105,004	4,438,916	- 61,179	13,605,518	- 230,361
LTUC	6,050,554	- 15,409	5,836,281	67,664	17,710,444	102,438
PSC	6,125,545	- 16,019	5,843,595	141,848	17,670,836	125,777
Corporate	3,016,545	177,449	3,243,486	60,455	9,503,518	298,359

- As outlined in the IBR the Trust risk rating for April was reported as a 3. This is a result of the deficit position driving higher risk ratings for Capital Service Cover and I&E Margin. This is anticipated to improve in the second half of the financial year.

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

- While the Trust anticipates an improved position in relation to cash later in the financial year, this area remains a pressure as outlined to the right.

Harrogate and District NHS
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Board Committee report to the Board of Directors

Committee Name:	Quality Committee (QC)
Committee Chair:	Laura Robson NED
Date of last meeting:	1 May 2019
Date of Board meeting for which this report is prepared	29 May 2019

6

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

Hot Spots:
Mrs Foster assured the committee that there was no risk to patients from the use of a particular staple gun used in theatre for colorectal surgery. An alert notice had been received and an alternative was being sourced.

Board Request for QC to seek assurance:
The quality committee maintains its interest in end of life care and documentation, following the decision not to implement ReSPECT. The resuscitation lead will be attending the June meeting to provide an in depth presentation of the current situation to the committee.

Reports Received:

- An inspirational presentation was received from Ms L Kitching regarding work being undertaken by the Trust as part of the National Maternity and Neonatal Safety Collaborative. The presentation focussed on smoking cessation in pregnancy. The presentation gave some excellent examples of progress and some brilliant initiatives which had been presented nationally. The quality committee were very impressed and considered that some of these initiatives should be applied to the wider patient and staff base.
- The Health and Safety annual report was received. The focus was on SALUS control books and their completion. The progress was noted.
- Children's and county wide Directorate Governance report was received. Some concerns were noted but the report on the whole provided significant assurance.
- Progress on the Quality Charter April 2018-19. This report was received and provided significant assurance about the implantation and embedding of the Charter. It was essential that momentum was not lost and work continued to improve quality in the organisation through the use of the quality champions.
- The Draft Quality Account was received and priorities agreed.
- Quality Indicators were received and scrutinised.
- IBR quality items were considered.

Other Items The committee was pleased to note that complaints response time were being given an increased level of attention by the Executive Team
Are there any significant risks for noting by Board? (list if appropriate)
No significant risks identified
Matters for decision
No decisions required

Action Required by Board of Directors: To note.

Harrogate and District NHS Foundation Trust

6.2

Date of Meeting:	29 May 2019	**Agenda item:**	6.2
Report to:	Board of Directors		
Title:	Eighth quarterly report on safe working hours for doctors and dentists in training		
Sponsoring Director:	Dr D Scullion, Medical Director		
Author(s):	Dr C Gray, Guardian of Safe Working Hours		
Report Purpose:	**Decision**	**Discussion/ Consultation**	**Assurance** ✓	**Information**
Executive Summary:	The Board of Directors is asked to note: • The Guardian has no on-going concerns. • The number of Exception Reports is below the national average • There is a continuing national recruitment crisis in doctors in training but vacancies in this Trust are at 5%, which is comparatively low.		

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

Key implications	
Risk Assessment:	Risks associated with the content of the report are reflected in the Board Assurance Framework
Legal / regulatory:	None identified.
Resource:	None identified.
Impact Assessment:	Not applicable.
Conflicts of Interest:	None identified.
Reference documents:	None.
Assurance:	

Action Required by the Board of Directors:

The Board of Directors is asked to:

- **Receive and note** the content of the report;
- **Consider the points** at the end of the report.

This is the eighth quarterly report of the Guardian of Safe Working Hours. Its purpose is to report to the Board of Directors the state of safe working of doctors in training ('junior doctors') in relation to their working hours, gaps in rotas and their educational experience. This report covers the period 1 January to 31 March 2019.

The orderly stream of quarterly reports was interrupted by the Board's instruction to change the periodicity of written reports to four-monthly intervals. This is out of synchronization with the regional quarterly reporting pattern. The Trust's reports will following alternately in and out of phase with the quarters. The tri-annual reports will still convey completed quarterly data for one or two quarters as appropriate. The last report reported data to 31 December 2018

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

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

44 [Q4] exception reports have been received from trainees and dealt with. This is an increasing trend. These have mainly concerned over-runs of working hours ('hours and rest') owing to the busy state of the wards and to individual patient matters. There were no reduced educational opportunity exception reports in quarter. Exception reporting, although increasing, remains comparatively low in this Trust although highly variable across the region.

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

There has been no regional or national meeting for guardians in the last quarter. Two trainee doctors' fora have been held jointly with the Director of Medical Education. These will continue bi-monthly.

The Guardian met the CQC inspectors in December 2018. No issue arose.

On-going national developments include a joint review of the 2016 Contract by NHS Employers and BMA to be completed by August 2019 and a piece of work on improving exception reporting.

This is the key quality assurance statement for the Board:

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

1 Introduction

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

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

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

2 High level data

In March 2019:

The position is not significantly changed since December 2018:

Number of doctors / dentists in training (total established Deanery posts)	119 [last quarter: 121]
Number of doctors / dentists posts on 2016 TCS (total)	119 [last quarter: 121]
Number of doctors / dentists in training actually in post	106 [last quarter: 106]
Number of doctors/dentists Trust posts (additional to Deanery posts)	12 [last quarter: 12]
Number of doctors/dentists in Trust posts actually in post	11 [last quarter 10]
'Gaps' in deanery posts	5%
Amount of time available in job plan for Guardian to do the role	1.5 PAs per week
Admin support provided to the Guardian (if any)	none [assistance from HR Dept]
Amount of job-planned time for educational supervisors	0.5 PAs per trainee

The bi-annual change over takes place in early February each year.

6.2

3 Exception reports

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

Clinical supervisors are in many cases poor at responding to exception reports. This task was dropped on consultants without their agreement by the 2018 Trainees new contract. The Guardian has to review and agree outstanding reports.

This report presents Quarter 4 2018/19 (1 January 2019 to 31 March 2019).

Q4: 1.1.2019-31.3.2019 - Exception reports by department: hours/rest				
Specialty	No. of exceptions carried over from last report	No. of exceptions raised	No. exceptions closed	No. exceptions outstanding
General Medicine	0	23	23	0
General Surgery	0	10	10	0
GP	0	9	9	0
ED	0	2	2	0
Total	**0**	**44**	**44**	**0**

These include no education exception in this quarter. Reports are up slightly on Q3 (41). Nearly all reports are of over-working at the end of the day when clinical workload, acutely ill patients and too few colleagues demand working beyond normal hours. This is especially true in general medicine. To put this in context, if 119 trainee doctors work about 20 days per month, then 44 exception reports have occurred on only 0.7% of the c6360 doctor-days worked in the quarter. [Exception reports are known to under-report over-working].

If a doctor has overworked their contracted hours on an occasion, then they are entitled under the TCS to over-time pay or time off in lieu. If the over-work is caused by rota gaps, then time off is not appropriate if it will compound the shortage situation. The doctor is entitled to overtime pay

even if their overtime commitment followed from their own inefficiency or misjudgment. Clinical supervisors are expected to guide their trainees in efficient working, prioritizing clinical activities and making timely hand-overs to over-night teams. The Trust will incur a small cost each month in some hours' over-time pay; but this is offset somewhat by vacant posts owing to rota gaps. But overall, the Trust is heavily over-spent on medical locum costs for consultants and trainees.

The job of filling posts, balancing rotas and workloads properly belongs to clinical directorates with professional support from the HR function. Individual trainees' employment experiences are managed by their individual clinical supervisor - a clinical consultant usually in the same or a related specialty. Clinical supervisors are intended to respond to each exception report. Despite repeated advice some never do and the report has to be managed by the Guardian. The Guardian has no actual managerial power over individuals in directorates.

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

4 Work schedule reviews and interventions

4a Work schedule review

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

4b Interventions

One enquiry significant was raised in Q4 2018-Q1 2019. A trainee identified a week of overworking with insufficient rest days. This was a definite breach of contractual maxima and of European Working Time Directive. Strictly speaking, this would require an exemplary fine to be levied upon the Directorate. However, investigation showed that the trainee had themselves taken up paid additional work to fill gaps and had by their own action contributed to the overworking. However, the rota coordinator had not detected and prevented this.

Dissatisfaction was reported in one directorate over the efficiency of rota coordination. This is currently under active management in the directorate. Rota coordination is a difficult and thankless task: complete gap filling is not realistic in present market circumstances.

5 Vacancies

The vacancies are improved upon previous quarters: 5% of training posts [12.4% Q2/3 2018-19].

The successful filling of rota gaps is of course a measure of the diligence and ingenuity of the Medical Workforce and Recruitment team but challenged by the availability and willingness of suitable doctors to apply.

Of course, any rota gaps will add to the strain on the trainees in post and add to the Trust's workforce costs by necessitating locum and other temporary employees and working down of senior grades of staff.

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

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

There are also 12 Trust posts for doctors not in training schemes who participate in the same rotas as trainees. One of these is currently vacant.

6 Fines

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

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

Working time rules may of course change after BREXIT.

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

7 Meetings

The Guardian had no regional or national meetings to attend in the quarter.

8 Trainees' Forum

Recent fora have been well attended. In informal discussion with the young doctors, it is striking how few of our current trainees intend to follow a linear training programme in the 'normal' way. There appears to be a worsening trend in trainees avoiding deanery training programmes. Less than 50 per cent of trainees intend to proceed directly from FY School to higher training in primary care or hospital specialties. Many good trainees are choosing the non-deanery route and intend to spend a few years in short-term trust posts variously termed 'FY3' and 'Trust Doctor' or going abroad. Reportedly, recruitment to training posts has increased in general practice and histopathology.

The importance of exception reporting has been canvassed to the trainees and this may have contributed to increased rates of exception reporting in the last two quarters.

9 Disclosure

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

Health Education England will receive periodical download of the entire database of exception reports for the purpose of research by the mining of big data. The Board has agreed to this.

10 Confidentiality

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

11 CQC

The Guardian met the CQC inspectors alone for the 'Well Led' inspection on 5th December 2018. No issues arose in the subsequent report.

12 Issues arising

a. The Trust continues in comparatively good standing. We have had a below-average rate of exception reporting but there is an increasing trend.
b. There is an on-going problem of sporadic over-work and reduced educational opportunity for trainee doctors owing to colleagues off sick and rota gaps. This is especially true in general medicine. The clinical directorate is actively managing the situation.
c. Reluctance in trainees to report exceptions exists regionally and nationally.
d. Exception reports are being received and processed.
e. There are gaps in rotas owing to failed recruitment. This a worsening issue throughout medical specialties especially in the North of England, but this Trust is doing relatively well with vacancies in process of being filled.
f. The Guardian has met the CQC inspectors in December 2018.
g. Regional and national meetings are planned in 2019.
h. NHS Employers and BMA are reviewing the 2016 contract in fulfilment of the original promise to do so. This review and any contractual changes are expected to be completed for August 2019.
i. NHS Employers and NHSI are working on improving exception reporting in 2019.

13 Actions taken to resolve issues

a. No fine has been necessary this quarter.
b. One intervention has been necessary this quarter to investigate an over-working situation and rota coordination issue.
c. At the date of reporting, the Board of Directors is assured from the evidence available that:
    i. The exception reporting system is operational for all trainees; they are now all on the 2016 TCS.
    ii. Overworking owing to pressure of work and rota gaps is a chronic problem in medicine. This is under active management by the directorate.
    iii. The Guardian can only intervene on notified problems.
    iv. The Guardian will continue to attend regional and national meetings.

14 Questions for consideration by the Board of Directors

a. The Board is asked to receive the combined quarterly report and to consider the assurances provided by the Guardian. The Board has changed its requirement for written reports: future reports will be four monthly.
b. There are presently no issues outlined in the report which are not being (or cannot be) tackled.
c. The Guardian makes no request for escalation, internally, externally or both, which might be recommended in order to ensure that safe working hours would not be compromised in the future.
d. Issues of medical [and indeed all healthcare professional] workforce planning are an urgent strategic challenge to the Trust and to the entire NHS. The Trust always has vacancies gaps in trainee doctor posts; these currently run at 5%.

NHS
Harrogate and District
NHS Foundation Trust

Date of Meeting:	29 May 2019	**Agenda item:**	6.3
Report to:	Board of Directors		
Title:	Annual Patient Experience and Complaints Report 2018/19		
Sponsoring Director:	Jill Foster, Chief Nurse		
Author(s):	Melanie Jackson /Andrea Leng / Megan Matthewman, Risk Management		
Report Purpose:	**Decision** ✓ **Discussion/ Consultation** ✓ **Assurance** ✓ **Information** ✓		
Executive Summary:	Whilst there are many aspects to delivering excellent patient care, I would like to draw the Board's focus to complaints: • In total 238 complaints were received in 2018/19, an increase of 14% from 2017/18 • The overall response rate is currently at 37% • The complaints process is an agreed Quality Priority in 2019/20		
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 not learning from patient feedback.		
Legal / regulatory:	Compliance with the Duty of Candour is a statutory requirement that is monitored by the Care Quality Commission.		
Resource:	None identified		
Impact Assessment:	Not applicable		
Conflicts of Interest:	None identified		
Reference documents:	Risk Management Policy; Making Experiences Count Policy		
Assurance:	Patient Experience Reports and progress on the Quality Priorities are overseen quarterly by the Quality Committee		
CQC key line of enquiry	Caring and responsive domains		
Action required by the Board of Directors:			
It is recommended that the Board of Directors: • **Notes** items included within the report			

6.3

You matter most

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1. Patient and Public Involvement (Including FFT)

NATIONAL PATIENT SURVEYS

New Survey Results

- National Inpatient Survey 2018 – initial Picker results received and awaiting publication of CQC report (expected June 2019)
- National Emergency Department Survey 2018 – initial Picker results received and awaiting publication of CQC report (expected June 2019)

Current National Surveys

- National Cancer Patient Experience Survey 2018 – Fieldwork
- National Children & Young People's Survey 2018 – Fieldwork
- National Maternity Survey 2019 – Sampling

Upcoming National Surveys this year

- National Inpatient Survey 2019
- National Cancer Survey 2019

LOCAL PATIENT SURVEYS

Surveys registered during 2017/18

A total of 18 surveys were registered with Clinical Effectiveness in 2017/18 and completion of the 2017/18 programme currently stands as follows:

- Completed – 14/18 (78%)
- Abandoned / Postponed – 1/18 (6%)
- Ongoing (in date) – 1/18 (5%)
- Ongoing (overdue) – 2/18 (11%)

NB: All ongoing surveys had completion dates extended due to low numbers of survey returns

Surveys registered during 2018/19

A total of 27 surveys were registered with Clinical Effectiveness in the last year and completion of the 2018/19 programme currently stands as follows:

- Completed – 11/27 (41%)
- Abandoned / Postponed – 2/27 (7%)
- Ongoing (in date) – 10/27 (37%)
- Ongoing (overdue) – 4/27 (15%)

Twenty-seven surveys have been registered since 1 April 2018:

Title	Directorate	Specialty	Expected completion date
Bereavement Survey special	LTUC	Palliative Medicine	Ongoing
Patient Survey on Information Sharing/Data Protection	Corporate	Information Governance & Clinical Effectiveness	Complete
Colposcopy Patient Satisfaction Survey	PSC	Women's Unit/Gynaecology	Complete
Acute Oncology Patient Experience Survey	LTUC	Acute Oncology	Complete
A survey on the confidence and competence of patients and their families on the use of their Adrenaline auto injector (AAI).	CCWCC	Paediatrics	Complete
Patient experience Survey: Review of Primary Care Streaming	LTUC	Urgent & Emergency Care	Cancelled /Closed
IVT: Patient Experience	PSC	Opthalmology	01/11/2018
Monitoring patient experience in Cardiology.	LTUC	Cardiology	Complete
Clinical Psychology in Cancer Services	LTUC	Cancer Services	30/10/2019
Infection Prevention & Control - MRSA Patient Survey	LTUC	Infection Prevention & Control	30/04/2019
Patient survey of Breast cancer awareness campaign -2018	LTUC	Radiology	Complete
Paediatric Diabetes Satisfaction Survey	CCWCC	Paediatrics	Complete
Patient satisfaction of exodontia under general anaesthetic'	CCWCC	Dental	30/06/2019
Skin Cancer Patient Satisfaction Survey	Cross Directorate	Maxillo Facial and Orthodontics	31/12/2019
MSK – Patient Survey	LTUC	Physiotherapy	30/04/2019
Virtual Diabetic Eye Clinic Survey	PSC	Opthalmology	31/01/2019
Gynaecological Cancer: Patient Survey	LTUC	Cancer Services	Complete
Upper GI Cancer: Patient Survey	LTUC	Cancer Services	Postponed to 2019/20
Lung respiratory Cancer: Patient Survey	LTUC	Cancer Services	Complete
Orthopaedic ERP Patient Survey	PSC	Orthopaedics	Complete
C. difficile Patient Survey	LTUC	Community Infection Control and Prevention	30/04/2019
Content/Usefulness information given to clients about obstetric ultrasound	LTUC	Radiology	28/02/2019
Early Diagnosis of Cancer (EDOC)	LTUC	Cancer Services	31/05/2019
Patient Carer Feedback on Children's Surgical Services	PSC	Anaesthetics	28/02/2019
Mesothelioma Outcomes Research and Experience Study	LTUC	Cancer Services	30/09/2019
PROM after Total hip replacement for fracture neck of femur	PSC	Trauma and orthopaedics	Complete
SNSP Service Evaluation, Patient and GP Survey	LTUC	Cancer Services	31/12/2019

Further detail is provided in the Appendix 3.

Recent Survey Results

Paediatric Diabetes Satisfaction Survey

The 2018-19 paediatric diabetes satisfaction survey set out to collect patient views on the paediatric diabetes service. The aims of the project were to identify areas of high patient satisfaction to enable the team to maintain a high quality service; and identify any areas where patients think we could be "doing better" - in order that we can implement improvements.

All survey respondents were satisfied with the service provided and reported that the doctors, nurses and dieticians gave enough time for discussion of questions and concerns (about diabetes).The majority (89%) found that access to advice and information - particularly from the diabetic team, was "very good". In addition, most respondents were also in receipt of information and knowledge on managing issues around their diabetes i.e. managing high blood pressure (95%), low blood sugar (98%) and carbohydrate counting (92%). However, the following key concerns were highlighted:

- 45% waiting time over 15 minutes.
- 5% of respondents did not get enough time to discuss concerns of their diabetes with the psychologist.
- Respondents "disagreed" that they had received knowledge and information with managing emotional wellbeing (15%); managing future health with diabetes (6%) and with their devices - Insulin pump (18%); continuous glucose monitoring (15%). An additional 11% of patient on continuous glucose monitoring were "undecided".

Recommendations for action included investigation of what "worked well" for the patients that were seen in the first 15 minutes of presenting. Psychologists will also be encouraged to spend more time discussing patient's concerns around their diabetes, and ensure clarity and understanding of the information given regarding the management their diabetes and devices.

Enhanced Recovery in Orthopaedics Patient Survey

Enhanced recovery (ER) is the process of delivering continuous improvement across the whole acute care pathway, centred on shared decision-making between the patient and their healthcare team. Enhanced Recovery Programs (ERPs) which optimize the patient journey as well as employ a range of analgesia and anaesthetic techniques to aid early mobilization, have been used in the UK since 1997. Enhanced recovery aims to improve patient experience by getting patients better sooner, and to make care safer and more efficient through changes in clinical practice.

At Harrogate and District Foundation Trust, an Enhanced Recovery Pathway document and pre-assessment education program and been introduced for orthopaedic patients having bilateral primary or revision hip and knee replacements surgery. The aim of this project is to assess patient satisfaction of the Enhanced Recovery Pathway for patients following orthopaedic surgery; establish whether ERP material is being used correctly, and provide opinion for areas of further quality improvement.

The majority of patients replying to the survey found that the information provided pre-operatively was useful, helped them understand the ERP pathway and what they could do themselves to help recovery. The majority of patients said their Nursing and Medical Team was supportive with explaining progress and keeping pain under control, with their experience of Physiotherapy to be good to excellent. However, the following key concerns were highlighted:

Key Concerns

- "Goals for the day checklist" – 68% of patients completed / used the tool
- 20% of patients said they were not aware of their planned discharge date
- Some patient reported a "lack of active follow-up" once home

It is hoped that the recent introduction of follow-up phone-calls and provision of information for patients on "who to contact for advice once home" should ease some of the concerns regarding lack of follow-up. Recommendations put forward included the suggestion that the "Goals for the day" checklist could be adapted onto laminated cards to be kept at bedside and promoted by the physiotherapy team. It is hoped that sharing the results of the survey with pre-operative and ward nursing staff will embed the requirement for patients to be made aware of their proposed discharge date; that the Enhanced Recovery Group to discuss follow-up of all patients after discharge.

Podiatry Group Sessions: Patient Survey

The podiatry department has been running group session for plantar fasciitis and bunions for several years. They were set up initially to try and reduce waiting times for these two commonly seen conditions and free up clinical time for more complex conditions. Groups of up to 10 patients are invited to these sessions and provided with evidence based treatments and advice to take away and self-care. It was felt that evaluation was needed to ensure that the service provided was adequate and meeting patient's expectations. A patient survey was therefore undertaken to evaluate the group sessions for clinical effectiveness and patient satisfaction.

The majority of patients responding reported either a reduction in pain or a plateauing of pain levels after their group sessions, and found them to be "good or very good". The group sessions have also helped the Podiatry department to manage waiting times / lists. However, the following key concerns were raised:

Key Concerns

- Patient expectations of what outcome a group session would achieve were different to the aims and objectives of the department.
- There was some confusion reported over what to do if symptoms do not improve (how to get a follow-up)
- The waiting times still too long for a "fast-track" session
- Triaging of patients to group session's dependant of GP referral which is not always clear.

The podiatry team set in place recommendations to ensure patients are aware that they are attending a group session and that all staff are giving the same information about follow-up (and how patients can access this).The podiatry lead will liaise with GP's about appropriateness of referrals and ensure patients are triaged quickly to group sessions to justify "fast track" status.

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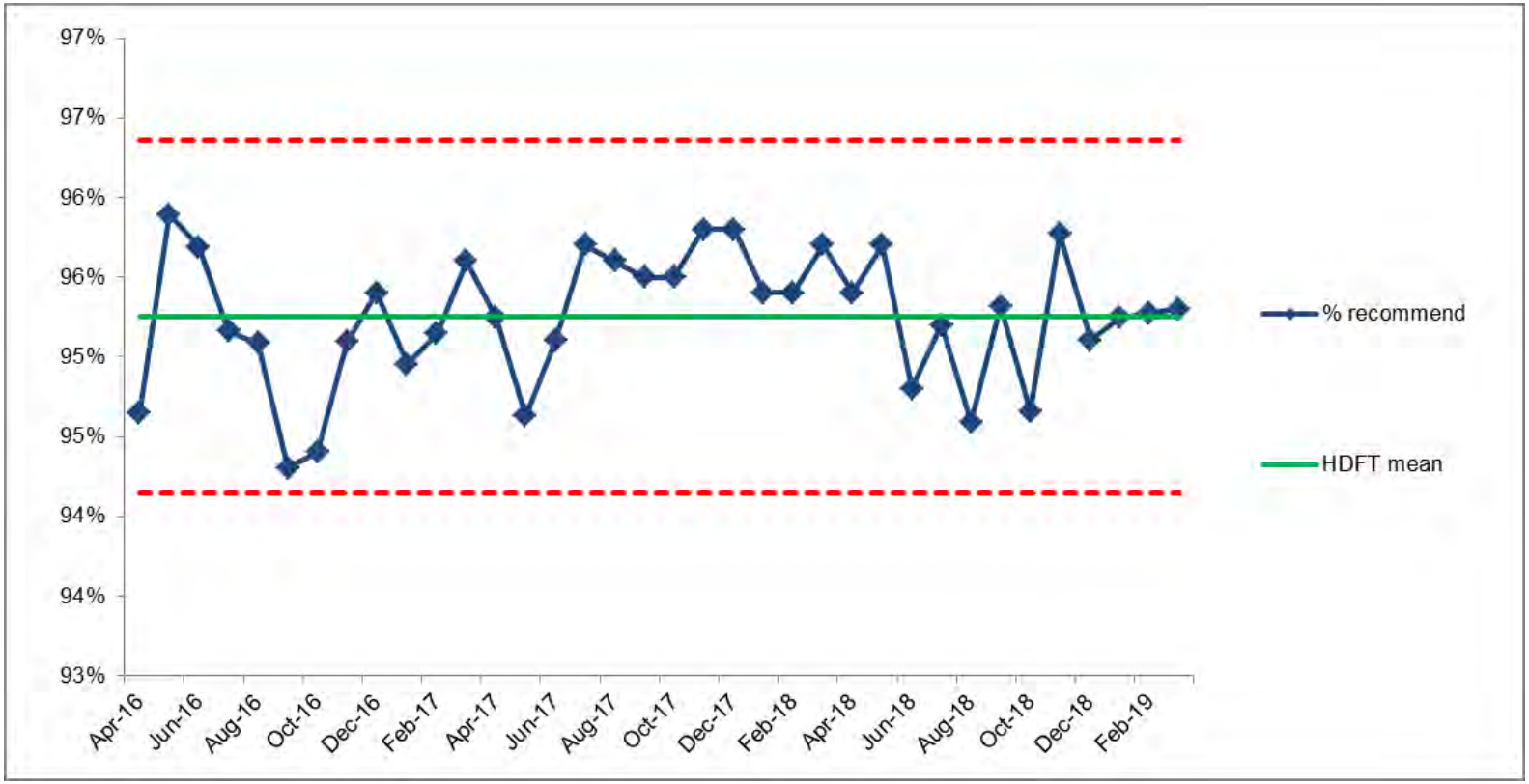
Friends and Family Test (FFT)

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

Service		Q1	Q2	Q3	Jan 2019	Feb 2019	Mar 2019	Q4
Inpatients incl. Day Cases	Recommend %	96.38 %	96.71 %	96.48 %	97.94 %	97.63 %	96.53 %	97.32 %
	Not recommend %	1.55 %	1.30 %	1.47 %	0.64 %	0.87 %	1.63 %	1.08 %
	Resp. Rate %	26.59%	25.65%	25.09%	25.76%	26.87%	28.35%	27.03%
	Inputted Resp.	2130	2155	2243	776	803	922	2501
Inpatients	Recommend %	96.32 %	97.09 %	96.17 %	96.76 %	97.93 %	96.17 %	96.92 %
	Not recommend %	1.47 %	1.12 %	2.02 %	0.97 %	0.89 %	1.53 %	1.15 %
	Resp. Rate %	20.22%	18.85%	18.13%	17.51%	20.70%	22.26%	20.14%
	Inputted Resp.	950	892	939	309	338	392	1039
Day Cases	Recommend %	96.44 %	96.44 %	96.70 %	98.72 %	97.42 %	96.79 %	97.61 %
	Not recommend %	1.61 %	1.43 %	1.07 %	0.43 %	0.86 %	1.70 %	1.03 %
	Resp. Rate %	35.63%	34.43%	34.67%	37.45%	34.29%	35.55%	35.71%
	Inputted Resp.	1180	1263	1304	467	465	530	1462
Outpatients/ Ward Attenders	Recommend %	95.55 %	94.99 %	95.11 %	94.60 %	94.78 %	95.09 %	94.82 %
	Not recommend %	2.00 %	1.74 %	1.89 %	2.25 %	2.11 %	1.77 %	2.04 %
	Resp. Rate %	21.55%	26.44%	26.16%	27.65%	27.92%	26.71%	27.42%
	Inputted Resp.	7460	9582	9241	3424	3412	3338	10174
Emergency Department incl. MIUs	Recommend %	91.02 %	91.06 %	91.30 %	92.86 %	92.35 %	92.88 %	92.71 %
	Not recommend %	3.76 %	3.14 %	3.90 %	2.00 %	3.98 %	2.74 %	2.88 %
	Resp. Rate %	8.42%	7.62%	8.24%	8.86%	9.46%	9.29%	9.19%
	Inputted Resp.	1091	1018	1000	350	327	365	1042
Maternity	Recommend %	98.92 %	98.44 %	98.62 %	98.96 %	100.00 %	98.51 %	99.13 %
	Not recommend %	0.27 %		0.14 %			0.99 %	0.29 %
	Resp. Rate %	34.55%	32.22%	33.46%	40.74%	31.75%	29.53%	34.14%
	Inputted Resp.	741	769	725	288	200	202	690
Community	Recommend %	94.02 %	95.08 %	94.95 %	97.00 %	94.68 %	95.22 %	95.67 %
	Not recommend %	2.21 %	2.08 %	1.79 %	1.09 %	1.68 %	3.07 %	1.87 %
	Resp. Rate %	7.15%	8.41%	8.34%	8.08%	8.72%	8.13%	8.31%
	Inputted Resp.	903	1056	950	367	357	293	1017

We are aiming to incorporate some FFT results that are currently captured locally within some of the CCCC services into the Trust database in order that these results are also included in the quality dashboard and other Trust wide reporting processes. These will include community dentistry and podiatry services.

Overall



The chart shows the overall score (% who would recommend the service) for all HDFT services currently participating in the FFT survey and recorded in the Trust database. 95.3% of patients surveyed in March would recommend our services, an increase on last month and remaining above the latest published national average (93.6%). Around 5,200 patients responded to the survey this month.

Patient Information

There is a process for developing new patient information leaflets that includes clear guidance about content, format and readability and this is evaluated by our volunteer lay reader panels. The lay readers are sent draft patient information leaflets and asked to review these against some specific standards and to return any comments and suggestions for improvement. The author is expected to consider the feedback and use this to develop the final draft. The final draft is then given an final review and approval by the Senior Nurse/ Matrons team.

Once approved and uploaded it is the responsibility of the author to review their resource on the intranet to ensure that it is accurate and contains up to date information. On 02/05/19 there were 747 documents uploaded to the Information for Patients section of the intranet. Of the 747 documents, 88 had passed their review date. There are also 148 current documents with a review date longer than 2 years which is the current standard review period, and 2 with a review date longer than 3 years.

Performance around document control and number and percentage of information leaflets past review date is as follows:

- October 2015: 219/610 (35.9%)
- January 2016: 115/595 (19.3%)
- April 2016: 96/586 (16.4%)
- August 2016: 107/593 (18%)
- November 2016: 130/590 (22%)
- January 2017: 148/597 (24.8%)
- May 2017: 161/598 (26.9%)
- July 2017: 160/606 (26.4%)
- October 2017 209/594 (35.2%)
- January 2018 299/581 (51.4%)
- May 2018 195/564 (34.3%)
- July 2018 165/659 (25%)
- October 2018 57/657 (8.68%)
- January 2019 83/657 (12.6%)
- May 2019 88/747 (11.7%)

There has been some progress with reducing the number of out of date information leaflets on the intranet. However a recent re-audit by Internal Audit has offered an opinion of Limited Assurance regarding the implementation of incomplete recommendations made in the previous Policy Management Follow Up reports *(H2016/23 and H2017/30).* There are several key issues:

- The intranet is not an efficient or effective document management system;
- There is no central resource to manage the administration of the intranet and support document management;
- Movement of staff means that ownership of documents change and there is no process for managing this;
- The review and updating of documents relies on busy staff prioritising this alongside other work;

The risks and issues are to be reviewed at Director Team in May and a proposal for further actions prepared for SMT in June.

2. NHS Choices & Care Opinion

NHS Choices

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

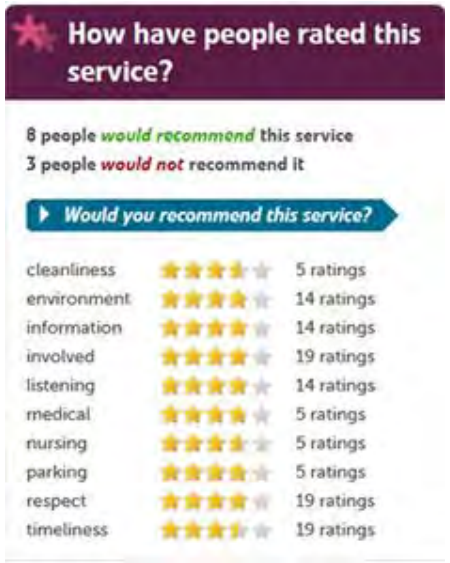
Harrogate District Hospital – Based on 60 ratings

There were 4 reviews were left during Q4, 3 of which were positive whilst the other was negative. It is noted that the Hospital overall rating has not changed since the last quarter.

Ripon & District Community Hospital –Based on 20 ratings

There were 2 reviews left during Q4, one of which was positive whilst the other was negative.

Care Opinion



The Communications and Marketing Manager is responsible for responding to feedback left on NHS Choices and Care Opinion. Generally a comment is left to thank the person for leaving feedback. If the comment is positive, it is passed onto relevant staff. If the comment is negative, the person is asked to contact the Patient Experience team. Concerns and complaints are then followed up by the Patient Experience Team however it's not always possible to link these to the feedback left on either website.

As the Care Opinion Activity information above describes, 98% of the last 100 stories have now been responded to however, whilst it appears that only 1 story has led to a change, this is not a fair reflection on the outcome of those concerns and complaints passed on to the Patient Experience Team.

Social Media

The Communications and Marketing team have provided examples of the contact that they have with the public via social media with regards to the services provided by Harrogate and District NHS Foundation Trust. As with NHS Choices and Care Opinion, any queries or concerns with regards to a patient's care are passed on to the Patient Experience Team for review and action. Below is a sample of social media posts from the last quarter (January 2019 – March 2019).

Positive

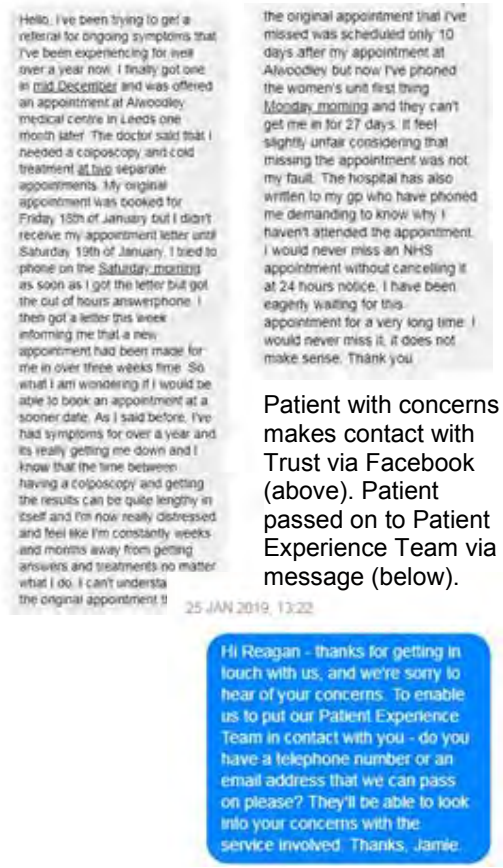
Kind words about our services from a member of the public:

Dementia bus visit to Harrogate Hospital – allowing staff to experience what dementia feels like for patients:

Latest CQC inspection – positive focusing on key points and video of staff.

Negative

Member of the public reacts to publicly around Changing Places facility in the Endoscopy Unit.



Patient with concerns makes contact with Trust via Facebook (above). Patient passed on to Patient Experience Team via message (below).

3. Complaints

Quarter Data	2015/16	2016/17	2017/18	2018/19			
	Total	Total	Total	*Q1*	Q2	Q3	Q4
Total Number of formal complaints*	213	234	209	52	73	55	**58**
% responded to by deadline (target 95%**)	52%	38%	55%	**37%**	45%	47%	**29%**
% upheld	68%	61%	67%	54%	58%	65%	**76%**
Number returned for further local resolution	31	5	3	0	8	11	**1**
Number of new PHSO requests	5	5	5	1	0	0	**0**
Total informal requests (PALS contacts)***	676	936	1056	233	171	216	**244**

**Number of complaints compared with average of complaints received in previous year. (Green if below HDFT average for 2017/18 Amber if above HDFT average for 2017/18)*
*** of those deadlines reached at time of report. Target rate set in Jan 2016*
**** Our aim is to increase informal contacts and reduce complaints*

Year to Date Position	2015/16	2016/17	2017/18	2018/19			
	Total	Total	Total	Q1	Q2	Q3	Q4
Complaints received by PHSO (YTD)	5	5	5	1	**0**	**0**	**0**
Complaints investigated by PHSO as % of received by PHSO	80% (4 out of 5)	4/5 (80%)	3 (60%)	1 (100%)	**N/A**	**N/A**	**N/A**
Complaints upheld by Ombudsman as % of received (nat av=47% at Q4)	20%	0%	0% (1 under invest)	0% (1 under invest)	**N/A**	**N/A**	**N/A**
Number of complaint actions developed	445	406	374	80	**108**	**90**	**16**
% of actions completed within deadline (target 100%)	34%	40%	46%	53%	**31%**	**39%**	**75%**

Out of the 58 complaints received in Q4 98% of cases were acknowledged within 3 working days (where we were the lead organisation in charge of the investigation).

Following discussion at Quality Committee, in conjunction with the Quality Assurance Leads we extended the timeframe for response to yellow complaints that were multiagency or were shared with CORM from 25 to 40 working days. This was in place for 2 months in Q4 and following review this then reverted to 25 working days again for all green and yellow complaints from 1st April 2019.

Number of working days complaints were overdue response timeframe

Annual Data 2018/19	Q1	Q2	Q3	Q4
Total number or complaints received	52	73	55	58
Average number of days overdue*	19	21	20	15
Number of complaints overdue*	33	39	28	13
Longest number of days overdue*	63	62	85	37

**at time of report that have been responded to*

Annual Data 2018/19	Q1	Q2	Q3	Q4
0-4 days*	5	7	6	1
5-9 days*	4	7	6	2
10-19 days*	12	9	4	7
20-39 days*	10	9	7	3
40 or more days*	2	7	5	0

**No. of days overdue past the 25 days working metric*

Reopened Cases

	Minor clarification required	Reinvestigation required	Meeting arranged to discuss findings	Total	% of total number of complaints
Q1	0	0	0	0	0
Q2	3	2	3	8	11%
Q3	6	1	4	11	20%
Q4	1	0	0	1	2%

Complaints can be reopened at any stage , this may be a few days after the investigation is completed or several months. Reopened numbers are reported against the quarter the complaint was first received.

Complaint numbers by Directorate

Quarter Data

Quarter Data (2018/19 Q4)	LTUC	PSC	CCWCC	Corp
Total Number of formal complaints	27	23	6	2
% responded to by deadline (target 95%*)	36%	25%	33%	0%

Quarter Data (2018/19 Q3)	LTUC	PSC	CCWCC	Corp
Total Number of formal complaints	25	24	5	1
% responded to by deadline (target 95%*)	35%	55%	100%	100%

Quarter Data (2018/19 Q2)	LTUC	PSC	CCWCC	Corp
Total Number of formal complaints	29	34	9	1
% responded to by deadline (target 95%*)	48%	47%	38%	0%

Quarter Data (2018/19 Q1)	LTUC	PSC	CCWCC	Corp
Total Number of formal complaints	32	17	3	0
% responded to by deadline (target 95%*)	31%	47%	33%	n/a

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

Annual Data

Annual Data (2018/19)	LTUC	PSC	CCWCC	Corp
Total Number of formal complaints	113	98	23	4
% responded to by deadline (target 95%*)	37%	46%	45%%	33%

Annual Data (2017/18)	LTUC	PSC	CCWCC	Corp
Total Number of formal complaints	80	101	25	3
% responded to by deadline (target 95%*)	43%	64%	68%	66%

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

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

Update on actions developed in light of complaints

Quarterly data

Actions Q1 18/19	
Number of actions developed	80
% completed within deadline	52%
% still open (of total)and past due date	33%

Actions Q2 18/19	
Number of actions developed	108
% completed within deadline	34%
% still open (of total)and past due date	67%

Actions Q3 18/19	
Number of actions developed	79
% completed within deadline	49%
% still open (of total)and past due date	36%

ACTIONS Q4 18/19	
Number of actions developed	16
% completed within deadline	75%
% still open (of total)and past due date	19%

Annual data

Actions 2016/17	
Number of actions developed	406
% completed within deadline	40%
% still open (of total)and past due date	2%

Actions 2017/18	
Number of actions developed	396
% completed within deadline	46%
% still open (of total)and past due date	21%

Actions 2018/19	
Number of actions developed	294
% completed within deadline	42%
% still open (of total)and past due date	43%

Parliamentary Health Service Ombudsman (PHSO)

PHSO Cases Q4 2018/19

There have been no cases reported to the PHSO in Q4.

4. Concerns and Comments (positive suggestions for improvement)

	Total 16/17	Total 17/18	Total 18/19	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4
Number of Concerns	**556**	**653**	**610**	150	123	173	164
Number of Comments/ Information Requests	**380**	**403**	**254**	83	48	43	80
Total Informal requests	**936**	**1056**	**864**	233	171	216	244

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

Q4
Out of the 58 complaints logged in Q4, 3 (5%) of these were originally handled and logged as concerns. We do not have any data on how many cases may have been handled informally by front line staff before reaching the PET.

18/19
Overall out of the 238 complaints logged in 18/19 17 (7%) of complaints were originally logged as concerns

5. Compliments

	Total 16/17	Total 17/18	Total 18/19	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4
Total Number of Compliments received by PET	**325**	**316**	**339**	99	71	84	85

Theme	%
Communication/ Attitude	19%
Clinical Care	59%
Efficiency of service/ professionalism	22%

The compliments received by the PET in Q4 18/19 were grouped into themes as detailed in the table above.

Going forwards we are expecting the data in relation to compliments to be reflected in the monthly dashboard so the detail of compliments will no longer be presented in this report.

6. Appendix 1- Open local patient surveys

2016/17 Open local patient surveys

Survey Title	Directorate	Specialty	Expected completion date	Project Status	Additional Information	E&D questions included?
Ad-hoc projects						
Advanced Care Planning for Parkinson's Patients	Long Term & Unscheduled Care	Neurology	On-going	On-going (in date)	Small numbers of patients. Continuous piece of work on behalf of Consultant Neurologist.	No

2017/18 Open Local patient surveys

Survey Title	Directorate	Specialty	Expected completion date	Project Status	Additional Information	E&D questions included?
Ad-hoc projects						
Do Elective Patients Retain Information Given to Them During the Consent process	Planned & Surgical Care	Orthopaedics	Revised to 28/02/2019	Data Collection	Small numbers of returns: data collection continuing. 31/1/2019: Analysis	Unknown
SCBU parent satisfaction survey 2017	Children's & County Wide Community Care	SCBU	30/03/2019	Ongoing	Surveys are sent to CE team who collate posters for display on the unit	No
Cardiac Rehabilitation Survey	Long Term & Unscheduled Care	Cardiology	30/04/2019	Draft Report Complete	Awaiting recommendations and action plan	Yes

2018/19 Local patient surveys

Survey Title	Directorate	Specialty	Expected completion date	Project Status	Additional Information	E&D questions included?
Annual plan						
Bereavement Survey	Long Term and Unscheduled Care	Palliative Medicine	Ongoing	Data Collection-ongoing		Age, Gender, Ethnicity, Religion
Patient Survey on Information Sharing/Data Protection	Corporate	Information Governance & Clinical Effectiveness	31/12/2018	Complete		No
Colposcopy Patient Satisfaction Survey	Planned and Surgical Care	Women's Unit/Gynaecology	31/03/2019	Complete		No
Ad Hoc Projects						
Acute Oncology Patient Experience Survey	Long-term & Unscheduled Care	Acute Oncology	01/06/2018	Complete		Gender; Age
A survey on the confidence and competence of patients and their families on the use of their Adrenaline auto injector (AAI).	Childrens and County Wide Community Care	Paediatrics	30/06/2018	Complete		
Patient experience Survey: Review of Primary Care Streaming	Long-term & Unscheduled Care	Urgent & Emergency Care	01/11/2018	Abandoned/Closed	02/11/2018: Project lead capacity was too limited to facilitate the survey	Gender; Age; Disability, Sexuality; ethnicity & Religion
IVT: Patient Experience	Planned & Surgical Care	Opthalmology	01/11/2018	Design	Nov-18 update on progress requested	
Monitoring patient experience in Cardiology.	Long-term & Unscheduled Care	Cardiology	30/03/2019	Complete		Gender, Disability, Religion, Age, Ethnicity.
Clinical Psychology in Cancer Services	Long-term & Unscheduled Care	Cancer Services	30/10/2019	Data Collection		Gender, Age

Survey Title	Directorate	Specialty	Expected completion date	Project Status	Additional Information	E&D questions included?
Infection Prevention & Control - MRSA Patient Survey	Long-term & Unscheduled Care	Infection Prevention & Control	30/04/2019	Data Collection		To be confirmed
Patient survey of Breast cancer awareness campaign -2018	Long-term & Unscheduled Care	Radiology	31/08/2018	Complete		Age
Paediatric Diabetes Satisfaction Survey	Childrens and County Wide Community Care	Paediatrics	01/11/2018	Complete		NA
Patient satisfaction of exodontia under general anaesthetic'	Childrens and County Wide Community Care	Dental	30/06/2019	Data Collection	Data collection extended due to low numbers	Unknown
Skin Cancer Patient Satisfaction Survey	Cross Directorate	Maxillo Facial and Orthodontics	31/12/2019	Data collection		Age,Gender,Ethnicity
MSK Patient Survey	Long-term & Unscheduled Care	Physiotherapy	30/04/2019	Design		
Virtual Diabetic Eye Clinic Survey	Planned and Surgical Care	Opthalmology	31/01/2019	Data Collection		Gender,Disability, Age, Sexuality, Religion, Ethnicity
Gynaecological Cancer: Patient Survey	Long-term & Unscheduled Care	Cancer Services	30/03/2019	Complete		Gender, Age, Disability, Religion, Race/Ethnicity
Gastro Cancer: Patient Survey	Long-term & Unscheduled Care	Cancer Services	30/03/2019	Postponed to 2019/20		Gender, Age, Disability, Religion, Race/Ethnicity
Lung respiratory Cancer: Patient Survey	Long-term & Unscheduled Care	Cancer Services	30/01/2019	Complete		Gender, Age, Disability, Religion, Race/Ethnicity
Orthopaedic ERP Patient Survey	Planned and Surgical Care	Acute Pain	28/02/2019	Complete		Gender, Age, Disability, Religion, Race/Ethnicity

Survey Title	Directorate	Specialty	Expected completion date	Project Status	Additional Information	E&D questions included?
C. difficile Patient Survey	Long-term & Unscheduled Care	Community Infection Prevention & Control	30/04/2019	Analysis		Gender, Age, Disability
Content/Usefulness information given to clients about obstetric ultrasound	Long-term & Unscheduled Care	Radiology	28/02/2019	Analysis	Results provided to clinical team for analysis-chasing	Disability, Age, Sexuality, Religion, Ethnicity
Early Diagnosis of Cancer (EDOC)	Long-term & Unscheduled Care	Cancer Services	31/05/2019	Data Collection		2-protectected characteristics questions
Patient Carer Feedback on Childrens Surgical Services	Planned and Surgical Care	Anaesthetics	28/02/2019	Design		Age
Mesothelioma Outcomes Research and Experience Study	Long-term & Unscheduled Care	Cancer Services	30/09/2019	Data Collection		Age, Gender
PROM after Total hip replacement for fracture neck of femur	Planned and Surgical Care	Trauma and orthopaedics	30/03/2019	Draft report completed	Awaiting completion of report by clinician	Gender; Age; Ethnicity; Religion;
SNSP Service Evaluation, Patient and GP Survey	Long-term & Unscheduled Care	Cancer Services	31/12/2019	Data Collection		Gender, Age, Disability, Religion and Race

7. Appendix 2- Grading of Concerns and Complaints

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

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

Harrogate and District NHS Foundation Trust

Date of Meeting:	29 May 2019	**Agenda item:**	6.4
Report to:	Board of Directors		
Title:	Learning from deaths report Q4 2018/19		
Sponsoring Director:	Dr David Scullion, Medical Director		
Author(s):	Dr Sylvia Wood, Deputy Director of Governance		
Report Purpose:	**Decision**	**Discussion/ Consultation** ✓	**Assurance** ✓ **Information** ✓
Executive Summary:	Board to note quarterly report of learning from deaths process. During Q4 2018/19 five structured judgement reviews (SJRs) were completed. 100% (5/5) patients reviewed had good or excellent overall care. 60 SJRs were completed during 2018/19, 31 related to deaths that occurred during 2017/18 and many of these relate to the review of orthopaedic cases previously reported. 58/60 (97%) were found to have good or excellent overall care. No problems in care were identified in four of the cases in Q4. One case identified issues relating to end of life care although this was graded as no harm. The 2018/19 data shows two cases with problems in care associated with uncertain harm, and two cases where problems in care resulted in harm. These were included in previous reports. The deaths were both recognised and investigated as serious incidents. There was one death of a patient with learning disabilities that underwent a SJR during Q4. All relevant phases of care were judged as being good or excellent (4 or 5). All cases of a patient with learning disabilities dying in hospital are automatically referred to the national Learning Disabilities Mortality Review (LeDeR) programme, and five cases were referred during 2018/19. In general the structured judgement reviews contained numerous detailed descriptions of good practice. The results of case notes reviews of in-hospital cardiac arrests confirmed that the most prevalent reason to deem resuscitation inappropriate remains “patient had life limiting illness so a DNACPR should have been considered”. This is the focus of the Appropriate Resuscitation and Escalation Operational (AERO) Group. General problems and themes are reported to Improving Patient Safety Steering Group to discuss and agree any appropriate actions. Themes and learning are shared across the organisation using the #ChatterMatters		

6.4

Harrogate and District NHS Foundation Trust

	newsletter.

Related Trust Objectives

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

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

Action Required by the Board of Directors:

It is recommended that the Board:

- **Notes** items included within the report;

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Harrogate and District NHS Foundation Trust

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

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

The Trust has adopted the RCP National Mortality Review Tool which is hosted on Datix. This enables easy access to the information gathered but is not yet proving useful to prepare data for this report. We are communicating with Datix about this. We are also close to testing an in-house platform that will enable us to implement a screening process for all in hospital deaths, to prioritise early review of deaths that would or might benefit from a SJR.

The date of death is the date that we aim to use for the data analysis rather than the date that the SJR was undertaken. However this is currently difficult in that there is not a date of death field on Datix – only the quarter in which the death occurred – without the relevant year. This introduces the potential for error when some historic cases are being reviewed at the same time as current cases.

All case note reviews undertaken during Q4 2018/19 have been included in this report, and summary data for 2018/19 has also been included.

All hospital cardiac arrests are reported to the National Cardiac Arrest Audit (NCAA) to monitor and report on the incidence of, and outcome from, in-hospital cardiac arrest in order to foster improvements in the prevention, care delivery and outcomes from cardiac arrest. It is a joint initiative between the Resuscitation Council (UK) and ICNARC (Intensive Care National Audit & Research Centre) and is included in the Department of Health Quality Accounts. Further learning is sought by case notes reviews of all in-hospital cardiac arrests which are reviewed by the Resuscitation Committee to identify any areas of learning to share and determine whether the resuscitation is deemed appropriate or inappropriate; this information is also included in this report.

Harrogate and District NHS Foundation Trust

Results of structured case reviews

Summary of inpatient deaths and structured case note reviews

		Quarter or year in which the death occurred													
					2017/18					2018/19					
		2014/15	2015/16	2016/17	Q1	Q2	Q3	Q4	2017/18	Q1	Q2	Q3	Q4	2018/19	Total undertaken
	No of inpatient deaths				145	140	167	205	657	142	140	177	182	641	
Number of structured judgement reviews (SJRs)	SJRs previously reported	4	27	40	3	8	14	6	31	N/a	N/a	N/a	N/a	N/a	102
	SJRs undertaken during Q1 2018/18				5	4	9	7	25	8	N/a	N/a	N/a	8	33
	SJRs undertaken during Q2 2018/19				1	0	0	3	4	2	5	N/a	N/a	7	11
	SJRs undertaken during Q3 2018/19				0	0	0	1	1	0	7	3	N/a	10	11
	SJRs undertaken during Q4 2018/19				0	0	1	0	1	0	0	2	2	4	5
	Total SJRs undertaken during 2018/19 by year of death								31					29	60
	Total number of SJRs undertaken relating to deaths in the period	4	27	40					62	10	12	5	2	29	162

This table shows the number of inpatient deaths by quarter during 2017/18 and 2018/19, and the number of structured judgement reviews (SJRs) undertaken since 2014/15.

For 2018/19 the number of SJRs is given by quarter that the review was undertaken, and by the quarter and year that the death occurred. 60 SJRs were completed during 2018/19, 31 related to deaths that occurred during 2017/18 and many of these relate to the review of orthopaedic cases previously reported. During Q4 2018/19 five SJRs were completed.

Assessment of care

The table below shows the assessment of care for the identified stages of care provision for each of the five case reviews completed during Q4. 100% (5/5) patients reviewed had good or excellent overall care. The care is rated for each of up to seven phases of care. Out of 35 possible phases of care, 8 were not applicable, and 26/27 (96%) were rated as good or excellent.

Harrogate and District NHS Foundation Trust

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Care scores summary: 2018/19 Q4

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

The table below shows the assessment of care for the identified stages of care provision for each of the 60 case reviews completed during 2018/19. 58/60 (97%) were found to have good or excellent overall care. There were 9 identified stages of care where the standard of care provided was judged to be poor. The reasons for the poor care have been included in previous reports. As each patient may have up to seven stages of care, there are a total of 420 phases of care, of which 64 stages were not applicable. 325/356 stages of care (91%) were judged to be good or excellent.

Care scores summary: 2018/19 total

	Good or excellent care (score 4-5)	Average care (score 3)	Poor care (score 1-2)	N/a	Total
Admission and initial management	49	6	5	0	60
On-going care	53	3	1	3	60
Care during procedure	30	2	0	28	60
Peri-operative care	24	3	0	33	60
End of life care	55	4	1	0	60
Overall assessment of care received	56	3	1	0	60
Overall assessment of patient record	58	1	1	0	60

As previously reported, the review of deaths included in the orthopaedic HSMR for the period Feb-17 to Jan-18 confirmed that the main theme was of good or excellent care with 96% (24/25) scoring 4 or 5 for overall care.

Harrogate and District NHS Foundation Trust

Problems with care

The SJR proforma has a section that enables the identification of problems in care. No problems in care were identified in four of the cases in Q4, and one case identified issues relating to end of life care and disagreement of cause of death between the coroner and the clinical teams although this was graded as no harm.

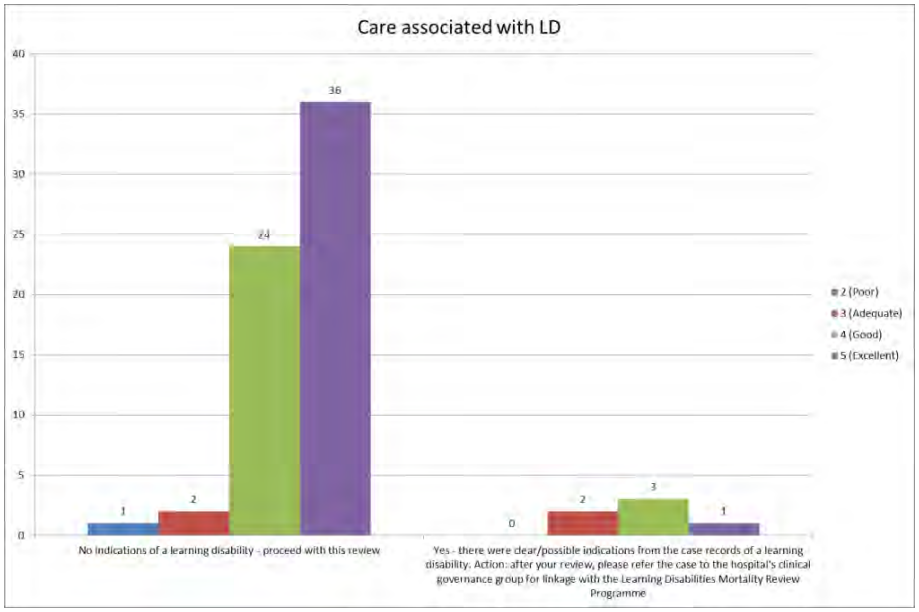
Problems with care: 2018/19 Q4				
	Degree of harm if problems identified			Total
	No harm	Uncertain harm	Harm	
No problems with care identified				4
Problems in care identified	1	0	0	1
Total				5

The 2018/19 data shows two cases with problems in care associated with uncertain harm, and two cases where problems in care resulted in harm. These were included in previous reports. The deaths were both recognised and investigated as serious incidents, with the outcome reported to the families involved, the Board of Directors, commissioners, HM Coroner and the Care Quality Commission. Detailed recommendations, including change of clinical practice and policy have been agreed and action plans produced in order that appropriate steps are taken to address problems in care and to share learning. Discussions are ongoing as to how learning is most effectively shared across acute trusts within the integrated care system.

Problems with care: 2018/19 Total				
	Degree of harm if problems identified			Total
	No harm	Uncertain harm	Harm	
No problems with care identified				45
Problems in care identified	11	2	2	15
Total				60

Deaths of patients with learning disabilities

There was one death of a patient with learning disabilities that underwent a SJR during Q4. All relevant phases of care were judged as being good or excellent (4 or 5).



The graph above shows the overall assessment of care for patients with learning disabilities (no=5) and without learning disabilities (no=63) from all HDFT SJRs recorded on Datix (n=68). There is no theme identified from this data but it is being regularly monitored.

All cases of a patient with learning disabilities dying in hospital are automatically referred to the national Learning Disabilities Mortality Review (LeDeR) programme, and five cases were referred during 2018/19. This is the national multi-agency programme for review of death in patients with learning disabilities commissioned by NHS England.

Specific learning points identified

There were no specific learning points identified from the Q4 SJRs. Any specific learning identified during 2018/19 has been addressed.

Results of case notes reviews of in-hospital cardiac arrests

This report includes the case note reviews for Q3 and Q4.

	2017/18						2018/2019					TOTAL
	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	**2017/18 Total**		Q1	Q2	Q3	Q4	**2018/19 Total**	
No of inpatient cardiac arrests	8	11	16	9	**44**		12	7	17	13	**49**	93
No of case note reviews	8	11	16	9	**44**		12	7	17	13	**49**	93
No of appropriate cardiac arrests	4	3	13	4	**24**		10	3	12	6	**31**	55
No of inappropriate cardiac arrests	4	8	3	5	**20**		2	4	5	7	**18**	38

The cardiac arrest case note reviews show that the care provided prior to and during resuscitation calls is of a high standard, following national guidelines and hospital policy.

The Resuscitation Committee deemed 40% of Q3 and Q4 and 37% of 2018/2019 resuscitation attempts as inappropriate. This is a slight improvement compared to 45% in 2017/2018. The reasons for deeming resuscitation inappropriate are detailed below for Q3 and Q4:

Patient had a DNACPR decision in place but not known of or not found	Resuscitation stopped quickly due to futility therefore DNACPR should have been considered pre arrest	Patient had life limiting illness so a DNACPR should have been considered	DNACPR put in place post arrest therefore should have been considered prior to arrest
3	1	9	1

The total number of reasons is greater than the number of cases as there have been more than one reason for being deemed inappropriate in some case note reviews.

Harrogate and District NHS Foundation Trust

Reflection and learning identified

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

The SJRs continue to emphasise the increasing frailty and complexity of medical elderly patients in particular, and confirm the excellent care received by the great majority of patients whose death in hospital is expected. In a smaller number of cases during 2018/19, examples of where practice could be improved were documented. The great majority of these did not affect the eventual outcome. For example:

- Ensuring patients assessed in ED as having a stroke are not given oral intake prior to swallow assessment;
- Ensuring patients with a stroke are admitted to the stroke unit, not other medical wards;
- Ensuring patients transferred back from other hospitals have a timely medical assessment;
- Considering input from orthogeriatric colleagues at the pre-assessment clinic to manage frailty and start advanced care planning;
- Ensuring correct procedures regarding certification of death, and correct Coronial procedures are followed;
- Improving Neurosurgical advice available when the online referral system is not sufficient and holistic and contextual decision-making is indicated;
- Ensuring delays related to percutaneous endoscopic gastrostomy (PEG) tube insertion to feed patients who need this are minimised;
- Ensuring post mortem examination is considered in all relevant cases;
- Improving recognition of the dying phase at end of life to enable unnecessary treatments to be stopped at an appropriate time.

The results of case notes reviews of in-hospital cardiac arrests confirmed that the most prevalent reason to deem resuscitation inappropriate remains “patient had life limiting illness so a DNACPR should have been considered”. This is the focus of the Appropriate Resuscitation and Escalation Operational (AERO) Group to help clinicians to identify which patients they should be having these discussions with and to provide an easy to use platform to document this on and communicate with the MDT in the Trust and across community specialties. The Resuscitation Department are working with the Clinical Effectiveness Department to produce a survey for patients and carers to understand how we can improve the way we discuss treatment escalation and resuscitation with our patients.

Once the AERO group has agreed an appropriate tool to use to guide discussions and documentation, work can progress to provide education on this and a RPIW is planned to improve the culture and willingness to start and document discussions and decisions regarding treatment escalation and resuscitation.

Actions taken

The following actions have been taken during 2018/19 as a result of the learning identified to date:

1. Local dissemination through feedback to teams and across the organisation where appropriate. This is led through the Improving Patient Safety Steering Group. We have used our #ChatterMatters newsletter to share findings;
2. At national level through the implementation of a web based methodology for documentation of SJR which will enable more effective identification of themes and further opportunities for learning;

3. Combining outcomes and learning from reviews of deaths following attempted cardio-pulmonary resuscitation to inform resuscitation training, and resuscitation decision making training materials.

The impact has been:

- Increased awareness of the mortality review process and the benefits of reviewing deaths to inform learning;
- Further education of doctors in training within the Trust regarding Coronial processes and correct certification of deaths;
- Amending our SJR process to encourage the clinician completing the case review to report any specific problem regarding care that is identified as an event on Datix, so this can be followed up. General problems and themes continue to be identified following the SJRs and in-hospital cardiac arrests are reported to the Improving Patient Safety Steering Group where appropriate actions are agreed and progressed.

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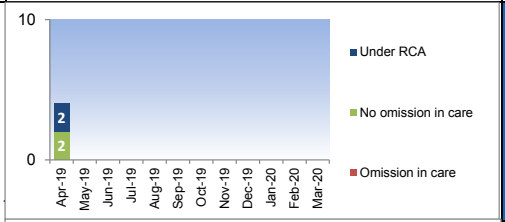
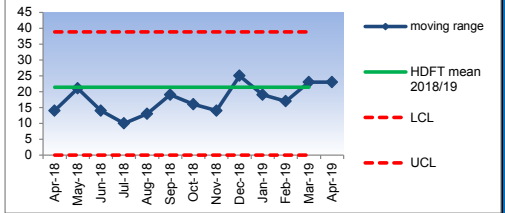
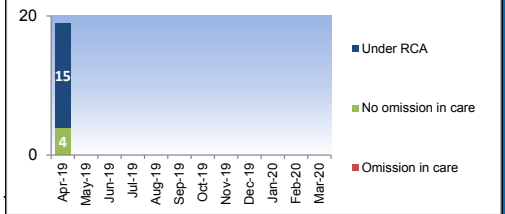
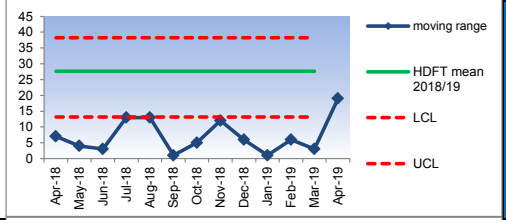
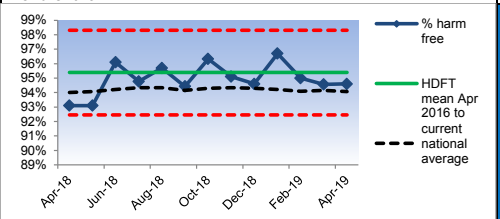
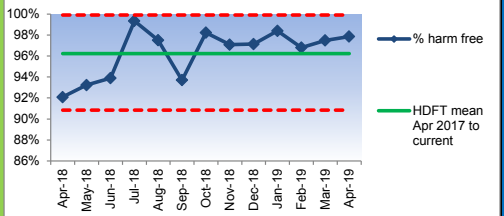
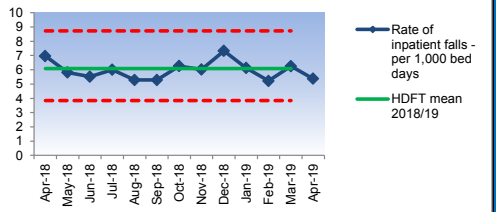
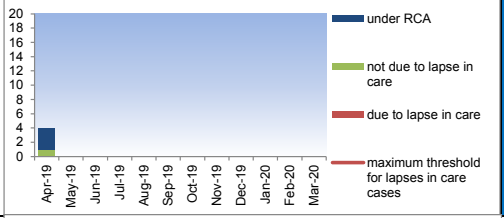
Section 1 - Safe - April 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.1a	Pressure ulcers hospital acquired DQ		There were 4 hospital acquired category 3 and above pressure ulcers reported in April (including device related and device related mucosal). This is in slightly lower than last year with an average of 6 per month reported in 2018/19. Of the 4 reported there were 0 omission in care, 2 no omission in care and 2 under RCA.
1.1b	DQ		The number of hospital acquired category 2 and above pressure ulcers reported in April was 24. The reported number is inclusive of device related and device related mucosal pressure ulcers.
1.2a	Pressure ulcers community acquired DQ		There were 19 community acquired category 3 and above pressure ulcers reported in April (including device related and device related mucosal). The average per month reported in 2018/19 was 11. Of the 19 reported there were 0 omission in care, 4 no omission in care and 15 under RCA.
1.2b	DQ		The number of community acquired category 2 and above pressure ulcers reported in April was 44. The number reorted is inclusive of device related and device related mucolsal pressure ulcers.

Section 1 - Safe - April 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.3	Safety Thermometer - harm free care DQ		The Trust harm free percentage for April was 94.6%. The Trust average for 2018/19 was 94.9%.
1.4	Safety thermometer - harm free care - Community Care Teams DQ		The harm free percentage in the Community for April was 96.4% and remains above 95%.
1.5	Falls DQ		The rate of inpatient falls was 5.38 per 1,000 bed days in April. This is lower than the average HDFT rate for 2018/19 (6.01)
1.6	Infection control DQ		There were 4 cases of hospital apportioned C. difficile reported in April. 1 Case is no lapse in care, and 3 cases are under RCA. No MRSA cases have been reported in 19/20. **(Annual target trajectory required)**

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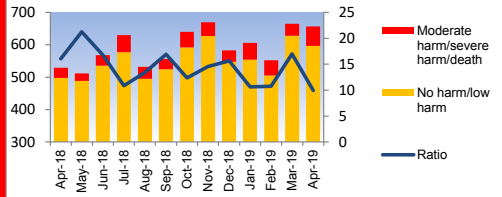
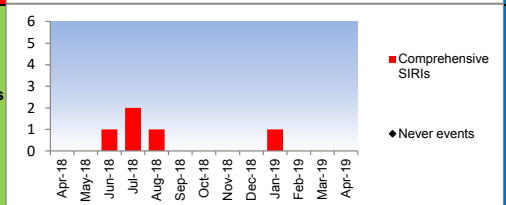
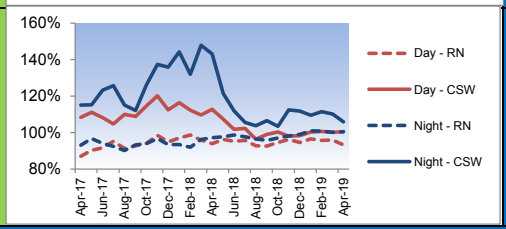
Section 1 - Safe - April 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
1.7	Incidents - all DQ		The latest published national data (for the period Apr 18 - Sept 18) shows that Acute Trusts reported an average ratio of 46 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 22, an increase on the last publication but remaining in the bottom 25% of Trusts nationally. HDFT's latest local data for April gives a ratio of 10, a deterioration on the March position of 17.
1.8	Incidents - SIRIs and never events DQ		There were no comprehensive SIRI or Never Events reported in April. No Never Events were reported in 2017/18 or 2018/19.
1.9	Safer staffing levels DQ		In April staff fill rates were reported as follows: Registered Nurses Day 93.3% and Night 100.5%, Care Staff Day 100.5% and Night 105.8%. Reported care hours per day per patient was 7.90 hours per day.

Narrative

Total number of hospital falls have reduced by 4% YTD compared to April to January 2017/18.

Safer staffing

The table below summarises the average fill rate on each ward during April 2019. 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 April was 7.90 care hours per patient per day.

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Section 1 - Safe - April 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation

	Apr-19						
	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(MSS)	98.20%	97.60%	98.80%	118.90%	4.26	2.73	6.98
Byland	89.50%	91.70%	99.30%	116.10%	2.63	3.12	5.75
CATT(MAU)	93.40%	101.70%	103.80%	103.30%	4.69	2.75	7.45
Farndale	88.00%	92.80%	100.00%	120.00%	3.23	3.42	6.65
Granby	111.70%	138.30%	100.00%	105.00%	3.21	3.19	6.39
Harlow	103.30%	86.70%	100.00%	-	6.82	1.86	8.69
ITU/HDU	102.60%	-	110.00%	-	23.29	1.74	25.03
Jervaulx	95.20%	98.80%	94.70%	112.80%	2.78	3.33	6.12
Lascelles	103.20%	94.70%	100.00%	100.00%	4.55	3.92	8.47
Littondale	95.20%	96.70%	98.90%	106.70%	4.14	2.47	6.61
Maternity Wards	91.10%	85.80%	96.40%	80.00%	15.58	4.14	19.73
Nidderdale	91.30%	96.10%	98.90%	113.30%	3.72	2.3	6.03
Oakdale	86.90%	110.50%	106.70%	103.30%	3.68	3.84	7.51
Special Care Baby Unit	93.80%	43.30%	100.00%	-	23.86	2.95	26.82
Trinity	100.00%	106.00%	100.00%	100.00%	3.17	3.69	6.86
Wensleydale	78.60%	113.30%	100.00%	105.00%	3.95	3.15	7.1
Woodlands	81.40%	93.30%	95.60%	70.00%	10.37	2.83	13.2
Trust Total	**93.30%**	**100.50%**	**100.50%**	**105.80%**	**4.83**	**3.08**	**7.9**
ED	102.00%	146.70%	100.90%	129.60%			

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Section 1 - Safe - April 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation

Further information to support the April safer staffing data

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

On Granby, Oakdale and MAU the increase in RN hours and some care staff hours was to support the opening of additional escalation beds in April when required.

The ITU/HDU staffing levels reflect periods of increased activity within the unit during April.

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

In some wards the actual care staff hours show additional hours used for enhanced care for those patients who require intensive support. In April this is reflected on the wards; MSS, Byland, Farndale, Granby, Jervaulx, Nidderdale and Oakdale.

For the Special Care Baby Unit (SCBU) although the daytime RN 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

In April on Woodlands ward the RN hours were less than planned due to sickness and the care staff hours less than planned due to vacancy and sickness, however the ward occupancy levels vary considerably which means that particularly in this area the number of planned and actual nurses is kept under constant review.

On Wensleydale ward although the daytime RN hours were less than planned in April, the occupancy levels varied in this area throughout the month which enabled staff to assist in other areas.

Section 2 - Effective - April 2019

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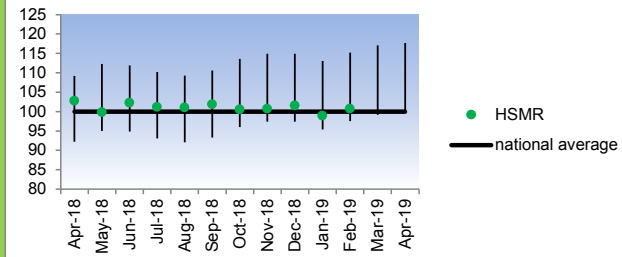
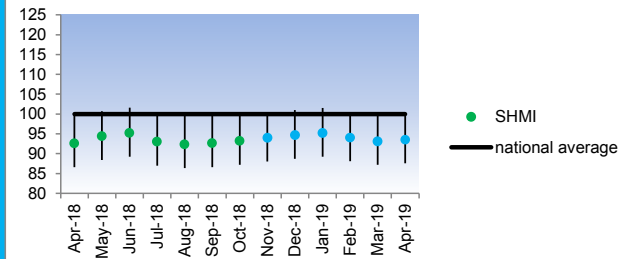
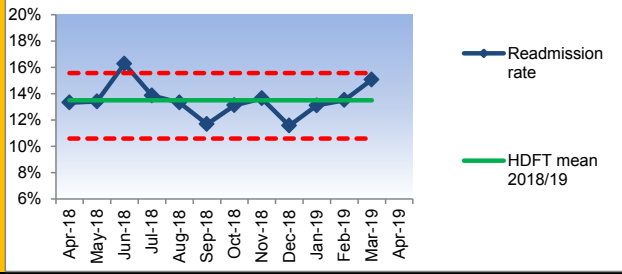
Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
2.1	Mortality - HSMR DQ		Our HSMR has increased to 100.68 for the last 12 months up to February 2019 (98.89 the previous month). Three specialties have a higher than expected standardised mortality rate: Anaesthetics, Geriatric Medicine and General Medicine. The trust is performing above national average which is currently 99.7.
2.2	Mortality - SHMI DQ		SHMI data is now available on HED up to end of December 2018. HDFT's SHMI for the most recent rolling 12 months was 94.11. This remains below expected levels. No new SHMI data is currently available, so it is still currently sitting at 94.11 At specialty level, 5 specialties (Trauma and Orthopaedics, Gastroenterlogy, Respiratory Medicine, Geriatric Medicine, and General Medicine) have a standardised mortality rate above expected levels.
2.3	Readmissions DQ		Emergency Readmissions increased in March to 15.08% resulting in an average of 13.5% for 18/19. This is an increase of 0.4% from 2017/18 which was 13.1%.

Narrative

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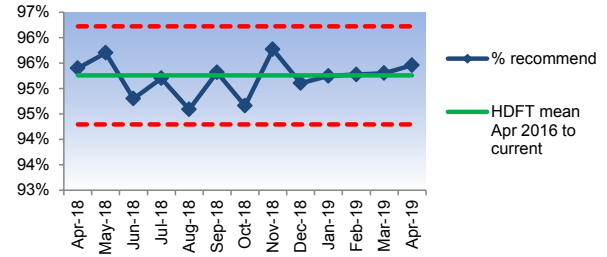
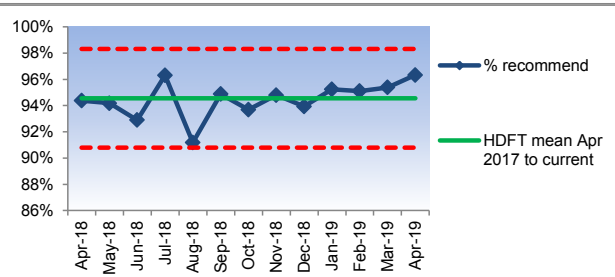
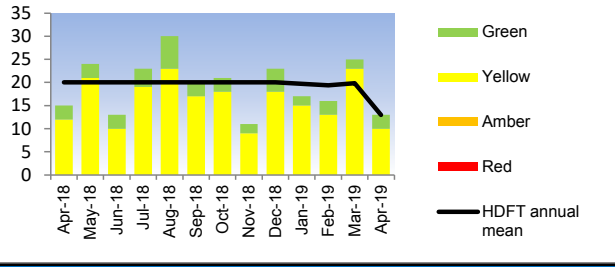
Section 3 - Caring - April 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
3.1	Friends & Family Test (FFT) - Patients DQ		95.5% of patients surveyed in April would recommend our services, an increase on last month and remaining above the latest published national average (93.6%). 4,624 patients responded to the survey this month of which 4,414 would recommend our services.
3.2	Friends & Family Test (FFT) - Adult community services DQ		96.3% of patients surveyed in April would recommend our services, an increase on last month (95.3%). Current national data (March) shows 94% of patients surveyed would recommend the services. 381 patients from our community services responded to the survey this month.
3.3	Complaints DQ		13 complaints were received in April, a decrease on March and below the average for 2018/19. No complaints were classified as amber or red this month.

Narrative

Board Committee report to the Board of Directors

Committee Name:	Resources Committee
Committee Chair:	Maureen Taylor
Date of last meeting:	23 April 2019
Date of Board meeting for which this report is prepared	29 May 2019

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

1. The committee received information on the financial position in March 2019 and the overall outturn for 2018/19. The Trust achieved a surplus position in March of £4.965m which is ahead of both the internal and external plans. The position reached in March means that the Trust has met its control total for the year and will therefore receive PSF funding for the final quarter. The surplus position for the year is £4.079m and in addition, having met the control total the Trust will receive bonus PSF funding expected to be £3.9m.
2. Due to the strong A&E performance in March and also further clarity on PSF relating to A&E performance, additional PSF funding was able to be brought into account, with the full amount now due to be received. The in-month spending pressures were drugs, CIP, theatre staffing and settlement of historic income disputes, offset by the PSF adjustment.
3. The CIP target for the year has been met. Long Term and Unscheduled Care directorate was behind plan but this was compensated for by other directorates over-achieving. 75% of CIP is recurrent.
4. Activity for the year was behind plan in elective in-patients, elective day-cases and follow up outpatients but ahead of plan in new outpatients, non-electives and A&E attendances. All activity for HaRD CCG was ahead of plan except for elective in-patients which were 1.3% behind plan.
5. Workforce information presented showed all workforce areas were under establishment in March. Cost pressures year to date were in theatres and day surgery, Ward Nursing and Ward Health Care Assistants.
6. The consolidated cash position (Trust and HIF) remains a concern with 95% of invoices being paid within 66 days (compared to the 30 day target). PSF cash for quarter 4 and the bonus PSF are likely to be received in June/July.
7. The Committee received an update on Planning for 2019/20. There is a gap of £8m between the cost of delivering the forecast activity and what HaRD CCG can afford for the acute contract. The Committee received information putting the CCG's financial position into context nationally. A summary of options was presented including the impact of each on operational standards. The preferred option is for a contract of £103.5m contract with the CCG receiving £6m of support through the Integrated Care System (ICS). The remaining £2m gap would be met through a programme of work across primary and secondary care alongside transformation of out of

hospital services.

8. For 2019/20 an efficiency requirement of £8.4m has been identified. To date risk rated plans of £5m are in place.
9. The Committee received an update on the ICS Financial Framework which develops the concept of a shared control total where an element of PSF is dependent on ICS financial performance. 15% of the Trust's PSF (£400k) would be at risk if the ICS did not meet the necessary standards. Agreement to the framework brings financial opportunities including access to transformation funding.
10. The Committee received an update on progress with the Harrogate Harlow private patient work. Progress has been made in signing up consultants and there is expression of interest from external consultants. It has been difficult to get on the lists of some insurance companies, the lack of an outpatients' facility is a weakness. There were discussions about the size of the market, how we progress marketing, who other providers are and whether we compete or collaborate. An activity plan for 2019/20 will be developed which the working group will monitor. The Business Development group oversee the activity plan and makes sure activity is on track.
11. The Committee considered the outcomes from the Resources Committee effectiveness survey and also considered the Resources Committee Annual Report which will be included on the Board agenda in May.

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

- Cash remains a risk and work needs to continue to manage payments and collect sums due.
- The contract with HaRD CCG has not been signed by the due date (21 March 2019) and discussions are ongoing.

Matters for decision

Nil

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Date of Meeting:	29 May 2019	**Agenda item:**	8.1
Report to:	Board of Directors		
Title:	Operational Plan 2019/20		
Sponsoring Director:	Jonathan Coulter, Finance Director / Deputy Chief Executive		
Author:	Jonathan Coulter, Finance Director / Deputy Chief Executive		

Report Purpose:							
Decision	✓	**Discussion/ Consultation**	✓	**Assurance**	✓	**Information**	✓

Executive Summary:	The Board approved the submission of the Trust's Operational Plan at the end of March. All organisations are given the opportunity to resubmit their plan on 15 May to account for any material changes since the end of March. Due to national changes (capital resource availability & PSF bonus allocation) and local developments (contract with HaRD CCG), we have re-submitted the Plan. Performance trajectories, workforce plan, and control total commitment remain unchanged.

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:	As per plan
Legal / regulatory:	Operational Plan a regulatory requirement and used to assess performance
Resource:	As per plan
Impact Assessment:	None identified
Conflicts of Interest:	None identified.
Reference documents:	Plan submission paper, Board of Directors' meeting March 2019
Assurance:	Oversight by Resources Committee

Action Required:

The Board is requested to **endorse and approve** the amendments made to our Operational Plan 2019/20 as submitted on 15 May 2019.

8.1

You matter most

Introduction

The Board discussed the Operational Plan for 2019/20 at the Board meeting on 27 March 2019. The plan was submitted to NHSI on 4 April 2019 in line with approval from the Board and in line with the national timetable.

Plan submission 4 April

The plan submitted on 4 April had the following key elements:

- Agreement to the control total of a deficit before MRET/PSF of £0.8m;
- Achievement of the control total as agreed, with associated efficiency programme;
- Performance trajectories in line with the profiles discussed and agreed by the Board
- Workforce plan that triangulated with the financial and capacity plans;
- Capital programme of £5.2m; and
- A recognition that the contract with HaRD CCG was unsigned and a risk in terms of local system affordability of £8m.

Developments since plan submission

Since 4 April, a number of material issues have progressed, namely the contract discussions with HaRD CCG, a national triangulation of capital expenditure plans and resources, and confirmation of PSF bonus achievement in 2018/19 and cash impact in 2019/20.

Recognising the significant changes that have taken place, including the national request for all Providers to review capital plans in the light of restricted national capital resources, all organisations were offered the opportunity to resubmit operational plans for 2019/20.

Resubmission of the Operational Plan

We have taken the opportunity to resubmit our Operational Plan. The following are the changes that we have made:

- A slightly reduced capital programme for 2019/20, deferring expenditure of £150k into 2020/21. There may yet be a request nationally for Trusts to go further depending upon the impact of this resubmission process.
- Contract value that is agreed with HaRD CCG, and associated efficiency programme change
- Cash profile updated for the receipt of PSF bonus cash during 2019/20
- Rephrasing of pay expenditure across the year, taking into account the actual impact of the Month One pay award

There has been no change to our performance trajectories, workforce plan, or control total achievement.

These amendments have been discussed with NHSI, and will be discussed at Resources Committee.

Decision

The Board is requested to endorse and approve the amendments made to our Operational Plan 2019/20 as submitted on 15 May 2019.

Harrogate and District NHS Foundation Trust

Date of Meeting:	29 May 2019	**Agenda item:**	8.2
Report to:	Board of Directors		
Title:	Integrated Care System Financial Framework 2019-20		
Sponsoring Director:	Mr Jonathan Coulter, Director of Finance		
Author(s):	Mr Jonathan Coulter, Director of Finance		
Report Purpose:	**Decision** ✓ **Discussion/ Consultation** ✓ **Assurance** ✓ **Information**		
Executive Summary:	• The Resources Committee discussed the proposal to adopt the ICS Framework at its meeting on 23 April – the paper is attached • The Board subsequently discussed the adoption of this Framework at the workshop on 24 April • The deadline for acceptance was 26 April 2019 • The Board agreed to adopt the Framework to allow the ICS to respond within the deadline, subject to formal agreement at the May meeting of the Board		
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:	Potentially 15% of Provider Sustainability Funding (c£400k) would be at risk if the system did not meet the standard in each quarter. Realistically the risk would emerge in Q4, with therefore a proportion of this value at risk.		
Legal / regulatory:	None identified		
Resource:	None identified		
Impact Assessment:	Not applicable		
Conflicts of Interest:	None identified.		
Reference documents:	Report attached		
Assurance:	Resources Committee and WY&H Leadership Group.		
Action Required by the Board of Directors:			
The Board of Directors is invited to: • **Confirm** the decision, taken at the workshop on 24 April 2019, to adopt the ICS Financial Framework			

8.2

You matter most

Harrogate and District NHS Foundation Trust

Date of Meeting:	23rd April 2019	**Agenda item:**	7
Report to:	Resources Committee		
Title:	ICS financial framework 2019/20		
Sponsoring Director:	Deputy Chief Executive / Finance Director		
Author(s):	Finance Director		
Report Purpose:	**Decision**	**Discussion/ Consultation** ✓	**Assurance**	**Information** ✓
Executive Summary:	• As part of becoming an ICS, WY&H is expected to work constructively as a system to deliver care and manage resources • For 19/20, a financial framework for ICS's has been developed – **see letters 1 & 2**. • The framework develops the concept of a shared control total which includes an element of PSF being dependent upon the ICS financial performance rather than solely the organisation's financial performance • In order to take advantage of the financial opportunities of being an ICS (including control over c£8m of transformation funding), the ICS needs to agree to the new framework, although there is choice regarding how far the system wants to move in 2019/20 • Finance Directors across the ICS have discussed the proposal and a recommendation is being produced for the ICS leadership community **– see letter 3** • The recommendation is to approve the framework and put 15% of PSF dependent upon delivery of the system financial performance requirement.		

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:	Potentially 15% of our PSF (c£400k) would be at risk if the system did not meet the standard in each quarter. Realistically the risk would emerge in Q4 with a proportion of this value at risk.
Legal / regulatory:	As part of being in the ICS we are required to agree a financial framework
Resource:	
Impact Assessment:	
Conflicts of Interest:	none
Reference documents:	Letters attached

8.2

You matter most

Harrogate and District NHS Foundation Trust

Assurance:	To Resources Committee & WY&H leadership group
Action Required by the Committee:	
The Resources committee is asked to: • note and discuss the letter outlining the ICS financial framework and options within it • note the recommendation being made from the Finance Director community to accept the framework and include 15% of PSF across the ICS to be dependent upon delivery of the system financial performance standard	

To: Integrated Care System Leads
By e-mail

Publishing Approval
Reference: 000428

Thursday 4 April 2019

Dear Integrated Care System Lead,

2019/20 financial framework for Integrated Care Systems

The 2019/20 planning guidance published in January set out the financial framework and the planning timetable for all systems. The planning guidance included an expectation that ICSs would link a proportion of their Provider Sustainability Fund (PSF) and any applicable Commissioner Sustainability Fund (CSF) to delivery of their system control totals.

This letter outlines the detail of the ICS financial framework including the system PSF scheme, transformation funding and ICS oversight. The planning guidance sets out the overall financial framework for 2019/20 and remains applicable to ICSs in 2019/20, except where updated in this letter.

Our approach and aims of the ICS financial framework

As stated in the Planning Guidance, 2019/20 is a transition year. It is our ambition that the PSF will be removed from 2020/21 with funding transferred into the newly created Financial Recovery Fund (FRF). The total value of the PSF has been reduced from £2.45bn in 2018/19 to £1.25bn in 2019/20.

We have worked with ICS and finance leads to update the ICS financial framework for 2019/20, taking into account feedback received, particularly on the operation of the PSF scheme in 2018/19. As this is a transition year, we have looked to simplify and improve the approach rather than introduce a wholly new framework. We are particularly grateful for the feedback we've received and the input from system leaders in considering how we move forward.

The overarching aims of the ICS financial framework are as follows:

- putting the system at the centre of managing financial resources, promoting new ways of working and behaviours;
- encouraging collaboration between individual organisations to support integrated models of care and achieve system financial balance;
- strengthening system governance and decision-making mechanisms; and
- acting as a test bed for further system-focused changes to the NHS financial framework, in the future.

We agreed that the financial arrangements for ICSs must be fair to both ICSs and non-ICSs. ICSs should not be made systematically worse off than non-ICSs as a

result of agreeing to work within these arrangements. There should also be clear advantages for those who take on system risk within these arrangements.

The rest of this letter outlines the different components of the 2019/20 financial framework for Integrated Care Systems following our engagement with ICS leads and finance leads. ICSs are expected to sign up to all parts of the financial framework as part of demonstrating their commitment to system working.

Components of the ICS financial framework

Value of system PSF/CSF

To calculate the PSF payable to an ICS, we distinguish two types of PSF:

- **Trust PSF** – to be paid based on achievement of a trust's individual CT, as for non-ICS.
- **System PSF** – to be paid based on achievement of the system CT, but reducing on a sliding scale (in line with the approach agreed in 2018/19) at a rate of £1.50 for every £1 of under-performance.

For 2019/20, we expect:

- All ICSs who opted into the scheme in 2018/19 to link at least the same financial value of PSF to system control totals as they did in 2018/19 (in pounds million, not as a percentage).
- For those ICSs that linked all of their PSF to system performance in 2018/19 we expect them to continue to link all of their PSF to system performance in 2019/20.
- And for ICSs that are participating in the scheme for the first time, we expect them to link a minimum value of 15% of PSF to system performance.
- Taking part in this scheme is a key indicator that a system is operating as a full ICS.

All ICSs have the flexibility to increase the value of system PSF if they choose to do so. PSF will not be linked to system performance for ICSs operating at a sub-STP level.

Further details on the operation of the scheme can be found in appendix A.

ICS flexible funding

As the ICS programme expands to the rest of the country, we have been considering a number of options as to how the 'flexible' funding can be fairly distributed. This is the final year in which 'flexible' transformation funding is available as we are taking steps to ensure programme transformation funding is increasingly under the direction of ICSs (as set out below).

In this context, we are allocating wave 1 and wave 2 ICSs the same indicative allocation of 'flexible' transformation funding in 2019/20 as they received in 2018/19. However, this funding will only be available to ICSs who are opting into the PSF scheme. Any flexible funding released through ICSs not opting into the PSF scheme will be used to fund the next wave of ICSs joining the programme.

Devolution areas already have fully devolved transformation funding and this will not change.

National programme transformation funding

In the 2018/19 MOUs we made a commitment to take steps where possible to increase the flexibility of transformation funding streams dedicated to specific priorities from 2019/20 and beyond. In line with this commitment, we are working with national programmes to put more transformation funding under the direction of the ICSs.

Within the overall total transformation funding available, we expect to distribute at least £450m in 2019/20 across STPs and ICSs for Five Year Forward View and Long Term Plan transformation programme areas, including primary care, mental health, cancer and maternity. ICSs constitute around 22% of the weighted population and we would therefore expect the ICS share of this funding to be around £100m.

Some areas of this are still being worked through, but we anticipate that ICSs will receive their shares of the funding as part of their ICS MOUs, stating delivery requirements, both in relation to this funding and pre-existing commitments. STPs will be expected to produce plans which will be assured in the usual way prior to the release of funds. We expect to provide further clarity on the funding for each ICS shortly, along with agreeing ICS MOUs.

Oversight and regulation for ICSs

NHS England & NHS Improvement has already committed to developing a joint oversight framework that supports system working and producing an agreed set of freedoms and flexibilities for ICSs to guide system and regional ways of working.

Where ICSs agree to sign up to the system PSF scheme and demonstrate the capabilities of a mature ICS, NHS England & NHS Improvement will agree with these systems a set of freedoms and flexibilities to take on a shared or leading role in the oversight and regulation of trusts and CCGs, supported as necessary by regional teams. This will be based on a set of freedoms and flexibilities that is currently under development.

We are committed to supporting ICSs and regional teams in enacting this model in 2019/20 and this will form part of the MOUs signed between the ICSs and national and regional teams.

Further modifications to the framework

2019/20 year-end PSF incentive/bonus - NHS England & NHS Improvement has not set a year-end incentive/bonus for 2019/20, and have no plans to do so. We have made a number of changes to the overall NHS financial framework for 2019/20 that mean it is less likely that a year-end incentive scheme will be necessary.

However, if a scheme is introduced, we commit to consult with ICSs on the operation of the scheme. We do note that we will continue to adhere to the principle, established in 2018/19, that systems will not be able to benefit twice from the same improvement under such schemes.

Ambulance providers - The planning guidance set an expectation that ambulance providers' control totals would be included in the system control totals of their host CCGs. We have listened to feedback from systems on the additional risk that this proposal presents, and systems will be able to elect for ambulance providers not to be included within ICS PSF calculations.

Offsets - As in 2018/19, ICSs will be able to agree net-neutral changes to individual control totals at the beginning of the financial year and/or in-year offsets of financial performance between organisations. We have listened to feedback from systems regarding the burden of the approval process for offsets and are removing the approval process for 2019/20. This means that the performance of over-performing organisations will automatically be used to offset the performance of under-performing organisations for the purpose of ICS PSF calculations.

We will work with ICSs to agree the details of how offsets will be applied automatically early in the financial year. In-year offsets will only be available to ICSs linking some or all of their PSF to system performance (i.e. those operating at an STP level).

Timetable and next steps

We understand that ICS leaders will need time to discuss the financial framework with the organisations in their systems. We therefore ask you to notify us of agreement to the financial framework and the value of system PSF no later than Friday 26th April using the following address: nhsi.strategicfinance@nhs.net. Please also notify us if you wish to elect for the performance of ambulance providers in your systems not to count towards the calculation of system PSF.

As previously notified, any proposed net-neutral changes to organisation-level control totals within systems must be agreed with your Regional Director. Please raise any such proposals under consideration with your regional planning and finance leads as soon as possible.

Thank you all for your feedback and engagement to date on this important matter. Please contact Rachael Backler (Rachael.Backler@nhs.net) if you have any queries or would like to discuss any points in this letter.

Yours sincerely,

Julian Kelly

Chief Financial Officer

NHS England and NHS Improvement

APPENDIX 1- PSF/CSF RULES

- To link PSF to system performance, an ICS must have accepted all individual control totals and be planning to meet or exceed its system control total.
- ICSs will be able to propose net-neutral changes to individual control totals at the beginning of the financial year.
- PSF will be classified as set out in this letter as:
    - **Trust PSF** – to be paid based on achievement of a trust's individual CT, as for non-ICSs.
    - **System PSF** – to be paid based on achievement of the system CT, but reducing on a sliding scale (in line with the approach agreed in 2018/19) at a rate of £1.50 for every £1 of under-performance.
- The performance of over-performing organisations will automatically be used to offset the performance of under-performing providers for the purpose of PSF calculations. We will work with ICSs to agree the details of how offsets will be applied automatically early in the financial year.
- If an organisation does not meet its individual control total then NHS England and NHS Improvement will agree – in consultation with the ICS – an alternative distribution of that organisation's share of any System PSF and CSF (where applicable) that is earned.
- Where CCGs are eligible for CSF this will be linked to system performance when ICSs have linked all of their PSF to the SCT. CSF will be linked to individual CCG performance for ICSs that have some of their PSF linked to the SCT.
- System PSF, Trust PSF and CSF will be paid quarterly and phased in the same way as for non-ICSs in line with the applicable PSF/CSF guidance.

West Yorkshire and Harrogate
Health and Care Partnership

8 April 2019

Dear System Leadership Executive

ICS Financial Framework 2019-20

Integrated care systems are expected to take greater responsibilities for the collective improvement, performance and finances of the local health and care system. In return, we expect greater freedoms, financial flexibilities and up front resources. I have been part of a group of ICS leaders working with the national team to develop the ICS financial framework for 2019/20. This was published last Thursday.

I am writing to share this document with you, and to set out a process for how we to respond by 26th April. In doing so, we will need to work outside of our usual meeting cycle.

The framework includes a package of proposals that are consistent with our ambitions as an ICS:

- A proposition whereby if the Integrated Care System agrees to link a proportion (minimum 15%) of Provider Sustainability Funding (PSF) to delivery of a system control total, they will receive a pot of local transformation funding. This is expected to be at the same level as 2018/19, £8.75m.
- Greater local control of the national transformation funding that we expect to receive in 2019/20. It is estimated that around £100m of funding earmarked for specific programmes will be available for Integrated Care Systems. Based on our population size as one of the largest, we would expect a significant share in the region of £15-£20m.
- An automatic right to PSF for all organisations if the overall control total is achieved each quarter, without recourse to the regulators to agree variances.
- Automatic right to access any incentive schemes that become available, although these are not anticipated in 2019/20.
- Further movement towards the next stage as a fully mature ICS.

For West Yorkshire and Harrogate the total value of the PSF across all trusts in 2019/20 is around £55.5m. If we went for the minimum 15%, this would mean that around £8.3m would be contingent on delivery of the system control total. We also understand that System PSF can only be lost up to the value of the available in that quarter. NHSE&I will not 'claw back' any System PSF that has been earnt in previous quarters, based on moves later in the year. This reduces the likelihood of the total sum being lost.

We have had a number of conversations about taking greater collective responsibility of our financial performance. From my perspective, this proposition seems to me like a reasonable first step into this way of working. It also provides additional, flexible resources for transformation that could make a difference to services in the coming year. I am confident that we have the relationships and strength of financial leadership across the system to make a success of it.

I have asked Bryan Machin to work with our Director of Finance leadership this week to work through the framework, and provide a recommendation for us to consider. Our intention is to share this with you for agreement by Tuesday 16th April at the latest.

I hope this is clear. I'm very happy to discuss any aspect of this.

Rob Webster

Chief Executive Lead, West Yorkshire and Harrogate Health and Care Partnership

West Yorkshire and Harrogate
Health and Care Partnership

17 April 2019

Dear System Leadership Executive

ICS Financial Framework for 2019-20

Further to my letter of 8 April I am now writing to seek your agreement to the West Yorkshire & Harrogate Health and Care Partnership operating under the ICS Financial Framework for 2019/20.

Our Finance Directors and Chief Financial Officers have considered the national framework and their recommendation is that we should operate under the proposed ICS Financial Framework, with 15% (i.e. the minimum) of each Trust's Provider Sustainability Fund (PSF) linked to system performance.

In making their recommendation the finance leaders have taken into account the following factors:

- To be eligible to receive local transformation funding, expected to be at the same level as 2018/19, £8.75m, an ICS must operate under the ICS Financial Framework.
- To have greater local control of national programme transformation funding, expected to be circa £15m to £20m, an ICS must operate under the ICS Financial Framework.
- The minimum level of PSF to link to system performance is 15%. This is the level finance leaders are recommending for WY&H based on their collective understanding of the level of financial risk across the system in 2019/20.
- System performance is assessed quarterly and System PSF earned in previous quarters will not be clawed back if there is underperformance in subsequent quarters.
- Payments of PSF/CSF will be made automatically to all organisations if the collective position is on track.

Annex A provides some scenarios and worked examples of the impact on Trusts and CCGs in under the 15% Framework. I'm also attaching a FAQ document that we have received from NHSE/I.

I fully support the Finance Leaders' recommendation. The benefits received from the allocation of flexible transformation funding, expected to be £8.75m, and the increased control of circa £15m to £20m national programme transformation funding, compare favourably to the

likely scale of financial risk faced under this arrangement. The model of working also supports our collective ambition to remain a leading edge ICS in 2019/20.

Finance leaders have committed to develop approaches to monitor and support individual and collective delivery of the best possible financial performance in 2019/20 – we will have the opportunity to consider these in System Leadership Executive later in the summer.

The national timescale for notifying NHSE&I of our decision precludes the opportunity for full discussion at SLE. I will leave it to each organisation to ensure that the appropriate internal arrangements are made to agree this position. I appreciate that in many cases a formal discussion with your Board or Governing Body may not be possible. I know that this is not ideal but I would be very grateful for confirmation on behalf of your organisation that you agree to the 15% ICS Financial Framework before 24 April so that we can access additional transformation funding and move forward together in delivering sustainable services.

With best wishes

Rob Webster

Chief Executive Lead, West Yorkshire and Harrogate Health and Care Partnership

Annex A: Illustrative Scenarios

On a quarterly basis		West Yorkshire and Harrogate ICS	
		Delivers Aggregate CT	**Doesn't Deliver Aggregate CT**
All Trusts & CCGs Deliver CT		All Trusts earn 100% PSF Eligible CCGs receive CSF	
Not all Trusts & CCGs deliver CT	**Trust Delivers CT**	Trust earns 100% PSF	Trust earns 85% Trust PSF Trust loses 15% System PSF**
	Trust Doesn't Deliver CT	Trust earns 85% Trust PSF Trust loses 15% System PSF*	Trust loses 85% Trust PSF Trust loses 15% System PSF**
	CCG Delivers CT	CCG earns CSF	CCG earns CSF Trust loses 15% System PSF**
	CCG Doesn't Deliver CT	CCG loses CSF	CCG loses CSF Trust loses 15% System PSF**

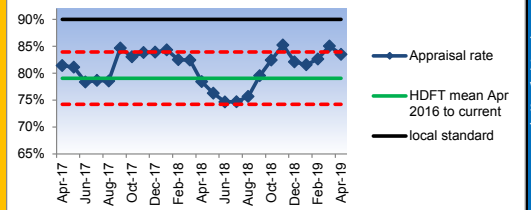
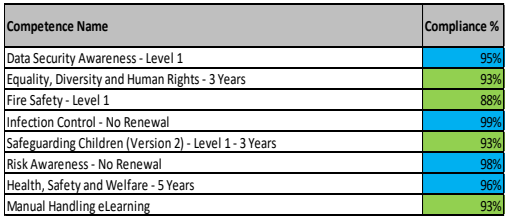
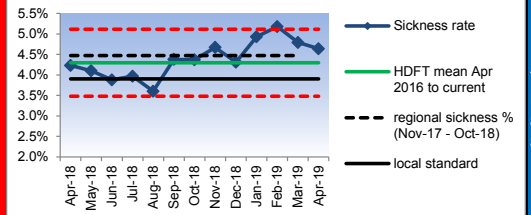
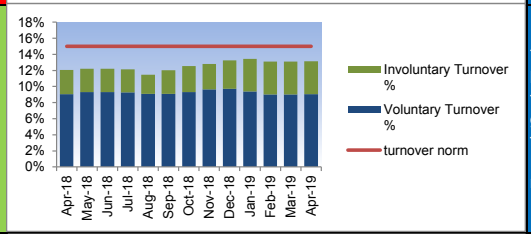
* on a sliding scale, ICS involved in decision about redistribution

** on a sliding scale, ICS not involved in decision about redistribution

- In terms of expected numbers, the total WY&H PSF is £55.5m. 15% System PSF is £8.3m
- Finance leaders expect that financial risk will materialise in forecasts in Quarter 4; perhaps in Quarter 3. System PSF in Q3 is £2.5m, in Q4 its £2.9m
- System PSF is "lost" on a sliding scale of £1.50 for every £1 of system underperformance. So, if our system underperformed by £1.9m in Q4, the full System PSF of £2.9m would be lost. That would be the maximum PSF loss in Q4 even if underperformance exceeded £1.9m. In reality we would not expect to underperform by as little as £1.9m or less without finding a solution. Effectively then, any likely system underperformance in Q4 will lead to the maximum loss to our system of £2.9m PSF.
- As an example of a 'average' Trust in WY&H, The Average & District Foundation Trust (ADFT) will be planning to receive £1.8m total PSF in Quarter 4, £1.53m Trust PSF and £0.27m System PSF
    - If WY&H meets its aggregate CT but ADFT misses its CT by £1.0m then ADFT's £0.27m System PSF will be redistributed by NHSE&I in consultation with the ICS. All other Trusts receive their full PSF
    - If WY&H does not meet its aggregate CT and ADFT misses its CT by £1.0m then ADFT loses its full £1.8m Q4 PSF. All other Trusts lose their System PSF on a sliding scale; in this example, their proportionate share of £1.5m. For an 'average' Trust this would be £136k.

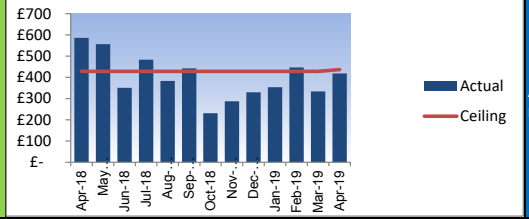
NHS Harrogate and District NHS Foundation Trust

Section 5 - Workforce - April 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
5.1	Staff appraisal rates DQ		There has been a slight reduction in appraisal rates to 83.48% in April from 84.77% in March 2019. The Appraisal window opened on the 1 April 2019 and closes on 30th September 2019, with the aim of ensuring 90% of staff are appraised during this period. Communications with staff have commenced to highlight the launch of this year's appraisal window which offers tips for managers and signposts staff to the relevant appraisal resources in the HR Toolkit.
5.2	Mandatory training rates DQ		Mandatory % Report – Trust exc HIF 01.04.19 The data shown is for the end of March and excludes the Harrogate Integrated Facilities (HIF) staff who transferred into the new organisation on the 1st March 2018. The overall training rate for mandatory elements for substantive staff is 94% and has increased since the last reporting cycle.
5.3	Sickness rates DQ		The Trust sickness absence rate for April 2019 is 4.64% which is a further reduction from March's rate of 4.79%. This remains above the Trust target of 3.9%. A review of sickness absence data has been undertaken and shared at Directorate Boards in April. The report and associate recommendations will be provided to SMT in May.
5.4	Staff turnover rate DQ		Turnover has seen a marginal decrease from January into March 2019, with combined turnover being reported as 13.10% (13.26% in January). A gradual upward trend can be seen with turnover at the beginning of the financial year being reported as 12.08%. Turnover for key staff groups and departments is reported through the Workforce Efficiency Group and has been factored into ongoing recruitment plans for 2019/20 and beyond. In addition, the Nurse Recruitment and Retention Group is working through a number of initiatives to help increase retention across the Trust.

Competence Name	Compliance %
Data Security Awareness - Level 1	95%
Equality, Diversity and Human Rights - 3 Years	93%
Fire Safety - Level 1	88%
Infection Control - No Renewal	99%
Safeguarding Children (Version 2) - Level 1 - 3 Years	93%
Risk Awareness - No Renewal	98%
Health, Safety and Welfare - 5 Years	96%
Manual Handling eLearning	93%

Section 5 - Workforce - April 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
5.5	Agency spend in relation to pay spend DQ		Agency expenditure is within the ceiling set for the Trust, however, there remains pressures in a number of areas which will need careful management throughout the year.

Narrative

Sickness Absence
The Trust sickness absence rate for April 2019 is 4.64% which is a further reduction from March's rate of 4.79%. This remains above the Trust target of 3.9%. A review of sickness absence data has been undertaken and shared at Directorate Boards in April. A review of the sickness absence policy is underway to ensure the process supports effective management of absence.

Turnover
Turnover for April shows a slight increase to 13.14% in April from 12.97% in March 2019. This has remained fairly static and the recruitment and retention group continue to meet on a monthly basis to discuss a number of initiatives.

Appraisal Rate
There has been a slight reduction in appraisal rates to 83.48% in April from 84.77% in March 2019. The Appraisal window opened on the 1 April 2019 and closes on 30th September 2019, with the aim of ensuring 90% of staff are appraised during this period. Communications with staff have commenced to highlight the launch of this year's appraisal window which offers tips for managers and signposts staff to the relevant appraisal resources in the HR Toolkit.

NHS
Harrogate and District
NHS Foundation Trust

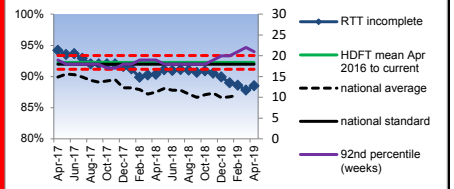
Section 4 - Responsive - April 2019

NHS Improvement Single Oversight Framework

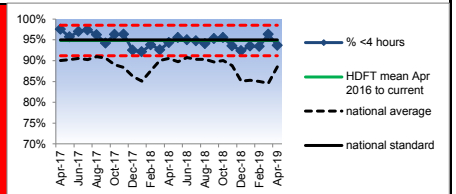
Standard	Q1	Q2	Q3	Q4	YTD
RTT incomplete pathways	88.5%				88.5%
A&E 4-hour standard	93.6%				93.6%
Cancer - 62 days	86.8%				86.8%
Diagnostic waits	99.3%				99.3%
Dementia screening - Step 1	91.6%				91.6%
Dementia screening - Step 2	92.3%				92.3%
Dementia screening - Step 3	100.0%				100.0%

4.1 NHS Improvement Single Oversight Framework — DQ

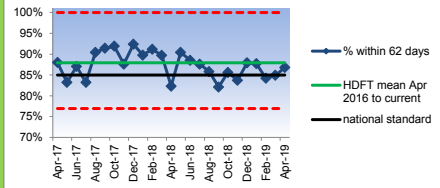
4.2 RTT Incomplete pathways performance — DQ



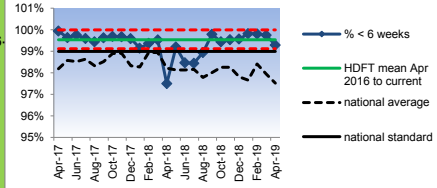
4.3 A&E 4 hour standard — DQ



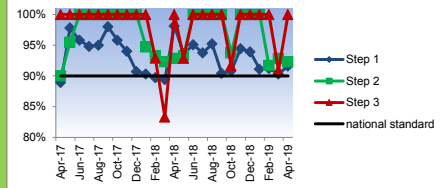
4.4 Cancer - 62 day wait for first treatment from urgent GP referral to treatment — DQ



4.5 Diagnostic waiting times - 6 week standard — DQ



4.6 Dementia screening — DQ



Narrative

Performance against the 62 day cancer standard was delivered in April with provisional performance at 86.8% , however the Breast symptomatic standard continues to be challenging due to a continued rise in referral rates. The COO is working with NHSI and the WY&H Cancer Alliance to review opportunities across the ICS to support the delivery of this standard by improving referral guidance and planned capacity.

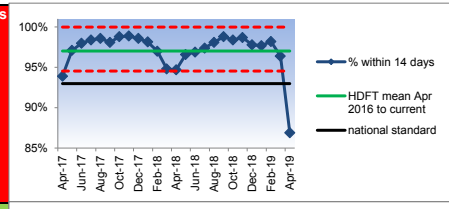
Two patients waited longer than 31 days for subsequent surgical treatment (1 skin and 1 bladder) - these were due to patient choice/cancellation and two urological theatre lists being lost because of the Easter bank holiday. The current forecast denominator for April is 20 (90.0%).

The COO held a summit with the clinical team delivering the Breast Care clinics. This focussed on the specific capacity and demand issues leading to the significant drop in performance. This approach is being used across West Yorkshire and Harrogate in conjunction with the Cancer Alliance team as this is an issue across the ICS. A detailed action plan was developed and implementation of this will be managed through Operational Delivery Group. There are a number of short term measures which should stabilise the position, but it will take some months to recover to the expected standard.

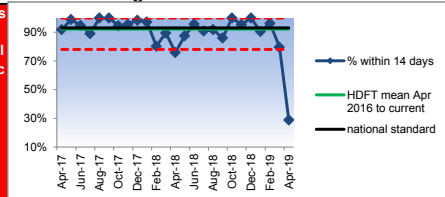
Section 4 - Responsive - April 2019

Cancer waiting times standards

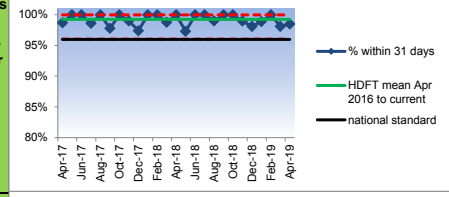
4.7 Cancer - 14 days max wait from urgent GP referral for suspected cancer (DQ)



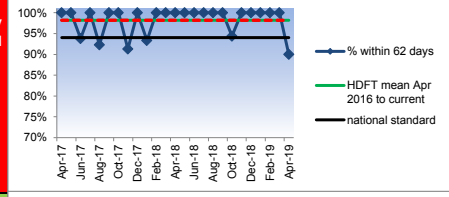
4.8 Cancer - 14 days maximum wait from GP referral for symptomatic breast patients (DQ)



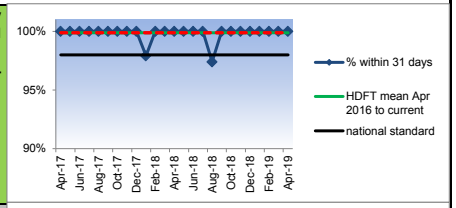
4.9 Cancer - 31 days maximum wait from diagnosis to treatment for all cancers (DQ)



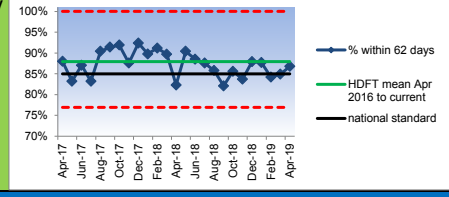
4.10 Cancer - 31 day wait for second or subsequent treatment: Surgery (DQ)



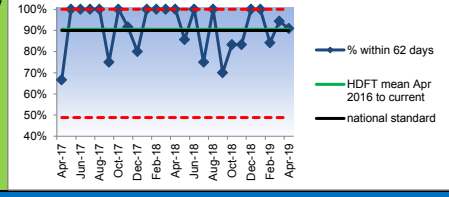
4.11 Cancer - 31 day wait for second or subsequent treatment: Anti-Cancer drug (DQ)



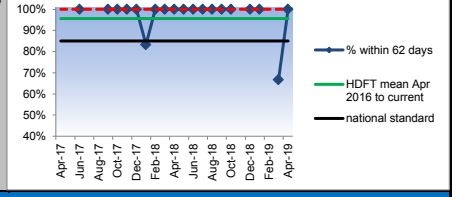
4.12 Cancer - 62 day wait for first treatment from urgent GP referral to treatment (DQ)



4.13 Cancer - 62 day wait for first treatment from screening service (DQ)



4.14 Cancer - 62 day wait for first treatment from consultant upgrade (DQ)



Narrative

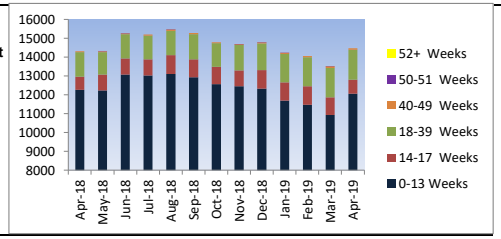
Provisional data indicates that all cancer waiting times standards were achieved in April, with the exception of both 14 day standards. The were 38.0 accountable 62 day treatments in the month with 5.0 breaches, meaning performance was above the standard of 86.8%.

There were 45 non-cancer related breast symptomatic attendances in April, with 32 patients seen after day 14 (28.9%). The denominator for the 14 day suspected cancer standard was 739 in April with 97 patients first seen outside 14 days (86.9%). Of these 97 patients, 86% (83) were breast referrals.

For the main 62 day standard, of the 11 tumour sites, 2 had performance below 85% in April - Gynaecology (2.0 breaches) and Urological (3.0). 2 patients waited over 104 days for treatment in April - both were complex pathways.

RTT waiting list metrics

4.15 RTT waiting list split by weeks (DQ)



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Section 4 - Responsive - April 2019

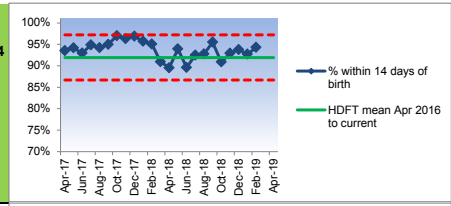
Narrative

Of the 14469 patients on the waiting list at the end of April, 12049 have been waiting 0-13 weeks, 754 for 14-17 weeks, 1578 for 18-39 weeks and 88 between 40-49 weeks. No patients have been waiting 50 weeks or over.

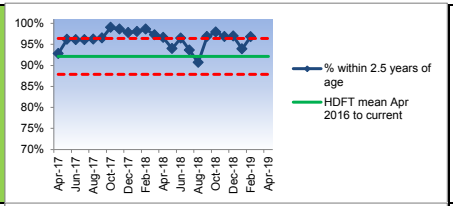
Section 4 - Responsive - April 2019

Children's Services metrics

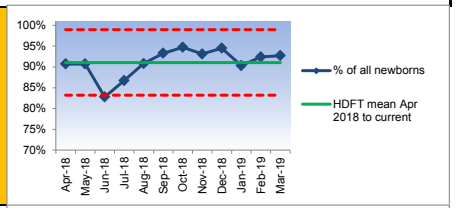
4.16 Children's Services - 10-14 day new birth visit — DQ



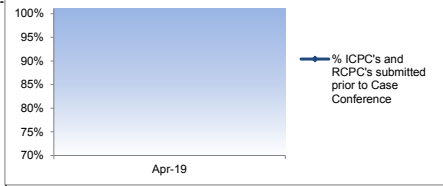
4.17 Children's Services - 2.5 year review — DQ



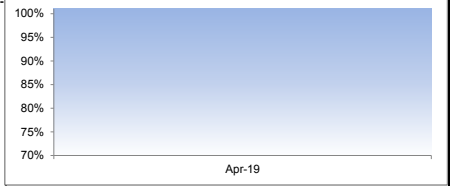
4.18 Children's Services - Use of the Home Environment Assessment Tool — DQ



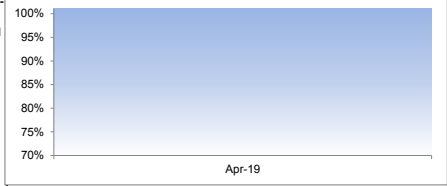
4.19 Children's Services - Reports for Initial and Review Child Protection Case Conferences — DQ



4.20 Children's Services - Staff compliance with Safeguarding Supervision. — DQ



4.21 Children's Services - Reports for Achievement of KPI for Breast Feeding Prevalence. — DQ



Narrative

10-14 day new birth visits is reported one month behind. For February 2019, 94% of newborns received a new birth within 10-14 days. This is an improvement on January where 91.9% was reported.

2.5 year review is reported one month behind. For February 2019, 96.% of children due a 2.5 review received their review in timescale. This again is an improvement on January where 93.9% was reported.

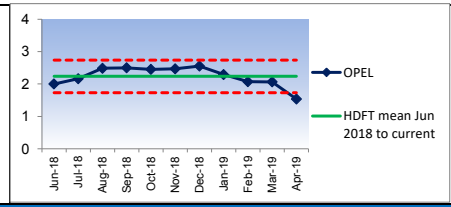
New Metric - this is reported one month behind._Use of the Home Environment Assessment Tool. The Home Environment Assessment Tool enables an assessment of the suitability of the home in relation to basic amenities, health and safety issues, supervision etc. This tool is used by HDFT's Durham 0-19 team. HDFT aim for 95% of eligible children to receive an assessment. For March 2019 91% of eligible children were assessed.

3 new metrics will be reported monthly/quarterly in arrears for 2019/20.

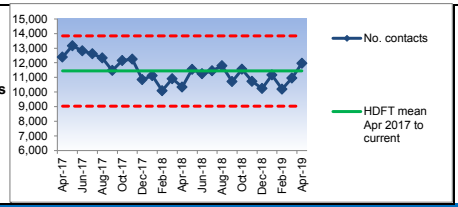
4.19 will be reported on quarterly in arrears for 2019/20. HDFT provide Initial and Review Reports for Child Protection Case Conferences. HDFT aim for 95% of reports to be submitted prior to the CPCC.
4.20 will be reported on quarterly in arrears for 2019/20. HDFT provide Safeguarding Supervision to all staff. Supervision compliance of 80% is required for all staff receiving supervision. % of staff achieving the 80% compliance will be reported quarterly.
4.21 6-8 weeks breast feeding will be reported on monthly in arrears for 2019/20. All Children's Services share a joint KPI for breast feeding prevalence at 6-8 weeks. % achieved against the prevalence KPI will be reported monthly.

Adult Community Services metrics

4.22 OPEL level - Community Care Teams — DQ



4.23 Community Care Teams - patient contacts — DQ



Narrative

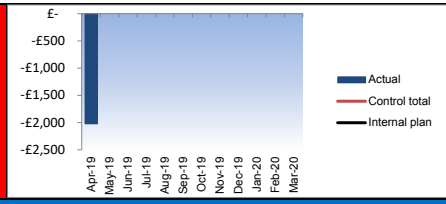
NHS Harrogate and District NHS Foundation Trust

Section 6 - Efficiency and Finance - April 2019

Finance

6.1 Surplus / deficit and variance to plan

DQ



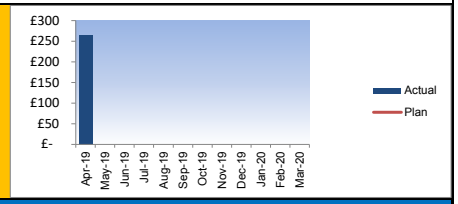
6.2 NHS Improvement Single Oversight Framework - Use of Resource Metric

DQ

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

6.3 Capital spend

DQ



Narrative

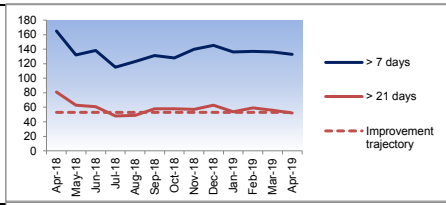
Surplus/deficit and variance to plan - The Trust reported a favourable variance in April of £434k. While this is positive, it is against a deficit plan and therefore it is crucial that we improve the run rate position. The information below outlines Trust overall performance, performance against the control total and the drivers for the current month variance.

NHS Improvement Use of Resource Metric - The Trust reported a UoR rating of 3 in April.

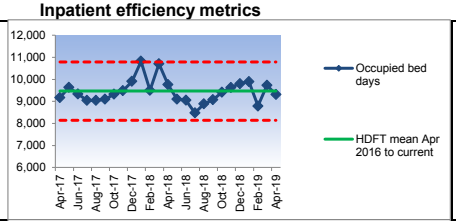
Capital Spend - Discussions continue at a national level regarding the availability of capital resource. The Trust will look to manage pressures through the year and the position is currently balanced to plan.

Inpatient efficiency metrics

6.4 Long stay patients

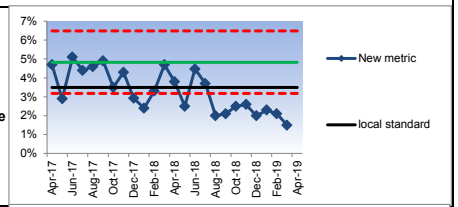


6.5 Occupied bed days

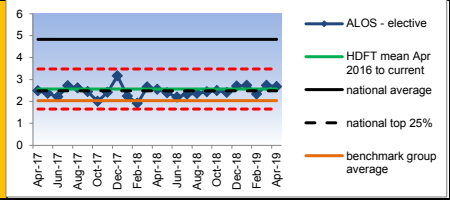


6.6 Delayed transfers of care

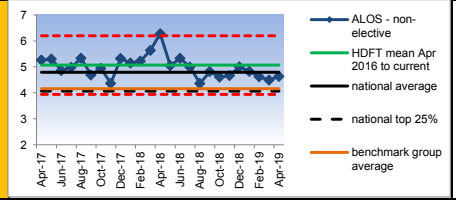
DQ



6.7 Length of stay - elective

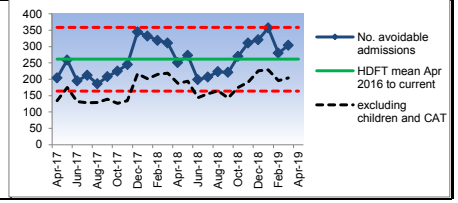


6.8 Length of stay - non-elective



6.9 Avoidable admissions

DQ



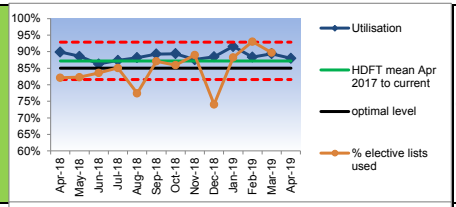
Section 6 - Efficiency and Finance - April 2019

Narrative

Non Elective Length of stay continues to be below the long term Trust average and below the national average. Work continues through the Discharge programme to seek to further reduce long stay patients with a trajectory set through the year to make further reductions (which will be included in the next IBR). The continued stable low level of DTOCs is supporting the delivery of this.

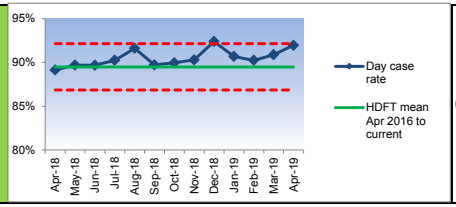
Productivity metrics

6.10 Theatre utilisation



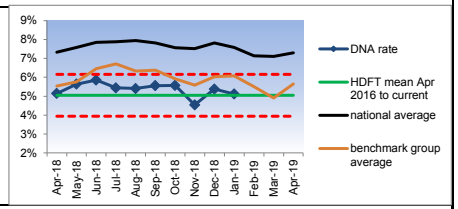
6.11 Day case rate

DQ



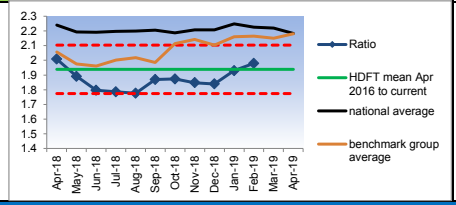
6.12 Outpatient DNA rate

DQ



6.13 Outpatient new to follow up ratio

DQ



Narrative

New to Follow-up ratio's have risen back up to April 18 levels, the planned care group have plans to continue to focus on this through different elements of the programme and therefore it is expected they will begin to fall again.

Theatre utilisation levels remain stable and therefore more work is needed to review further opportunities to increase this.

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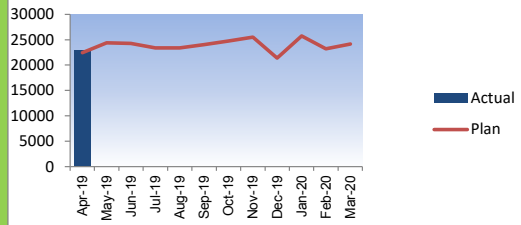
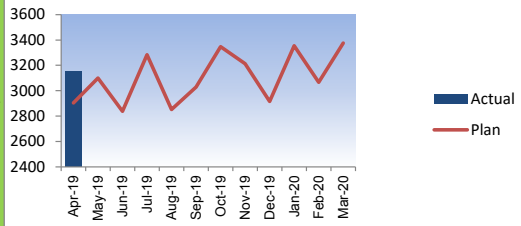
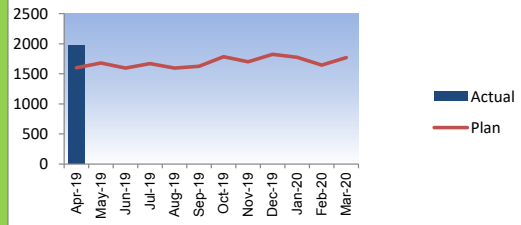
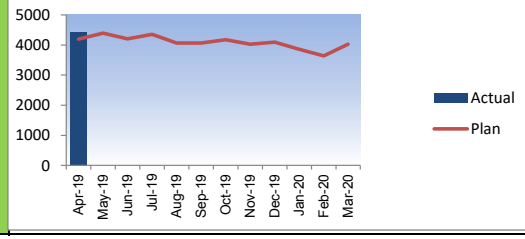
Section 7 - Activity - April 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation
7.1	Outpatient activity against plan DQ		Outpatient activity was 2.6% above plan for April.
7.2	Elective activity against plan DQ		Elective activity was 8.5% above plan for April.
7.3	Non-elective activity against plan DQ		Non-elective activity was 22.7% above plan for April.
7.4	A&E activity against plan DQ		A&E attendances were 5.3% above plan for April. The figures presented include patients streamed to primary care.

Section 7 - Activity - April 2019

Indicator number	Indicator name / data quality assessment	Trend chart	Interpretation

Narrative

The rate of Non Elective activity in April is concerning, this has continued into May and is causing the requirement for escalation beds to be open. Teams continue to focus on reducing occupancy in order to de-escalate the bed situation. There remains work to do on all planned levels based on the final contract agreement with HaRD CCG and therefore plans will be updated next month. However, comparing actuals from April 18 to April 19 shows significant additional pressure in NEL pathways in particular.

Activity Summary - Trust total

	Apr-18 YTD			Mar-19			Apr-19			Apr-19 YTD		
Activity type	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
New outpatients	7679	7779	-1.3%	8424	8273	1.8%	7719	7819	-1.3%	7719	7819	-1.3%
Follow-up outpatients	15493	15630	-0.9%	16249	16435	-1.1%	15307	14633	4.6%	15307	14633	4.6%
Elective inpatients	295	291	1.4%	283	315	-10.0%	254	271	-6.3%	254	271	-6.3%
Elective day cases	2440	2602	-6.2%	2813	2944	-4.4%	2897	2633	10.0%	2897	2633	10.0%
Non-electives	1665	1809	-7.9%	2003	1982	1.1%	1966	1602	22.7%	1966	1602	22.7%
A&E attendances	4153	4108	1.1%	4306	4245	1.4%	4419	4196	5.3%	4419	4196	5.3%

Activity Summary - HARD CCG

	Apr-18 YTD			Mar-19			Apr-19			Apr-19 YTD		
Activity type	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
New outpatients	5214	5135	1.5%	5975	5471	9.2%	5369	4454	20.5%	5369	4454	20.5%
Follow-up outpatients	10913	10307	5.9%	11536	10844	6.4%	10867	9801	10.9%	10867	9801	10.9%
Elective inpatients	175	178	-1.8%	183	198	-7.6%	154	169	-8.7%	154	169	-8.7%
Elective day cases	1604	1540	4.1%	1775	1730	2.6%	1799	1475	21.9%	1799	1475	21.9%
Non-electives	1274	1343	-5.1%	1551	1471	5.4%	1480	1087	36.1%	1480	1087	36.1%
A&E attendances	2949	3033	-2.8%	3202	3134	2.2%	3205	2941	9.0%	3205	2941	9.0%

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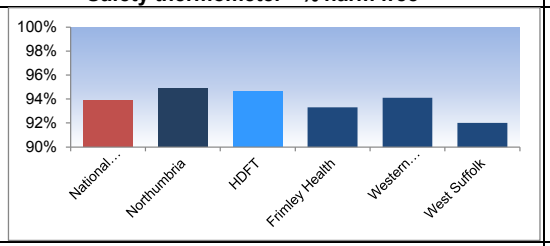
Section 8 - Benchmarking - April 2019

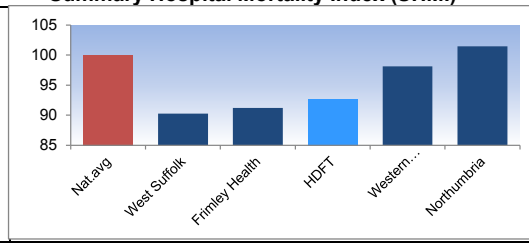
Safety thermometer - % harm free

8.1



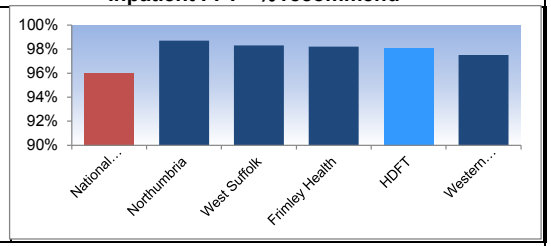
Summary Hospital Mortality Index (SHMI)

8.2



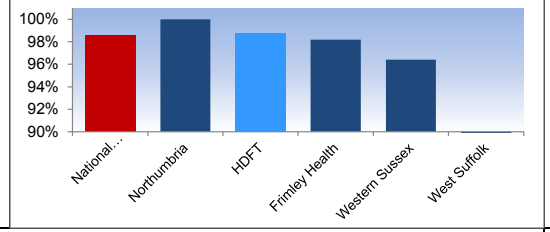
Inpatient FFT - % recommend

8.3



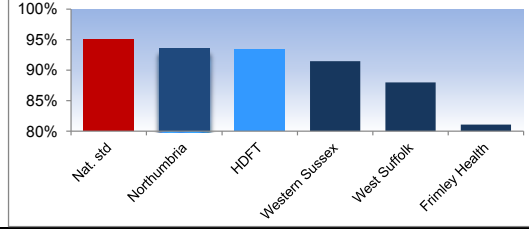
Maternity FFT - Q2 Birth - % recommend

8.4



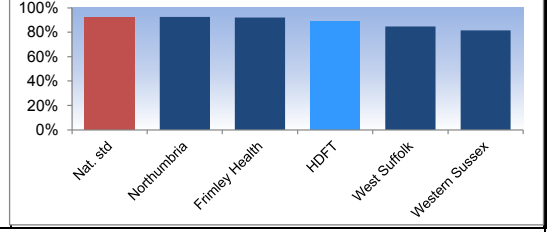
Emergency Department 4 hour standard

8.5



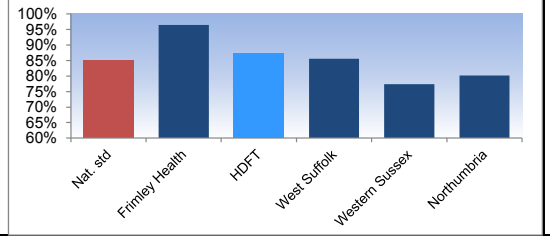
RTT incomplete pathways

8.6



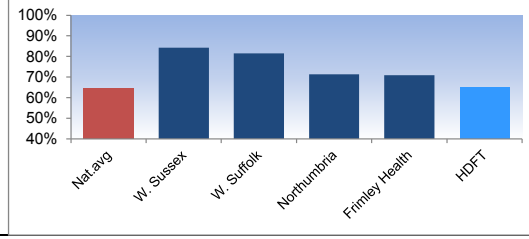
Cancer 62 days

8.7



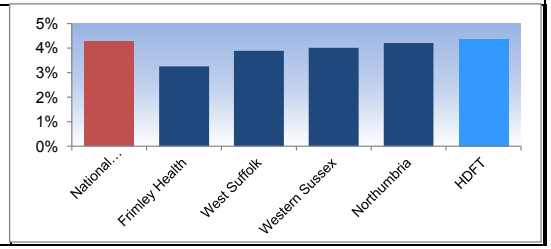
Staff FFT - % recommend (place to work)

8.8



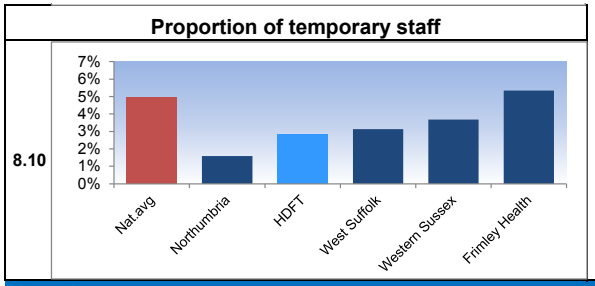
Sickness absence

8.9



Section 8 - Benchmarking - April 2019

8.10



Narrative

The charts above show HDFT's latest published performance benchmarked against small Trusts with an outstanding CQC rating. The metrics have been selected based on a subset of metrics presented in the main report where benchmarking data is readily available. For the majority of metrics, the data has been sourced from NHSE Website, Data Statistics.

NHS
Harrogate and District
NHS Foundation Trust

Board Committee report to the Board of Directors

Committee Name:	Audit Committee
Committee Chair:	Chris Thompson, NED
Date of last meetings:	Thursday 8 May and Tuesday 21 May 2019
Date of Board meetings for which this report is prepared	Friday 24 May and Wednesday 29 May 2019

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

1. At its meeting on 8 May, the Committee considered, and where appropriate approved, a number of documents that had been prepared in connection with the end of year process. These included the following:
   a. Draft Audit Committee Annual Report
   b. Quality Committee Annual Report
   c. Corporate Risk Review Group Annual Report
   d. Code of Governance Self Assessment
   e. Local security management Specialist Report
   f. Counter-Fraud Annual Report
   g. Draft Financial Statements for the Trust
   h. Draft Financial Statements for the Trust Charitable Fund
   i. Draft Financial Statements for Harrogate Healthcare Facilities Management Limited
   In particular the Committee considered a number of changes that had been made to the draft financial statements following the Accounts Review Meeting on 23 April.
2. The Audit Committee has also undertaken its "normal" programme of work and review during the course of the two meetings. This has included reviews of the minutes of Corporate Risk Review Group and the Quality Committee.
3. The most recent version of the Corporate Risk Register was reviewed, with the Committee noting the most recent set of changes that had been made to the Register and confirming that the detailed analysis was consistent with the information most recently provided to the Trust Board of Directors.
4. The Periodic Internal Audit Report considered on 8 May contained details of 7 audits that had been finalised during the period under review. Of these audits, one was a follow-up audit following a past Limited Assurance outcome (IV Cannula Care), where the conclusion was now one of Significant assurance. Of the remaining 6 finalised audits, all resulted in Significant Assurance, apart from the audit of Medical Outliers, where the audit had been requested by the Directorate as they were aware that there was a need to improve the processes in place.
5. The Committee discussed the minutes from the most recent meeting of the PPE Group and the analysis of outstanding PPE submissions. The Committee recognised that significant progress had been achieved by the PPE Group and were confident that the focus of the need for comprehensive and timely PPE submissions would have resulted in improvements in the quality of business case submissions prepared across the organisation.
6. At the meeting on 21 May, the following documents were considered:
   a. Draft Quality Report 2018/19
   b. Annual Corporate Governance Statement presented by the Chief Executive
   c. Draft Annual Report 2018/19
   d. Staff Register of Gifts and Hospitality
   e. Review of Losses and Special Payments
   f. Internal Audit Annual Report and Head of Internal Audit Opinion in support of the Annual Governance Statement

g. External Audit ISA 260 Audit Highlights Memoranda and draft Letters of Representation
h. Confirmation of External Audit independence

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

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

Matters for decision

- The Committee has carefully considered a range of documents relating to the financial year-end that are coming to the Board for consideration and approval. These include:
    - Accounts Briefing paper
    - Draft financial statement for the Trust
    - Draft representation letters for the Trust
    - ISA 260 Audit Highlights Memoranda prepared by the External Auditors
- The Committee considered at length the treatment that had been adopted in the draft financial statements for the Trust in respect of 2 particular issues:
    - In 2017/18 the Trust decided to become a member of a Group Action with a number of other NHS organisations relating to the rateable value of the properties utilised for the provision of healthcare. The action applies retrospectively and therefore the anticipated benefit of £2,631k has been recorded as negative expenditure within the 2018/19 financial statements on the basis that the Executive consider that the outcome of the Group Action will ultimately benefit the Trust to the full extent anticipated. The external auditors, KPMG do not consider it appropriate to recognise this transaction in the year as the outcome is not "virtually certain", as is prescribed by International Accounting Standard number 37 (IAS37). At 31 March 2018, the equivalent amount held on the Trust balance sheet was £1,897k.
    - The Trust has recognised £3.5m of charitable income in year in relation to new CT scanning facilities. The Trust have only incurred £2.266m of costs in respect of the provision of these facilities at year end and therefore the balancing value of £1.234m has not met the income recognition criteria set out in International Accounting Standard IAS20. The view of KPMG is that the credit for the amount of £1,234k should not be recognised in the financial statements for 2018/19.

  Whilst fully understanding the views of KPMG on these two issues, the Committee were in agreement with the treatment that had been adopted for both of these issues in drafting the financial statements.
- During 2018/19, the Trust has moved to a new cloud-based General Ledger system. The implementation of the new system has proved to be more challenging than was expected and the consequent lack of availability of detailed transactional history has has resulted in both considerable additional work for the Trust Finance team and has necessitated a revised audit approach to be adopted by KPMG. The situation has been exacerbated by the decision that the systems administrators would make available an audit certificate that is more limited in scope than has been available in the past. Consequently, further work remains to be undertaken over the next 7 days to enable KPMG to complete the audit testing that is required for them to be able to provide a "clean" audit report. The Committee understands that all of the necessary work will be undertaken, the appropriate external audit report will be issued and the financial statements will be completed within the agreed timetable.
- Whilst recognising that further work is to be undertaken by KPMG before the financial statements can be submitted to the Regulators, the Committee recommends that the Board of Directors approves the signing of the 2018/19 financial statements for the Trust. The Committee also recommends the signing of the letters of representation for the Trust.
- The Committee also submits its Annual Report for consideration by the Board.

Action Required by Board of Directors:

The Board is asked to:

- **note** the considerations that took place at the two meetings of the Audit Committee on the 8 May and the 21 May
- **approve** the Financial Statements for 2018/19
- **approve** the Letters of Representation, and also the recommendations made by the Committee.

Harrogate and District NHS Foundation Trust

Council of Governors' Meeting

Minutes of the public Council of Governors' meeting held on 26 January 2019 at 10:00 hrs at The Civic Centre, Harrogate Borough Council, St Lukes Avenue, Harrogate, HG1 2AE

Present:

Mrs Angela Schofield, Chairman
Ms Pamela Allen, Public Governor/Deputy Chair of Council of Governors
Dr Pam Bagley, Stakeholder Governor
Mr John Batt, Public Governor
Mrs Cath Clelland, Public Governor
Mrs Angie Colvin, Corporate Affairs and Membership Manager
Mr Jonathan Coulter, Deputy Chief Executive/Finance Director
Mr Martin Dennys, Public Governor
Mr Tony Doveston, Public Governor
Miss Sue Eddleston, Public Governor
Dr Sheila Fisher, Public Governor
Mr Andrew Forsyth, Interim Company Secretary
Mrs Jill Foster, Chief Nurse
Ms Carolyn Heaney, Stakeholder Governor
Mrs Rosemary Marsh, Public Governor
Cllr Samantha Mearns, Stakeholder Governor
Mrs Laura Robson, Non-Executive Director
Mr Richard Stiff, Non-Executive Director
Mrs Maureen Taylor, Non-Executive Director
Mr Chris Thompson, Non-Executive Director
Dr Ros Tolcher, Chief Executive
Mr Steve Treece, Public Governor
Mrs Lesley Webster, Non-Executive Director

In attendance: 6 members of the public

1. Welcome and apologies for absence

Mrs Schofield was delighted to see members of the public at the meeting and offered them a warm welcome. She hoped they would find the meeting interesting and informative.

She introduced Mr Batt and Mr Dennys to their first Council meeting as newly elected public Governors.

Mrs Schofield was also pleased to introduce Mr Steve Russell, who would be taking over from Dr Tolcher as Chief Executive for the Trust from 1 April.

Apologies were received from Mrs Sarah Armstrong, Non-Executive Director, Mr Ian Barlow, Public Governor, Mr Robert Cowans, Public Governor, Ms Clare Cressey, Stakeholder Governor, Mrs Emma Edgar, Staff Governor, Mrs Pat Jones, Public Governor, Mr Neil Lauber, Staff Governor, Mrs Mikalie Lord, Staff Governor, Cllr John Mann, Stakeholder Governor, Dr Christopher Mitchell, Public Governor, and Mrs Helen Stewart, Staff Governor.

It was noted that on this occasion, there were no Staff Governors present; however this was unusual for such a meeting.

Mr Forsyth would be taking photographs during the meeting to use for promotional purposes.

2. Declarations of Interest

There were no further declarations of interest in addition to paper 2 and Governors were reminded of their obligation to inform the Trust in writing within seven days of becoming aware of the existence of a relevant or material interest.

It was noted Mr Coulter and Mr Thompson were Directors of Harrogate Integrated Facilities (HIF – previously known as 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 HIF.

3. Minutes of the last meeting held on 7 November 2018

The minutes of the last meeting held on 7 November 2018 were agreed as a true and accurate record.

3.1 Minutes of the Annual Members' Meeting held on 3 September 2018

The minutes of the Annual Members' Meeting held on 3 September 2018 were agreed as a true and accurate record subject to the following amendment:

Item 4, page 3, second paragraph, Carolyn Heaney had been referred to as Caroline Heaney in error.

4. Matters arising and review of action log

Dr Tolcher summarised an update from Ms Wilkinson regarding the recruitment process highlighted at the last Council of Governors' meeting. Development and improvement work was underway including a Rapid Process Improvement Workshop scheduled to take place week commencing 18 February. The ambition would be to reduce the overall time of the recruitment process, from advert to commencement in post, from 77 to 60 days, and reduce the time of specific stages in the process including pre-employment checks. Data was being collected from current vacancies to identify potential areas of inefficiency, delay or opportunities for improvement. A selection of new starters and recruitment managers were also being surveyed to

ensure feedback from both candidates and staff was being incorporated into future improvements.

There were no further matters arising.

5. Chairman's verbal update

Mrs Schofield thanked Mrs Foster and Mr Coulter for attending the meeting on behalf of Executive Directors. In addition to the two new public Governors introduced earlier, Mrs Schofield confirmed that Mrs Helen Stewart, Ward Manager from Granby Ward had been elected as the new Staff Governor for Nursing and Midwifery; however she was unable to attend that day. Mrs Schofield reminded the Council about the vacancy for a Staff Governor for Medical Practitioners and the Trust would be looking to fill this position in the spring By-Election.

The Governor Working Group for Membership Development and Engagement had discussed the arrangements for the 2019 Annual Members' Meeting (AMM) and proposed this would be held on 24 July. As a member of the group, Ms Allen clarified that the AMM should be convened within a reasonable timescale after the end of the financial year. Mr Forsyth also commented that the timing of the AMM was dependent on the Annual Report and Accounts being laid before Parliament before the summer recess. He was confident that this would have occurred before the proposed date.

Mrs Schofield referred to the recent Medicine for Members' event about the new state of the art SPECT CT scanner in the radiology department. The next event would be held in March and would focus on nutrition. Mrs Marsh was happy to see a group of students at the event from Ripon Grammar School. Miss Eddleston was also pleased that students were given the opportunity to speak to the consultants after the event to ask more questions.

Since the last meeting, Mrs Schofield confirmed that a group of Governors had attended a joint core skills training day in December run by NHS Providers with Governors from York Teaching Hospital NHS Foundation Trust. She thanked those Governors who had attended and hoped they had found the day useful. The aim would be to share learning with all Governors and identify any specific areas to follow up.

Mrs Schofield summarised the meeting agenda and looked forward to hearing from Dr Tolcher who would be presenting key areas from the NHS 10 Year Plan.

Mrs Schofield highlighted the work of the Youth Forum and confirmed that a paper on the Hopes for Healthcare would be received at the Board meeting the following week. There would be a further meeting scheduled in March for the Youth Forum to meet with the Board to formally launch their work and discuss how their 'Hopes' become a reality across the organisation. A huge thank you to all the young people in the Youth Forum for their dedication to such a valuable project.

Finally, Mrs Schofield paid tribute to Dr Tolcher as this would be her last Council of Governors' meeting before she retired at the end of March. She reflected on Dr

Tolcher's outstanding leadership and on behalf of the Council of Governors, thanked her and wished her well.

There were no questions for Mrs Schofield.

6. Update on Quality Report Process

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

Mrs Foster highlighted the importance of stakeholder engagement in producing the Quality Report and to determine the quality priorities for the coming year. This would involve engaging with a variety of stakeholders, including Clinical Commissioning Groups (CCGs), Healthwatch and Governors, to ensure local community representation.

Mrs Foster summarised the quality priorities for 2018/19 and asked Governors to think about areas to focus on in 2019/20. The Quality Report timetable had been circulated prior to the meeting and this included the stakeholder meeting scheduled in March and the submission of the final report at the end of May*.

Mr Thompson confirmed the Audit Committee would be reviewing the external audit plan in relation to the Quality Report at their meeting the following week. The steer from NHS Improvement (NHSI) for the local indicator this year was for external auditors to look at the Summary Hospital-level Mortality Indicator (SHMI); this is the report on mortality at trust level across the NHS in England using a standard and transparent methodology.

There were no questions for Mrs Foster.

7. Audit Committee Terms of Reference

Mr Thompson referred to the Audit Committee Terms of Reference circulated prior to the meeting and confirmed that Governors were being consulted on this document as required by the NHS Foundation Trust Code of Governance. Next steps would be to discuss the document at Audit Committee meeting the following week and then submit to the Board meeting for final sign off.

There were no comments from Governors on the proposed amendments to the Terms of Reference.

8. Presentation – The NHS 10 Year Plan (www.longtermplan.nhs.uk)

Dr Tolcher presented a summary of The NHS 10 Year Plan highlighting the three overriding ambitions to:

- Making sure everyone gets the best start in life.
- Delivering world-class care for major health problems.

- Supporting people to age well.

Dr Tolcher reflected on everyone having a personal investment in these goals. She referred to the Trust being the largest provider of community children's services in England and highlighted the recognitions and awards the Trust had received from The Baby Friendly Initiative, set up by UNICEF, for the Growing Healthy North Yorkshire 0-5 Health Visiting services, the Growing Healthy 0-5 Health Visiting services in County Durham and Darlington and Harrogate District Hospital's Maternity and Special Care Baby Unit.

She talked through the detailed requirements of each of the three ambitions summarised on her slides and referred to the challenges these would bring, opportunities to make further improvements, and further plans required to meet demand such as an increase in diagnostics to provide better screening programmes.

The six chapters of The NHS Long Term Plan set out:

1. How the NHS will move to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting.
2. New, funded, action the NHS will take to strengthen its contribution to prevention and health inequalities.
3. The NHS's priorities for care quality and outcomes improvement for the decade ahead.
4. How current workforce pressures will be tackled, and staff supported.
5. A wide-ranging and funded programme to upgrade technology and digitally enabled care across the NHS.
6. How the 3.4% five year NHS funding settlement will help put the NHS back onto a sustainable financial path.

Dr Tolcher summarised each chapter in more detail and highlighted areas of focus for the Trust.

A new service model for the 21st Century included digitally enabled primary and outpatient care, reducing pressure on emergency hospital services and a focus on population health via Integrated Care Systems.

Further action on prevention and health inequalities with a change in the funding formula to improve support for people with learning disabilities.

Further progress on care quality and outcomes; by 2028 the Plan commits to dramatically improve cancer survival, partly by increasing the proportion of cancers diagnosed early, from a half to three quarters.

NHS staff will get the backing they need; a focus on continuing to increase the NHS workforce and make the NHS a better place to work. Julian Hartley, Chief Executive of Leeds Teaching Hospitals NHS Trust, will lead the development of the new workforce implementation plan for the NHS.

Referring to the fifth chapter, digital enabled care, Dr Tolcher highlighted a question raised by Governors – how does the Trust plan to use technology in patient care?

She confirmed the Trust was already doing a huge amount around the effective use of technology and would talk more about this in her next presentation.

Taxpayers' money – Dr Tolcher summarised plans to continue to drive efficiencies including the NHS to return to financial balance, a reduction in unjustified variation in performance and better use of capital investment and its existing assets to drive transformation. The Model Hospital, a digital information service designed to help NHS providers to improve their productivity and efficiency, would be used for benchmarking and Dr Tolcher would provide further details and snap shots of such data in her next presentation.

Moving on to what all this means for HDFT services, Dr Tolcher talked about how the Plan would shape the Trust's emerging proposals on community services and how an expanded community workforce would be required in addition to workforce and infrastructure changes to meet the ambition to drive up same day emergency care. There was ongoing work required in maternity services and diagnostic and workforce capacity to meet the goals and demands around cancer services.

What does all this mean for HDFT finances? Dr Tolcher quoted the Plan, that the local NHS would receive sufficient funds over the next five years to grow the amount of planned surgery year on year, to cut long waits and reduce the waiting list. Dr Tolcher stated that with the right leadership and collaboration she felt optimistic about this statement.

Dr Tolcher's final slide confirmed that local plans for 2019/20 would be published in April 2019 and the West Yorkshire and Harrogate Integrated Care System (WYH ICS) five-year plan would be published by autumn 2019.

Mrs Schofield thanked Dr Tolcher for her informative summary and opened up the floor for questions.

In response to Mr Batt, Mrs Schofield confirmed that Dr Tolcher's slides would be uploaded to the website along with the agenda and papers for the meeting.

Mrs Clelland asked if local plans would be benchmarked against the NHS Long Term Plan. Dr Tolcher confirmed that plans with key milestones and deliverables would reflect the Plan such as the WYH ICS plan. Mr Stiff was leading a task and finish group working on the Trust's five-year strategic plan; the Plan would form part of the framework and the engagement plan would include Governors and members of the public.

Mr Doveston asked how the national inequality issues would be tackled. Dr Tolcher acknowledged there were health inequalities including pockets of deprivation and rural communities across the Trust's catchment population area and this was an ongoing challenge. NHS England would continue to target a higher share of funding for Commissioners towards geographies with high health inequalities. Dr Tolcher acknowledged that services must be designed to reach the people who need them.

There were no further questions for Dr Tolcher.

Dr Tolchers' slides would be made available on the Trust website - slides are available on the Trust's website at https://www.hdft.nhs.uk/about/council-of-governors/governors-meetings/

9. Chief Executive's Strategic and Operational Update, including Integrated Board Report (IBR)

Dr Tolcher presented the following headlines:

Operational Performance

The Integrated Board Report (IBR) circulated prior to the meeting provided further detailed information to support Dr Tolcher's summary.

Dr Tolcher's first slide demonstrated the Q3 (October to December 2018) operational performance position; key messages included referral to treatment times remained below the 92% standard and this was in line with the national picture that the NHS was finding it hard to sustain key performance indicators. The Accident and Emergency (A&E) 4-hour standard continued to drop however the overall year to date position was 94.4%, just below the standard of 95%. To put the position in to context, Dr Tolcher added that Emergency Department attendances were 4.8% higher than the same period last year.

The next two slides provided the A&E 4 hour standard national distribution and the 18-week Referral to Treatment standard national distribution taken from the Model Hospital data referred to earlier in the meeting. Trusts could use the tools provided on the Model Hospital website to dive deeper into their data and compare with peers to understand what good looked like and identify areas for improvement.

Dr Tolcher summarised both slides highlighting the fact that the Trust was positioned top nationally in relation to the A&E target for a couple of days in January however the overall performance remained at red. She assured Governors that the Trust was doing its very best by keeping patients safe and there had been no incidences of any delays causing harm to patients. The Trust had undertaken the 'Every Hour Matters' initiative in the first two weeks of January which had been extremely successful. The initiative was Harrogate and District's system response to challenge and aims to prioritise acute work in order to recover rapidly from the impact of the two long bank holidays at Christmas and New Year.

Moving to Community Children's Services, Dr Tolcher was delighted to report that performance remained very strong.

In relation to Q3 finances, the current position showed a deficit of £687,000 following receipt of national funding. Cash remained a concern leaving minimal capital investment opportunities. Dr Tolcher summarised a number of incentives for the Trust to meet the financial plan agreed at the start of the year; everything was being done to secure a further £1m incentive funding at year end.

News and current issues

Dr Tolcher highlighted several points of news including a recent outbreak of flu affecting patients and staff in addition to winter pressures. The CQC inspection report was still awaited.

As mentioned earlier in the meeting, following a question about technology, Dr Tolcher was pleased to report there was lots going on. She provided examples of how the Trust had been using technology to support patient care for a long time and confirmed ambitious plans for the future. Examples included electronic prescribing; the Trust had been an early adopter of this initiative. Other examples included the pharmacy robot, mobile/agile working in community children's services, digital voice recognition reports/letters and electronic test requests and reporting. Ongoing projects and future plans included a radiology imaging collaborative meaning that trusts in the system would be using the same digital technology allowing shared access to imaging, electronic patient record, hospital at night and digital bed management.

Dr Tolcher summarised her slide regarding the Trust's EU Exit planning group which consisted of colleagues from procurement, human resources and pharmacy to understand the foreseeable impact of Brexit, in particular a 'no-deal' scenario. She assured Governors that the Trust was doing everything it could to understand and mitigate any risks.

As referred to earlier, Dr Tolcher went on to talk about the CQC inspection which had taken place in November and the Well Led Review in December 2018. The outcome was still awaited however Dr Tolcher wanted to share some of the comments received from inspectors following the inspection. They confirmed the inspection was a very positive experience, staff were brilliant and there was an overwhelmingly patient-centred culture across the organisation. It was acknowledged that work in some areas was in progress and there were some inequalities, in particular reported by black, Asian and minority ethnic (BAME) staff via the Staff Survey. Action plans were shared with the CQC, including the ambition for diversity on the Board and Council of Governors. The draft report was expected to be received by the Trust the following week for factual accuracy before being published in March.

Dr Tolcher was proud to report that about 30 colleagues had signed up to be 'Fairness Champions' to support the fair and just culture across the organisation. The Trust and HIF had also signed the 'Time to Change' pledge to raise awareness of mental health; Mrs Schofield, Chairman and Mr Sturdy, Managing Director of HIF were pictured on Dr Tolcher's slide with their signed pledge.

Before moving on to key risks, Dr Tolcher highlighted the generosity of the public who had donated to Harrogate Hospital and Community Charity and picked out examples of donation schemes resulting in a new family support room on Byland Ward and a new nuclear medicine gamma scanner.

Key Risks

Dr Tolcher summarised the top scoring strategic and operational risks for the Trust; key to some of these risks were financial constraints as discussed earlier in the presentation.

Before moving to questions, this was Dr Tolcher's last public Council of Governors' meeting before she retired at the end of March. She wished to record her thanks to Governors for their support and commitment, and for their challenge in helping to drive forward continuous improvement and high quality patient care.

Mrs Schofield thanked Dr Tolcher for her last presentation and opened up the floor for questions.

Mr Dennys commented that it was helpful to see the IBR. He asked for more details in terms of A&E and RTT challenges, and the fact that if the Trust didn't reach the national standards, the provider sustainability funding (PSF) would not be received; what actions were being taken?

Dr Tolcher explained that annual financial targets must be achieved to unlock access to national funding and other financial benefits. For the Trust, funding of around £4m was at stake over the current financial year; 70% related to financial planning and 30% related to the Emergency Department national standard. As quoted earlier, year to date, the Trust was achieving 94.4% for the A&E 4-hour standard, slightly below the national target of 95% - if 95% was reached by the end of March the Trust would receive £1.2m for the full year. Dr Tolcher explained the Trust had not received any funding to date as each quarter the required standard had not been met. There would be another 'Every Hour Matters' week in the last week of February to optimise the best possible outcome. In terms of financial planning there were a number of technicalities that would determine the outcome, but Dr Tolcher described that for every pound the Trust exceeded our plan, we would receive funding to match.

Mrs Taylor added that the Resources Committee would be meeting the following week. She was assured that the Trust had met the control total in Q3 and was positive about the end of year financial plan.

Mr Coulter also commented on the risks the Trust faced in the last quarter such as winter pressures and costs related to the recent clinical waste issue however, he echoed Mrs Taylor's comments that the operational budget and the situation had improved.

In response to Dr Fisher's comments about the patient safety domain in the IBR, Dr Tolcher confirmed the three key performance indicators were the safety thermometer, falls and incidents. Senior Management Team continued to keep a close eye on the detail within the IBR and overall trends had gone down. Mrs Foster added that falls had increased and were reported as higher than average but in December there were no falls resulting in a fracture and overall there had been a 3% reduction in falls compared with last year.

Dr Fisher also referred to section 3, the caring domain, and whilst this particular area was normally very good she had noticed a reduced percentage in the Friends and Family Test results. Dr Tolcher summarised these results and explained that, following a careful assessment of the results, and as described in the narrative on the IBR, the results reflected an issue around the GP out of hours service; this was being followed-up in order to drive improvements. Dr Tolcher also highlighted page 19, benchmarking information, enabling the Trust to compare our services with others rated as outstanding by the CQC.

Mrs Clelland thanked Dr Tolcher for both presentations which she found most informative. She noted the Trusts position in regard to mental health services and the challenge in the face of funding cuts. She asked whether the Local Authority were similarly committed to financially supporting mental health needs in the Harrogate area.

Dr Tolcher clarified that mental health services were commissioned by the CCGs and provided by Tees, Esk and Wear Valleys NHS Foundation Trust. She confirmed there was a very positive and supportive relationship however acknowledged the debate over investment versus demand. Dr Tolcher described the high demand for mental health services in the Harrogate area in comparison with some other areas and acknowledged that it was not always easy for patients to navigate the system. The need to focus on this area was reflected in the NHS Long Term Plan.

Mrs Schofield thanked everyone for a helpful discussion regarding both Dr Tolcher's presentations.

There were no further questions for Dr Tolcher.

Dr Tolcher's slides would be made available on the Trust's website - slides are available on the Trust's website at https://www.hdft.nhs.uk/about/council-of-governors/governors-meetings/

10. Update from Senior Independent Director

Mrs Webster summarised the role of the Senior Independent Director (SID) which she had taken up recently; Mr Ward had been the previous SID until he left the Trust at the end of September 2018.

The role of SID was in addition to her existing role as Non-Executive Director and she was also a member of the Resources Committee and Audit Committee. She had stepped down as Chair of the Quality Committee which was now being chaired by Ms Robson.

She provided some background to the role of SID; a role which first developed in 2006. Mrs Webster highlighted some key responsibilities from the role description including being available to staff and to Governors if they had concerns which contact through the usual channels such as the Chairman and Chief Executive had failed to resolve or where it would be inappropriate to use such channels.

There may be situations where the SID might intervene however this would not be in respect of trivial or inappropriate matters.

The SID would maintain regular contact with the Council of Governors and attend regular meetings including the public meetings and the bi-annual Board to Board. The SID would also carry out the appraisal of the Chairman on behalf of the Council of Governors, working closely with the Deputy Chair of Governors.

The SID also supported the Chairman and acts as a sounding Board and source of advice.

In the first month of her new role as SID, Mrs Webster met with Dr Wood, the Freedom to Speak Up Guardian, to determine her responsibility in line with the Speaking Up Policy.

Mrs Webster would be meeting with Ms Allen and Mrs Schofield the following week to review the Non-Executive Director appraisal process.

There were no questions for Mrs Webster.

Mrs Schofield thanked Mrs Webster for her informative update.

11. Question and Answer session for Governors and members of the public

Mrs Schofield moved to the tabled questions submitted prior to the meeting.

Mrs Clelland, Public Governor, had submitted the following question which had been raised with her from a member in the Rest of North Yorkshire and York catchment area:

"What is the Trust's plan to replace the old wheelchairs which are difficult to push in a forward direction?"

In response, Mr Coulter confirmed there were approximately 59 of these specific wheelchairs and a key part of their design was for them to be pulled rather than pushed. He explained the reasons behind this were for patient safety; the person pulling the chair would meet an obstacle before the person who was sat in the chair. He confirmed the chairs were replaced when needed, and were maintained as designed.

Mrs Clelland commented that she had never seen this style of wheelchair in other hospitals.

[*paragraph removed pending agreement of rewording to better reflect discussion at the meeting*]

Mr Newton, member of the public, raised the following issues:

"As a member of the public residing in Ripon I use services at Ripon Community Hospital. Outpatients department is located on the first floor, the building is old fashioned, the lift has two sliding doors and I am unable to reach the button inside of the lift as I am a wheelchair user. It is fine whilst the receptionist is present and can help otherwise I have to wait until someone is going past and I can ask for help?"

Mrs Schofield thanked Mr Newton for his comments; similar issues at Ripon had been raised previously by Governors over the last few meetings.

In response, firstly Dr Tolcher apologised on behalf of the Trust for the difficulties Mr Newton and others were experiencing. She acknowledged there had been a break-down in communication. She agreed that Ripon Community Hospital was an old

building which resulted in challenges logistically. The lift did not comply with the Equality Act 2010 and, although it could not be changed, there was a requirement to provide reasonable adjustments in order that people could access the appropriate services. She confirmed that clearer signage had been actioned so people could be signposted to the receptionist or staff in the Minor Injuries Unit, who would be able to assist. Dr Tolcher also confirmed that a phone would be installed in reception for people to use to seek assistance.

Mr Newton also talked about issues he had when he needed to attend the hospital to pick up a splint. Dr Tolcher apologised for his inconvenience and confirmed she would look into this with the appropriate Directorate in order to action a solution for the future.

Mrs Clelland asked why splints could not be sent to patients in the post. Dr Tolcher confirmed this issue would be looked into and Mr Newton would be contacted outside of this meeting as soon as possible.

Mrs Schofield thanked Mr Newton for raising these issues and for attending the meeting; she confirmed that the care we provided was of paramount importance and we would always seek to make improvements to improve both the quality of care and experience for the patient.

Miss Eddleston added a comment that she had been informed that week the reception had been open Monday to Friday, 9am through until 2pm and that clear signage would be made but the phone was yet to be connected.

Action:

- **Dr Tolcher would follow-up the issues with collecting splints for Mr Newton.**

Mr Doveston, Public Governor, had submitted the following question:

"Can you give us assurance that the café on the ground floor at Harrogate Hospital is generating the optimum amount of revenue for the Trust and servicing patient and visitor's needs? Can you also confirm if the café will be extending the hours of opening?"

In addition to his question, Mr Doveston mentioned that the café had closed at 3.30pm the previous day and the fridge containing food had disappeared.

Mrs Schofield confirmed that this service was provided by HIF and therefore asked Mr Coulter to respond.

Mr Coulter confirmed that HIF was considering a business case regarding the café in the near future. A pilot was underway to see if it was viable for the café to be open until 6.30pm and at weekends so he was unsure why it would have closed at 3.30pm the previous day. The café was being run by HIF staff. Mr Coulter was also unaware of the situation with the fridge.

A further conversation followed about the fridge and the café closing early and Mr Coulter agreed to pass this back to Mr Harrison following the meeting.

Action:

- **Follow-up the concerns in relation to the fridge and the café closing early.**

Mrs Marsh, Public Governor, had submitted the following question:

"Can we have an update on plans to upgrade Harrogate Hospital entrance? The current image is looking tired and dated. Could there be small changes made to phase the overall upgrade?"

Mr Coulter confirmed there were draft plans to make improvement to the front entrance; some of the work had been done including the entrance to the Emergency Department and the Patient Experience Team information screens. There were plans to do more however, there were constraints on resources to complete the work and clinical equipment was higher on the priority list.

Dr Fisher commented on the recent work around the experience for bereaved families and asked that consideration was factored in to any future plans regarding how bereaved families were welcomed when they arrive at the hospital.

Dr Tolcher clarified that a private room had been made available in the main entrance for General Office staff to see bereaved families when they were picking up death certificates. Viewing was held in the mortuary and bereaved families would be met and supported to this viewing area which had been refurbished.

Dr Fisher had taken part in a mini CQC visit to see where people waited when they arrived through the front door. It had been reported that people were left sitting in the main reception area and office space had been suggested. In response, Dr Tolcher echoed what she had already reported but would need to check how the process was communicated.

Mrs Clelland asked for clarification on why there was a further delay in response to questions submitted. She used the example of the question about the cafe which had been submitted several weeks prior to the meeting yet the response received today was that the issue would be passed to Mr Harrison.

Dr Tolcher referred to Mr Coulter's earlier comments and confirmed the business case was being worked through including the consideration of facilities being made available at weekends and later in the day.

Mrs Schofield apologised for not being able to provide a clearer response than this at this time; there would be times at meetings when the team present would not be able to respond to additional queries in relation to the submitted question.

Ms Allen, Public Governor, had submitted the following question:

"Has the Trust received any more feedback from the Care Quality Commission (CQC) following their inspection? What is the process for any actions to be addressed?"

Ms Allen confirmed that her question had been covered by Dr Tolcher's presentation.

Mr Treece, Public Governor, had submitted the following question:

"What assurance can the NEDs give us that the Clinical Commissioning Group (CCG) Board fully appreciates the financial situation that they are creating for the Trust?"

As Chair of the Resources Committee, Mrs Taylor responded by stating the CCG were aware but acknowledged that the two organisations were in a different position. There was an understanding however that whilst the two organisations were not always in agreement, they continued to have discussions to reach the best outcome.

Mr Coulter confirmed that financial information was submitted every month to NHSI and copied to the CCG. The principle was to work together to strive for joint financial and clinical sustainability.

Mrs Schofield referred to the meetings that she and Dr Tolcher had attended with the CCG. Non-Executive Directors from the Trust had met with CCG Lay Members to focus on relationships and financial issues.

Mrs Webster clarified that the meetings with the CCG contained some challenges yet discussions were productive.

There were no further questions.

12. Any other relevant business not included on the agenda

Mrs Clelland requested that best wishes were sent to a fellow Governor on behalf of the Council. Mrs Schofield thanked Mrs Clelland and agreed that she and Ms Allen would action this.

Ms Allen thanked everyone for their contribution to the meeting and she welcomed Mr Russell who was in attendance.

On behalf of the Council she thanked Dr Tolcher for her wonderful leadership and presented her with flowers wishing her all the very best for the future.

In response, Dr Tolcher thanked everyone for her flowers and to Ms Allen for her kind words; she added that it was a privilege working with Governors who volunteered their time and commitment to the organisation, and people who use its services.

13. Member Evaluation

Mrs Schofield sought views about the meeting.

In general comments about the meeting were positive. The air conditioning was noisy and Mr Batt stated that the hearing loop was not working. Mrs Colvin agreed to feed this back to her contact at the Council.

Mr Treece felt a little detached from the members of public who were sat at the back of the room.

Dr Fisher stated that it was really good to have time for questions; she asked for items that could not be resolved in the meeting to be reflected in the agenda next time.

There were no further comments.

14. Close of meeting

Mrs Schofield closed the meeting. She thanked everyone for attending and confirmed the next public meeting would take place on Wednesday, 1 May 2019 at 5.45 – 8.00pm (to note, the private meeting would take place at 5 – 5.45pm), venue to be confirmed.

* Post meeting note – it had been agreed by Mrs Foster and Dr Wood to seek feedback from stakeholders via email rather than hold a meeting to discuss the Trust's quality work and the quality improvement priorities to be highlighted in the Quality Report for the coming year. Such meetings in previous years had been poorly attended and it was considered that an email would allow more stakeholders to comment.

Harrogate and District NHS Foundation Trust

Report title: **Finance / Resources Committee Annual Report 2018/19**

Report to: **Board of Directors**

Report author: **Mrs M Taylor, NED**

Date: **29 May 2019**

1. Introduction

1.1 This report has been prepared to provide the Board of Directors with a summary of the work of the Finance Committee/Resources Committee during the period April 2018 – March 2019, and in particular how it has discharged its responsibilities as set out in its Terms of Reference.

2. Meetings & Attendance

2.1 The Governance arrangements for the Trust were reviewed during the year and revised Terms of Reference for the Committee were approved by the Trust Board in September 2018. From October 2018, the Committee took on the role of in-month scrutiny of the Trust's financial, activity and workforce position, The frequency of meetings was increased to monthly and the Committee was renamed the Resources Committee.

2.2 The first four meetings of the year were held under the Terms of Reference of the Finance Committee, switching to the new Terms of Reference from the October 2018 meeting. Committee members' attendance is set out in the table below.

9.2

Membership as defined by Terms of Reference	April 2018	June 2018	3Sept 2018	24Sept 2018	Oct 2018	Nov 2018	7Jan 2018	28 Jan 2018	Feb 2018	Mar 2018	Total 10	%
Mrs M Taylor,	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	**10**	**100**
Mr I Ward,	N	Y	Y	N							**2**	**50**
Mrs L Webster,	N	Y	Y	N	Y	Y	Y	Y	Y	Y	**8**	**80**
Mrs A Schofield					Y	Y	Y	Y	Y	Y	**6**	**100**
Chief Executive									N	Y	**1**	**50**
Deputy Chief Executive / Director of Finance	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	**10**	**100**
Chief Operating Officer	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	**9**	**90**
Deputy Director of Finance	Y	N	Y	Y							**3**	**75**
Deputy Director of Performance and Informatics	N	Y	Y	Y							**3**	**75**
Director of Workforce & Org Development					Y	Y	Y	Y	Y	Y	**6**	**100**

2.3 The Finance Committee has a membership of three Non-Executive Directors and during 2018/19 these were:

Mrs Maureen Taylor (Chairman)
Mr Ian Ward (Until end of September 2018)
Mrs Lesley Webster
Mrs Angela Schofield (from October 2018)

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

2.4 During the year other people have attended the Committee as observers including Angela Schofield Chairman of the Trust, before taking up the role of Committee member, Richard Stiff, Non-Executive Director, The Company Secretary, observing Governors, a representative from NHS Improvement and other staff attending to present reports. The Committee received secretarial support from Mrs Elaine Culf. Details of all attendees during 2018/19 are attached at Appendix 1.

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

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

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

3. Duties of the Resources (Finance) Committee

3.1 The Finance Committee's terms of reference were updated in January 2018 and following a review of the Trust governance arrangements a further review of terms of reference took place in September 2018. In addition it was agreed in January that the Trust Chief Executive would become a member of the Committee.

3.2 This review changed the remit of the Committee to include monthly monitoring of the Trust financial position and oversight of workforce plan. The frequency of the Committee was changed to monthly and given its wider role the Director of Workforce was included within the Committee membership and the Committee was renamed Resources Committee. The key responsibilities of the Resources Committee can be categorised as follows:

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

Scrutiny & Efficiency	To support the board by scrutinising the Trust's monthly financial position including operational activity levels (excluding performance against operational standards) and the workforce plan. To scrutinise and ensure appropriate due diligence is undertaken in relation to any significant transactions as defined by NHS Improvement. Scrutiny of the annual Cost improvement Programme and review the impact on the Trust and to scrutinise the Trust budget prior to approval by the Board. To scrutinise and endorse assumptions in significant business cases prior to consideration by the Trust Board
Financial Performance	To review the activity plans in line with the financial planning assumptions, including reviewing the financial performance before submission to NHS Improvement and assessing the impact of financial performance on the Use of Resources Risk Rating Overseeing how initiatives highlighted by use of the Model Hospital benchmarking are being implemented within the Trust. . To undertake any relevant matter as requested by the Board of Directors

4. Work Performed

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

- Budget Strategy
- Performance Against Current Annual Financial Plan
- Benchmarking Model Hospital
- Commissioned Contract Issues
- Business Development
- Significant Projects

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

4.2 Budget Strategy

4.2.1 In November 2018 the Committee received a report from the Director of Finance on the business planning timeline and process. At the 7 January meeting the Committee received a report on the planning process including activity assumptions, outstanding risks, draft workforce plan, Cost Improvement Programme and timetable.

4.2.2 Further reports on 28 January, February and March updated the Committee on progress made in developing the operational plan, forecasting activity, contractual options, capital programme priorities and discussions/negotiations with HaRD CCG and the Integrated Care System on the arrangements for 2019/20. The Committee scrutinised the processes from which capacity plans and income levels are derived as well as the workforce assumptions and cost information and sought assurance as to the robustness of the proposed budget and plan.

4.3 Performance Against Current Annual Financial Plan

4.3.1 At the April and June 2018 meetings, the Committee looked at the latest financial position of the Trust against the financial plan so that this can give the context to forward looking role of the Committee.

4.3.2 With effect from the 3 September 2018 meeting, the Committee took on its new role and received financial, activity and workforce information to enable the Committee to carry out the detailed scrutiny function. Each month the Committee receives details of the financial position compared to internal and external plans, the key drivers for variations, the income and activity position and the workforce position in terms of both expenditure and numbers employed. A breakdown of financial information by directorate is received to enable the Committee to see issues specific to individual areas.

4.3.3 Each month the Committee sees an update on the Trust's cash position and progress towards achieving the Better Payment Practice Code relating to payment of creditors. Progress towards achieving the Cost Improvement Programme is presented and a capital programme update is received 3 times each year.

4.3.4 The financial information includes a forecast for the year based on the best, medium and worse case positions together with a year to date and forecast of the Use of Resources metric that we are required to report monthly to NHS Improvement.

4.3.5 The Committee received a report in June 2018 giving a progress report and financial update on the implementation of the Aligned Incentive Contract put in place between the Trust and HaRD CCG for the 2018/19 financial year.

4.4 Benchmarking Initiatives

4.4.1 The Committee oversees the implementation within the Trust of benchmarking initiatives arising from The Model Hospital. These are aimed at improving financial performance and efficiency by enabling providers to compare their costs and efficiency with other providers.

4.4.2 The Committee received reports in April and September 2018 and March 2019 which included presentations of the Model Hospital dashboard showing the information available and updating the Committee on how initiatives are being considered within the Trust, including engagement with clinicians. The report in September 2018 also included information on the 2017/18 benchmarking exercise for corporate services across the West Yorkshire Association of Acute Trusts.

4.5 Board Assurance Framework

4.5.1 Under the original terms of reference for the Finance Committee, the Committee considered financial risks as set out in the Board Assurance Framework. In April 2018 the Committee received a report from the Director of Finance providing and update on three financial risks within the Board Assurance Framework:

- Misalignment of commissioner/partner plans
- Failure to deliver the operational plan
- External funding constraints

The risks were reviewed with a view to ensuring that there were no other actions that could be taken to mitigate risk.

4.5.2 Following the review of terms of reference this role is now undertaken by the Board.

4.6 Business Development and Significant Projects

4.6.1 The Committee received reports throughout the year relating to new business developments and progress in implementing projects. The role of the Committee is to scrutinise assumptions and projections on behalf of and in advance of consideration by the Board.

4.6.2 During the year, the Committee received a number of reports:

- In April 2018 an update on progress in developing Harrogate Harlow Private Healthcare was received with a second update in October 2018.
- In September 2018 an update was received on the implementation of Carbon Energy Fund project.
- In October 2018, the Committee considered a business case for the replacement of the Trust's Virtual Server, an update on the operation of the new Endoscopy Unit and a business case for the development of a Health Referral Service for patients living with cancer.
- In January 2019 the Committee received an update report on the position with the Briary Wing within the hospital site and an update on the implementation of the WebV Electronic Patient Record system including plans for further development.

5. Conclusion

5.1 The Resources Committee can demonstrate that it has conducted itself in accordance with its Terms of Reference and work plan during 2018/19 and has considered items specifically at the request of the Trust Board.

Appendix 1: Attendance monitoring

	12 April	14 June	3 Sept	24 Sept	29 October	26 November	7 January	28 January	25 February	25 March
	2018	2018	2018	2018	2018	2018	2019	2019	2019	2019
Resources Committee Members										
Mrs M Taylor, Non-Executive Director and Chair	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mr I Ward, Non-Executive Director	N	Y	Y	N						
Mrs L Webster, Non-Executive Director	N	Y	Y	N	Y	Y	Y	Y	Y	N
Mr J. Coulter, Deputy Chief Executive and Director of Finance	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mr R. Harrison, Chief Operating Officer	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mrs Angela Schofield, Chairman of HDFT					Y	Y	Y	Y	Y	Y
Mrs Angela Wilkinson, Director of Workforce and Organisational Development						Y	Y	Y	Y	Y
Mrs R. Tolcher, Chief Executive									N	Y
Mrs Joanne Harrison, Interim Director of Workforce and Organisation Development				N	Y					
Mr J. McKie, Deputy Director of Finance	Y	N								
Mr P. Nicholas, Deputy Director of Performance and Informatics	N	Y								
In Attendance										
Mr J. McKie, Deputy Director of Finance	Y	N	Y	Y	Y	Y	Y	Y	N	Y
Mr P. Nicholas, Deputy Director of Performance and Informatics	N	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mrs K Roberts, Company Secretary	Y	Y								
Mr Andrew Forsyth, Interim Company Secretary				Y	Y	Y	Y	Y	Y	Y
Mrs Elizabeth Barron, Elective and Private Patient Development Manager	Y				Y					

Mrs Angela Schofield, Chairman of HDFT			Y	Y						
Mrs Joanne Harrison, Interim Director of Workforce and Organisation Development							Y	Y		Y
Mr Jonny Hammond, PSC Operational Director					Y					
Ms Vikki Wester, PSC Service Manager					Y					
Dr Matt Shepherd, Consultant in Emergency Medicine								Y		
Richard Atkinson, Head of IMT Projects								Y		
Observers										
Mr C Thompson, Non-Executive Director	Y	Y	Y	Y	Y	N	Y	N	Y	
Mr John Lester, NHSI		Y								
Mr Richard Stiff, Non-Executive Director				Y						
Mrs Sheila Fisher, Public Governor	Y							Y		
Mr John Mann, Stakeholder Governor		Y								
Mrs Cath Clelland, Public Governor			Y							
Mr Stephen Treece, Public Governor					Y					
Mr Tony Doveston, Governor							Y			
Mr Bob Cowans, Governor								Y		
Mr S. Russell, Chief Executive Designate										Y
Quorum: 2 Non-Executive Directors and 1 Executive Director	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes

NHS
Harrogate and District
NHS Foundation Trust

Annual Report of the Quality Committee

Prepared for the Audit Committee April 2019

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

Purpose of the Committee

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

Background

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

Membership and attendance

Attendance at meetings has been very good (quorate being six core members). When unable to attend core members have arranged for deputies to attend on their behalf.
Lesley Webster stood down as the chair of the committee when she became Senior Independent Director. Lesley has been responsible for the committee since it started and has been an exceptional chair, establishing a robust and effective committee to provide the Board with significant assurance regarding quality governance.
Two new non-executive directors joined the committee in November - Sarah Armstrong and Richard Stiff; taking over from Lesley Webster and Neil McLean. The Director of Quality and Governance/Executive Nurse of the HARD CCG also joined the committee in order to improve the integration and the quality assurance process across the organisations.
Laura Robson took over as the Non-Executive Chair of the committee from November.

Quality Committee - Record of Attendance

Member (by title or group representing as per ToR) / Date of Meeting	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Total Attended	No of Meetings per Year	Percentage
Non-Executive Director (Chair)	1	1	1	1	0	1	1	1	1	0	1	1	10	10	100%
Non-Executive Director / Chairman	1	1	0	0	0	0	2	1	1	0	1	1	8	10	80%
Non-Executive Director	1	1	1	1	0	1	1	1	1	0	1	0	9	10	90%
Chief Nurse	1	1	1	1	0	1	1	1	1	0	1	1	10	10	100%
Deputy Medical Director/Medical Director	1	1	0	0	0	1	1	1	1	0	1	1	8	10	80%
Chief Operating Officer	0	1	1	0	0	1	1	1	1	0	1	1	8	10	80%
Deputy Director - Improvement & Transform	1	1	1	1	0	1	1	1	1	0	1	0	9	10	90%
Deputy Director of Governance	1	1	0	1	0	1	1	1	1	0	1	1	9	10	90%
Head of Risk Management	0	1	1	1	0	1	1	1	1	0	0	1	8	10	80%
Clinical Director - LTUC	1	1	1	1	0	1	1	0	1	0	1	1	9	10	90%
Clinical Director - P&SC	1	1	1	1	0	1	1	1	1	0	1	1	10	10	100%
Clinical Director - C&CWCC	1	1	1	1	0	1	1	1	1	0	1	1	10	10	100%
Head of Midwifery								0	1	0	0	1	2	5	40%
Dir of Quality & Gov/Exec Nurse, H&RDCCG**											1	1	2	2	100%
Total of members per meeting	10	12	9	9	0	11	13	11	13	0	12	12			
Heads of Nursing: LTUC & PSC *	*2*	*2*	*1*	*2*	*0*	*1*	*0*	*0*	*2*	*0*	*1*	*1*			
*Ad hoc attendance may be by invitation of the Chair. The representative of the subgroups may also be a directorate representative.															
Katherine Roberts (observing)	0	0	1	1											
Mrs C Clelland, Public Governor (observing)	1														
Mrs R Wixey, Patient Safety Manager	1		1	1		1			1			1			
Dr S Rahman, Consultant, Paediatrics															
Mrs R Marsh, Public Governor (observing)		1							1		1				
Ms A Paley, Nye Bevan Pro (observing RH)		1													
Ms P Allen, Public Governor (observing)			1												
Mrs J Farnhill (Adult Safeguarding A/Rep)			1												
Dr P Hammond, Consultant, Endocrinolgy				1											
Mr S Treece, Public Governor (observing)				1											
Mr R Cowans, Public Governor (observing)						1									
Ms A Smith, General Manager (observing)						1									
Dr D Scott, Staff Governor (observing)								1							
Ms F Hartley, Specialist CS, Physio (obser)									1						
Ms J Rennison, Mngr Maxillo & Orthod Dept									1						
Ms S Eddleston, Public Governor												1			
Ms R Wilde, Physiotherapist												1			

9.3

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

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

ToR were reviewed in November 2018. The ToR were reviewed in light of a workshop to review the structure and function of the Committee. The committee altered slightly as a result of the workshop and the ToR will be further reviewed to ensure the new structure is working well and delivering the required assurance to the Board of Directors.

Progress on stated committee objectives or key areas of responsibility

The committee has continued its work to gain assurance in relation to the CQC quality domains ensuring compliance with fundamental standards of care in acute and community services.

The work-plan focuses on the following seven key headings:
1. To identify current concerns
2. Quality improvement strategy
3. Quality reports
4. Patient safety
5. Effective care and outcomes
6. Patient experience
7. Regulatory and compliance

Identify Current Concerns – There are three areas considered under this section:

1. 'Hot Spots' - The QC can hear from members about current issues that are impacting upon the ability of the Trust to deliver quality care and to gain assurances that suitable actions / activity is underway to address these. Examples of this are:

a) Impact on quality care as a result of the financial recovery plan, added as a standing item under this section during the year;
b) Impact of the recruitment situation on quality of care;
c) Impact of equipment failure on quality of care.

This section also includes items that the Board of Directors require the QC to scrutinise on its behalf. An example of this being the decision of the Trust not to implement the ReSPECT documentation and ensure that alternative process gives the best quality of care to patients at the end of life.

2. A new section was introduced after the workshop relating to the Quality Improvement Strategy. This reviews the current progress and celebrates the success of some of the projects undertaken by the Trust Quality Champions. The Committee has received three presentations from champions. These have demonstrated real improvement in patient focused care and shown how small improvements can make a big difference to patient experience and staff satisfaction.

3. The QC reviews the Quality Dashboard and Integrated Board Reports (quality section) in depth each month and pursues areas of concern and seeks further assurance where necessary. QC initiated a review of this report, the data it contains, who uses the data and how this could be improved to add value at Ward and Directorate level. As a result of this a new Dashboard was introduced during Quarter One of FY18/19. The dashboard provides a good insight into quality issues and concern but there are still improvements to make to its content. Providing consistent data between reports and the dashboard has been highlighted as a concern and is being reviewed by the responsible teams. Where there are concerns individuals are requested to attend the committee to provide valuable insight and

explanation.

Quality Reports – Throughout the year the committee has heard regular updates from the leads on their progress to deliver the Trusts 2018/19 quality priorities which were:

a) Reduce morbidity and mortality related to sepsis
b) Ensuring effective learning from incidents , complaints and good practice
c) Improving the clinical models of care for acute services
d) Promoting safer births, with a specific focus on reducing still births.

Directorate Quality Governance reports These are presented to the committee on a rolling monthly basis and provide assurance that the quality priorities are embedded from the Board to the front line across the Trust

Annual Quality Account Report – The QC retains oversight of this annual account.

Patient Experience Report – The Patient Experience Report is received quarterly – this comprehensive report provides details of a wide range of areas relating to patient experience. The committee has approved the Patient Experience Strategy and is awaiting the monitoring and action plan for its implementation. Dealing with complaints in a timely manner remains a focus of the committee.

Patient Safety Report The committee receives a quarterly report on untoward events and issues of patient safety. The report looks for concerns or trends that may require further scrutiny. Serious Untoward incidents are reported directly to the Board of Directors. The review of the Datix system has been a focus of the year. The objective to improve incident reporting and make the system more user friendly and intuitive. The amendments have now been completed and the impact is still to be demonstrated.

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

External Reports Received – The system for recording receipt of external reports and a log for the lead individual responsible to action these remains robust. Where we consider that a plan requires support or focus we invite the lead to provide an update on progress on action plans to provide the level of assurance required.

Regulatory and Compliance - A list of reports received is shown overleaf.

Summary of Reports received by the Committee

Report received 2018-19	Item Lead	Reports received
Quality Account		
Timetable for quality account preparation	S Wood	December
Draft report	S Wood	April
Final report	S Wood	May
Quality priority updates		
Ensuring effective learning from incidents, complaints and good practice	A Leng	Baseline, Q2, Q3
Reducing the morbidity and mortality related to sepsis	D Earl	Baseline, Q2, Q3
Improving the clinical model of care for acute services	M Forster/ J Hammond	Baseline, Q2, Q3
Increasing patients and the public participation in the development of services	R Chillery/ K Roberts	Baseline, Q2, Q3
Promoting safer births, with a specific focus on reducing stillbirths	K Johnson/ A Pedlingham	Baseline, Q2, Q3
Annual reports and reviews		
Local Supervising Authority audit report / action plan	A Pedlingham	October
Annual Maternity screening report	A Pedlingham	September
Health and safety annual report	R Mitchell	May
Annual report from directorate governance groups	Clinical Directors	May
Annual report Quality Committee	L Webster	May
Annual review Quality Committee TOR	L Webster	November
Safeguarding children annual report	L Fox	July (draft report May)
Adult safeguarding annual report	J Farnhill	June
Annual report on pressure ulcers	J Foster	June
Annual report on falls	J Foster	June
Annual report on the management of Controlled Drugs	A Alldred	April
Patient FFT	S Wood	May
North Yorkshire Safeguarding Adults Annual Board Report	J Foster	January
Tees Esk & Wear Valley NHSFT Annual Report	J Foster	September
Progress update on external report action plans	Directorates	February, July
Maternity assurance statement	K Johnson	February
Quality Charter update/annual report	D Plews	April
Quarterly reports		
Patient experience report - quarterly	A Leng	Sept (Q1), Dec (Q2), March (Q3), June (Q4)
Clinical audit plan / report - quarterly	R Wixey	Sept (Q1), Dec (Q2), March (Q3), June (Q4)
NICE compliance report	R Wixey	Sept (Q1), Dec (Q2), March (Q3), June (Q4)
Patient safety quarterly report	S Wood	Sept (Q1), Dec (Q2), March (Q3), June (Q4)
Corporate risk register and risks to quality	S Wood	July (Q1), Oct (Q2), Jan (Q3), April (Q4)
National Maternity & Perinatal Audit	K Johnson	February , July
Safety Visits	S Wood	Monthly
Quality Improvement Projects	D Plews	Monthly

Quality Committee Effectiveness Survey

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

A survey has not been completed for the current year; this will be undertaken within the next month. The October workshop however undertook an exercise to review the committee's effectiveness and consider what the best quality committee would look like. The workshop was attended by all members and demonstrated that the committee was working effectively but some areas could change to improve the committee's contact and ability to gain assurance from front line staff.

Proposed objectives for 2019/20
The committee will continue to gain assurance under the headings listed above. The committee will hear updates from the Directorates on progress to deliver the Quality Priorities for the year. These are not yet agreed although there are a number which are yet to complete and will be carried forward. These will be agreed when the Quality Account is finalised. The committee will increase its focus on quality improvement work. The committee will respond to Board of Directors' requests for detailed scrutiny as required.
Conclusion
The Quality Committee considers it has delivered to the Terms of Reference as requested by the Board and has comprehensive minutes and actions log on file to further demonstrate this. The committee has continued to deliver the forward plan. The membership of the committee has been engaged and attendance has been excellent. The Executive lead and Clinical Directors demonstrate significant engagement in the committee's objectives to provide assurance regarding the quality of care provided across the organisation.
Author
Laura Robson, Non-Executive Director, Chair Quality Committee. *Date: 26/04/2019*

Harrogate and District NHS
NHS Foundation Trust

ANNUAL REPORT OF THE HDFT AUDIT COMMITTEE 2018/19

1. Introduction

In accordance with best practice and the NHS Audit Committee Handbook, this report has been prepared to provide the Board of Directors with a summary of the work of the Audit Committee during the period April 2018 – March 2019, and in particular how it has discharged its responsibilities as set out in its Terms of Reference.

2. Meetings & Attendance

The Audit Committee met formally on six occasions during 2018/19. Audit Committee members attendance is set out in the table below. In addition, all Audit Committee members attended an informal meeting in late April 2018 to undertake a detailed review of the draft accounts (relating to the 2017/18 financial year). Members of the Committee also attended relevant Audit Committee training events during the course of the year.

Audit Committee Members' Attendance

	3 May	17 May	6 Sept	5 Dec	28 Jan	6 Mar
Mr Chris Thompson	Y	Y	Y	Y	N	Y
Ms Laura Robson	Y	N	Y			
Mr Ian Ward	Y	Y	Y			
Mrs Maureen Taylor	Y	Y	Y	Y	Y	Y
Mrs Lesley Webster				N	Y	Y
Mr Richard Stiff				Y	Y	N

The Audit Committee had a membership of four Non-Executive Directors and during the 2018/19 financial year this comprised of:

- Mr Chris Thompson (Chairman)
- Mr Ian Ward
- Ms Laura Robson
- Mrs Maureen Taylor
- Mrs Lesley Webster
- Mr Richard Stiff

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

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

- External Audit (Director and Senior Manager)

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

The attendance details of all attendees at Audit Committee Meetings during 2018/19 are set out in the attached appendix.

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

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

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

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

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

3. <u>Duties of the Audit Committee</u>

Following a review of the Audit Committee's terms of reference in January 2019, the key duties of the Audit Committee could be categorised as follows:

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

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

4. <u>Work Performed</u>

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

4.1 <u>Financial Management</u>

The Committee regularly receives updates and reports from the Finance Director on the Trust’s financial position and any issues arising. Items discussed in particular during 2018/19 were in relation to the Trust’s interaction with its wholly owned subsidiary company Harrogate Healthcare Facilities Management Limited (HHFM).

The Committee oversees and monitors the production of the Trust’s financial statements. During the 2018/19 financial year, this included:

- an informal but detailed review of the draft accounts prior to submission to Monitor and External Audit on 23 April 2018,
- a formal Committee meeting to discuss the draft accounts and External Audit’s findings on 3 May 2018,
- a formal Committee meeting on 17 May 2018 to review the final accounts and Annual Report for 2017/18 (including the Quality Account) prior to submission to the Board of Directors and Monitor.

[Note: similar meetings have occurred during April and May 2019 relating to the 2018/19 financial statements, Annual Report and Quality Account].

In March 2019 the Committee formally reviewed and approved the Trust’s accounting policies (to be used in relation to the 2018/19 financial statements), considering consistency over time and compliance with the Foundation Trust Financial Reporting Manual. At the same meeting, the Audit Committee also considered the plan and timetable for the production of the Trust’s 2018/19 financial statements and annual report.

The Committee also oversees and monitors the production of the Charitable Trust's financial statements. The final Charitable Funds Accounts and Annual Report for 2017/18 were reviewed by the Committee on 17 May 2018 prior to submission to the Corporate Trustee.

The Audit Committee also reviewed and approved:

- Single Tender Actions,
- the Trust's Losses & Special Payments register in May 2018,
- the Annual Procurement Savings Report in September 2018,
- revisions to the Trust's Treasury Management Policy in September 2018, and
- the recommendation to the Trust Board of the use of the going concern principle as the basis for the preparation of the 2017/18 accounts in May 2018.

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

4.2 Governance, Risk Management & Internal Control

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

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

Additionally the Staff Registers of Interests and Gifts and Hospitality were reported to the Audit Committee in 17 May 2018.

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

In relation to the governance of the Audit Committee itself, the Committee undertook the following tasks during 2018/19:

- Assessment of Audit Committee Effectiveness in December 2018, the findings of which were presented to the Board of Directors.
- Review and approval of Audit Committee Terms of Reference in January 2019 which were presented to the Board of Directors for approval.
- Ongoing review and revision of the Audit Committee's timetable.

4.3 Clinical Assurance

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

4.4 Internal Audit & Counter Fraud Service

Internal Audit and Counter Fraud Services are provided by Audit Yorkshire. The Chair of the Audit Committee sits on the Audit Yorkshire Board which oversees Audit Yorkshire at a strategic level. The Board met on four occasions during 2018/19.

An Internal Audit Charter formally defines the purpose, authority and responsibility of internal audit activity. This document was updated, reviewed and approved by the Audit Committee in September 2018.

The Audit Committee approved the planning methodology to be used by Internal Audit to create the Internal Audit Plan for 2018/19, and gave formal approval of the Internal Audit Operational Plan in March 2018.

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

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

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

The effectiveness of Internal Audit was reviewed by HDFT staff and the Audit Committee in January 2019, resulting in a satisfactory evaluation. The action plan arising from the review is monitored via the Internal Audit Periodic Report to the Audit Committee.

4.5 External Audit

External Audit services are provided by KPMG.

During the 2018/19 financial year the Audit Committee reviewed External Audit's Annual Governance Report and Management Letter in relation to the 2017/18 financial statements. Work was undertaken during 2018/19 to provide guidance on the accounting treatment to be adopted in respect of certain financial arrangements in place at the 31 March 2019.

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

The Audit Committee reviewed and approved the External Audit Plan in relation to the 2018/19 financial statements and the related audit fee in January 2019.

The effectiveness of External Audit was reviewed by HDFT staff and the Audit Committee in 3 May 2018, resulting in a satisfactory evaluation which was reported to the Council Governors.

5. Specific Significant Issues discussed by the Audit Committee during 2018/19

The following additional significant issues have been discussed by the Audit Committee during 2018/19:

- The issues regarding evening security
- The timeliness of Post Project Evaluations (PPE's)
- The timeliness of response by management to internal audit draft reports and the implementation of outstanding internal audit recommendations

6. Conclusion

The Audit Committee considers that it has conducted itself in accordance with its Terms of Reference and work plan during 2018/19.

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

This draft Audit Committee Annual Report is subject to approval at 8 May 2019 Audit Committee.

Appendix – Attendance Details of Attendees at the Audit Committee

	3 May	17 May	6 Sept	6 Dec	28 Jan	6 Mar
HDFT						
Mr Jonathan Coulter	Y	Y	N	Y	Y	N
Mr Thomas Morrison	N	Y	Y	N	N	Y
Mr Jordan McKie	Y	Y	Y	Y	Y	Y
Dr Sylvia Wood	Y	N	Y	Y	N	Y
Mrs K Roberts	Y	Y				
Mr A Forsyth			Y	N	N	Y
Mr David Barker	N		Y			
Internal Audit & Counter Fraud						
Ms Helen Kemp-Taylor	Y	N	Y	Y	Y	Y
Mr Tom Watson	Y	Y	Y	Y	Y	Y
Mr Steve Moss	Y			N		Y
External Audit						
Mr Rashpal Khangura	Y	Y	Y	Y	Y	N
Mr Matthew Ackroyd				Y	Y	Y